UTS Ageing Research Collaborative (UARC)

UTS

Australia's Aged Care Sector: Mid-Year Report 2023–24

For the 6 months ending 31 December 2023

UTS

Suggested citation

Sutton, N., Ma, N., Yang, J.S., Woods, M., Tsihlis, E., Brown, D., Debono, D., Ries, N. (2024) *Australia's Aged Care Sector: Mid-Year Report (2023–24)*. UTS Ageing Research Collaborative.

Acknowledgements

The authors would like to thank our Editorial Board, Professor Michael Woods (Chair), Professor David Brown (Deputy Chair), Grant Corderoy and Professor Deborah Parker for their guidance and contributions to this report. In addition, our thanks extend to David Sinclair and StewartBrown data collection and analyst team members who provided access to the data used to compile parts of this report and offered their expert knowledge and diligent assistance to the author team.

Disclaimer

Parts of this report are based on the results of StewartBrown's Aged Care Financial Performance Survey. Although the survey is extensive, it does not provide a complete set of results for all aged care providers operating in the sector.

The authors have used all due care and skill to ensure the material is accurate as of the date of this report. UTS and the authors do not accept responsibility for any loss that may arise by anyone relying on its contents.

© UTS 2024

This work is licensed under a Creative Commons Attribution-NonCommercial 4.0 International License

Australia's Aged Care Sector: Mid-Year Report 2023–24

Contents

Editorial Board Foreword 8

Executive Summary 10

Part 1: Analysis and commentary

Financial viability 16

Residential care funding 16
Widening disparities in residential care 24
Capital financing 30

Workforce issues 36

Direct care staffing 37
Fair Work Commission wage case 41
Workforce turnover 43

Star Ratings 46

Recent trends in Star Ratings 47
Financial outcomes of Star Ratings 52
Staffing ratings and direct care expenditure 54

Legislation update 56

New Aged Care Act 57
Legal planning for older adults 59

Sector sustainability 62

Budget 2024-25 63
Deferral of the response to the Aged Care Taskforce Report 64
Ongoing expansion of Home Care Packages 65

Part 2: Analysis of the StewartBrown sector dataset

Approved provider analysis **72**

Overview 72
Approved provider profiles 73
Financial performance 76
Liquidity and capital adequacy 80

Residential care analysis **82**

Overview 82
Residential aged care home profiles 83
Key performance indicator summary 85
Financial performance 85
Operating Result breakdown 89
Occupancy 97
Workforce 99

Home care analysis **104**

Overview 104
Home care provider profiles 105
Key performance indicator summary 106
Financial performance 107
Revenue analysis 110
Cost analysis 113
Workforce 115

Editorial board **118**

Research team **119**

Appendix: Methodology **120**

Tables and Figures

Part 1: Analysis and commentary

Financial viability

Figure 1: Government spending on aged care, total and per capita 17
Figure 2: Financial results of residential aged care homes, by service area 18
Figure 3: Average revenue and expenditure per resident per day 19
Table 1: Average revenue for residential aged care homes, per resident per day, by source 20
Figure 4: Direct care result, by average AN-ACC revenue and care minute targets, per resident per day 22
Figure 5: Operating Result, per resident per day, by quartile 25
Figure 6: Financial results of residential aged care homes, by service area and quartile 26
Table 2: Selected statistics of residential aged homes, by quartile (July – December 2023) 27
Figure 7: Comparing the returns on capital (Average EBITDA Return on Assets) 32
Figure 8: Sources of capital for residential aged care providers 33

Workforce issues

Figure 9: Proportion of homes meeting their service-level care minute targets 38
Figure 10: Proportion of homes that meet care minute targets, by remoteness (October – December 2023) 39
Figure 11: Proportion of homes that meet care minute targets, by ownership type (October – December 2023) 40

Star Ratings

Figure 12: UARC Star Ratings Dashboard 48
Figure 13: Trends in the distribution of homes by overall Star Rating 49
Figure 14: Average Star Rating, by sub-category 51
Figure 15: Operating Result, per resident per day, by overall Star Rating 52
Figure 16: Operating Result, per resident per day, by Staffing Star Rating 53
Figure 17: Direct care expenditure and margin, per resident per day, by Staffing Star Rating 54

Sector sustainability

Figure 18: Number of people with a home care package and waiting for a home care package 65
Table 3: Total estimated cost of clearing the home care package waitlist 68
Table 4: Estimating wait times for home care package services 69

Part 2: Analysis of the StewartBrown sector dataset

Approved provider analysis

Table 5: Profile of surveyed approved providers 74

Figure 19: Proportion of loss-making providers, Operating Result and Operating EBITDA 76

Table 6: Approved provider average profit and loss results 78

Table 7: Approved provider average balance sheet figures 81

Residential care analysis

Table 8: Profile of surveyed residential aged care homes 83

Table 9: Key performance indicators of residential aged care homes 85

Figure 20: Operating Result, per resident per day, and proportion of loss-making homes 86

Figure 21: Operating EBITDA, per resident per day, and proportion of loss-making homes 87

Figure 22: Operating Result, top 25% vs remaining 75%, per resident per day 88

Table 10: Detailed financial results, per resident per day 90

Figure 23: Service area revenue and expenditure, per resident per day 91

Figure 24: Median labour cost per worked hour, by direct care role 92

Figure 25: Direct care result, by average AN-ACC revenue, per resident per day 93

Figure 26: Administration expenditure, per resident per day 96

Figure 27: Occupancy rate 97

Figure 28: Operating Result, by occupancy rate, per resident per day 98

Table 11: Staffing time of residential aged care homes, minutes per resident per day 99

Figure 29: Staffing time, by category, per resident per day 100

Figure 30: Direct care staffing, by role, per resident per day 101

Figure 31: Agency staffing as a proportion of direct care hours 103

Home care analysis

Table 12: Profile of surveyed home care providers 105

Table 13: Key performance indicators of home care providers 106

Figure 32: Financial results of home care providers 107

Table 14: Detailed financial results of home care providers, per client per day 108

Figure 33: Home care revenue and expenditure, per client per day 109

Figure 34: Home care revenue, per client per day 110

Figure 35: Revenue and unused subsidy, per client per day 111

Figure 36: Average accumulated value of unspent funds per package 112

Figure 37: Home care expenditure, per client per day 114

Figure 38: Direct care expenditure, internal and third-party, per client per day 115

Table of abbreviations

ACAR	Aged Care Approval Round
ACFA	Aged Care Financing Authority
ACFPS	Aged Care Financial Performance Survey
ACQSC	Aged Care Quality and Safety Commission
AIHW	Australian Institute for Health and Welfare
BCT	Base Care Tariff
AIN	Assistants in nursing
CHSP	Commonwealth Home Support Progamme
COTA	COTA Australia
DAP	Daily accommodation payment
EBITDA	Earnings Before Interest, Taxes, Depreciation and Amortisation
FTE	Full-time equivalent
FWC	Fair Work Commission
GDP	Gross Domestic Product
IHACPA	Independent Health and Aged Care Pricing Authority
MMM	Modified Monash Model
MPIR	Maximum Permissible Interest Rate
NDIS	National Disability Insurance Scheme
NPS	National Priority System
RAD	Refundable Accommodation Deposits
RN	Registered nurse
SCHADSS	Social, Community, Home Care and Disability Services
UARC	UTS Ageing Research Collaborative
UTS	University of Technology Sydney

Editorial Board Foreword

Welcome to the June 2024 edition of Australia's Aged Care Sector.

This edition brings you UTS Ageing Research Collaborative's (UARC) current analysis of available data and evidence-based policy commentary on the 2024-25 Budget, the state of play of provider viability, the challenge of capital financing, a look at what the Stars are telling us, the truth behind the home care package waiting lists, and so much more.

The Government's latest Budget made modest improvements to the quality and quantity of subsidised aged care for those older Australians in need of these services. Still, it proposed no amelioration of the rising public costs. More on this a little later.

First, however, I want to highlight our take on the recent financial performance of residential care over the last year. While it shows an uplift on previous results, it is most likely a temporary aberration and, potentially of more significant concern, it is an inappropriate consequence of how staffing input controls have been introduced, regulated and funded.

Specifically, the uplift derives principally from a significant surplus from residential direct care (which is almost entirely funded by taxpayers). At the same time, there have only been modest gains in the two major loss-producing activities of everyday living services and accommodation. Our report's analysis demonstrates that the direct care surplus is largely earned by the portion of providers who have not delivered their mandatory care minutes, despite AN-ACC funding being set with that as one of its principal foundations.

It is well understood by all that the economy-wide workforce shortages are a strong contributory factor. Many providers, through significant effort, have been able to approach their target, even though they still fall short. However, some providers are currently well short of their legislated targets and, as a result, are retaining a sizable surplus from government funding for their direct care services. A critical issue for the Government is how it can ensure that its substantial funding commitments to increase the number of aged care workers and their wages are actually spent on improving direct care staffing.

At a broader level, our report draws attention to the sizable growth in Budget commitments to subsidise aged care over the last five years. During this time, the average value of resident contributions has also grown, but at a much slower pace and much smaller scale. Yet, despite the substantial increase in funding, half of all residential aged care homes are still losing money in 2023–24. The Aged Care Taskforce made some sensible recommendations to reform aged care funding, including that direct care services should remain primarily a government responsibility, but higher co-contributions should be required for everyday living services and accommodation from individuals who have the financial means to do so. We hope this will be the centrepiece of a multipartisan agreement among our parliamentarians.

The Budget's provision to further expand the home care packages program responds to the recent increase in the time that older people have to wait to receive a package that meets their assessed needs. Yet, the value of unspent funds in current packages continues to climb. This underlines the imperative of a timely replacement of the current Home Care Package program with the new Support at Home program and a reformed single assessment regime. The Aged Care Taskforce supported the fee-for-service model in which clients would only contribute to services they received, and the level of contributions would vary according to the type of service delivered. Again, these proposals deserve widespread support and early implementation.

Older people in need of subsidised aged care services continue to wait for the new Aged Care Act and a legislated recognition of their rights, as well as the protection of new Quality Standards. The new Act will also assign residential care places directly to them so they can exercise greater choice and control over where they live and who provides their care and support. Providers are similarly awaiting the new Act to gain clarity on the detailed Rules and a (hopefully liberal) definition of residential care.

The recent Department report on the Exposure Draft consultations shows several stakeholders' concerns have been recognised – we trust this will translate into improvements in the next draft. We also hope the current Constitutional entanglement that the Government finds itself in when drafting the new Act can be resolved to facilitate good public policy rather than constraining it.

As a final note, I draw your attention to the Capital Financing section in Part 1, which presents some initial analysis of the challenges facing the capital market to finance growth of the aged care sector and potentially refinance RADs. This is one of many capital funding issues, which also include the DAP value distortions arising from MPIR settings, the adequacy of accommodation supplements and the need for policy settings to ensure that all older people in need have equitable access to a wide range of residential care. I could go on!

With Winter settling in, we hope the information and analysis in this report provide you with new insights and nourishing food for thought to help you through the longer indoor hours.

Professor Mike Woods (Chair)

On behalf of the Editorial Board and the UTS Ageing Research Collective
20 June 2024

Executive Summary

The first half of 2023-23 presented a mix of outcomes as the sector navigates recovery from several challenging years marked by the Royal Commission, the pandemic, workforce shortages, and a host of significant changes and policy reforms. On the financial front, many residential care homes experienced a modest rebound in results, while the performance of home care services continues to deteriorate. At the same time, providers' financial outcomes reflect significant variations in staffing across the sector as workforce challenges persist. Recent Budget announcements have clarified some key timeframes, but several policy uncertainties remain.

For older Australians, the 2024-25 Federal Budget included funding for more home care packages, enhanced regulation to ensure quality care, and improved interfaces between hospital and aged care services. However, they will need to wait until July 2025 for the primacy of their rights to be legislated in the new Aged Care Act. In the coming months, the Government is also expected to clarify anticipated changes to aged care funding, including further personal contributions for everyday living and accommodation services, from those with the financial capacity to do so.

Australian taxpayers are now subsidising aged care to a far greater extent than five years ago. Government spending on aged care is estimated to be $32.3 billion in 2023–24, $12.6 billion more than in 2019–20. This growth reflects substantial funding commitments to expand the availability of home care packages, lift staffing levels, fund award wage increases, and strengthen the regulatory regime to improve service quality. Yet, despite this funding uplift, half of residential aged care homes are still operating at a loss and home care providers' margins have reached a new low of just $1.77 per client per day. Services experiencing sustained periods of financial distress are at greater risk of closure, which may undermine reliable access to services for older people, particularly those outside major cities."

The 2023–24 half-year financial results of residential care homes were, on average, better than anticipated, with the loss per resident per day shrinking to $4.02 compared to $17.47 for the same period in 2022-23. However, once again, many homes are generating margins from publicly funded direct care services to cross-subsidise their losses from delivering everyday living services and accommodation services.

Furthermore, UTS Ageing Research Collaborative (UARC) analysis shows that the primary reason for this turnaround is the significant underspend on direct care staff by some of the 63.9% of homes that have not met their mandatory care minute targets. In contrast, the 36.1% of homes that have met or exceeded their staffing targets are operating close to breakeven for direct care, averaging $1.66 per resident per day.

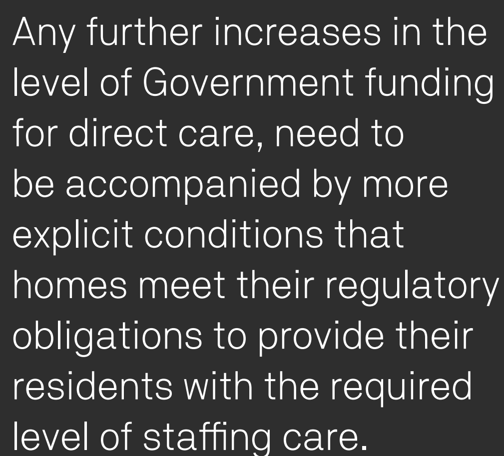
These staffing patterns are also causing a widening dispersion in the financial outcomes of residential homes. UARC's analysis shows that, on average, the most profitable quartile of homes earn an additional $111 per resident per day than those in the bottom quartile. While this gap is partly attributable to differences in occupancy, supported resident ratios and eligibility for additional funding support, the key difference is in homes' expenditure, especially on direct care. Homes in the top quartile were furthest from meeting their care minute targets, whereas those in the lowest quartile were delivering care time well above their targets. We also find that homes with the lowest care minute compliance rates tend to be operated by for-profit providers and located in large cities and regional centres.

While recognising the workforce challenges facing the sector and the economy, any further increases in the level of Government funding for direct care, need to be accompanied by more explicit conditions that homes meet their regulatory obligations to provide their residents with the level of staffing care required. Importantly, any policy response should avoid using blunt approaches (e.g. whole-sector adjustment of the AN-ACC base price), that unfairly penalise homes that are meeting their staffing obligations.

A critical element of providers' workforce strategies is addressing the high rates of staff turnover experienced across the sector. This report offers a synthesis of substantive evidence about organisational, personal and relational, and environmental drivers that providers can use to reduce attrition and improve the retention of workers.

The sector also facing considerable challenges in raising capital to provide care for the growing population of older people in need. Estimates of the capital investment required for new builds and refurbishments in the medium term have been up to $72 billion. However, the sector's returns have been trending downward and are uncompetitive compared to alternative investment opportunities, such as publicly listed healthcare providers.

Furthermore, persistent operating losses have meant that the proportion of residential care assets funded by equity has declined significantly. RADs now finance two-thirds of the sector's assets. While the Aged Care Taskforce has proposed to phase out RADs subject to a further study at the end of the decade, policy uncertainty and the sector's poor financial performance will make raising sufficient capital from other sources highly problematic. Hopefully, the Government's upcoming response to the Taskforce's recommendations will address some of these fundamental issues to ensure the sector's long-term sustainability.



> Any further increases in the level of Government funding for direct care, need to be accompanied by more explicit conditions that homes meet their regulatory obligations to provide their residents with the required level of staffing care.

Since Star Ratings for aged care homes were introduced in December 2022, there has been a gradual improvement in the headline 'overall' rating across the sector, as many homes shifted from 3 to 4 stars. However, 96% of homes currently fall within the 3-4 overall star range, raising questions about how informative ratings are to individuals trying to compare the relative quality of residential care homes.

The largest improvements occurred within the staffing sub-category. However, the average rating across all homes' staffing ratings is 2.9 stars, which is still below 'acceptable' quality (i.e. below 3 stars). These ratings reflect homes' spending on direct care staff. For example, homes receiving 1 or 2 stars for staffing (i.e. below their care minute targets) tend to generate large direct care margins, while homes with 4 and 5 stars generate significant deficits.

To complement MyAgedCare, UARC has developed an online Star Ratings Dashboard that presents the Star Ratings data in an interactive visual format. Users can search ratings by provider, service name and location, analyse the results by provider characteristics, view homes geographically on a map and compare homes and providers side-by-side.

The new target date for commencement of the Aged Care Act is 1 July 2025, which will coincide with the start of the proposed Support at Home program and enable the introduction of the new Quality Standards. The Exposure Draft of the new Act demonstrated some positive progress in its drafting, but key sections remained blank. Recently, the Department has released a report summarising its consultations on the Exposure Draft. The report acknowledges many stakeholder concerns, including those related to whistleblower provisions, nominee arrangements, introducing the term 'sickness', and concerns around the broad definition of an 'aged care worker'. An important consideration is how the Act will intersect with the Retirement Village legislation and its definitions of where residential care can be provided, what constitutes 'high' quality care, and what is 'protected information' for freedom of information purposes relating to providers.

Although an extensive amount of new drafting of the Act and all of the Rules is yet to be completed, as well as subsequent consultation and reworking in response, sufficient time must also be made available for providers and older people to prepare for the new legislation.

The 2024-25 Budget announcement of more home care packages is a welcome response to the recent rise in waiting lists and times. However, wait times will only fall if supply-side constraints are addressed. Furthermore, greater transparency is required regarding the entire time older people wait for home care, noting that the Department's statistics ignore the time spent waiting for assessment approval and finding a provider to deliver services.

As always, Part 2 of this report provides detailed evidence that supports UARC's analysis of the aged care programs and policies.

Part
1

Analysis and commentary

Part 1 of this report provides analysis and commentary on many of the most pressing issues facing the Australian aged care sector as of June 2024.

Financial viability concerns remain at the forefront despite the substantial uplift in Australian taxpayer spending on aged care over the last five years. In this edition, we focus on the current funding outcomes of residential care, noting widening dispersion in the financial performance of homes across the sector, predominantly driven by different expenditure patterns on direct care staffing. Taking a longer-term view, Part 1 also discusses the coming challenges regarding capital financing and the future infrastructure needs for residential care.

The second critical area is the aged care workforce. Part 1 provides evidence about the status of homes' direct care workforces vis-à-vis the care minute targets, showing the varying rates of compliance by geographic location and ownership. It also provides an update in regard to the Fair Work Commission wage case and a synthesis of research evidence about the factors influencing workforce turnover.

With Star Ratings now more than a year old, Part 1 explores trends in overall and sub-category scores. The analysis then explores some of the financial implications of the Star Ratings, such as the direct care expenditure patterns of homes and the resultant differences in staffing ratings.

Part 1 also continues to feature legislative and legal issues across the sector. This includes further reflections on the new Aged Care Act and research insights about legal planning for older adults.

Part 1 concludes with an updated review of the sector's sustainability, summarising the key outcomes for Budget 2024-25 and the Aged Care Taskforce's recommendations. Finally, it looks at the continued expansion of the Home Care Packages program and its implications regarding workforce pressures and wait times.

Financial viability

Residential care funding

Key messages

- Australian taxpayers are now subsidising aged care to a far greater extent than five years ago. The Government will spend $32.3 billion on aged care in 2023–24, which is $12.6 billion more than in 2019–20.

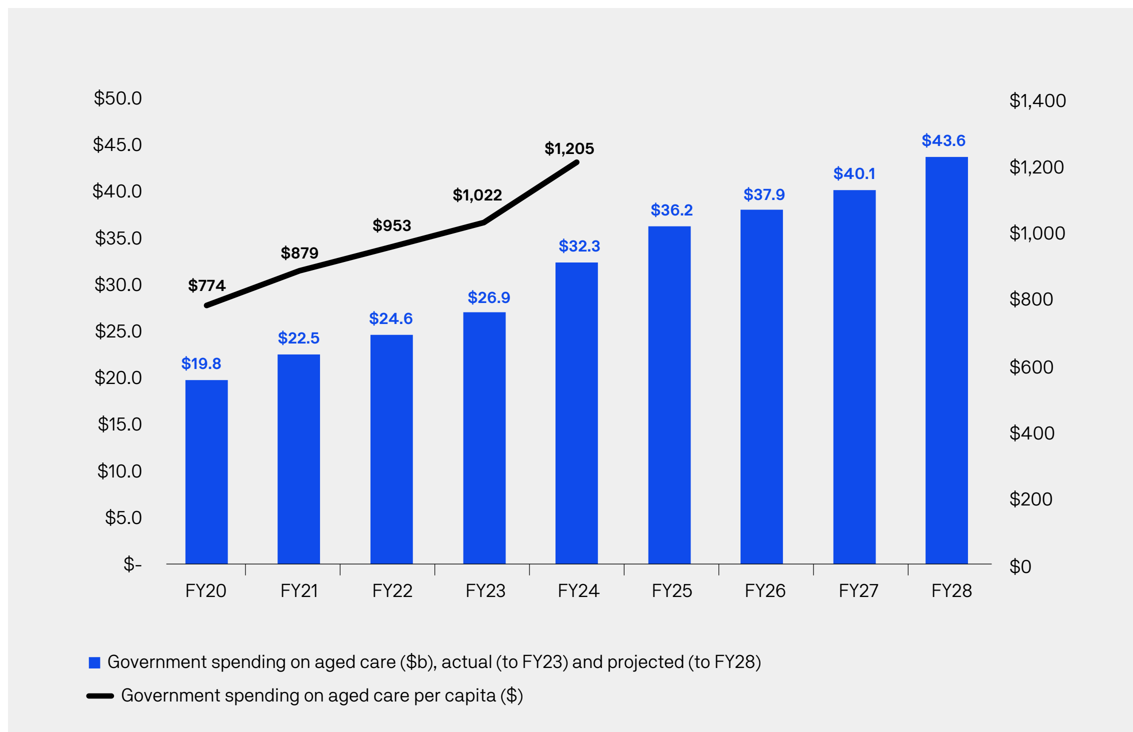
- While the half-year residential care financial results for 2023–24 are better than the prior year, there has been a reversion to a problematic cross-subsidisation pattern. Homes are offsetting deficits from everyday living and accommodation with surpluses from direct care.

