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## What does ACFA's 2016 Annual Report tell us?

Minister Ley has released the [fourth annual report](#) of the Aged Care Financing Authority (ACFA), the body established to provide independent analysis of the impact of funding and financing arrangements on the viability and sustainability of the aged care sector.

ACFA's financial analysis is in large part, and unavoidably, a retrospective as it has to rely on 2014-15 financial data ie. 2014-15 General Purpose Financial Reports (GPFRs) and 2014-15 home care financial reports submitted to the Department of Health by residential and home care providers. As was the case for ACFA's previous annual reports, the analysis of the residential sector is more comprehensive than that of either home care packages or home support because much more data is available for the residential sector.

The report contains limited new analysis of the aged care workforce. The Aged Care Sector Workforce Census and Survey that is currently underway, if completed in time, may be available to inform next year's ACFA Report.

Overall, ACFA concludes that the financial performance of the sector and investor sentiment continued to improve during 2014-15, including as a result of the reforms.

The Report notes that ACFA will monitor the impact on financial performance and investor sentiment of the recent changes to the Aged Care Funding Instrument (ACFI). However, the GPFRs for 2016-17 and beyond, the period that will be affected by the changes to ACFI, will not be available for several years.

The rest of this Update addresses matters arising from the Report.

### Financial performance

#### *Residential care*

Average earnings before interest, tax, depreciation and amortisation (EBITDA) per resident increased from \$9,224 in 2013-14 to \$10,222 in 2014-15, an increase of 10.8%. Average net profit before tax (NPBT) per resident over the same period increased from \$4,150 to \$5,220, or 25.8%. These results build on the positive results reported for 2013-14, which together mean that average EBITDA and NPBT per resident over the two year period increased by 17.3% and 44.6% respectively.

Some 68% of providers reported a profit in 2014-15, compared with 66% in 2013-14.

As expected, the large variation in financial performance across providers that has been the case since comprehensive analysis of performance was commenced is still a feature, and no doubt will continue for the foreseeable future. Management is a factor, including the ability to maximise ACFI revenue, but so is facility size

(not so much portfolio size) and remoteness.

Average EBITDA for the top quartile of providers was \$23,687 in 2014-15, compared with -\$5,814 for the bottom quartile and a sector average of \$10,222. What was not anticipated, however, was the improvement in the 2014-15 results for the bottom and second bottom quartile of providers. The bottom and second bottom quartile providers on average improved their EBITDA per resident in 2014-15 by 34.4% and 12.5% respectively. Many of the providers in the bottom quartiles operate services in rural and remote areas which benefitted from a 20% increase in the viability supplement from 1 July 2014 as a result of the redirection of the former Workforce Supplement. Nevertheless, the bottom quartile result remained in the red.

ACFA last year reported on the variations in performance across the sector, and this year reported on factors affecting the financial performance of rural and remote providers. Catholic Health Australia's assessment of these reports, which also include links to the reports themselves, may be [accessed here](#).

Following ACFA's report on rural and remote services, these services received a further increase in the viability supplement in the 2016-17 Budget (on top of the 20% increase through the Workforce Supplement redirection), the effect of which should show up in future financial results.

The for-profit sector continues to out-perform other groups in financial terms, with EBITDA and NPBT margins in 2014-15 of 13.3% and 9% respectively compared with 10.9% and 4.6% for the not-for-profits. Government providers reported the poorest returns, with EBITDA and NPBT of 0.3% and -7.1% respectively.

A major contributor to the improvement in average financial performance in 2014-15 was an average real increase in ACFI care revenue of 7.6% per resident per day claimed by providers, which increased care revenues by \$724 million (excluding growth of \$103 million due to an increase in the number of residents). Real growth included the 2.4% real increase in ACFI prices from 1 July 2014 as a result of the redirection of the Workforce Supplement, with the balance largely due to increased claiming under the Complex Health Care domain of ACFI. The increase was offset by the half year effect of the cessation of the Payroll Tax Supplement from 1 January 2015 (affecting mainly for-profit providers).