- Direct care margins are likely temporary, reflecting an underspend on direct care staff by homes that have not met their care minute targets. Homes that have met or exceeded their targets are operating close to breakeven for direct care, averaging $1.66 per resident per day.

- While recognising the workforce challenges facing the sector and the economy, increases in direct care funding need to be accompanied by more explicit conditions that homes meet their legal obligations to lift direct care staffing.

Australian taxpayers are now subsidising aged care to a far greater extent than five years ago. In aggregate terms, the Government now spends $12.6 billion more on aged care than it did in 2019–20 (see Figure 1).[1] Per capita (across the whole population), the Government spent $774 on aged care in 2019–20; five years later, it is estimated to be $1,205.[2]

Figure 1: Government spending on aged care, total and per capita

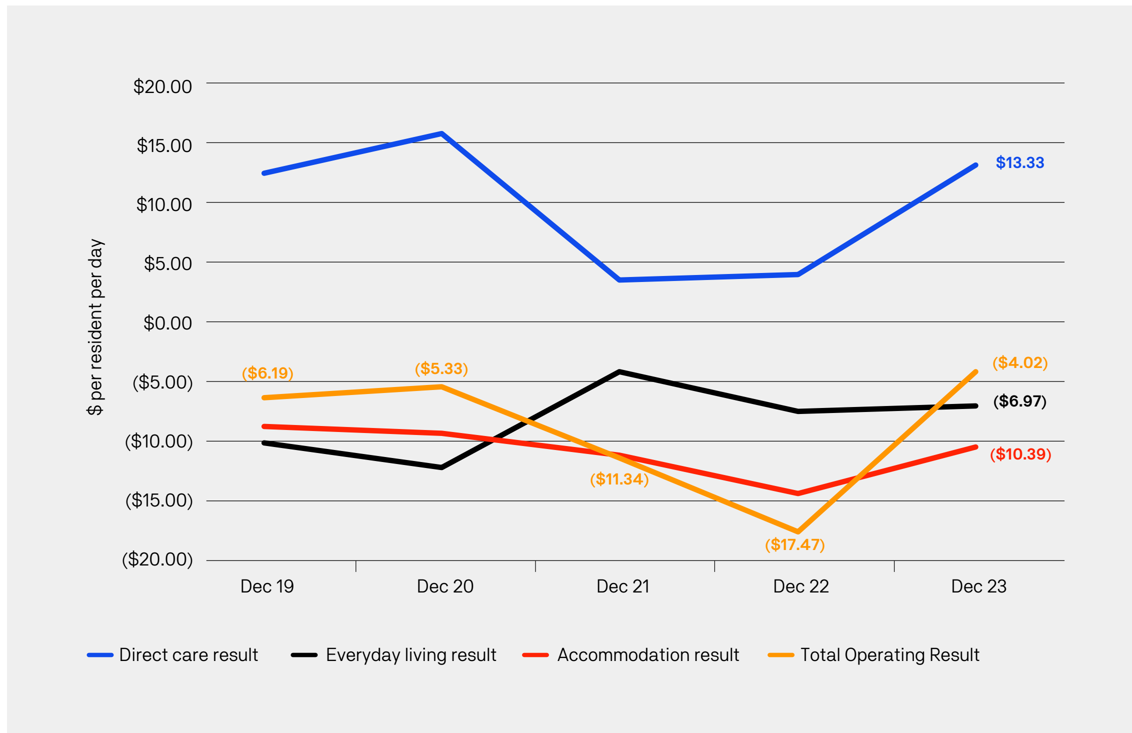


In terms of residential care, compared to a year ago, the financial outcomes of many aged care homes have substantially improved. On average, homes in the StewartBrown *Aged Care Financial Performance Survey* (ACFPS) dataset incurred, on average, a deficit of $4.02 per resident per day in the first half of the 2023–24 financial year, less than a quarter of the $17.47 deficit incurred for the same period the year prior (see Figure 2).

While this result is likely to be seen as a positive outcome for those providers who are reaping the financial benefits, it is essential to discern the extent to which it signifies a genuine turning point in the viability of residential aged care towards long-term sustainability. It is important to ensure the viability of residential care as a sector, so that older people can by assured of reliable access to quality services near where they live.

1. According to the Budget papers, in 2019–20, Government spending on Aged Care programs was $19.7 billion. In 2023–24, it is expected to be $32.3 billion: Commonwealth of Australia (various years) *Budget Papers Volume 1*.
2. Per capita estimates were calculated by dividing Government spending on aged care (Budget Papers 2019–20 to 2024-25) by the estimated resident population of Australia reported by the Australian Bureau of Statistics. Australian Bureau of Statistics. (2023, September). *National, state and territory population*

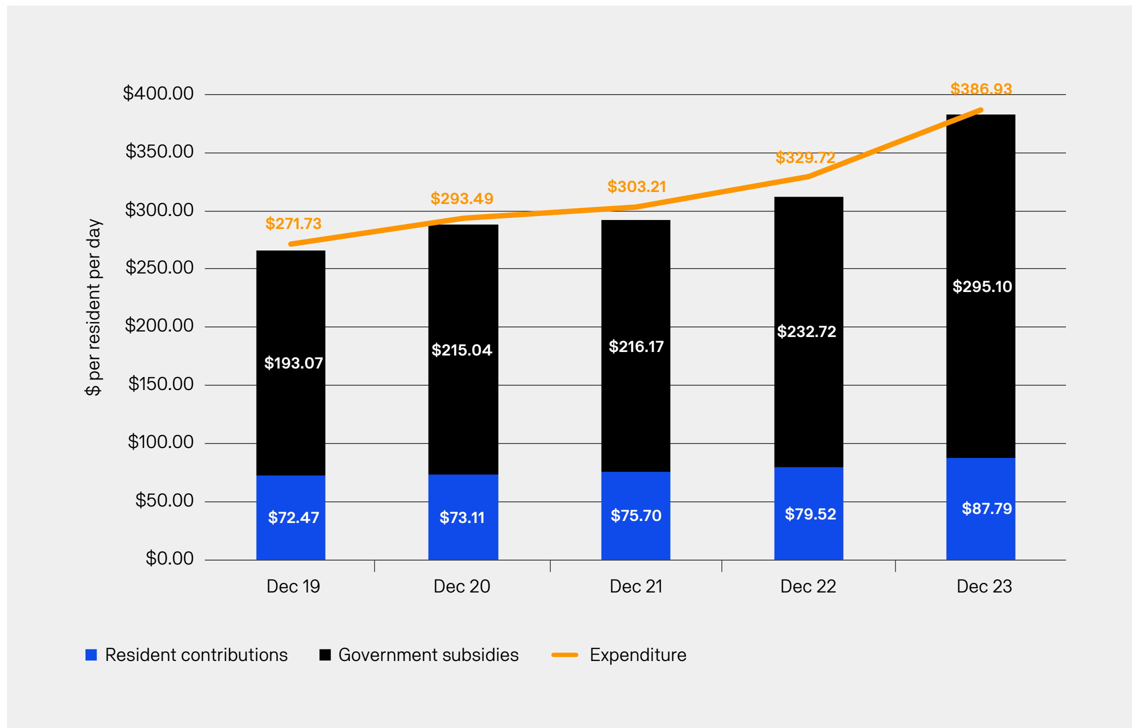
Figure 2: Financial results of residential aged care homes, by service area



In very general terms, the most recent results place the sector close to where it was five years ago, immediately before the outbreak of the COVID-19 pandemic, where 56.1% of homes operated at a loss, losing an average of $6.19 per resident per day. The most recent Operating Result breakdown depicted in Figure 2 also shows a similar pattern to the pre-pandemic business model of residential care. Once again, homes, on average, are achieving a modest deficit, which comprises a large surplus from direct care consumed by losses in everyday living and accommodation.

However, much has changed over these five years. Most notably, each home now receives substantially more Government funding to subsidise the services it provides to its residents. As shown in Figure 3, in the first half of 2023–24, each home received an average of $295.10 per resident per day of Government funding, more than $100 more than five years ago ($193.07).

Figure 3: Average revenue and expenditure per resident per day



The growth in Government funding for residential care, detailed in Table 1, includes the following:

- The introduction of the AN-ACC funding model in October 2022 substantially increased direct care funding. Homes now receive, on average, $257.06 in direct care subsidies and supplements, an additional $83.81 per resident per day compared to 2019–20. This additional funding has been designed to cover:
  - an uplift in direct care staffing to meet the care minute targets
  - higher base care tariff subsidies for homes in MMM5-7 areas and those that service specialised communities
  - the 15% increase in award rates, as determined by Stage 2 of the Fair Work Commission aged care wage case
  - annual increases in the national award rate, including 5.75% in 2023–24
  - increases in the superannuation guarantee
  - indexation to account for historical wage rises and inflation
  - the 24/7 registered nurse supplement paid to eligible homes from 1 July 2023.
- Various COVID-19-related grants and reimbursements have also been paid since 2019–20, as well as other targeted viability supports for homes in severe financial distress.
- The Basic Daily Fee supplement (now called the hotelling supplement) was introduced on 1 July 2021, with further indexation increases as recommended by Independent Health and Aged Care Pricing Authority (IHACPA).
- The accommodation supplement paid by the Government on behalf of low-means residents has increased via indexation.

Table 1: Average revenue for residential aged care homes, per resident per day, by source

	Dec-19	Dec-20	Dec-21	Dec-22	Dec-23
Resident:					
Means-tested care fees	$6.27	$6.13	$7.68	$6.82	$7.99
Basic daily fees	$51.41	$52.16	$53.13	$55.92	$60.33
Fees for additional services	$1.61	$2.13	$2.26	$2.76	$3.31
Daily accommodation payments	$13.18	$12.69	$12.63	$14.02	$16.16
Total resident contributions	**$72.47**	**$73.11**	**$75.70**	**$79.52**	**$87.79**
Government:					
Direct care subsidies and supplements	$173.25	$181.70	$183.66	$199.97	$257.06
Recurrent grants for care	$0.29	$0.36	$0.80	$1.51	$2.50
Non-recurrent operating grants for care	$0.00	$12.81	$1.55	$0.00	$0.00
Basic daily fee (hotelling) supplement	$0.00	$0.00	$9.80	$9.93	$10.94
Accommodation supplements	$19.53	$20.17	$20.36	$21.31	$24.60
Total Government funding	**$193.07**	**$215.04**	**$216.17**	**$232.72**	**$295.10**
Total revenue	**$265.54**	**$288.15**	**$291.87**	**$312.24**	**$382.89**
Proportion contributed by residents (%)	27.3%	25.4%	25.9%	25.5%	22.9%
Proportion contributed by Government (%)	72.7%	74.6%	74.1%	74.5%	77.1%

Residents also make financial contributions to the cost of their care. All residents pay the basic daily fee (capped at 85% of the basic single-age pension), and those with the financial means may also pay a means-tested care fee, fees for any additional services they choose (e.g. for alcohol or pay TV), and a daily accommodation payment.[3]

Over the last five years, the average value of resident contributions has also grown, but at a much slower pace and much smaller scale than government funding. Each resident pays an average of $89.79 per day, $15.52 more than they did in 2019–20. Just over half of this increase is attributable to the indexation of the basic daily fee, which is tied to the age pension and thus indexed by inflation. As a result, residents' share of the total funding for residential care has progressively declined over the last five years, from 27.3% in 2019–20 to 22.9% in 2023–24 (Table 1).

3. Accommodation payments are means-tested, and those with the financial means can pay via a lump sum (refundable accommodation deposit, a 'RAD'), a daily accommodation payment (DAP), or a combination of the two. While RADs are fully refundable, the daily payments are not.

Yet, even with this additional funding support from taxpayers and residents, just over half of aged care homes (51.6%) are still losing money in 2023–24 (see Part 2 of this report for more details). Thus, these results reinforce calls for a definitive response from the Government about the Aged Care Taskforce recommendations to reform the funding for aged care in Australia. If further funding is required to cover the costs of providing quality and safe residential care services, such reforms should focus on enabling higher resident contributions from individuals who have the financial means to do so.

Another reason there is some urgency for a response to the Taskforce recommendations is that, as noted above, there has been a reversion to a problematic pattern in the business model of residential care. That is, it appears that, on average, homes are generating surpluses from direct care services (primarily taxpayer-funded) to cross-subsidise losses from everyday living and accommodation (two service areas generally considered to be areas of personal responsibility except for those in need of a safety net).

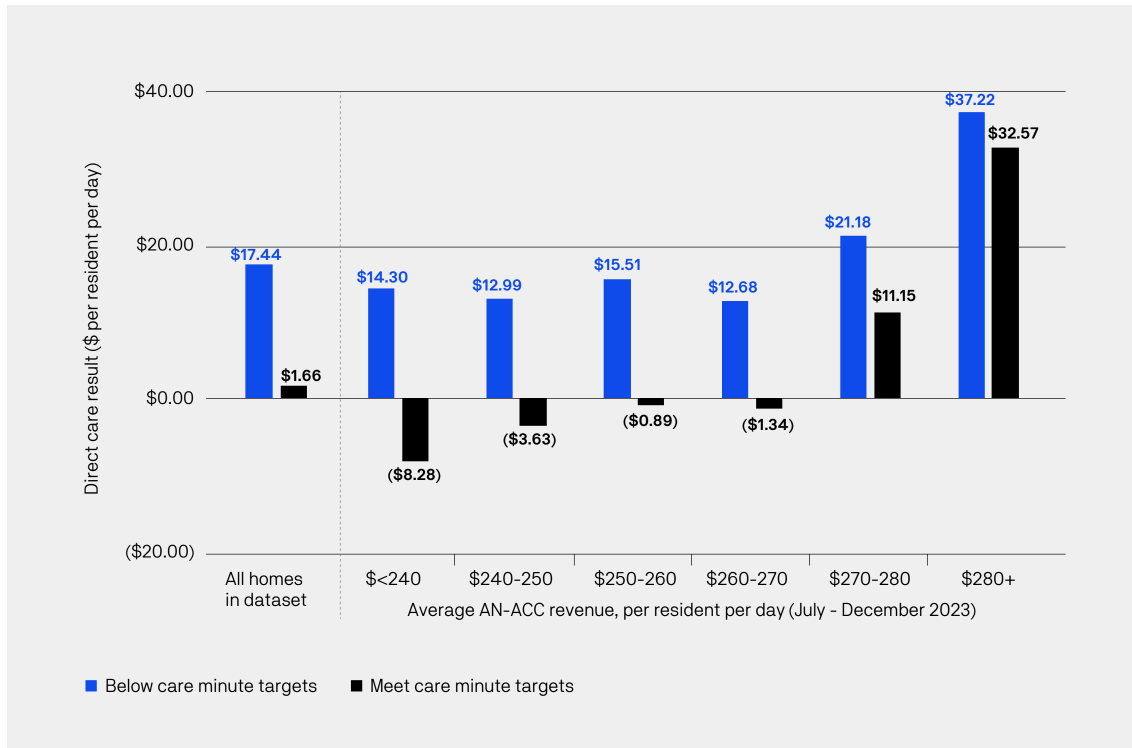
Furthermore, this business model is precarious because the margins that homes currently earn from direct care will likely be temporary. Homes have received substantial uplifts in direct care funding, predominantly to pay the wages for the increased amount of direct care staffing while also enabling them to meet the costs of the decisions of the Fair Work Commission. However, as detailed in the Workforce Issues section of this report, most homes (63.9%) across the sector still have yet to meet their mandatory care minute targets. Thus, for these homes, any direct care margin they earn largely stems from an underspend on direct care staff.

To illustrate the financial implications of the direct care staffing shortfall, UARC has separately estimated the average direct care margin for homes meeting both of their direct care minute targets versus those still below them.[4] The leftmost two columns of Figure 4 show that, in general, homes still below their care minute targets are earning substantial direct care margins (averaging $17.44 per resident per day). In contrast, homes meeting or exceeding their targets are much closer to funding parity (averaging $1.66 per resident per day).

Further analysis of direct care margins by staffing Star Rating (provided later in this report) suggests that large outlier effects are not driving the average result of those homes meeting their targets.

4. This modelling was conducted on 1,124 de-identified homes in the StewartBrown residential aged care dataset for the first half of 2023–24. The analysis compared their actual and target direct care minutes for October – December 2023, published by the Department of Health and Aged Care Star Ratings Extract. Homes were classified as 'meet' if their staffing was at or above both their care minute targets for registered nursing and total direct care and were otherwise classified as 'below'.

Figure 4: Direct care result, by average AN-ACC revenue and care minute targets, per resident per day



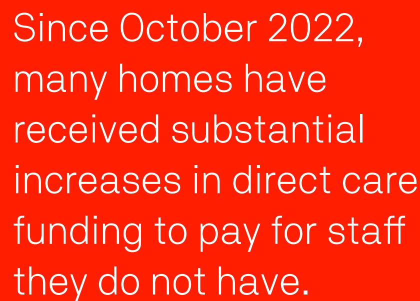
The remaining columns of Figure 4 show this same analysis stratified by the average AN-ACC funding homes receive per resident per day. This shows that homes that have not met their care minute targets generate substantial margins from direct care across all AN-ACC funding levels.[5]

By comparison, most homes meeting or exceeding their care minute targets are not covering their direct care costs. On average, homes earning less than $270 per resident per day in direct care subsidies incur losses of between $0.89 and $8.28 per resident per day. The remaining homes on the rightmost side (i.e. those earning much higher AN-ACC subsidies) generate direct care margins. However, these likely reflect either small homes accessing the 24/7 registered nurse (RN) supplement and/or homes in rural and remote locations that receive higher base care tariff funding.

These results suggest that if more homes lift their direct care staffing to meet their care minute targets as the year progresses, then the margins from direct care across the sector will reduce and approach the levels of those homes that already meet the care minute targets. Owing to the current cross-subsidisation of everyday living and accommodation services, any fall in direct care margins will further compromise the overall viability of residential aged care homes.

In addition, from a policy perspective, there will be a limit on how much taxpayers and the Government are willing to tolerate in terms of homes making margins from direct care beyond an acceptable return on assets.

5. This breakdown confirms that the average result ($17.44) is not entirely driven by some outlier effects relating to the base care tariffs (i.e. small remote homes).



Since October 2022, many homes have received substantial increases in direct care funding to pay for staff they do not have.

Last financial year, homes received a transitional funding benefit from AN-ACC, where they received higher direct care funding for an entire year before their care minute targets became mandatory.[6] However, even though care minute targets became a mandatory legal requirement on 1 October 2023, the mismatch between funding and spending on direct care staff has persisted. This mismatch occurs because AN-ACC funding – the primary mechanism the Government uses to fund additional staff or award wage increases – is tied to the number and acuity of residents (i.e. paid per occupied or operational bed day). Thus, a home's direct care funding is not tied to its staffing levels. Put another way, since October 2022, most homes have received substantial increases in additional direct care funding to pay for staff they do not have.

This problem is likely to continue, given that the Government has committed to further increasing the AN-ACC base price to fund even higher direct care minute targets (from 1 October 2024) and, most likely, the FWC Stage 3 award rate increases and the National Wage Case increases.

The shortfall of direct care workers can largely be attributed to ongoing workforce challenges across the sector and the economy. Nonetheless, at some point, providers have an onus to take meaningful actions to recruit and retain enough appropriately qualified staff, as is the case in any industry.

Thus, any further increases in direct care funding should be accompanied by more explicit conditions that homes meet their mandatory direct care staffing level obligations. This may be accomplished by a change in stance adopted by the regulator and/or a reset of incentives on providers to recruit and retain staff by way of the level of direct care funding provided, reflecting the achievement of care minutes. Importantly, any policy response should avoid using blunt approaches (e.g. whole-sector adjustment of the AN-ACC base price), that unfairly penalise homes that are meeting their staffing obligations. Such approaches could result in greater alignment between taxpayer funding and better direct care staffing across the sector.

6. This transitional effect was detailed in UARC's full-year edition of *Australia's Aged Care Sector Report 2022-23*.

Widening disparities in residential care

Key messages:

- Over the last five years, there has been a widening dispersion in the financial outcomes of residential homes. The latest results show that the most profitable homes (top 25%) earn an additional $110.58 per resident per day than those in the bottom 25%.

- In terms of service areas, the most substantial differences in margins arise in direct care, with top-quartile homes earning an average of $48.16 per resident per day.

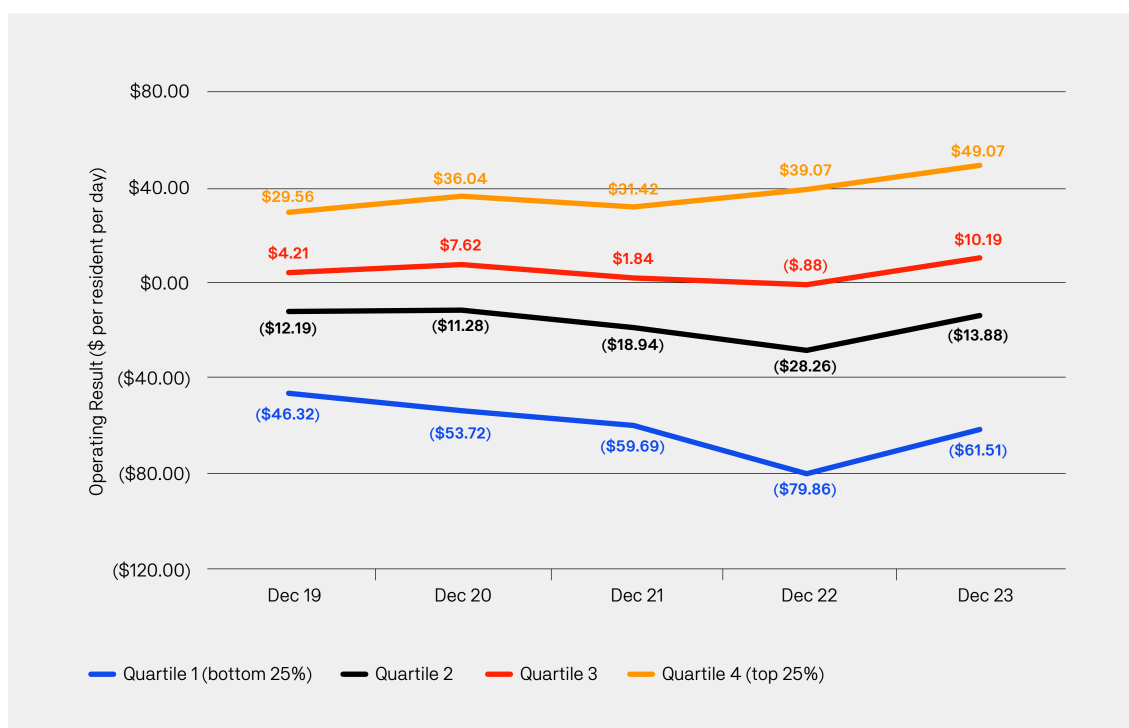
- Differences in expenditures, rather than revenues, cause most of the variation in financial outcomes. While this is partly attributable to occupancy rates, there is a stand-out difference in spending on direct care staffing, with the most profitable homes being furthest from meeting their care minute targets. The least profitable homes are delivering care minutes well above their targets.

The growing dispersion of financial performance

A notable finding in the residential care analysis in Part 2 is the growing dispersion in the average Operating Result between the top 25% of homes compared to the remaining 75%. The difference was $47.66 per resident per day in the first half of 2019–20, which grew to $75.41 in 2022-23, coinciding with the introduction of AN-ACC. The gap between these homes has since experienced a slight decline and, as of 2023–24, is $70.81 per resident per day.

To further explore this dispersion, Figure 5 compares the trend in the average Operating Result by quartiles.[7] This confirms that there has been a growing dispersion in the financial outcomes of residential aged care homes across the sector in the last five years. For example, in the first half-year of 2019–20, there was a difference of $75.88 per resident per day between the top and bottom quartiles (Quartile 1 and Quartile 4), which has grown to $110.58 for the same period in 2023–24.

Figure 5: Operating Result, per resident per day, by quartile

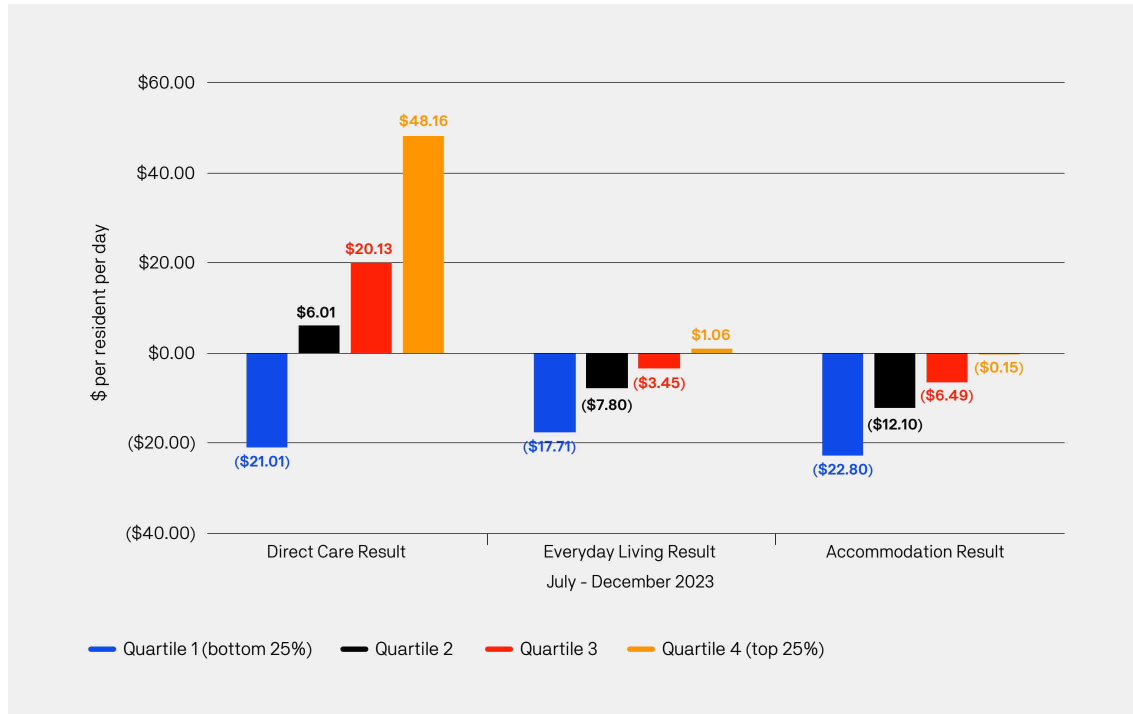


7. Quartile analysis splits homes into four even groups, stratified by their Operating Result. This means that Quartile 1 represents the 25% of homes with the lowest financial performance, whereas Quartile 4 represents the 25% of homes with the highest financial performance. The quartile groups are constructed each year, which means that, dependent on their relative performance, the same home may be categorised in the same or different quartiles each year.

What is driving the result?

To delve further into these differences, Figure 6 presents the average result (net margin) earned for each service area in the first half of 2023–24, again split by quartile.[8] Consistent with Part 2, these results are net of the allocation of administration expenditure across the three service areas.

Figure 6: Financial results of residential aged care homes, by service area and quartile



This shows that direct care services are causing the largest disparities in homes' financial results. For example, whereas the top quartile of homes generated a direct care surplus of $48.16 per resident per day in the first half of 2023–24, the bottom quartile lost $21.01 per resident per day (a difference of $69.17). There are still differences between homes in different quartiles for the other service areas, but they are more condensed. For example, the top quartile of homes earns $18.77 per resident per day more than the bottom quartile for everyday living services and $22.65 more per resident per day for accommodation services.

Further analysis of the differences between homes by quartile (see Table 2) reveals that from a financial perspective, the main variation point is in their average expenditure rather than revenue. There are only modest differences in total revenue per resident per day between the top and bottom quartiles ($19.35 per resident per day). This reflects slight differences in direct care funding, driven by differences in 24/7 RN supplement support, AN-ACC base care tariff rates and other grants (noting the care minute targets are ostensibly the same across the quartiles). There are also differences in the average rates of accommodation supplement earned across the quartiles, corresponding to variation in the supported resident ratio. For example, the top quartile homes have a supported resident ratio of 49.9% compared to 42.9% for the bottom quartile.

8. In this analysis, the Quartile groupings are based on homes' average Operating Result for the first half of 2023–24.

Table 2: Selected statistics of residential aged homes, by quartile (July – December 2023)

	Quartile 1 (bottom 25%)	Quartile 2	Quartile 3	Quartile 4 (top 25%)
Number of homes in dataset	297	296	297	297
Direct care revenue	$265.42	$262.05	$265.20	$277.49
Everyday living revenue	$73.74	$74.23	$74.81	$75.59
Accommodation revenue	$38.56	$39.17	$41.33	$43.99
Total revenue (per resident per day)	**$377.72**	**$375.45**	**$381.34**	**$397.07**
Direct care expenditure	$286.43	$256.03	$245.07	$229.32
Everyday living expenditure	$91.45	$82.03	$78.26	$74.53
Accommodation expenditure	$61.36	$51.27	$47.82	$44.14
Total expenditure (per resident per day)	**$439.24**	**$389.33**	**$371.15**	**$347.99**
Direct care expense ratio	108.1%	97.8%	92.5%	83.8%
Average total direct care minutes (target)	200.3	199.5	201.6	200.1
Average total direct care minutes (actual)	215.5	201.0	196.9	187.5
Average RN direct care minutes (target)	39.6	39.4	39.8	39.5
Average RN direct care minutes (actual)	42.3	38.9	37.1	35.6
Occupancy rate (%)	89.2%	93.2%	94.5%	94.2%
Supported resident ratio (%)	42.9%	43.4%	45.6%	49.9%
Average home size (number of places)	77	84	87	82
Location splits:				
Metropolitan (MMM1)	47.5%	64.2%	68.4%	69.0%
Regional and rural (MMM2-4)	36.0%	27.4%	22.8%	20.2%
Small rural and remote (MMM5-7)	16.5%	8.4%	8.8%	10.8%
Provider scale:				
Single home	10.4%	8.1%	7.7%	7.1%
2-6 homes	22.9%	18.2%	16.8%	15.5%
7-19 homes	28.3%	30.7%	35.7%	20.9%
20+ homes	38.4%	42.9%	39.7%	56.6%
Home size:				
Less than 40 places	12.5%	9.8%	6.7%	7.1%
40-80 places	46.8%	39.5%	40.7%	44.4%
More than 80 places	40.7%	50.7%	52.6%	48.5%

In contrast, in the first half of 2023–24, there are substantial differences in total expenditure patterns of homes across the four quartiles.[9] For example, homes in the bottom quartile spend, on average, $91.25 more per resident per day than homes in the top quartile.

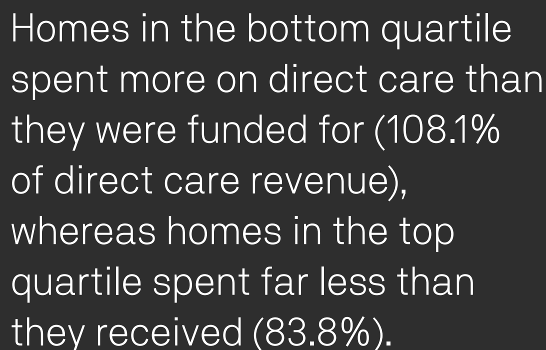
One obvious reason is the difference in occupancy rates, which are substantially lower for the bottom quartile (89.2%) than the other three (93.2–94.5%). Lower occupancy is a critical precursor to poor financial performance as fixed costs are spread over fewer resident days, increasing the average expenditure per resident per day.

In addition, most of the spending differences are in direct care, where the top quartile of homes spend an average of $229.32 per resident per day, $57.11 lower than bottom quartile homes ($286.43). Most of this can be attributed to the underspend of top quartile homes on direct care staff, which are the furthest from their care minute targets. As shown in Table 2, homes across the four quartiles have similar care minute targets, close to the sector-average targets (i.e. 200 minutes of total direct care, with 40 minutes of registered nurse time). Yet, the most profitable homes provide substantially less than that (averaging 187.5 minutes of total direct care time per resident per day, with 35.6 minutes of registered nurse time). Of note, the least profitable homes provide direct care staffing well above their care minute targets (averaging 215.6 minutes of total direct care time per resident per day, with 42.3 minutes of registered nurse time).

As a result, the four quartiles exhibit substantially different direct care expense ratios. Homes in the bottom quartile spent more on direct care than they were funded for (108.1% of direct care revenue), whereas homes in the top quartile spent far less than they received (83.8%).

There are also differences in the expenditure patterns between the top and bottom quartiles regarding everyday living and accommodation. In everyday living, the expenditure line items with the most substantial differences across quartiles include catering and cleaning, whereas, for accommodation, these items include depreciation and maintenance. Across all three service areas, there are also substantial differences in the administration cost (which has been allocated in Table 2), with top quartile homes spending $45.95 per resident per day compared to $61.24 for bottom quartile homes.

9. All expenditures are reported net of allocation of administration.



How do these homes differ?

The financial dispersion may also reflect differences in homes' underlying characteristics. As Table 2 shows, there are distinct patterns in home location. Compared to the overall distribution of homes across the sector, homes in the bottom quartile are much more likely to be based in non-metropolitan areas (i.e. in MMM2-7 areas).[10] In contrast, metropolitan homes (MMM1 areas) are over-represented in the top quartile. This suggests that even with the additional base care tariff AN-ACC funding for homes in rural and remote areas, homes in metropolitan locations operate at a financial advantage compared to their non-metropolitan counterparts. Relevant factors that can drive lower margins for regional and rural homes include lower accommodation pricing, lower occupancy rates and a greater reliance on agency staff.

Considering size and scale characteristics, there is some evidence of economies of scale effects, particularly at a provider level. Poor-performing homes tend to be smaller and operated by a standalone (single) (10.4%) or small chain provider (2-6 homes) (22.9%). By comparison, the top quartile of homes are most likely run by the largest providers (20+ homes) (56.6%). Overall, these results demonstrate the advantages of scale, with larger homes and providers possessing financial advantages over their smaller counterparts.

10. When interpreting these distributions, readers are advised to compare the percentages to those over the entire dataset, presented at Residential aged care home profiles (in Part 2).

Capital financing

Key messages:

- For the residential sector to sustain sufficient capital investment, its returns on capital must equal at least the cost of capital invested and be competitive compared to other health-related investments.

- The proportion of assets held as equity has declined significantly in response to ongoing operating losses. In contrast, RADs now finance two-thirds of the sector's assets. The Aged Care Taskforce's proposal to phase out RADs from 2035, subject to a further capital sustainability review in 2030, could provide a more stable base of operating income, but also pose a significant challenge to recapitalising the sector.

- There is increasing demand for the refurbishment of current aged care facilities and new development, with projected expenditure over the next decade in the range of $55–72 billion, contingent on assumptions and timeframes.

- Policy uncertainty and the sector's poor financial performance will make raising sufficient capital to meet capital requirements in the coming decades highly challenging.

Current challenges with capital financing in the aged care sector

There has been considerable discussion on the capital financing needs of the aged care sector, traversing topics such as the growing numbers of older people needing subsidised care, the consequent longer-term capital requirements, the lack of viable capital returns, the sustainability of RADs as a source of provider capital, and the current policy uncertainty that impacts on the appeal of the sector for investors.

A starting point for the following discussion is that sustaining sufficient capital investment in the aged care sector is where the returns on the assets held by organisations are equal to or greater than the cost of capital invested in them. This holds for both the capital financing and investment decisions made within organisations and for decision-making by fund managers, private equity providers and debt providers such as banks and financial institutions. It applies to private and not-for-profit organisations, noting that the latter may have a broader social purpose and different capital return requirements and, in some cases, can draw on underutilised land holdings.

The recent Aged Care Taskforce Report summarised the issue in the following terms (Principle 4):[11]

> "The residential sector should have access to sufficient capital to develop and upgrade accommodation, including in rural and remote areas and First Nations communities."

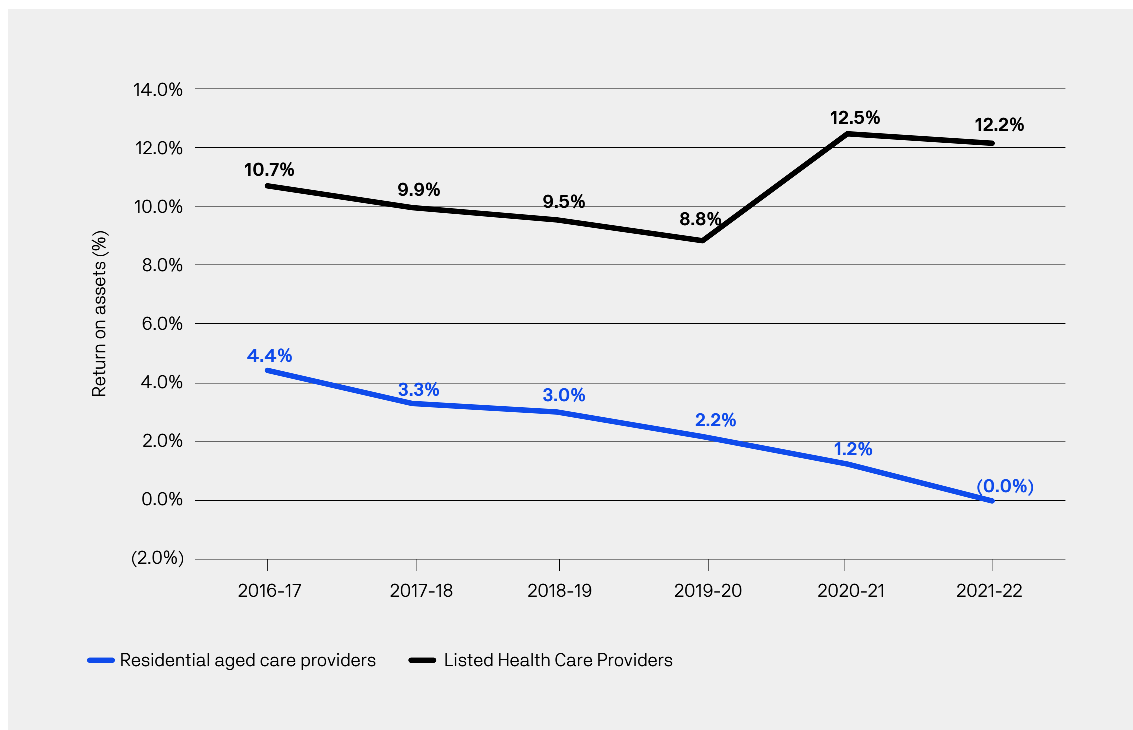
11. Australian Government (2024), *Final report of the Aged Care Taskforce*, p. 11

What's the 'state of play' in the sector's returns on capital?

There has been much public discussion on the financial viability of the aged care sector as a whole, including in the various editions of this sector report. In relation specifically to the return on capital for aged care providers, analysis shows a significant downward long-term trend, with the 2021-22 return just dipping into negative territory.

Investors interested in directing their capital into health-related sectors have a range of options, such as investing in aged care, private hospitals and clinics or other health-related organisations. Figure 7 compares returns for aged care providers to publicly listed health care providers.[12] Comparatively, aged care has not been a profitable investment option over the long term, and its results have worsened further in the last few years.

Figure 7: Comparing the returns on capital (Average EBITDA Return on Assets)

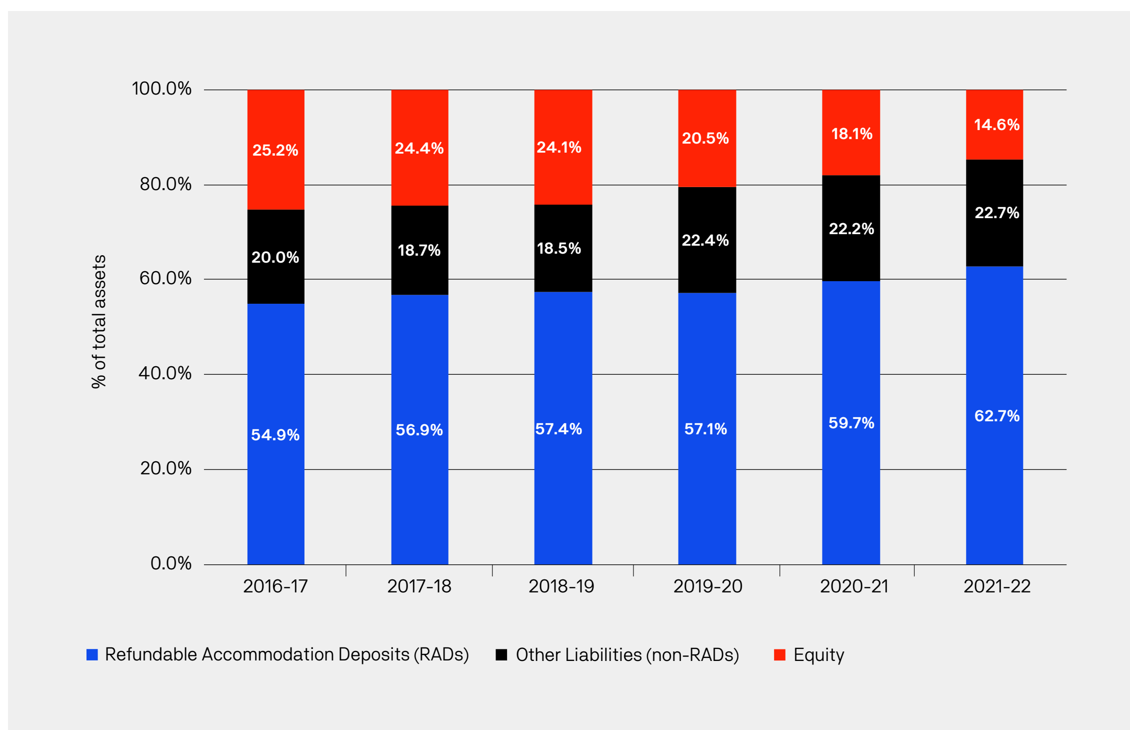


12. Financial data for residential aged care providers are sourced from the *Financial Report on the Aged Care Sector (2021-22)*, while data from publicly listed health care providers (GICS code 351020) are available from their publicly available annual reports.

Current sources of capital in aged care

Analysis of the capital structure of aged care providers as a proportion of their assets shows a trend of reducing equity over time in response to the need to fund ongoing losses (Figure 8).[13] There has also been a progressive increase in the value of Refundable Accommodation Deposits (RADs). The net result of these trends is that providers have increased their leverage over the last five years, with liabilities increasing as a percentage of assets.

Figure 8: Sources of capital for residential aged care providers



13. Data sourced from: Department of Health and Aged Care (2023), *Financial Report on the Aged Care Sector (2021-22)*.

Future demand

Critical to capital planning is understanding the future demand for residential care and the likely government response to providing public funding for the associated supply of services and accommodation.

Aside from the ever-present uncertainties of public policy decisions, one of the key limitations to understanding future demand and capital requirements is the lack of current publicly available data and analysis and projections of trends of the underlying demand for aged care. The Department's most recent relevant projections forecast continued increases in demand for residential places over the next two decades.[14]

On the supply side, modelling conducted by the Aged Care Financing Authority (ACFA) in 2021 predicted that in the following decade, there would be a need for 79,000 new residential places and 60,000 residential places requiring refurbishment or rebuilding.[15] ACFA also considered that future places will increasingly need to be in 'greenfield' (new) sites rather than as expansions of current facilities. The capital investment required for these places was estimated to be $55 billion. Grant Thornton revisited ACFA's analysis in their submission to the Aged Care Task Force.[16] They forecasted a need for 115,000 new beds and 60,000 replacement beds over the next seven years, requiring a capital investment of $72 billion.[17]

Challenges with meeting the sector's future capital requirements

The key challenge in addressing the demand for aged care is the need for capital investment in building and refurbishing residential care accommodation, new IT infrastructure and software, and research and development for innovation in business models and models of care – all of which are capital-intensive. However, given that capital follows returns, when a firm or industry generates insufficient returns, it typically has challenges in raising capital.