The latest available data from the Department of Health for 2015-16 indicates a continuation of high real growth rates in ACFI revenue (a real increase of 5.1% per resident per day), which would suggest positive results for 2015-16 as well. Survey data for 2015-16 by Stewart Brown seems to bear this out.

### ***The changes to ACFI***

However, as all readers would be aware, the Government is taking action to stem ACFI growth rates by phasing in changes to the ACFI funding arrangements from 1 July 2016. As a result of these changes, the Government is budgeting for a real average increase of only 1.2% per annum over the next four years, on top of indexation linked primarily to minimum wage adjustments.

This will put pressure on financial performance in the years ahead, including the capacity to compete in the labour market where wage rates paid in the public health sector set the pace, even in a low wage increase environment. When considered together with the volatility in care payments experienced in recent years, the latest ACFI changes may also flow through to investor confidence in service expansion. Financial pressures may also constrain the capacity to sustain improvements in quality and wellness that many providers have been pursuing to match the increasing number of residents with complex health care and pain management needs. The impact of the changes will also depend on the nature of the ACFI changes themselves ie. the extent to which they involve an indexation pause or target the Complex Health Care domain.

While contributions to the bottom line and investment trends are transparent, improvements in quality and wellness (other than increased inputs) are not easy to measure and substantiate on a systemic basis. As a consequence, in controlling prices, the Government does not take into account in any meaningful way the

implications for the quality of care beyond resident safety. Nor does it factor in what may be a reasonable risk-rated return to sustain the sector, including for the for-profit sector which has the option of investing in other sectors. The latter consideration is particularly relevant for the listed providers whose net worth is a day to day proposition. Instead, the Government relies on proxy indicators such as the level of applications for places under the ACAR, the level of investment in new services and refurbishments, the financial performance of the top quartile of providers and past funding levels.

### ***Additional services in residential care***

The response by some providers to the ACFI changes is to identify other sources of revenue, especially fees for additional services. Indeed, some providers had already looked to additional services even before the ACFI changes following the encouragement given in the *Living Longer Living Better* package for providers to consider fees for additional services on an opt in/opt out basis (provision for which existed in the *Aged Care Act* before the *Living Longer Living Better* package). Arguably, room refurbishment fees and club fees as a condition of entry in a supply constrained environment do not fit this criterion, and were belatedly jumped on by the Department of Health.

The constraints on additional services do not apply in home care where providers are not being paid or expected to provide 24 hour care and support based care and services specified in legislation. Therefore consumers and providers are free to negotiate privately funded services in addition to those purchased through each consumer's individual budget. The Roadmap envisages greater flexibility for residential providers to set care prices, as they do for accommodation prices, but not until consumers have real control and choice (such as funding following the consumer), are better informed to exercise control and choice, and there is greater competition in the provision of aged care services.

### ***Home care***

Average EBITDA per package in 2014-15 was \$2,235 compared with \$1,973 in 2013-14, an increase of 13%, but with similar variability in financial performance that occurs in residential care. The top quartile of home care providers averaged an EBITDA per package of \$4,357 compared with -\$726 for the bottom quartile.

Some 72% of home care providers reported a profit in 2014-15 compared with 66% in 2013-14.

In contrast to 2013-14, when the for-profit sector reported significantly higher EBITDA than not-for-profit providers, the performance of the two sectors converged in 2014-15. For-profit home care providers achieved an average EBITDA per package of \$2,384 (a 7% reduction), compared with \$2,341 per package for not-for-profit providers (an 11.7% improvement). This is a remarkable change in such a short time. It will be interesting to see whether this is sustained in the years ahead, especially after the introduction of package funding following the consumer from February 2017.

Government providers continued to have the lowest results, with an average EBITDA of \$1,052.

### **Accommodation payments**

ACFA's report includes information on accommodation payments since the new arrangements were introduced on 1 July 2014.