In addition, other factors currently impact the lack of investment appeal. First is the uncertainty hanging over legislative and regulatory reform, including the direction of development of the new Aged Care Act. While the abolition of the Aged Care Approval Round (ACAR) was designed to create an opportunity for more diversity in the settings in which services are delivered, thus providing more choice for consumers, as well as an opportunity for innovation for providers,[18] the Exposure Draft's definition of residential care is unnecessarily restrictive.[19]

Another related policy uncertainty is the form and function of the forthcoming Support at Home program, particularly concerning the provider landscape and the categorisation of included services. The changing prudential oversight is another uncertainty, with expectations that the new Aged Care Act will include legislation around minimum liquidity and capital thresholds coupled with stronger regulatory powers for the Aged Care Quality and Safety Commission (ACQSC).

14. Department of Health and Aged Care (2023), *Financial Report of the Aged Care Sector 2021-22*, p.111-12
15. ACFA (2021), *Ninth Report on the Funding and Financing of the Aged Care Industry*.
16. Grant Thornton (2023), *Key considerations for a capital model to support sustainability in the aged care sector*
17. UARC notes that one of the challenges in estimating the value of the sector's capital investment is that the historical costs of providers' assets do not necessarily correspond to their replacement value, either now or in the future.
18. Woods, M., & Corderoy, G. (2020). *Impact analysis: Alternative models for allocating residential aged care places, Final report*.
19. Tsihlis, E., Woods, M., Ries, N., Somes, T., Parker, D., Debono, D., P. Carnemolla, & Schofield-Georgeson, E. (2024). *A New Aged Care Act: A Submission on the Aged Care Bill 2023 Exposure Draft and Consultation Paper No. 2.*

Second, with the ongoing increase in the supply of subsidised home care, the revealed preferences of older people have become more evident.[20] The desire to be cared for at home was recognised by the Productivity Commission[21], Tune Review[22] and the Government[23] and has been echoed in the Aged Care Taskforce Report's Principle 1: "The aged care system should support older people to live at home for as long as they wish and can do so safely."[24]

While there has been a progressive change in the mix of home-based care and residential care, the Taskforce Report is also one of many to acknowledge that the increase in the numbers of older people, their incidence of dementia and greater frailty, and their complex care needs, all underpin an increase in the demand for residential aged care.

A third group of challenges concern the sustainability of providers' reliance on RADs as a form of capital financing. This policy enabled the sector to be capitalised when needed.[25] However, as displayed in Figure 8, it now represents 62.7 % of assets. Both ACFA and the Royal Commission proposed phasing out RADs from 1 July 2025.[26] More recently, the Aged Care Taskforce suggested this was too soon and considered it possible to phase out RADs and replace them with a rental model over a longer time horizon.[27]

Specifically, the Taskforce Recommendation 12 proposed (p.30):

> "Following an independent review in 2030, transition the sector by 2035 to no longer accept RADs as a form of payment for aged care accommodation and move to a rental-only model, provided the independent review finds that there is improved financial sustainability, diversified and adequate sources of capital to meet future demand and residential aged care is affordable for consumers."

A rental model has the potential to provide more stable operating income on accommodation assets, better reflect the returns on those assets than current RAD or daily accommodation payment (DAP) models and reduce liquidity risks for providers. Nonetheless, the fundamental challenge remains that providers will struggle to raise the capital needed for new and refurbished assets if the overall business model does not generate sufficient returns.

In this context, a central problem with phasing out RADs is their current sector value and the need to replace this source of capital. The latest published Department figures placed the value of RADs held by aged care providers at $35.5 billion (noting that at Senate Estimates in June 2024, this figure was updated to $38.1 billion).[28] While recapitalizing the sector by this amount would be a significant challenge, it becomes even more so when coupled with the projections from ACFA of additional capital requirements ($55 billion) and, more recently, projections from Grant Thornton ($72 billion), as outlined above.

20. Department of Health and Aged Care (2023), *Financial Report of the Aged Care Sector (2021-22)*, p.111-12
21. Productivity Commission (2011), *Caring for Older Australians*, Report No. 53, Final Inquiry Report, Canberra.
22. Department of Health (2017), *Legislated Review of Aged Care 2017*
23. Australian Government (2012), *Living Longer. Living Better. Aged Care Reform Package*
24. Australian Government (2024), *Final report of the Aged Care Taskforce*.
25. ACFA (2021), *Ninth Report on the Funding and Financing of the Aged Care Industry*.
26. ACFA (2021), *Ninth Report on the Funding and Financing of the Aged Care Industry* and Royal Commission into Aged Care Quality and Safety (2021), *Final Report – List of recommendations*, (Recommendation 142)
27. Australian Government (2024), *Final report of the Aged Care Taskforce*
28. Department of Health and Aged Care (2023), *Financial Report of the Aged Care Sector (2021-22)*.

Workforce issues

Key messages:

- Most residential aged care homes (63.9%) still have yet to meet both of their care minute targets.

- Homes with the lowest care minute compliance rates tend to be operated by for-profit providers and based in large population centres.

- In March 2024, the Fair Work Commission handed down Stage 3 of the aged care work-value case, increasing the awards of several different aged care roles. The Government has committed to funding the wage increases, although the exact timing of implementation has yet to be determined.

- With an increased focus on reducing workforce turnover, there is substantive academic evidence about the organisational, personal, relational and environmental drivers that providers and policymakers may consider as ways to reduce attrition and improve the retention of workers.

Direct care staffing

This financial year, the minimum direct care staffing requirements became mandatory for residential care providers. According to these minimum standards, providers must ensure that:

1. a registered nurse is on-site and on duty 24 hours a day, seven days a week, unless an exemption has been granted for up to 12 months (from 1 July 2023);
2. residents receive, on average across the sector, at least 200 minutes of total direct care per day (from 1 October 2023); and
3. a registered nurse provides at least 40 minutes of that care (also from 1 October 2023).

24/7 registered nurse coverage

Regarding the 24/7 registered nurse requirement, the latest statistics from the Department of Health and Aged Care (the 'Department') indicate that in March 2024, 91.3% of facilities reported having a registered nurse on-site 24/7.[29] However, as previously reported in UARC's 2022-23 full-year report, these statistics are based on exception reporting from providers and may not necessarily align with shift data on registered nurse hours worked (due, for instance, to the co-location of facilities, the allocation of RN care managers to nursing duties and the definition of being 'on-duty').[30] Previously, UARC reported that shift-level data indicated that homes may be experiencing challenges in consistently covering all three shifts throughout the 24 hours, particularly the overnight shift. UARC will continue to monitor registered nursing trends and report relevant emergent insights in its full-year 2023–24 report.

Information about each home's registered nursing coverage is now published on the MyAgedCare website.[31] The "Staffing" page for each provider provides the average hours per day a registered nurse was available and whether this met or did not meet the requirement.

To assist small homes in employing additional registered nurses to meet the requirement, the Government provides a 24/7 RN supplement on top of AN-ACC direct care funding. Eligible homes are those that have up to 60 residents and provide at least 20 hours of registered nurse coverage a day (i.e. 83.3% of the 24-hour requirement averaged over a month). This minimum coverage ratio will progressively increase over time (i.e. it will be 21 hours a day from 1 July 2024).

---

29. Registered Nurse (RN) coverage in residential aged care in March 2024 | Department of Health and Aged Care
30. Sutton, N., Ma, N., Yang, J.S., Lewis, R., Woods, M., Tsihlis, E., Lin, J., Parker, D. (2023), *Australia's Aged Care Sector: Full-Year Report (2022–23)*. UTS Ageing Research Collaborative.
31. Access Australian aged care information and services | My Aged Care

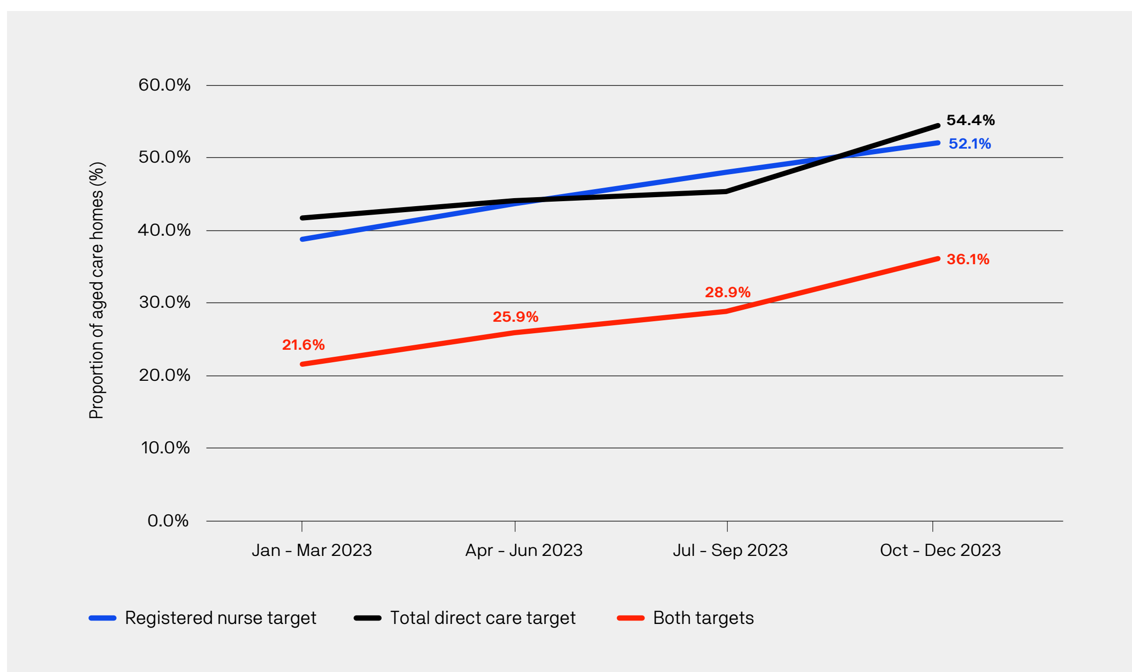
Majority of homes still below care minute targets

Regarding the two care minute requirements, each home's care minute targets are adjusted each quarter to account for differences in the relative needs of their residents, as assessed using the AN-ACC funding classification.[32] This means that homes with residents with more complex needs will have higher care minute targets, whereas homes with residents with less complex needs have lower care minute targets.

Each home's performance relative to their service-level targets is published on the MyAgedCare website, alongside the average hourly pay of direct care staff in different roles, resident experience survey results relating to staffing and the home's Star Rating for staffing.

Based on the last four quarters of Star Ratings data published by the Department, UARC has modelled the trend in the proportion of all homes across the sector that have staffing at or above their care minute targets.[33]

Figure 9: Proportion of homes meeting their service-level care minute targets



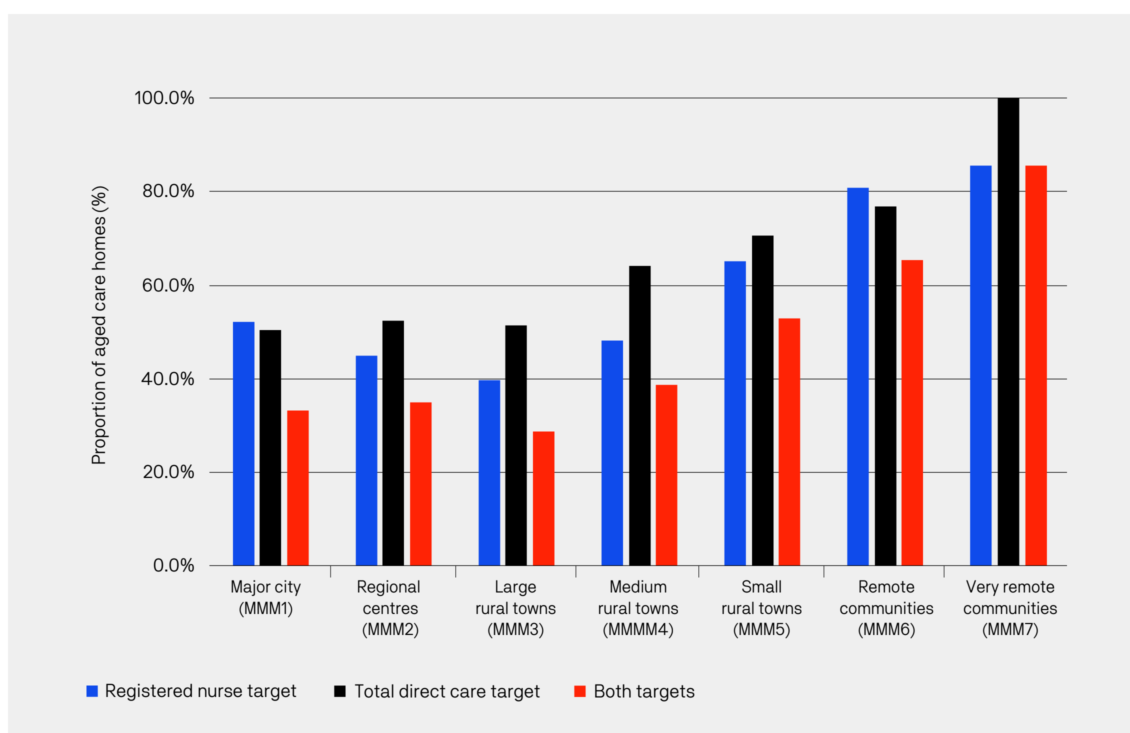
This analysis, depicted in Figure 9, shows that there has been a steady increase in the proportion of homes meeting their care minute targets. At the start of 2023, only 21.6% of homes had sufficient direct care staff to meet both care minute targets. By the October–December quarter, this had risen to 36.1% of aged care homes. Furthermore, in the October–December quarter, there was almost a ten percentage point increase in the proportion of homes meeting their total direct care minute targets.[34]

32. Care minutes and 24/7 registered nurse responsibility guide | Australian Government Department of Health and Aged Care
33. Data was sourced from four quarters of Star Ratings Quarterly extracts published by the Department of Health and Aged Care on its website. Each quarter of analysis included aged care services which received a Star Rating for staffing. There may be very minor differences in the unit of analysis, where a single home (or facility) may be separated into two co-located services for the purpose of reporting the care minutes for the Star Ratings.
34. There has been a very modest increase in targets as a result of homes' changing resident profile and slight adjustments in the care minute weighting formula over 2023. In January-March 2023, across all homes, the average total direct care minutes target was 195.6 minutes per resident per day. In October-December 2023, this had increased by 2.4% to an average total direct care minutes target of 200.3 minutes per resident per day.

However, these results also indicate that the majority of homes (63.9%) still have yet to meet both of their care minute targets. On the one hand, these results are a symptom of the ongoing challenges providers face in recruiting and retaining staff. However, on the other hand, these targets have been coming for a long time, having been first proposed by the Royal Commission and accepted by the then Coalition Government 3 years ago. Also, all homes across the sector have received substantial additional funding through higher AN-ACC subsidies to pay for additional direct care staff since 1 October 2022, with a further uplift since 1 July 2023. As described earlier in Part 1, homes have received this additional funding regardless of whether or not they have met their care minutes.

The effect of workforce shortages appears less straightforward once we disaggregate the latest results by remoteness. One could reasonably expect that the least challenging labour markets would be in the major cities, where homes have easier access to large working-age populations. However, counter to these expectations, Figure 10 shows that, as of December 2023, the highest compliance rates with care minute targets are in homes in small rural towns and remote communities (MMM5-7).

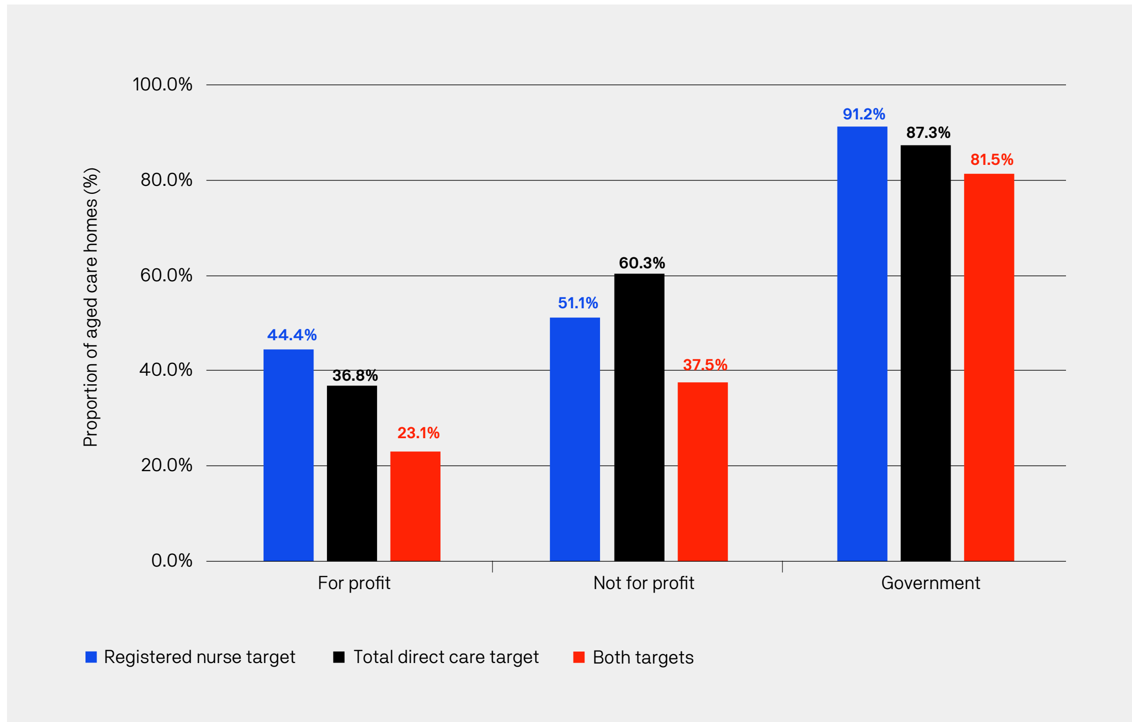
Figure 10: Proportion of homes that meet care minute targets, by remoteness (October – December 2023)



Similarly, substantial differences exist in the compliance rates of homes operated across different ownership types (see Figure 11). As of December 2023, government-operating homes have the highest compliance with care minute targets, noting that collective bargaining agreements with State Governments have previously determined their staffing levels.[35] However, even among privately run homes, there is variation. On average, only 23.1% of for-profit homes currently meet both their care minute targets, compared to 37.5% of not-for-profit homes.

35. Government-operated homes also operate under different funding arrangements, receiving State Government funding in addition to Commonwealth Government subsidies and resident contributions.

Figure 11: Proportion of homes that meet care minute targets, by ownership type (October – December 2023)



Care minute targets to increase further in 2024

From 1 October 2024, the care minutes target will increase to a sector-wide average of 215 care minutes per resident per day, including 44 minutes of registered nurse time.

Initial analysis conducted by UARC suggests that based on the October-December 2023 staffing levels, only 31.4% of homes would meet their incoming registered nurse care minute target, and only 27.4% would meet their incoming total direct care target. In combination, only 15.3% of homes have sufficient staffing to meet both their incoming targets.

The transition to the higher targets has been made slightly easier by a minor change announced by the Government that from 1 October 2024, providers will be allowed to meet up to 10% of their service-level registered nurse target with care time provided by an enrolled nurse. For example, a service with a registered nurse target of 50 minutes will be allowed to count 5.0 minutes delivered by enrolled nurses.[36] This measure contributes to mitigating the significant negative impact of the minimum standards on the employment of enrolled nurses. As detailed in Part 2 of this report, the average staffing time of enrolled nurses has fallen by 30.2% since December 2019.

36. Care minutes in residential aged care | Australian Government Department of Health and Aged Care

Fair Work Commission wage case

Effective on and from 30 June 2023, the Fair Work Commission (FWC) applied a 15% wage increase to aged care workers in the Aged Care Award, Nurses Award and Social, Community, Home Care and Disability Services (SCHADS) Industry Award as part of the Aged Care Work Value case. At the time, further issues around additional increases remained unresolved, including whether those increases should also be extended to other support services employees in aged care, such as laundry workers, cleaners, maintenance workers and administration staff.

The FWC handed down its decision in what has become known as Stage 3 of the work-value case in March 2024.[37] Due to a separate case before the FWC on pay rises for all nurses under the Nurses Award 2020, the exact percentage increase for registered and enrolled nurses has not yet been confirmed.

A key component of this latest development in the case was the Commission's delineation of the level of responsibility afforded to personal care workers (PCWs) and assistants in nursing (AINs) compared to indirect care workers, stating:

> On a review of the typical duties of the various categories of indirect care employees, it is readily apparent that they do not exercise either to the same degree or at all the skills and responsibilities of PCWs and AINs.
>
> …Without diminishing the importance of the work of indirect care employees in the above categories for the proper functioning of residential aged care facilities, it would depreciate the value of the 'invisible' skills of PCWs and AINs and vitiate the analysis of those skills in the Stage 1 decision and this decision to conclude that the above employees perform work of equivalent value justifying equal rates of pay.[38]

37. Decision [2024] FWCFB 150 | Fair Work Commission
38. Decision [2024] FWCFB 150 | Fair Work Commission (paragraphs 228 and 237)

Some of the main features of this FWC decision include:

- Substantial additional increases to the initial 15% increase awarded to PCWs and AINs depending on their level of experience and qualification. For example, a PCW with a Certificate IV would receive a total 23.7% wage increase (inclusive of the initial 15% already awarded). AINs would also move from the Nurses Award to be covered by the Aged Care Award.
- No further increase for head chefs/head cooks in aged care aside from the 15% awarded in the Stage 2 decision.
- The coverage of home care workers should remain in the SCHADS Award and should not be moved to the Aged Care Award, but their classification structure and rates of pay should be aligned with those of PCWs under the Aged Care Award as far as possible.
- A 3% increase was awarded to indirect care employees generally (such as clerks, laundry hands, cleaners and assistant gardeners) and a 6.96% total increase for laundry hands, cleaners and food services assistants due to a change in the Aged Care Award classification structure because they 'interact with residents significantly more regularly than other indirect care employees'.[39]

Workers and providers are both invested in the timing of the actual implementation of these wage increases. The Commonwealth's submission in reply to the decision on 'operative date and phasing in', published on 12 April, reveals that while it will commit to funding the wage increases for direct and indirect care workers, it would prefer a staggered and delayed implementation.[40] The FWC will make the final determination on this matter. If the FWC accepts the Government's position, the Budget will fund 50% of this Stage 3 wage increase for direct care workers from January 2025 with the remaining from January 2026. Indirect care workers would receive their increase in full, commencing from January 2025.

In its reasoning, the Government pointed to contextual justifications such as '…its fiscal strategy, which is focused on improving the budget position in a measured way, consistent with the overarching goal of reducing gross debt as a share of the economy over time, while seeking to deliver relief from cost-of-living pressures without adding to inflation' and that 'large one-off wage increases, particularly where large wage increases may draw workers from other sectors of the economy that also face employment shortages' such as 'hospital nurses, disability carers and childcare workers who have substitutable skills with aged care workers'.[41]

The Government's 2024-25 Budget notes that the operative date and phasing of the variations to award wages are subject to further consideration by the FWC. Funding has been set aside in the Contingency Reserve, which is: "a provision for the estimated financial impact of further wage increases resulting from the decision of the FWC's Aged Care Work Value Case – Stage 3, with the operative date and phasing in of wage increases still to be determined."[42]

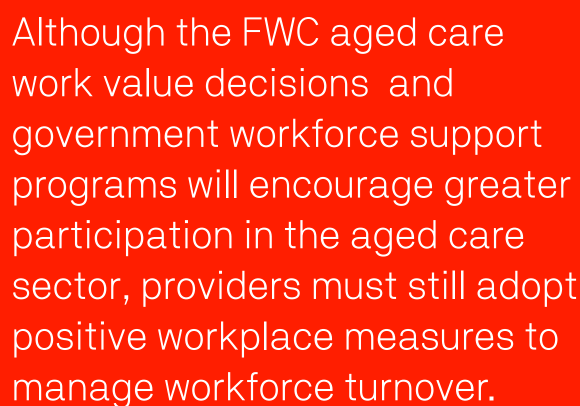
39. Summary of decision: Work value case – Aged care industry – Stage 3 [2024] FWCFB 150 | Fair Work Commission
40. Commonwealth's submissions concerning operative date and phasing in | Fair Work Commission
41. Commonwealth's submissions concerning operative date and phasing in | Fair Work Commission
42. Commonwealth of Australia (2024), *Budget 2024-25, Budget Strategy and Outlook (Budget Paper No.1)*, p.307

Workforce turnover

While residential aged care faces several major challenges, arguably the most publicised and detrimental to the continued delivery of quality care to older Australians is the challenge of workforce shortages and the ability to maintain appropriate staffing levels. Providers struggle to both recruit and retain qualified workers. In a recent survey, 49% of workers indicated their intent to leave the industry in the next five years, citing stress, overtime and low pay.[43]

In terms of figures about actual turnover rates, a survey of residential homes conducted in 2021-22 by StewartBrown on behalf of UARC found an average annual workforce turnover rate of 38%.[44] More recently, quarterly turnover data submitted by homes as part of the expanded National Mandatory Quality Indicator Program indicate an approximate annualized turnover of 23.2% (based on data showing 11.6% turnover for the first half of 2023–24).[45]

Although the FWC aged care work value decisions (discussed above) and government workforce support programs will encourage greater participation in the aged care sector, providers must still adopt positive workplace measures to manage workforce turnover. To provide insight into this topic, this section presents a synthesis of research evidence explaining the factors leading to workforce turnover and suggested mitigating interventions.



43. Ideagen (2023), *Ideagen Aged Care Workforce Report 2023*
44. Sutton, N., Ma, N., Yang, J.S., Lewis, R., Brown, D., Woods, M., McEwen, C., Parker, D. (2022) *Australia's Aged Care Sector: Full-Year Report (2021–22)*
45. Residential Aged Care Quality Indicators — October to December 2023 | AIHW GEN aged care data

Factors driving and mitigating of workforce turnover

Workforce turnover comprises two main drivers - attrition, which relates to employee intentions to leave a role, and retention, which focuses on reasons to stay.[46] These two main drivers can be categorised into three domains: organisational, personal and relational, and environmental.[47]

Organisational: this includes workload management and wages as key primary drivers of attrition and retention. However, research findings demonstrate that a range of other factors can have a positive impact:

- Adequate training during onboarding is seen as important, as it is an appropriate and accessible professional development opportunity to enable employees' skill enhancement and career progression.[48] Co-design of professional development programs can assist in the design of initiatives relevant to the aspirations of participants.[49,50]
- Transparency through communication and seeking regular staff feedback can identify issues before they escalate and provide a regular gauge of staff engagement and satisfaction.[51]
- Incorporating and regularly updating workplace structures such as safety policies, local staffing procedures, and frameworks for providing quality care also improves retention.[52,53]
- Staff empowerment and scheduling entails allowing more employee input into work conditions (e.g., rostering) and co-designing roles that provide employees with autonomy, decision-making power, and focus on interprofessional team development.[54, 55, 56] This includes policies and efficient scheduling practices to ensure appropriate skill mixes to manage workloads while allowing for flexibility in working conditions.[57, 58]

46. Radford, K., Shacklock, K., & Bradley, G. (2015). *Personal care workers in Australian aged care: Retention and turnover intentions. Journal of Nursing Management*, 23(5), 557-566.
47. Thwaites, C. McKercher, J.P. Fetherstonhaugh, D. Blackberry, I. Gilmartin-Thomas, J.F.-M. Taylor, N.F. Bourke, S.L., Fowler-Davis, S. Hammond, S. Morris, M.E. (2023). *Factors Impacting Retention of Aged Care Workers: A Systematic Review.* Healthcare, 11, 3008.
48. Jurij, R., Ismail, I. R., Alavi, K., & Alavi, R. (2023). *Eldercare's turnover intention and human resource approach: a systematic review*, International Journal of Environmental Research and Public Health, 20(5), 3932
49. M. E., Brusco, N. K., McAleer, R., Billett, S., Brophy, L., Bryant, R. & Blackberry, I. (2023). *Professional care workforce: a rapid review of evidence supporting methods of recruitment, retention, safety, and education*. Human Resources for Health, 21(1), 95
50. Martyn, J. A., Wilkinson, A., & Zanella, S. (2022). *Identifying the continuing education needs of personal care workers in two residential aged care facilities by an appreciative inquiry study*. Collegian, 29(6), 887-893
51. Thwaites, C., McKercher, J. P., Fetherstonhaugh, D., Blackberry, I., Gilmartin-Thomas, J. F., Taylor, N. F., & Morris, M. E. (2023). *Factors Impacting Retention of Aged Care Workers: A Systematic Review*, Healthcare 11(23), 3008
52. MacLaren, J., & Salmon, D. (2019). *Characteristics of successful interventions to reduce turnover and increase retention of early career nurses: A systematic review*. International Journal of Nursing Studies, 91, 47-59
53. Kennedy, K.A.; Applebaum, R.; Bowblis, J.R. *Facility-Level Factors Associated With CNA Turnover and Retention: Lessons for the Long-Term Services Industry*. Gerontologist 2020, 60, 1436–1444.
54. Radford, K. and Meissner, E. (2017), *Job satisfaction and intention to stay within community and residential aged care employees*. Australas J Ageing, 36: E1-E6.
55. Miller, V. J., Maziarz, L., Wagner, J., Bell, J., & Burek, M. (2023). *Nursing assistant turnover in nursing homes: A scoping review of the literature*. Geriatric Nursing, 51, 360-368
56. Foà C, Guarnieri MC, Bastoni G, Benini B, Giunti OM, Mazzotti M, Rossi C, Savoia A, Sarli L, Artioli G. (2020). *Job satisfaction, work engagement and stress/burnout of elderly care staff: a qualitative research*. Acta Biomed. 91(12-S)
57. Gao, F., Newcombe, P., Tilse, C., Wilson, J., & Tuckett, A. (2014). *Models for predicting turnover of residential aged care nurses: A structural equation modelling analysis of secondary data*. International Journal of Nursing Studies, 51(9), 1258-1270.
58. Krein, S. L., Turnwald, M., Anderson, B., & Maust, D. T. (2022). *Sometimes it's not about the money... it's the way you treat people: A Qualitative Study of Nursing Home Staff Turnover.* Journal of the American Medical Directors Association, 23(7), 1178-1184

Personal and relational: this includes job satisfaction, intrinsic motivation, and interaction with colleagues, residents and their representatives, and management.

- Hostile work relationships, high turnover among colleagues, and a lack of support, particularly around high-stress periods and emotional events (e.g., when residents die), have been highlighted as key drivers of attrition.[59, 60]
- Alternatively, support from management, work environments that foster a sense of belonging and psychological safety, and perceptions of job autonomy are all linked to higher retention rates.[61, 62]
- Fostering a supportive and positive workplace environment. This includes supporting the development of a strong teamwork culture by recognizing the importance of employee well-being, including stress-inducing factors, and supporting cultural diversity and inclusivity.[63, 64]

Environmental: this has a focus on the broader perceptions of aged care work across society and other circumstances that drive attrition and create difficulties in retaining staff at both the provider and sector levels.

- Employees are conscious of negative community views about the work in aged care and ageist societal attitudes, all of which deter continued work in the sector.[65, 66]
- Other employment opportunities can pose competitive threats if they offer equal paying jobs with less responsibility (e.g. retail) or higher-paying jobs (e.g. NDIS) and contribute to higher attrition rates in aged care when local unemployment levels are low.[67]

Overall, the research findings into the drivers of workforce attrition and retention have implications for providers and policymakers. For providers, managers play an important role in fostering an inclusive, transparent, and empowering workplace culture. For policymakers, the current perceptions and desirability of aged care work suggest further action is needed. More broadly, publicly available granular workforce turnover data can allow for better provider benchmarking and more research into understanding workforce turnover's social and economic consequences, appropriate management strategies, and government programs and regulatory settings to improve workforce attraction and retention.

---

59. Miller, V. J., Maziarz, L., Wagner, J., Bell, J., & Burek, M. (2023). *Nursing assistant turnover in nursing homes: A scoping review of the literature*. Geriatric Nursing, 51, 360-368.
60. Dijxhoorn, A.-F.Q.; Heijnen, Y.; van der Linden, Y.M.; Leget, C.; Raijmakers, N.J.H.; Brom, L. (2023). *Nursing assistants' perceptions and experiences with the emotional impact of providing palliative care: A qualitative interview study in nursing homes*. J. Adv. Nurs.
61. Matthews, M., Carsten, M. K., Ayers, D. J., & Menachemi, N. (2018). *Determinants of turnover among low wage earners in long term care: the role of manager-employee relationships*. Geriatric Nursing, 39(4), 407-413.
62. Foà C, Guarnieri MC, Bastoni G, Benini B, Giunti OM, Mazzotti M, Rossi C, Savoia A, Sarli L, Artioli G. (2020). *Job satisfaction, work engagement and stress/ burnout of elderly care staff: a qualitative research*. Acta Biomed. 91(12-S)
63. Miller, V. J., Maziarz, L., Wagner, J., Bell, J., & Burek, M. (2023). N*ursing assistant turnover in nursing homes: A scoping review of the literature*. Geriatric Nursing, 51, 360-368
64. Thwaites, C., McKercher, J. P., Fetherstonhaugh, D., Blackberry, I., Gilmartin-Thomas, J. F., Taylor, N. F., & Morris, M. E. (2023). *Factors Impacting Retention of Aged Care Workers: A Systematic Review*. In Healthcare 11(23), 3008
65. Amateau, G.; Gendron, T.L.; Rhodes, A. (2023). Stress, strength, and respect: *Viewing direct care staff experiences through a traumainformed lens*. Gerontol. Geriatr. Educ., 44, 380–395.
66. Booi, L.; Sixsmith, J.; Chaudhury, H.; O'Connor, D.; Young, M.; Sixsmith, A. *'I wouldn't choose this work again': Perspectives and experiences of care aides in long-term residential care*. J. Adv. Nurs. 2021, 77, 3842–3852.
67. Thwaites, C., McKercher, J. P., Fetherstonhaugh, D., Blackberry, I., Gilmartin-Thomas, J. F., Taylor, N. F., & Morris, M. E. (2023). *Factors Impacting Retention of Aged Care Workers: A Systematic Review*. In Healthcare 11(23), 3008

Star Ratings

Key messages:

- During the 2023 calendar year, there was a gradual improvement in the overall Star Ratings across the sector, as many homes shifted from 3 to 4 stars.
- 96% of homes now fall within the 3-4 overall star range, raising questions about the ratings' informativeness.
- The largest improvements occurred within the staffing sub-category. However, the average rating across all homes is 2.9 stars, which is still below 'acceptable' quality (i.e. below 3 stars).
- Homes rated 3 stars overall achieved the best financial returns in the first half of 2023–24.
- Staffing Star Ratings reflect homes' spending on direct care, particularly on staff. On average, homes receiving 1 or 2 stars for staffing generated large direct care margins in the first half of 2023–24.
- UARC's free online Star Ratings Dashboard has been recently updated to show quarterly trends and care minutes.

Recent trends in Star Ratings

The Australian Star Ratings program for residential aged care homes provides a broad suite of publicly available measures of home-level quality. The Star Ratings are published on the MyAgedCare website and provide older people and their families with information to aid their decision-making in selecting a residential home.[68] Each home is assigned an overall Star Rating and ratings for four sub-categories: resident experience, compliance, staffing and clinical quality.[69]

Star Ratings have been calibrated to correspond to the following:

- **1 star** – 'significant improvement needed'
- **2 stars** – 'improvement needed'
- **3 stars** – an 'acceptable' quality of care
- **4 stars** – a 'good' quality of care
- **5 stars** – an 'excellent' quality of care

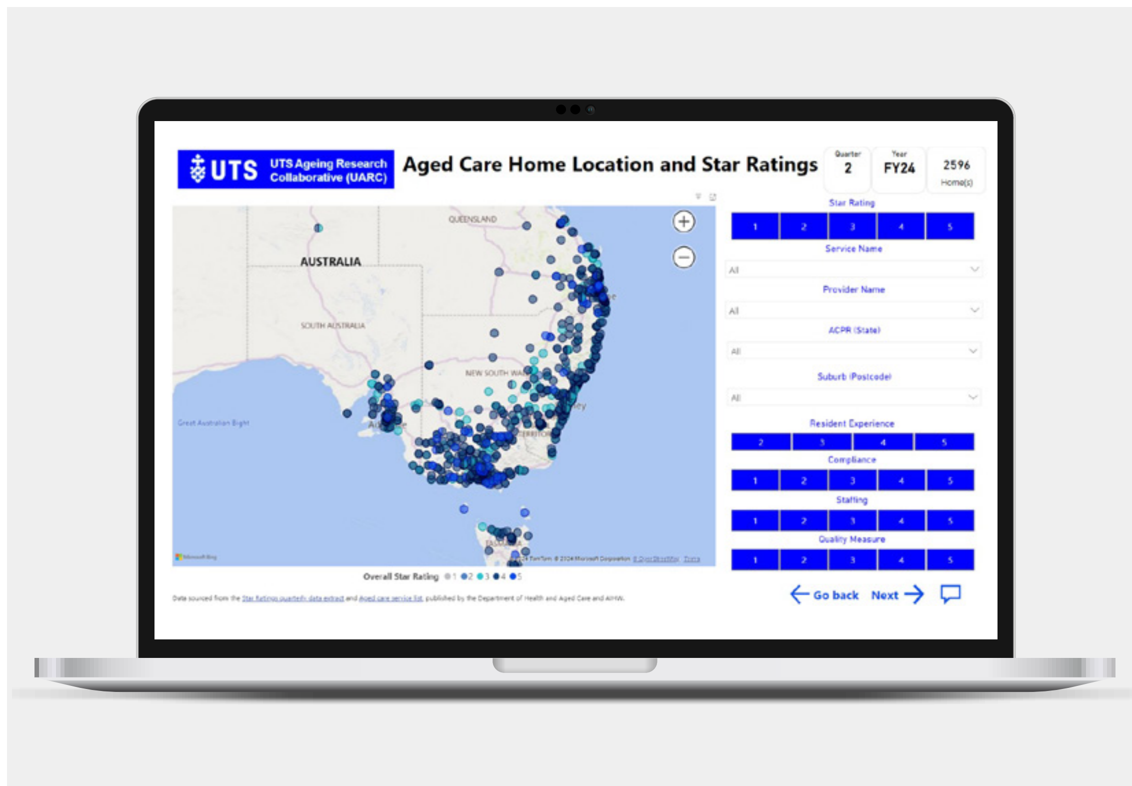
In addition, the Department has published five quarterly releases of Star Ratings data to date.[70] The availability of multiple quarters allows for an evaluation of emerging trends in the Star Ratings to understand the changes in quality as the recent suite of policy changes are implemented.

68. My Aged Care | Australian Government Department of Health and Aged Care
69. Star Ratings Provider Manual | Australian Government Department of Health and Aged Care
70. Star Ratings quarterly data extracts | Australian Government Department of Health and Aged Care

UARC Star Ratings Dashboard

To complement MyAgedCare, UARC has developed an online Star Ratings Dashboard that presents the Star Ratings data in an accessible, interactive visual format. Users can search ratings by provider, service name and location, analyse the results by provider characteristics, view homes geographically on a map (see Figure 12), and compare homes and providers side-by-side.

Figure 12: UARC Star Ratings Dashboard



Access UARC Star Ratings Dashboard

The UARC Star Ratings Dashboard is free to access online.

The most recent UARC Star Ratings Dashboard updates include care minute results (actual versus target) and longitudinal Star Ratings trends.

Trends in overall Star Ratings

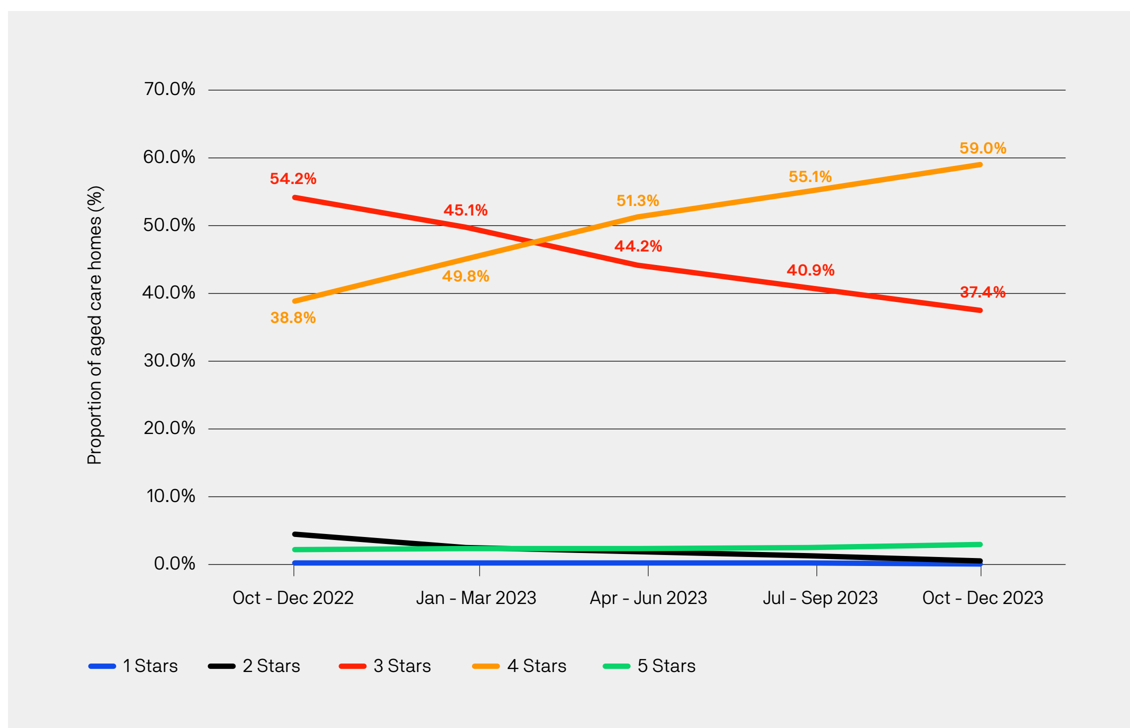
The overall rating is calculated by combining the ratings for the four sub-categories, noting that each has slightly different weightings:

- **Resident experience** – 33%
- **Compliance** – 30%
- **Staffing** – 22%
- **Clinical quality measures** – 15%

The average overall rating across all homes has gradually increased since the implementation of Star Ratings. In the first quarter of results (October – December 2022), the average overall rating was 3.4 out of 5. In the most recent quarter (October – December 2023), it is now 3.6 out of 5.

The main change has been a shift in the distribution of homes receiving 3 and 4 stars (see Figure 13). Whereas in the first quarter, 54.2% of homes received 3 stars and 38.8% received 4 stars, the most recent results show the inverse, with 37.4% now rated at 3 stars and 59.0% rated at 4 stars. There has been little change in the proportion of homes receiving 1, 2 or 5 stars (each of which has remained below 5%).

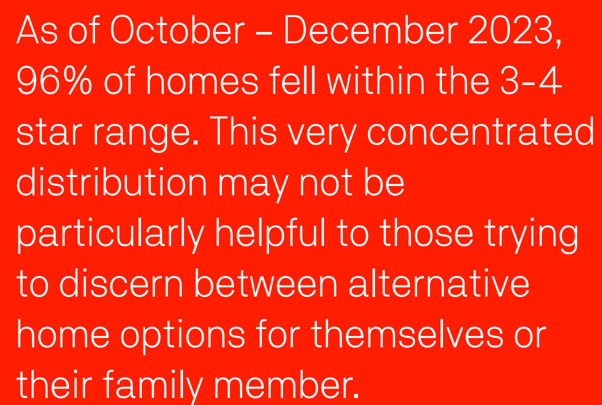
Figure 13: Trends in the distribution of homes by overall Star Rating



Although these trends point to small positive quality improvements across the sector, they also raise questions about the informativeness of ratings, at least in terms of the overall Star Ratings. As of October – December 2023, 96% of homes fell within the 3-4 star range. This very concentrated distribution may not be particularly helpful to those trying to discern between alternative home options for themselves or their family member.