In the period July 2014 to December 2015, it is estimated that lump sum deposits held or receivable by providers increased by \$5.2 billion to \$22 billion. Meanwhile, the ACFA review of the Bond Guarantee Scheme (which is due to report by 30 April 2017) is progressing as the Government's contingent liability continues to increase.

The method of payment has remained largely unchanged, with about 40% paying Refundable Accommodation Deposits (RADs), 35% paying Daily Accommodation Payments (DAPs), and 24% paying a RAD/DAP combination.

RADs continue to be used the most in for-profit services and in services located in metropolitan areas.

The average maximum RAD price published as at 31 May 2016 was \$377,000, compared with \$355,000 at July 2014, a 6% increase. Some 6% of published RAD prices were over the \$550,000 threshold for requiring approval by the Pricing Commissioner.

The average agreed price as at 31 May 2016 was \$342,000 (\$341,000 for not-for-profit; \$347,000 for for-profit; and \$326,000 for government services). Agreed prices decreased with remoteness, from an average of \$364,000 in metropolitan areas through to \$246,000 in rural and remote locations.

The average agreed price when presented as a DAP equivalent, about \$59 per day depending on the MPIR, was not significantly more than the accommodation supplement paid by the Commonwealth on behalf of supported residents living in new and significantly refurbished homes (\$53 per day), but significantly more than the accommodation supplement payable in all other homes (\$32 per day). As at 30 June 2015, 15% of facilities were eligible for the higher accommodation supplement (352 refurbished homes and 96 newly built homes).

## Sustainability

### *Investment*

As mentioned earlier, the level of investment in new and refurbished homes is an indicator of the financial health and sustainability of residential aged care.

The level of investment continued to increase in 2014-15, influenced by the introduction of market-based accommodation prices for non-supported residents, the higher maximum accommodation supplement for supported residents living in new and significantly refurbished aged care homes, and improving average profitability.

The 2015 Survey of Aged Care Homes estimated that \$1.7 billion of new building, refurbishment and upgrading work was completed during 2014-15, compared with \$1.56 billion in 2013-14, involving about 20% of all homes. The amount of new building in progress at the end of June 2015 was estimated at \$2.1 billion involving 17% of all homes. The value of building approvals in the 12 months to February 2016 averaged \$168 million per month, compared with \$129 million in the previous 12 months.

If the Government's current provision target of 78 residential places per 1,000 people aged 70 and over by 2021-22 is to be achieved, it is estimated that an additional 76,000 beds will be needed over the next decade to 2026. Taken together with the need to also rebuild existing stock, it is estimated that an additional capital investment of \$33 billion will be required over the next decade. This compares with the total asset value of the sector as at 30 June 2015 of \$36.6 billion.

However, there remains a question mark over the current target set for residential places should consumers be given greater control and choice over where to live while they receive care and support. Consumer choices will be influenced by perceptions of the value propositions offered by the different types of care, the means testing arrangements applying for each type of care, and advances in technology and innovation in service delivery.

Meanwhile, investment by the for-profit providers has been increasing. This is reflected in the proportion of operational places held by for-profit providers which has increased from 33% in 2007 to 38% in 2015. Even putting aside acquisitions, this proportion is set to increase further because 70% of places allocated in the last two ACARs went to for-profit providers.

The expansion of the for-profit sector stems from their willingness to leverage debt to finance new services, reflected in net worth/equity at 30 June 2015 of 16% compared with 38% for the not-for-profits. If this remains the case, it may well mean that the for-profit sector will be better placed to play a bigger role in meeting the increase

in supply of residential care that has been estimated.

It remains to be seen how sentiment following the recent ACFI changes impacts investment in the medium term, noting however that the sector now has the flexibility of market-based accommodation prices for all non-supported residents.

### **Consumer contributions**

The level of consumer contributions is another measure of affordability of aged care for the taxpayer and, in turn, also a measure of sustainability.