By comparison, in the United States, which has a similar Star Ratings system, there is a much more even distribution of homes across the 5 stars,[71] meaning prospective residents can more often consider options at each of the 5-star levels. It is worth reflecting that the Care Compare system in the United States is much more mature than in Australia, with Star Ratings first published in 2008. Ideally, as the Australian system matures, it can be calibrated to deliver a more gradated perspective of the sector, enabling users to better discern the relative quality of different homes.

In the interim, individuals can access many other types of quality information about homes on MyAgedCare, including sub-category ratings, detailed information about each domain (e.g. benchmarked quality indicator results, staffing minutes and pay rates), and information about services, infrastructure and financial outcomes. Users can also view this information across multiple homes in the comparison tool.[72] Further research is required to investigate how much this additional quality information is understandable and relevant to individuals and the extent to which it helps them make comparative assessments about alternative residential homes.



As of October – December 2023, 96% of homes fell within the 3-4 star range. This very concentrated distribution may not be particularly helpful to those trying to discern between alternative home options for themselves or their family member.

71. United States Government Accountability Office (2023), *CMS Offers Useful Information on Website and Is Considering Additional Steps to Assess Underlying Data*, Report GAO-23-105312.

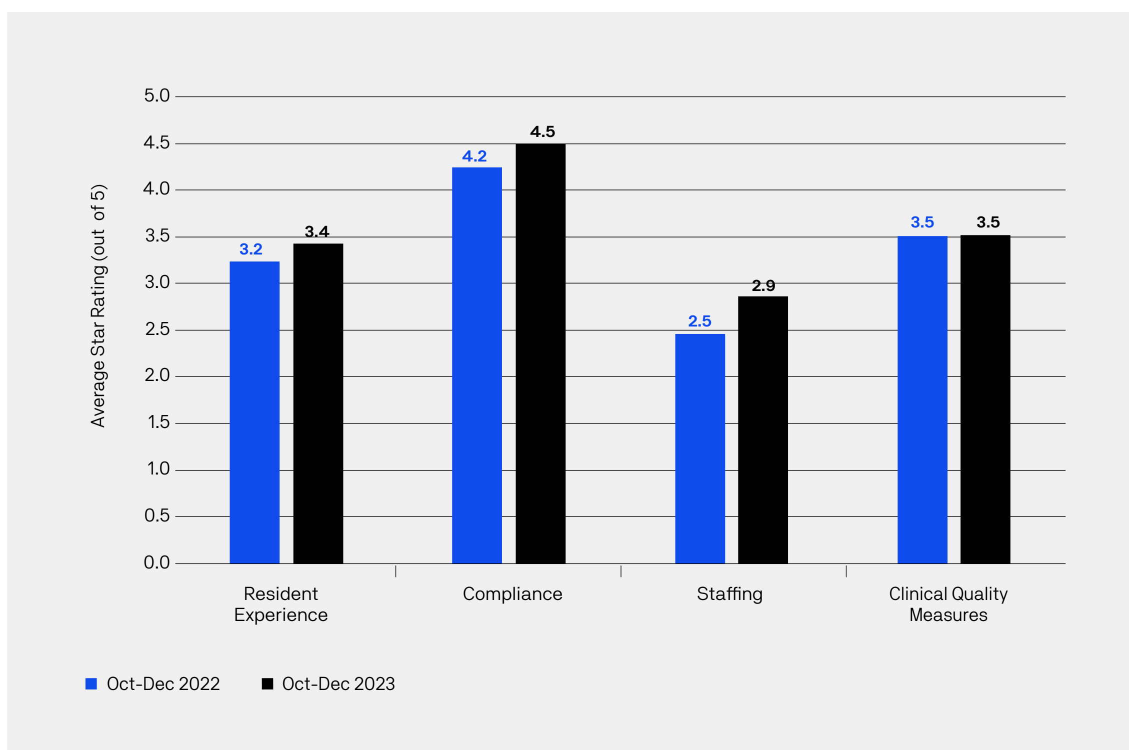
72. Find a provider | My Aged Care

Trends in Star Ratings sub-categories

The Star Rating sub-categories provide insight into trends relating to specific aspects of quality. Figure 14 shows the year-on-year change in the average ratings across the sector (i.e. across all homes) for the four sub-categories. The largest improvements occurred in the staffing ratings, rising from an average of 2.5 to 2.9 Stars, noting that this coincides with the care minutes targets becoming mandatory from 1 October 2023. While the modest improvement in staffing is a positive development, the average rating across the sector is still below what is considered 'acceptable' quality (i.e. below 3 stars). As the staffing rating reflects homes' direct care staffing levels vis-à-vis their care minute targets, this result aligns with the findings reported in the Workforce Issues section of this report that most homes have yet to meet their care minute targets.

In terms of the other sub-categories, there have been modest improvements in the average ratings for compliance and resident experience over the last year, with the rating for clinical quality measures remaining stable.

Figure 14: Average Star Rating, by sub-category

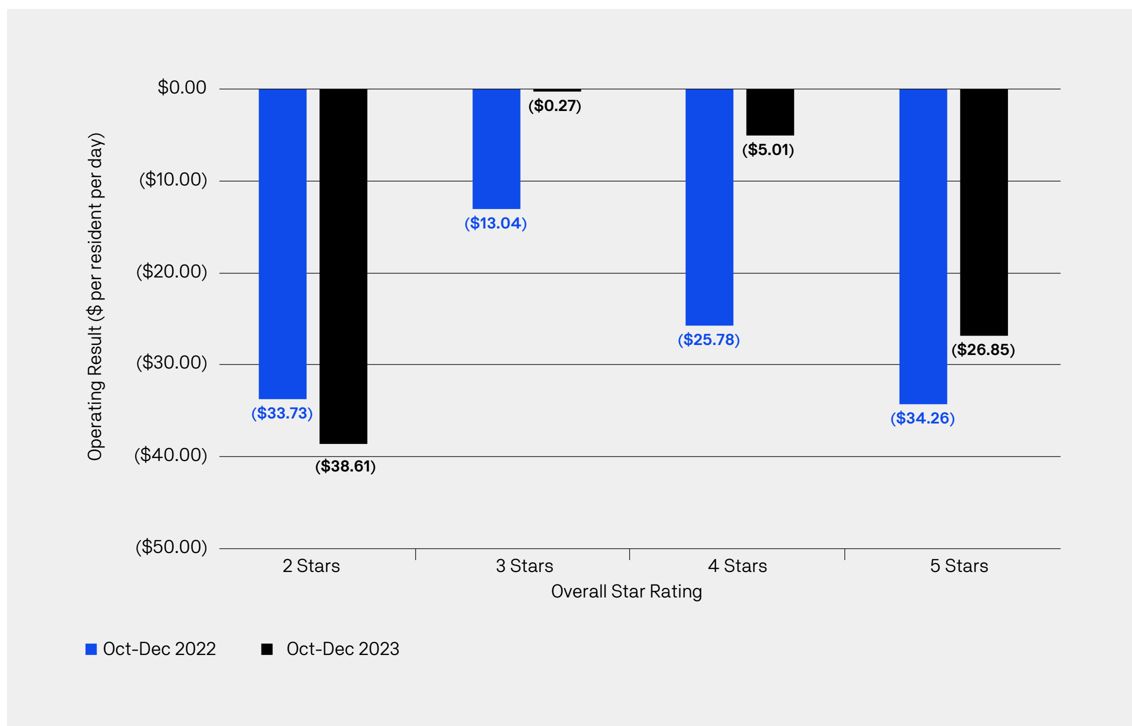


Financial outcomes of Star Ratings

In UARC's 2022-23 full-year report, we presented initial evidence that homes with the highest overall Star Ratings tended to have the worst financial outcomes, noting that homes with poor regulatory compliance scores (i.e. 2 stars) also reported substantial operating losses.[73] In this edition, UARC revisits this analysis, examining the average Operating Results of homes split by overall Star Rating (Figure 15). This analysis compares homes a year apart for the same quarter (October – December).[74]

The latest results show a similar pattern, with homes rated 3 stars overall achieving the highest financial result (i.e. smallest operating deficit averaging $0.27 per resident per day). By comparison, 4-star and 5-star homes generated operating losses of $5.01 and $26.85 respectively. As before, 2-star homes incur substantial operating losses, with an average operating deficit of $38.61 per resident per day.

Figure 15: Operating Result, per resident per day, by overall Star Rating

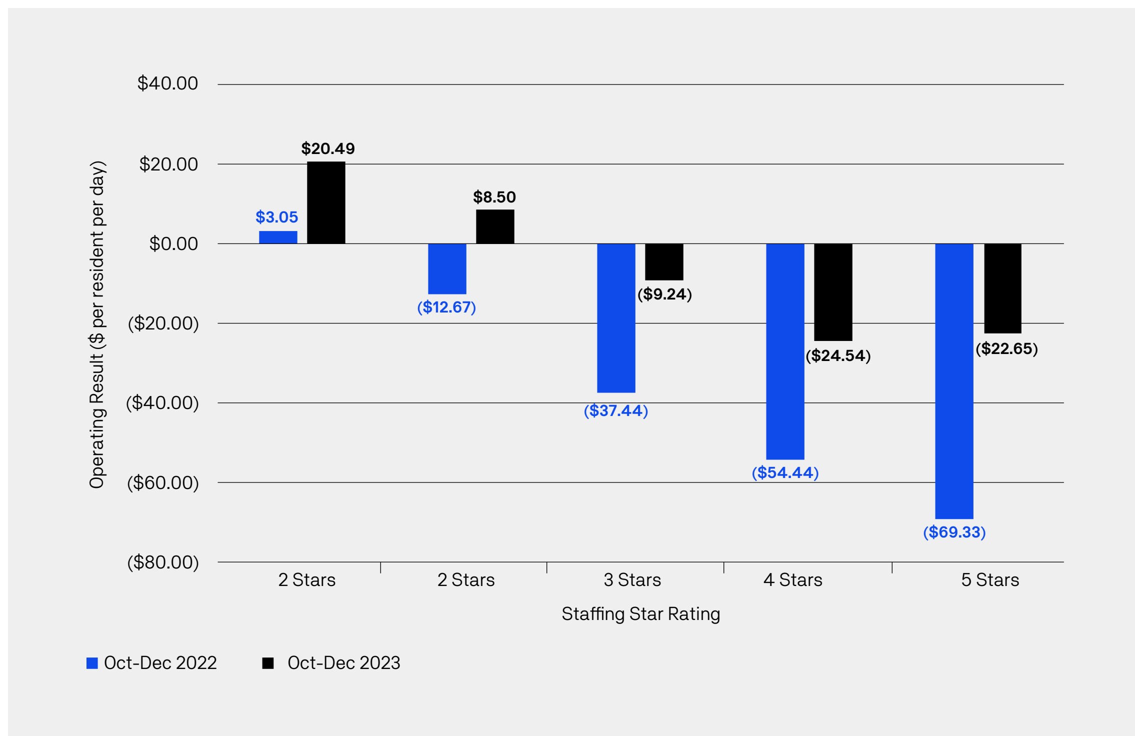


73. Sutton, N., Ma, N., Yang, J.S., Lewis, R., Woods, M., Tsihlis, E., Lin, J., Parker, D. (2023) *Australia's Aged Care Sector: Full-Year Report (2022–23). UTS Ageing Research Collaborative.*

74. This analysis was conducted by using the Star Ratings of de-identified homes in the StewartBrown Residential Care Dataset (1,088 homes in half-year 2022-23 and 1,141 homes in half-year 2023–24). Rating categories represented by fewer than 10 homes are not graphed.

In the prior period, the staffing sub-category caused the largest divergence in homes' Operating Results. Figure 16 revisits this analysis, showing the average Operating Result of homes, split by their staffing rating. Although the association between homes' financial outcomes and staffing ratings persists (generally, the higher the home's rating, the worse their overall profitability), it has moderated slightly compared to the same period a year before.

Figure 16: Operating Result, per resident per day, by Staffing Star Rating

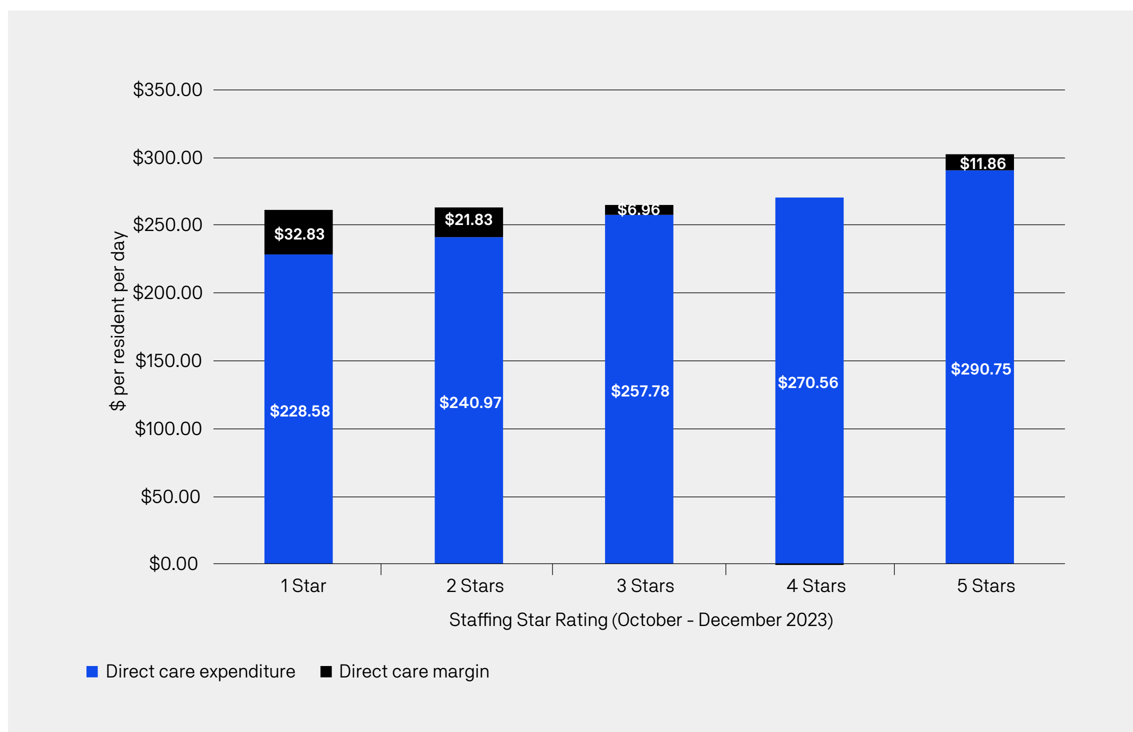


Staffing ratings and direct care expenditure

Delving deeper, Figure 17 shows the average direct care expenditure and margin of homes, split by staffing rating (as of October – December 2023). There appears to be some association between homes' spending on direct care and their staffing rating. Perhaps unsurprisingly, the highest-rated homes spend the most on direct care (on average, the spending differential between 1 and 5-star homes is $62.17 per resident per day).

However, an important caveat is that homes across the sector receive different levels of direct care funding, which will likely influence the scope of their expenditure and thus translate into different ratings. For example, a separate analysis (not shown) indicates that homes eligible for higher base care tariffs (in rural and remote areas) and 24/7 RN supplements (small homes) are both over-represented in the 5-star category. As can be seen in Figure 17, homes rated 5 stars have the highest average direct care revenue (depicted in the total height of the column, i.e. the sum of direct care expenditure plus direct care margin).

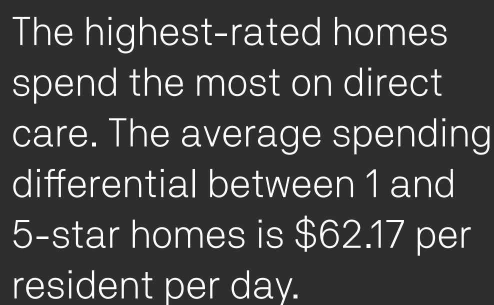
Figure 17: Direct care expenditure and margin, per resident per day, by staffing Star Rating



Aside from the 5-star homes, the remaining homes have similar direct care funding levels (averaging $261-$270 per resident per day) but vastly different expenditure patterns. Figure 17 shows that 4-star homes, on average, spend 100% of their direct care funding and earn no margin (-$0.19) from direct care, whereas 1-star homes spend only 87% and earn substantial direct care margins averaging $32.82 per resident per day. Homes with an 'acceptable' staffing rating (i.e. 3 stars) currently earn $6.96 per resident per day in direct care margin.

Further analysis of key line items (not graphed) confirms that the largest difference in direct care expenditure relates to registered nurse labour cost. On average, 4-star homes expenditure of registered nurses is almost double that of 1-star homes ($65.66 and $36.14 per resident per day, respectively). By comparison, there are only marginal differences in the expenditure on enrolled nurses and personal care workers.

These results corroborate other findings in this report, such as that a segment of the sector is not meeting its care minute targets and receiving 1 or 2 stars for staffing yet is deriving substantial direct care margins from the resulting underspend on direct labour.



Legislation update

Key messages:

- The Exposure Draft of the new Aged Care Act demonstrated some positive progress in the drafting, but key sections remained blank. The new target date for commencement is 1 July 2025, which will coincide with the proposed Support at Home program and the introduction of the new Quality Standards.

- Although there is an extensive amount of new drafting that requires consultation and reworking in response, including all the Rules, sufficient time must also be made available for providers and older people to prepare for the introduction of the new legislation.

- New research led by UARC proposes 'dementia capability' as a framework for improving legal planning for all older people who seek to safeguard their future.

New Aged Care Act

The Exposure Draft and second Consultation Paper for the new Aged Care Act was released in December 2023, following the release of the proposed foundations of the legislation in the months prior.[75] The new documents demonstrated some progress in developing the new legislation on matters such as the Statement of Rights for older people accessing care and the Statement of Principles for providers. A notable improvement was the inclusion of principles relating to fiscal sustainability and the need to efficiently and effectively utilise the taxpayer resources that fund the subsidies.

There have been some other notable improvements to the Exposure Draft, which UARC recognised in its submission, such as aligning the test used in whistleblower protection legislation with existing federal legislation.[76] Introducing a Complaints Commissioner is also a positive step, with consultation on complaints mechanisms and management systems for providers expected to occur separately at some stage, according to the Consultation Paper.[77] In April this year, a Memorandum of Understanding was signed between the Aged Care Quality and Safety Commission and the Office of the Inspector General of Aged Care, which, though not legally binding, aims to provide a framework for information-sharing between both parties, including on oversight of complaints at a systemic level.[78]

However, key sections of the Exposure Draft were left blank, including the entirety of Chapter 4, titled 'Fees, payments and subsidies', which UARC notes will be pivotal in ensuring the sustainability of the aged care system. After the consultation period ended, the Government released the Aged Care Taskforce final report in March 2024.[79] The report's funding recommendations were built on a set of principles, including that while public funding should focus on the delivery of care (including in thin markets) and safety nets for other services, personal co-contributions should be focused on accommodation and everyday living costs. The Government's response and the translation of those decisions into the legislation was not announced as part of the 2024-25 Budget brought down on 14 May 2024 and remains to be seen.[80] Further, 'the Rules', which are expected to provide insight into the mechanism of many provisions in the Exposure Draft, remain to be released for consultation.

Accordingly, the announcement from the Minister in April to defer the commencement date of the Act was anticipated.[81] The 2024-25 Budget included a new date of 1 July 2025, aligning with the proposed start date for the new Support at Home program.[82] The Government also announced that $1.2 billion will be invested into critical digital systems to support the introduction of the new Act and deliver a contemporary IT system.[83]

75. Exposure Draft – Aged Care Bill 2023 | Australian Government Department of Health and Aged Care
76. Tsihlis, E., Woods, M., Ries, N., Somes, T., Parker, D., Debono, D., Carnemolla, P. & Schofield-Georgeson, E. (2024), *A New Aged Care Act: A Submission on the Aged Care Bill 2023 Exposure Draft and Consultation Paper No. 2.*
77. Department of Health and Aged Care (2023). *A New Aged Care Act: Exposure Draft. Consultation Paper No. 2*
78. Aged Care Quality and Safety Commission (2024), *Memorandum of Understanding between the Commission and the Office of the Inspector General of Aged Care*
79. Department of Health and Aged Care (2024), *Final Report of the Aged Care Taskforce*
80. Department of Health and Aged Care (2024), *Final Report of the Aged Care Taskforce*
81. Minister for Aged Care - Statement - 3 April 2024 | Australian Government Department of Health and Aged Care
82. Commonwealth of Australia (2024), *Budget 2024-25, Budget Strategy and Outlook (Budget Paper No.1), p.229*
83. Commonwealth of Australia (2024), *Budget 2024-25, Budget Strategy and Outlook (Budget Paper No.1), p. 29*

UARC recognises that the far-reaching scope of the legislative reform requires diligent consideration of all its elements to ensure it reflects a true improvement on its 1997 predecessor, a notion clearly expressed in UARC's recent submission to the Department. That submission further explains the various issues requiring resolution, including those discussed below.[84]

The Aged Care Quality and Safety Commission has recently confirmed that the new strengthened Quality Standards will not come into effect until the new Act commences.[85] An unintended positive outcome of a delay in implementing the Act is that some of the complex interim provisions in the Exposure Draft relating to the current home care packages program can now be removed.[86] In any event, there will need to be ongoing communication on specific timelines for the remaining reforms and an explanation of what the community and providers can expect in terms of additional opportunities for consultation.

In UARC's view, an underappreciated aspect of the Act as it stands in the Exposure Draft is its complexity and reliance on an entanglement of Constitutional powers. This issue has the potential to distort the development of good policy, and, in turn, there may be challenges in future-proofing the Act's ability to respond to emerging circumstances. For example, due to its reliance on the hospital benefits power, as UARC raised in its submission, the focus on treating 'sickness' reverts to an earlier paradigm of medicalised aged care. Such an approach would not appear consistent with one of the stated objects of the aged care system in the Exposure Draft, which is to assist older people 'to live active, self-determined and meaningful lives'.

Further, it is well acknowledged that there will need to be a diversification of the types of places where care is delivered for older people as their needs and preferences change over time, whether at a private home, in a retirement village, supported accommodation or residential care home. However, as UARC noted in its submission, registration requirements under the proposed Act create constraints due to ambiguity around the definition of residential aged care. Compounding this is the differing State and Territory legislation governing retirement villages.

Development of the new Act could allow the Commonwealth to work with the states and territories to create a more consistent framework, not only regarding retirement village regulation but more broadly in terms of a referral of aged care powers by the states to the Commonwealth.

84. Tsihlis, E., Woods, M., Ries, N., Somes, T., Parker, D., Debono, D., Carnemolla, P. & Schofield-Georgeson, E. (2024), *A New Aged Care Act: A Submission on the Aged Care Bill 2023 Exposure Draft and Consultation Paper No. 2*.

85. Strengthened Aged Care Quality Standards guidance consultation | Australian Government Aged Care Quality and Safety Commission

86. About the Support at Home program | Australian Government Department of Health and Aged Care

Legal planning for older adults

All adults have legal rights to plan for future periods of incapacity and the end of life. Legal planning may include: appointing trusted people as supporters and enduring representatives; preparing advance directives; and making a will and other estate planning arrangements. Legal planning is of heightened importance for older people, especially those with chronic or life-limiting conditions. However, the uptake and quality of legal planning documents and practices are uneven.

New research led by UARC proposes 'dementia capability' as a framework for improving legal planning for all older people who seek to safeguard their future.

Background and benefits of legal planning

When done well, legal planning has a number of benefits. It enables choice and control for older people and ensures their values and preferences are known in the event of serious illness and incapacity. Effective legal planning helps supporters and enduring representatives be prepared for involvement in decisions during difficult circumstances, which, in turn, can reduce conflicts (e.g., about medical treatment decisions) and avoid legal disputes (e.g., estate litigation). Appointing trusted people with the time, aptitude, and skill to perform financial or medical decision-making roles can reduce the risks of older people being financially exploited or receiving care that is contrary to their wishes.

Unfortunately, many older people are deprived of these benefits due to deficiencies in the uptake and quality of legal planning.

Current deficiencies in legal planning

Gaps in uptake: Survey studies reveal that few Australians have completed all four of the main legal planning documents: a will, an enduring financial power of attorney appointment, an enduring healthcare decision-maker appointment, and an advance care directive. While the majority (over 80%) of people aged over 70 have a will, uptake drops to around 60-65% for an enduring power of attorney, around 50% for an enduring guardian, and less than one-third have any kind of advance directive.[87] Uptake rates are lower among people not of Anglo-Celtic or other European backgrounds.[88] Studies also reveal gaps in legal planning among people with dementia, even though such planning should be encouraged as part of post-diagnosis support. For example, audits of health and aged care facilities found that around 40% of people with dementia had no advance care planning documentation.[89]

87. Bryant, J. et al. (2021). *Participation in future planning by community-dwelling older Australians receiving aged care services: Findings from a cross-sectional survey. Australasian Journal on Ageing*, 40(4), 373–380.
88. Jeong, S. et al. (2014). *"Planning ahead" among community dwelling older people from culturally and linguistically diverse backgrounds: A cross-sectional survey*. Journal of Clinical Nursing, 24(1–2), 244–255.
89. Bryant, J. et al. (2022). I*nadequate completion of advance care directives by individuals with dementia: national audit of health and aged care facilities.* BMJ Supportive & Palliative Care, 12, e319–e328.

Gaps in quality: Even when older people report having legal planning documents, there is no guarantee those documents are up-to-date, well-drafted, and likely to be considered legally valid. While wills are commonly reported, a study found that less than half of older people had ever updated their will.[90] Other studies reveal gaps in understanding legal planning documents. Among over 200 participants in a NSW survey (mean age of 73 years), only 2.8% correctly answered six knowledge questions about legal planning.[91] For example, over half (58%) wrongly thought that an Enduring Power of Attorney (limited in NSW to financial powers) can make health care decisions. This also raises the broader issue of inconsistencies of powers and documentation across the States and Territories.

Another quality concern arises when legal planning documents are made by someone other than the older person. For people with dementia who have advance care planning documentation, research indicates that for around half of them, the document was completed by someone else, such as a healthcare provider or family member.[92] It is uncertain whether the documents truly reflect the values and preferences of the older person.

Documents written in vague or legalistic language may be difficult to implement in the future. For example, an audit study of advance care directives in a NSW public hospital found that only 50% were considered valid to inform clinical decisions.[93]

Deficient legal practices: Research also highlights problematic practices among legal practitioners when working with older clients. Problems include: poor processes for assessing client capacity; uncertainty about how to enable decision-making capacity for older people with cognitive disability, especially when a support person is involved; or making assumptions about a lack of capacity that denies older people their rights to engage in legal planning.[94] Practitioners may unwittingly facilitate the financial abuse of older people by drafting legal documents for someone who does not understand the nature and consequences of the document or is under the manipulative influence of another person.

90. Tilse, C. et al. (2016). *Making and Changing Wills: Prevalence, Predictors and Triggers*. Sage Open, 6(1), 1–11.
91. Cameron, E., et al. (2024). Advance personal planning knowledge, attitudes, and participation amongst community-dwelling older people living in regional New South Wales, Australia: a cross-sectional survey (under review).
92. Bryant, J. et al. (2022). *Inadequate completion of advance care directives by individuals with dementia: national audit of health and aged care facilities*. BMJ Supportive & Palliative Care, 12, e319–e328.
93. Friedewald, M.L. and Cleasby, P.A. (2017). *Advance care directive documentation: issues for clinicians in New South Wales*. Australian Health Review, 42(1), 89-92.
94. Barry, L. (2018). '*He was wearing street clothes, not pyjamas': common mistakes in lawyers' assessment of legal capacity for vulnerable older clients*. Legal Ethics, 21(1), 3-22.

Dementia Capability as a Strategy to Improve Legal Planning

The concept of 'dementia capability' provides a framework to improve legal planning for older people and bolster the uptake and quality of planning practices and documents. Dementia capability refers to the knowledge, skills, attitudes and behaviours that professionals – in legal, health and aged care sectors – need so as to work effectively with people living with dementia, as well as any older person concerned with planning ahead for their future.[95]

Pioneering Australian research – led within UARC's Law, Ethics & Regulation Theme – engaged with legal practitioners across the country (mainly specialists in elder law/wills and estates) and people with lived experience of dementia to develop a set of dementia capable attributes. These attributes span five categories:

- knowledge;
- legal rights and risks;
- capacity;
- communication; and
- advocacy.

The attributes emphasise the importance of encouraging earlier and comprehensive engagement with legal planning for older people. Planning must be approached as an ongoing process that reflects their contemporary values and preferences, rather than one-off legal transactions. The attributes encompass preventive strategies that seek to reduce the risks of exploitation and abuse for older people. Careful selection of supporters and enduring representatives is essential to prevent these risks, as is clear and open communication about the values and preferences the older person wants to be respected in future decisions that affect them.

Strengths-based approaches are at the core of the attributes. Decision-making capacity must be appropriately considered and supported through various practical strategies. Communication-related attributes set out guidance on effective and respectful communication. Beyond the professional-client relationship, systemic advocacy is necessary to campaign for laws, policies and practices that promote and protect the rights of older people in our society.

The full report on dementia capability is available here:
www.dementialawnetwork.org/dementia-capability

95. Pietsch, J. (2015). *Becoming a 'Dementia-Capable' Attorney - Representing Individuals with Dementia*. Hawaii Bar Review, 19(12), 1.; Godfrey, D. (2015). *Developing Dementia-Friendly Communities and Dementia-Capable Professionals.* Bifocal, 36(3), 5.

Sector sustainability

Key messages:

- The 2024-25 Budget headline for aged care focused on new investment of $2.2 billion, of which $1.4 billion will be directed to information systems development. An additional amount has been set aside to fund Stage 3 of the FWC work value wage case.
- As of this edition of the Sector report being finalised, the Government has not released its response to the Taskforce recommendations. This will be contingent on finalising negotiations with other parliamentary members and senators.
- Acceptance of the Taskforce proposals would introduce much-needed change to aged care funding and improve the sector's capital structure over time.
- The additional 24,100 home care packages are a welcome response to the recent rise in waiting lists and times.
- However, supply-side constraints in the delivery of home care persist, including workforce shortages, greater use of third-party providers and the continuing growth of unspent funds.
- Greater transparency is required regarding the time older people must wait for home care, noting that the Department's statistics ignore the time spent waiting for assessment approval and finding a provider to deliver services.

Budget 2024-25

The 2024-25 Federal Budget included $35.8 billion for aged care expenditure by the Department of Health and Aged Care in the coming financial year. Overall, aged care funding will represent at least 1.3% of GDP.[96]

An unspecified amount has also been included in the Budget's Contingency Reserve, primarily to fund additional wage increases resulting from the Stage 3 Aged Care Work Value case. As the Budget Papers note, the Government has committed to providing funding to support the award wage increases, but at this stage, their operative date and phasing are still to be determined.

The $35.8 billion expenditure in 2024-25 should be assessed in the context of the Government's often repeated aim of addressing long-term fiscal sustainability. As set out in last year's Intergenerational Report, aged care is one of the five enduring budget pressures facing the Government, along with health, disability care, defence and interest payments.[97] In addition, this Budget sought to balance the competing fiscal impacts of reducing inflation and providing some cost-of-living support.

The Government's Budget commentary emphasised a headline figure for new expenditure: "Total aged care investment $2.2 billion." [98] However, over half of this additional funding ($1.4 billion) is to "upgrade the technology systems and digital infrastructure across the sector, including to support the requirements of the new Aged Care Act and Support at Home program." Although there is insufficient detail to assess whether this funding will be well-spent, enhanced digital platforms have the potential to improve overall efficiency, and they also require ongoing investment in cyber security.

The new investment also includes $531.4 million to fund an additional 24,100 home care packages, which comes at a time when waiting lists have been rising again (see Figure 18 below). There is insufficient information to assess whether this will be enough to meet and exceed the growth in demand. However, the Government claims that the Single Assessment System will commence on 1 July this year, and the new Support at Home program is currently scheduled for 1 July 2025. Our latest analysis of home care packages is set out later in this section.

Over four years, $110.9 million has been provided to implement the new Aged Care Regulatory Framework and continue to invest in the Aged Care Quality and Safety Commission. A further $87.2 million will be spent to continue workforce initiatives, including the Aged Care Nursing Clinical Placements Program, Aged Care Transition to Practice Program and Aged Care Nursing Scholarships.

The 2024-25 Budget also includes improvements to the health services available to older people, including through the interface between mainstream health and aged care. To this end, and to reduce the number of older people stuck in hospitals when their needs can be better addressed in other care settings, $882.2 million has been allocated to support states and territories to provide hospital outreach in the community, deliver virtual care to prevent avoidable hospitalisations and upskill the residential aged care workforce.

96. Budget 2024-25: Budget overview | Department of Health and Aged Care
97. Commonwealth of Australia (2023), *Intergenerational Report 2023: Australia's future to 2063*
98. Budget 2024-25: Budget overview | Department of Health and Aged Care

Deferral of the response to the Aged Care Taskforce Report

While there was early hope that the Government would incorporate its response to the Taskforce into the Budget, this was not the case. Instead, it announced that: "The Government is continuing to consult with older Australians and stakeholders to ensure there is broader support for reforms to improve the standard of aged care."[99] This should be read, in particular, as needing to secure a majority in the Senate to pass the necessary legislation.

While the delay is unfortunate, much in the Taskforce report warrants an ongoing engagement with the Government's parliamentary colleagues with a view to the ultimate passage of the proposed reforms. Two central principles adopted by the Taskforce that underpin its various recommendations are (p.11):[100]

> "Principle 3: Government is and will continue to be the major funder of aged care. Government funding should be focused on care costs as well as delivering services in thin markets. Personal co-contributions should be focused on accommodation and everyday living costs with a sufficient safety net.
>
> Principle 4: The residential sector should have access to sufficient capital to develop and upgrade accommodation, including in rural and remote areas and First Nations communities."

Matters arising from these two principles are addressed elsewhere in this report's edition, although it is worth underlining the importance of increasing the level of personal contributions to everyday living services and accommodation by those with sufficient means. There is also substantial merit in raising contributions for home care for those services that provide domestic support and home maintenance (with appropriate safety nets), compared to direct health and personal care.

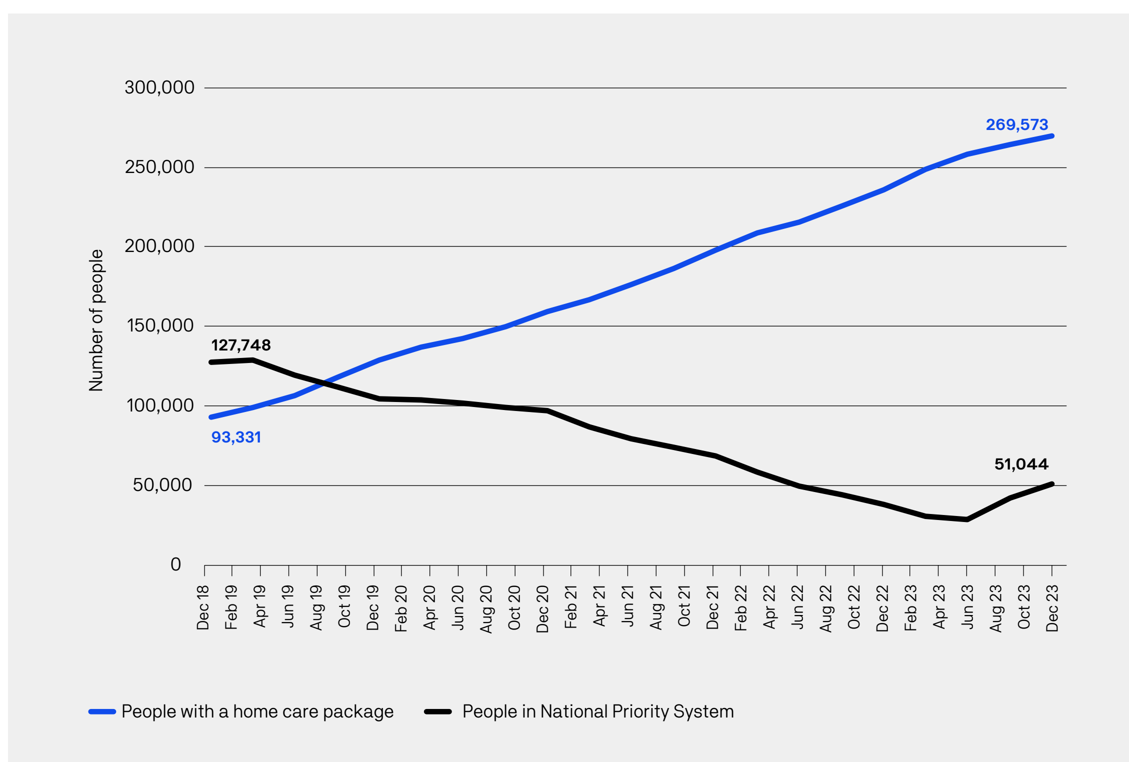
In relation to Principle 4 in particular, the earlier section on Capital Financing explores the option of phasing out RADs and replacing them with a rental model, provided the sector was able to access sufficient capital to remain viable and to deliver the services needed by Australia's ageing population. Until the RAD/DAP policy settings are restructured, the Taskforce's proposal for a small retention rate of lump sums will improve the viability of providing accommodation.

99. Budget 2024-25: Budget overview | Department of Health and Aged Care
100. Australian Government (2024), *Final report of the Aged Care Taskforce*

Ongoing expansion of Home Care Packages

As noted above, the 2024-25 Budget included over half a billion dollars to fund an additional 24,100 home care packages to enable more older people to receive care in their homes. To provide context to this announcement, UARC has compiled statistics published by the Department about the number of people with a home care package since the Royal Commission was announced (see Figure 18).[101] This demonstrates a continuous and substantial Home Care Package program expansion, tripling in size since 2018. More people than ever are receiving care in their own homes, which enables them to 'age in place' and remain independent and embedded within their local communities.

Figure 18: Number of people with a home care package and waiting for a home care package



101. Data compiled from *Home Care Packages Program Data Report* series, published by the Department of Health and Aged Care: Home care packages report | AIHW GEN aged care data

The growing wait list for home care packages

Figure 18 also charts the 'waitlist' for home care, measured by the number of people in the National Priority System (NPS). People in the NPS have been assessed and approved for a package at a particular level but are yet to be granted a package at that level. Although many will have access to some interim support provided via a lower-level package or the Commonwealth Home Support Program, by definition, these support services are not sufficient to address their assessed care needs fully.

As Figure 18 shows, although the waitlist for home care progressively reduced as the program expanded, it has recently begun to grow again. As of December 2023, 51,044 people were waiting for a package at their approved level. This represents a 35% increase since December 2022 (37,894).

The growing waitlist has also meant that the wait times for receiving care have also begun to rise again. In 2018, the average wait time for a Level 2, 3 or 4 packages was more than 12 months. The Royal Commission's Interim Report 2019 stated: "We have been alarmed to find that many people die while waiting for a home care package",[102] acknowledging that most people received some form of interim care.

Since the Royal Commission, package availability has substantially reduced wait times. As of December 2022, the average wait times for all packages were 1-3 months. However, the most recent statistics indicate that the growth in the NPS has caused wait times to increase again. For example, there is now a 9-12 month wait for a Level 3 package.[103]

Long wait times are problematic as they pressure carers and families to make up any gap in support. It can also mean that older people who do not have the means to purchase additional private care from the market may end up in hospital unnecessarily or in residential care before they need to be there.

Supply-side constraints in delivering home care packages

The Government believes that the additional 24,100 packages will alleviate some of these pressures and reduce the NPS wait times to 6 months.[104] An important caveat, however, is that unless this expansion of home care is matched by a further expansion of the aged care workforce, older people in need of subsidised care will continue to struggle to access the care services they need.

As detailed in UARC's previous reports, the aged care sector and the broader caring economy continue encountering shortages of skilled workers. There is a range of symptoms that the home care market is experiencing supply-side strain.

102. Royal Commission in Aged Care Quality and Safety (2019), *Interim Report: Neglect*
103. Department of Health and Aged Care (2024), *Home Care Packages Program Data Report 2nd Quarter 2023–24*
104. Budget 2024-25: Communication pack | Department of Health and Aged Care

First, as detailed in Part 2 of this report, there is an increased use of third-parties to deliver care services. This can result from provider decisions to outsource some services, though at times, it may reflect the choices of clients to favour services that are more often outsourced, such as allied health, home maintenance and meals. In 2019–20, third-party service provision constituted 18.9% of home care providers' direct care service costs, whereas now they represent 39.1%. This growing use of third-parties has coincided with a decline in the weekly average care time provided by internal staff.

Second, a recent analysis in *The Catalyst Report – Home Care Insights 2024* indicates that older people are experiencing challenges in finding available services in their local area.[105] Based on a large-scale consumer survey conducted in February-March 2024, over half (54%) of 1,776 older people currently using home care and their family members report waiting for at least one home care service. The most common services that respondents sought but were unable to find in their local area were home and garden maintenance, domestic assistance, and allied health and therapy services. Furthermore, 32% of respondents indicated their provider had delays or capacity issues.

Third, there is continued growth in the value of unspent funds, representing the accumulated unused portion of home care package subsidies granted to package holders. As of September 2023, the Department reports that the total value of unspent funds is $3.09 billion ($2.52 billion held by Services Australia and $0.57 billion held by providers).[106] As reported in previous UARC reports, the growth in unspent funds is driven by a complex combination of factors, including a lack of awareness by package holders of their entitlements, over-assessment of needs, issues in paying for larger items such as equipment and a tendency by some holders to 'save for a rainy day'. Nonetheless, it is also symptomatic of supply-side constraints, whereby funds accumulate because package holders cannot find available providers to deliver the services they need in their local area.

It is an ongoing policy frustration that many people are waiting for care while an enormous pool of allocated funds goes unused. The total value of unspent funds ($3.09 billion) exceeds the total cost of providing services to the 51,044 people in the NPS ($2.74 billion), as estimated by UARC in Table 3.

The incoming Support at Home program will likely include a time limit for using package subsidies, providing a mechanism for redistributing unused funds. However, for this to result in meaningful changes in the availability of home care, workforce capacity constraints will need to be addressed.

105. Catalyst Research (2024), The Catalyst Report – Home Care Insights 2024. This report is based on a large-scale survey 5,450 people. This includes 1,776 current users of home care and family of current/former users, 728 people currently considering and researching home care now, 2,781 people likely to consider home care in future and 165 people who would not consider home care.

106. Department of Health and Aged Care (2024), *Quarterly Financial Snapshot Aged Care Sector, Quarter 1 2023–24*

Table 3: Total estimated cost of clearing the home care package waitlist

Package level	Total number of people in NPS*	Home care package daily subsidy rate**	Expected package value per client***	Total program cost
Level 1	348	$28.14	$14,633	$5,092,214
Level 2	11,982	$49.49	$25,735	$308,354,374
Level 3	29,648	$107.70	$56,004	$1,660,406,592
Level 4	9,066	$163.27	$84,900	$769,707,026
Total	**51,044**			**$2,743,560,206**

* Department of Health and Aged Care (2024), Home Care Packages Program Data Report 2nd Quarter 2023–24.

** Department of Health and Aged Care (2024), Aged Care Subsidies and Supplements (effective 20 March 2024).

*** Package value calculated by multiplying daily subsidy rate by median length of stay for home care clients (520 days), based on data from AIHW (2023), People leaving home care 2021-22.