In 2014-15, the Commonwealth contributed 66% of provider revenues in residential care (\$10.4 billion) and residents contributed 27% (\$4.2 billion, excluding lump sum deposits). This proportion is virtually unchanged since 2013-14, despite the introduction of a new combined income and assets test from 1 July 2014.

Within this overall figure, the Commonwealth contributed 96.2% of total provider revenue for personal and nursing care (\$9.6 billion) and consumers contributed 3.8%, an increase of 0.4% or \$59.4 million over 2013-14. Commonwealth accommodation payments to providers on behalf of supported residents increased by \$65.2 million to \$827.6 million. Non-supported residents contributed 45% (\$680.7 million) of provider accommodation revenue, excluding lump sum payments, again about the same as in 2013-14.

Increases in resident accommodation payments flow directly to providers whereas increases in resident care contributions paid to providers reduce government outlays (and have a neutral impact of provider care revenues). Overall, the new means testing arrangements have had a minimal impact on consumer contributions in residential care, and will increase only marginally as grandparented residents are replaced by residents assessed under the new arrangements.

In 2014-15, the Commonwealth contributed an estimated 90% of total home care provider revenues (\$1.4 billion). Largely as a result of the introduction of an income tested fee in home care from 1 July 2014, consumer contributions increased from 7% of total provider revenues in 2013-14 to 10% in 2014-15 (\$147 million). The income tested fee is in addition to the long standing basic daily fee which is levied at the discretion of each provider. Unlike the basic daily fee, the income tested fee reduces Commonwealth subsidies paid to providers on behalf of consumers.

### **Access to care**

Notwithstanding the provision target of 125 operational places per 1,000 per aged 70 and over by 2021-22 announced in the *Living Longer Living Better* package, the operational ratio has remained unchanged since 2012 ie 111.8 in 2012 compared with 111.5 in 2015. Within this overall figure, the home care ratio has increased from 27.4 to 30.4 over the same period (compared with a target of 45 by 2021-22), and the residential ratio has decreased from 84.4 to 81.1 (compared with a target of 80 by 2021-22, which includes 2 for short-term restorative care).

An additional 68,000 home care packages will need to be allocated by 2021-22 if the home care target is to be achieved, and an additional 49,000 operational residential places created. This compares with about 35,000 residential commissioned over the previous decade.

As at 30 June 2015, there were 28,344 provisionally allocated residential places that are still to be constructed and commissioned, about 12% of total allocated residential places. Departmental data indicates that this proportion is about average over recent years.

The proportion of supported residents was 47% in 2014-15 compared with 44% in both 2012-13 and 2013-14.

As at 30 June 2015, the proportion of Australians aged 85 and over accessing home support, home care packages

and residential care was 53%, 6% and 22% respectively. The equivalent figures for Australians aged 70 and over are 30%, 2% and 38%.

## Occupancy

### *Residential care*

Average occupancy has been relatively stable, hovering between 92% and 93% over the past five years, with not-for-profit providers continuing to have higher average occupancy (94%) than for-profit providers (91%). The ratio of operational residential places has declined from 87 to 81 over that period.

The proportion of residents aged 85 and over has increased from 55% in 2007 to 59% in 2015, and the proportion aged between 70 and 84 has declined over the same period from 37% to 34%. The ratio of operational home care packages increased from 21 per 1,000 people aged 70 and over to 30 during that period.

The average length of stay has also remained relatively stable over the past five years. The average length of stay of residents leaving in 2014-15 was 36 months (41 months for females and 27 months for males).

On the other hand, reflecting the increasing average age of residents and higher assessed care needs, approximately 50 per cent of males admitted into aged care facilities die within the first 15 months of entering into care, and 50 per cent of females die within 30 months of admission. Eighty per cent experience a length of stay between 24 months and 48 months. The length of stay is longer for people with dementia. For residents who enter care without dementia, 41 per cent die in their first year, compared with 27 per cent for people who enter with dementia.

### *Home care*

The utilisation of home care packages continues to drop, declining from 92% per cent of package days available in 2012-13 and 88.4% in 2013-14 to 85.5% in 2014-15, with utilisation rates decreasing with remoteness. Lower utilisation rates in rural and remote areas are also evident for residential services.

Utilisation rates vary significantly across States, from 73.8% in WA to 92.7% in Victoria. The WA figure is a stand-out, and may be a result of the large number of home care packages released in WA through the ACAR to compensate for the significantly under-subscribed residential places in that state prior to the recent changes to accommodation payment arrangements. It will be important to track utilisation rates in both residential and home care as the supply of home care packages is expanded.

Utilisation rates also vary with package level. It is difficult to draw conclusions about the variation in rates as it may reflect the divergence of availability of packages across the different package levels (ie a mismatch between availability and demand), the impact on value for money considerations stemming from the currently configured income testing arrangements and the generally less onerous fee arrangements applying in home support.

The proportion of packages allocated to for-profit providers increased marginally from 9.6% in 2013-14 to 10.1% in 2014-15, increasing from 5.4% in 2008-09. The proportion of home care services provided by for-profit providers is expected to increase further following the move to 'funding following the consumer' from February 2017.

## Industry consolidation

There has been further consolidation in the residential aged care sector, with the number of providers declining from 1,016 in 2013-14 to 972 in 2014-15. At the same time, the number of operational residential places increased in 2014-15 by 1.6% from 189,283 to 192,370, about average for the last five years.

There continues to be a large number of single home providers (64% of all residential providers), though they

account for only 23% of places.

There were 504 providers of home care in 2014-15, the same as in 2012-13 and 2013-14. The number of home care packages has increased by 22% over that period, from 59,534 in 2012-13 to 72,702 in 2014-15.

There is a high degree of specialisation in terms of service types offered (residential, home care and home support), with some 84% of providers providing only one of the service types. In large part, this probably reflects the siloed approach to the regulation of services by successive governments. The Roadmap vision of allowing consumers greater control and choice over where they purchase services using their government means tested care contribution will likely result in a reduction in this level of specialisation, as well as integration with disability services under the NDIS.

## Extra service

There continues to be a significant decrease in the number of extra service status places in residential care.

During 2014-15, 2,110 extra service places were relinquished, compared with 501 in 2013-14, leaving 15,280 active places. The extension of market-based accommodation prices and lump sum deposits to mainstream high care largely accounts for this reduction.

It will be interesting to see whether the recent clarification of the constraints applying to the charging of fees for additional services in non-extra service facilities stems this trend.

## Workforce

Analysis of residential provider GPFRs and Departmental administrative data shows that employee expenses in 2013-14 (wages, superannuation and management fees) increased by 7.3% to \$9.99 billion, an increase of \$684million over 2013-14. Employee expenses have increased by 12.3% since 2012-13.

ACFA estimates that 81% of the increase in employee expenses in 2014-15 (\$555 million) is attributable to a 6% increase in the amount paid per claim day on wages and management fees, reflecting mainly wage increases but also contributed to by increased hours worked per claim day, increased staffing levels and changes in the mix of staff.

Around 18% of the increase (\$122 million) is attributed to an increase in the number of days of care provided as resident numbers have increased, with the balance being as a result of the inter-action of price and volume changes.

## Conclusion

In summary, the ACFA report concludes that the financial and funding impacts of the reforms continued to be positive, with lump sum deposits continuing to grow, improved financial performance on average and increased investment in aged care, all of which build on improvements in 2013-14. Significant real increases in ACFI payments per resident also contributed to the improvement.

Looking forward, it remains to be seen what impact the changes to ACFI will have on a hitherto positive outlook.

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*Previous editions of Aged Care Update may be [found here](#).*

*Disclosure statement: The author of this Update, Nick Mersiades, is a member of the Aged Care Financing Authority. The opinions in this Update should not be read as being an expression of the views of the Aged Care Financing*

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