The hidden wait times for home care

There are also growing concerns that the published statistics about the wait times for home care packages lack transparency about the total time it takes for older people to access services. The Department's wait times published in the Home Care Package Data Report series (reported above) only include the time between when someone is approved and then allocated a home care package. However, this time does not include the time older people spend waiting to be assessed or the time trying to find a service provider in their area that can deliver the services they need, let alone the time until the first service is received.

Thus, the published statistics about the performance of the Home Care Package program vastly underrepresent the actual duration of wait times experienced by older people.

To gauge the extent of this 'hidden' wait time, Table 4 compiles data from a variety of other sources, including:

- Average times compiled by COTA based on information supplied to Senate Estimates in October 2023 and in response to Senate Questions on Notice 2845 (January 2024)[107]
- Average waiting times reported by 1,776 current home care package participants and their families in The Catalyst Report – Home care insights 2024[108]
- Median elapsed times reported by the Productivity Commission for 2022-23 across all packages for any home care package level, regardless of whether it was at the approved level[109]

107. COTA (2024), *2024-25 Federal Budget Pre-Budget submission*, Appendix 2
108. Catalyst Research (2024), The Catalyst Report – Home Care Insights 2024. This report is based on a large-scale survey 5,450 people. This includes 1,776 current users of home care and family of current/former users, 728 people currently considering and researching home care now, 2,781 people likely to consider home care in future and 165 people who would not consider home care.
109. Productivity Commission (2024), *Report on Government Services 2024, Chapter 14 – Aged Care services*.

Table 4: Estimating wait times for home care package services

	Initial registration and eligibility screening	Completion of and assessment (including approval for package)	Allocation of a home care package	Service referral accepted by provider	Service commencement	Total
COTA (Senate estimates)	<1.9 days	35 days	14–161 days		28 days	79–226 days
Catalyst Research	5.5 weeks		5.8 weeks	4.6 weeks	3.7 weeks	19.6 weeks
Productivity Commission	-	17 days	132 days	38 days		187 days

Although results vary, these sources indicate that the true wait time for home care, from initial registration to service commencement, is substantial, with median/average estimates ranging from 11–32 weeks. Critically, these median/average estimates do not reflect the maximum wait times people may face.

Furthermore, only the middle column of Table 4, "Allocation of a home care package", is counted in the official wait time statistics published by the Department. Clearly, individuals confront substantial delays in accessing home care at other stages.

In its pre-budget submission, COTA called for greater transparency about wait times, recommending that the Government publish "a waitlist report for all service types, across all programs, from the time an individual registers for services until they commence."[110] UARC strongly endorses this position, noting that more complete metrics about wait times are required to assess the performance of the Home Care Package program. UARC also agrees that such a report should be developed to coincide with the introduction of the new Act and the new Support at Home program by 1 July 2025.

110. COTA (2024), *2024-25 Federal Budget Pre-Budget submission*, Recommendation 6.2

Part
2

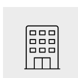
Analysis of the StewartBrown sector dataset

Part 2 of this report draws primarily on the 2023–24 StewartBrown *Aged Care Financial Performance Survey* (ACFPS), a de-identified large-scale dataset contributed to by aged care providers within Australia.[111]

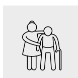
StewartBrown conducts a subscription-based quarterly data collection and analysis service, enabling aged care providers to track their performance over time and benchmark their operations against other providers. Where relevant, this data has been supplemented with references to available sector-wide statistics, such as those published by the Department of Health and Aged Care and the Australian Institute for Health and Welfare (AIHW).

The data covers the first half (July-December) of the 2023–24 financial year (2023–24). To enable meaningful trend comparisons, previous years' figures relate to the same reporting period (i.e. 1 July – 31 December) of each year.

The analyses have been conducted at three levels:



1. Approved providers



2. Residential aged care homes

3. Home care package providers[112]

The dataset does not cover the care and support provided by state government-owned agencies, the Commonwealth Home Support Programme (CHSP), or other subsidised programs such as Short-Term Restorative Care (STRC).

Due to variations in methodology, the results reported in this report differ in some minor respects from those reported by StewartBrown. An explanation of the methodology appears in an Appendix at the end of this report.

111. StewartBrown (2024) *Aged Care Financial Performance Survey Report December 20*

112. Many participant contributors to the dataset operate a combination of residential and home care services, which means that their data is represented in all three levels of analysis of the report. By comparison, those providers which only operate residential aged care homes are only represented in the Approved Provider and Residential Care analysis.

Approved provider analysis

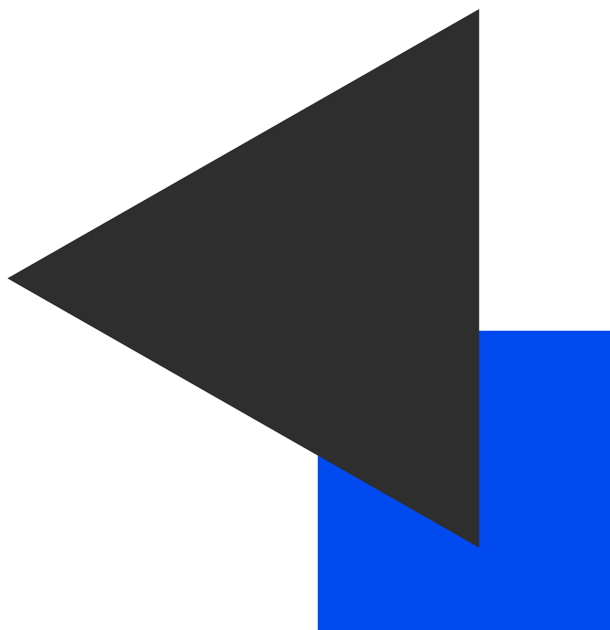
Overview

- The financial outcomes of participating providers for the first half of 2023–24 show some improvement compared to the prior year, with positive revenue growth that, on average, has outpaced growth in expenses.
- Despite this gain in financial performance, many financial challenges remain, with 39.5% of providers operating at a loss in the first half of 2023–24. Further, the extent of the gain may be temporary as some of their homes are required to improve their staffing levels.
- Providers' median Operating EBITDA margin was 4.7%, equivalent to generating $4.70 for every $100 of revenue earned before interest, tax, depreciation and amortisation expenses.
- The median wage expense per full-time employee has grown 15.0% compared to the prior year, reflecting the recent increase in sector award rates.
- Providers' total liabilities grew by 10.1% compared to the year prior, although their median liquidity (34.8%) and capital adequacy (33.8%) measures remained steady.

Approved provider profiles

The analysis at the approved provider level examines the financial outcomes of organisations that provide residential and/or home care services within Australia. These organisations may also operate a range of other business streams, such as home support and community care programs, disability care, childcare and retirement living. As such, the analysis provides a sense of the overall financial performance of the going concern entities that provide subsidised aged care services, noting that a more detailed analysis of their residential care operations and home care services follow later in this Part 2.[113]

Furthermore, care should be taken when interpreting average (mean) results from a dataset containing providers that vary considerably in their scopes, scales and outcomes. For example, a provider with 20 or more homes is weighted equally with a provider with only one home. Where appropriate, the analysis reports median (middle) values to reduce the effect of large outliers.



113. These are self-reported figures from contributing approved providers, and while all efforts have been taken to ensure the integrity of the data, it should be interpreted with some level of caution. For example, providers may have not split out COVID-related income and expenses from results from normal operations or may have used different categorisations of these figures.

Table 5: Profile of surveyed approved providers

	Dec-22	Dec-23
Number of providers in dataset	200	200
Ownership:		
For profit	9.0%	9.0%
Not for profit	91.0%	91.0%
Staffing:		
Average number of staff (headcount)	722	790
Average number of full-time equivalent staff (FTEs)	473	507
Providers with residential aged care homes (%)	95.0%	94.5%
Average number of residential aged care homes	4.7	5.1
Average number of operational places	385	421
Location:		
Metropolitan	47.5%	47.1%
Regional	42.4%	43.4%
Metropolitan and regional	10.2%	9.5%
Provider scale:		
Single home	46.5%	46.5%
2-6 homes	33.0%	32.5%
7-19 homes	10.5%	9.0%
20+ homes	5.0%	6.5%
No residential homes	5.0%	5.5%
Providers with home care operations (%)	46.5%	47.0%
Average number of home care packages	641	762
Providers with seniors housing (%)	62.0%	62.0%
Average number of retirement villages	6.4	7.0
Average number of retirement village units	292	306

This section analyses the outcomes of 200 approved provider organisations which contributed to the 2023–24 StewartBrown half-year dataset, representing 14.0% of Australia's 1,432 residential and home care package providers.[114] As shown in Table 5, most (91.0%) of these providers are not-for-profit, and the remainder (9.0%) are private, for-profit providers.[115] In the first half of 2023–24, contributing providers employed an average of 790 people (507 FTE staff).

Almost all surveyed providers (94.5%) offered residential aged care services, operating an average of 5.1 homes and 421 places. About half (47.1%) of surveyed providers operate predominantly in metropolitan areas.[116] The geographic spread of providers in the dataset is consistent with sector-level statistics for all residential care providers in Australia.[117]

As with the general trend across all residential care providers,[118] most (46.5%) providers in the dataset operate a single aged care home. However, the few providers that are larger in scale operate a substantial share of the total number of operational places. For example, providers that operated 20 or more homes comprised only 6.5% of the total number of providers in the dataset but operated 48.2% of all the operational places.

In the first half of 2023-2024, 94 of the surveyed providers (47.0%) offered home care services. The average number of home care packages per provider (762) is more than double that of the home care sector overall.[119] This indicates that the dataset is weighted towards larger providers with significant scale in their business segments, including home care services. In addition, 62.0% of providers offered seniors housing (regulated by the states and territories under their own retirement village legislation).

114. Department of Health and Aged Care (2023), *Stocktake data: Operational providers, 30 June 2023*, Australian Institute of Health and Welfare.

115. In part, these changes in ownership reflect recent acquisition activity, with several for-profit providers acquired by not-for-profit providers.

116. Provider location describes the geographic location and spread of the providers' residential care operations. Following the definitions used by the Department of Health and Aged Care in its *Quarterly Financial Snapshot of the Aged Care Sector*, a provider is classified as being "Metropolitan" if more than 70% of its homes are located in metropolitan areas; "Regional" if more than 70% of its homes are located in regional (non-metropolitan) areas; and "Metropolitan and regional" if between 30-70% of its homes are located in metropolitan areas.

117. According to the Department of Health and Aged Care's *Financial Report on the Australian Aged Care Sector (2021-22)*, as of 30 June 2022, 406 (50.4%) of all residential providers are located in metropolitan areas; 310 (38.5%) in regional areas; and 89 (11.1%) in metropolitan and regional areas.

118. The relative distribution of residential care providers in Australia, based on scale, is single home (63.0%), 2-6 homes (27.3%); 7-19 homes (6.8%) and 20+ homes (2.9%). These statistics are reported in the Department of Health and Aged Care's *Financial Report on the Australian Aged Care Sector (2021-22)*.

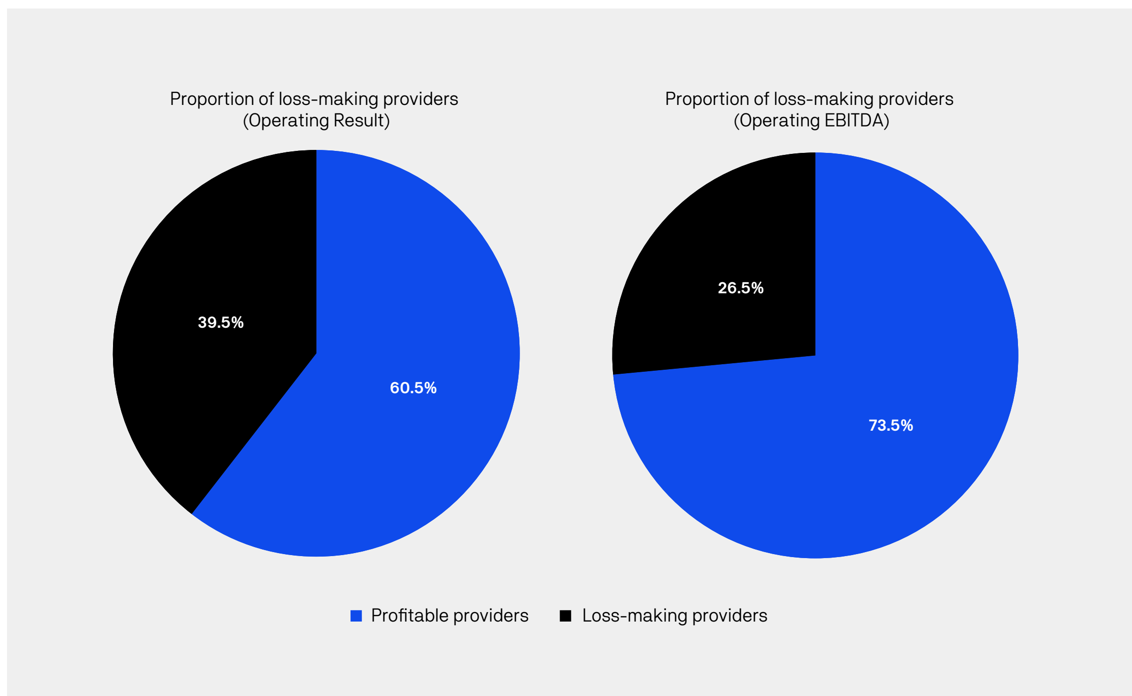
119. As of December 2023, there are 269,573 home care packages provided by 904 providers, which is equivalent to 298 home care packages per provider. Department of Health and Aged Care (2024), *Home care packages program, data report 2nd Quarter 2023–24*, Australian Institute of Health and Welfare.

Financial performance

The level of profit or loss made by approved providers indicates the overall financial viability of organisations that provide subsidised aged care services to older people in Australia. However, this can be clouded by different measures of profitability, which reveal different aspects of organisations' financial performance.

The left panel of Figure 19 shows that over a third (39.5%) of providers in the first half of 2023–24 had an operating loss. These providers reported a negative Operating Result[120] (also known as 'Net Profit Before Tax') for the first half of the financial year as their total operating expenses exceeded their total operating revenue. This operating measure excludes the more volatile non-recurrent income and expenses, enabling more meaningful year-on-year comparisons.[121]

Figure 19: Proportion of loss-making providers, Operating Result and Operating EBITDA

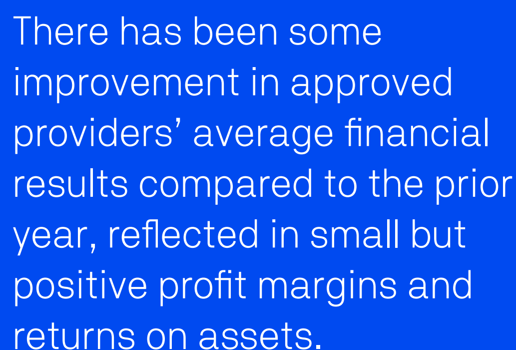


120. Operating Result generally refers to the Net Profit Before Tax (NPBT) earned by an approved provider but excludes non-recurrent revenues and expenses. By comparison, the Total Result shows the Operating Result net (i.e. inclusive) of non-recurrent revenues and expenses.
121. Non-recurrent revenues and expenses refer to items including flows relating to revaluations, impairments, donations, fundraising, bequests, gains or losses on asset sales and write-off of bed licences.

A second measure of profit or loss is Operating EBITDA[122] (Earnings Before Interest, Taxation, Depreciation and Amortisation). This measure allows for greater comparability between providers with different corporate structures, financing arrangements, tax obligations and depreciation rates. Furthermore, it tends to convey providers' profitability from operations, somewhat akin to cash flow. However, as it excludes depreciation expenses, there is a danger in relying solely on Operating EBITDA as a measure of viability, as it does not account for the cost of capital infrastructure (i.e. depreciation). Like the Operating Result, Operating EBITDA excludes non-recurrent items, including fundraising revenue, revaluations, donations, capital grants and sundry revenue.[123]

The right panel of Figure 19 shows that 26.5% of providers reported an Operating EBITDA loss in the first half of 2023–24. Although this proportion is lower than the Operating Result figure, it is still a cause for concern as it indicates that many surveyed providers are not generating a positive cash flow from their operations.

Nonetheless, Table 6 shows improvement in participating providers' average profit and loss results compared to the first half of 2022-23. The average reported Operating Result increased from an average loss of $2.11 m per provider in the first half of 2022-23 to breakeven in 2023–24. Likewise, the Operating profit margin and return on assets ratios were both positive in the latest reporting period (1.5% and 0.5%, respectively).



There has been some improvement in approved providers' average financial results compared to the prior year, reflected in small but positive profit margins and returns on assets.

122. Earnings Before Interest, Taxation, Depreciation and Amortisation (EBITDA) is a measure of profitability that excludes several key line items relating to the corporate structure, financing arrangements and tax status of an organisation. 'Operating EBITDA' also excludes all non-recurrent revenue and expenditure, including fundraising revenue, revaluations, donations, capital grants and sundry revenue.

123. When non-recurrent items are included, 16.5% of participating providers reported a negative total EBITDA for the first half of 2023–24.

Table 6: Approved provider average profit and loss results

	Dec-22	Dec-23
Revenue		
Service revenue ($'000)	$32,790	$41,294
Investment revenue ($'000)	$522	$870
Total operating revenue ($'000)	$33,311	$42,164
Expenses		
Employee expenses ($'000)	$23,729	$29,643
Depreciation and amortisation ($'000)	$2,240	$2,240
Finance costs ($'000)	$577	$638
Other expenses ($'000)	$8,873	$9,639
Total operating expenses ($'000)	$35,419	$42,161
Operating Result ($'000)	($2,108)	$3
Net non-recurrent income ($'000)	$833	$1,005
Total result ($'000)	($1,275)	$1,008
Operating EBITDA ($'000)	$0	$1,759
Net non-recurrent income ($'000)	$833	$1,005
EBITDA ($'000)	$833	$2,764
Ratios (Medians):		
Profit margin (Operating result)	(3.3%)	1.5%
Profit margin (Operating EBITDA)	1.3%	4.7%
Return on assets (Operating Result)	(0.9%)	0.5%
Return on assets (Operating EBITDA)	0.4%	1.5%
Wages to revenue	71.4%	71.5%
Median employee expense per FTE	$98,515	$113,305
Depreciation expense (as % of property assets)	3.3%	3.3%

The average reported Operating EBITDA results also show improved providers' financial performance. For the first half of 2023–24, the average Operating EBITDA was a positive $1.76m per provider, a marked improvement compared to the year prior. Furthermore, the median Operating EBITDA profit margin increased to 4.7%. This margin suggests that a given provider will generate a $4.70 margin for every $100 of revenue earned before accounting for further interest, tax, depreciation and amortisation costs.

However, the median Operating EBITDA return on assets remains low at just 1.4% in the first half of 2023–24. This modest (low) return on investment substantiates persistent concerns about the sector's financial sustainability, especially as most not-for-profit providers report assets at their cost, not replacement values.

Providers' profitability has improved because revenue has grown faster (26.6% year-on-year growth) than expenditure (19.0% year-on-year growth).

The largest area of expenditure continues to be employee wages, salaries and benefits, which account for 71.5% of total operating revenue.[124] The wage increases are evident in the substantial growth in total employee expenses (up 24.9% from the year prior). This outpaced the growth in full-time equivalent (FTE) staff. As a result, the median employee expense grew 15.0% from $98,515 per FTE in the first half of 2022-23 to $113,305 in 2023–24.[125]

Depreciation and amortisation expenses have been steady over two years and remain persistently low as a proportion of property assets, with a median rate of just 3.3%. This rate implies that providers are expensing long-term assets (including buildings, equipment and furniture), based on the assumption of an average useful lifetime of approximately 30.5 years.[126]

124. The median wages to revenue ratio is calculated by dividing the total of salaries and employee benefits, including management fees, by total revenue.

125. The increase in employee expenses also contains an adjustment made by some participating providers to their employee leave provisions, as a result of the Fair Work Commission wage case.

126. In practice, assumed useful life estimates may be even higher if providers record their property assets at their historical cost values.

Liquidity and capital adequacy

Approved providers' balance sheet figures provide an aggregate perspective on the value of their assets, liabilities and owners' equity, as well as their liquidity and capital adequacy risk profiles.

Approved providers must maintain access to sufficient liquid funds (i.e., cash, financial assets or lines of credit) to meet their debt obligations, which include repaying RADs. Furthermore, providers are expected to maintain sufficient capital adequacy, which means they have sufficient net assets to absorb unexpected losses.

On 1 July 2023, the responsibility for monitoring the financial health of approved aged care providers transferred from the Department to the ACQSC. This move allows the ACQSC to monitor and regulate the providers' financial and prudential reporting responsibilities and ensure that viability risks do not compromise the quality of care services.

Much of the existing prudential requirements relate to providers' responsibilities in managing, using and reporting about their RADs. However, their responsibilities have expanded under Phases 1 and 2 of the Government's new Financial and Prudential Monitoring, Compliance and Intervention Framework. Recent policy adjustments have focused on providers' financial reporting responsibilities (e.g. Aged Care Financial Reports, Quarterly Financial Reports, Annual Prudential Compliance Statements, and General Purpose Financial Reports) and the permitted uses of RADs. Phase 3 of the Framework will coincide with the introduction of the new Aged Care Act (currently scheduled for 1 July 2025) and is expected to include legislative arrangements around minimum liquidity and capital adequacy requirements and stronger regulatory powers for the ACQSC.[127]

Importantly, managing liquidity and capital adequacy risk must be balanced against sufficient investment in new and refurbished capital assets such as equipment, information systems, property and buildings that enable providers to provide quality aged care services into the future.

127. Financial and Prudential Monitoring, Compliance and Intervention Framework | Australian Government Department of Health and Aged Care

Table 7: Approved provider average balance sheet figures

	Dec-22	Dec-23
Assets		
Cash and financial assets ($'000)	$39,760	$45,732
Operating assets ($'000)	$13,071	$14,922
Property assets ($'000)	$154,496	$166,417
Right of use assets ($'000)	$3,356	$2,729
Intangibles - other ($'000)	$3,427	$6,034
Intangibles - bed licences ($'000)	$1,667	$472
Total assets ($'000)	$215,777	$236,308
Liabilities		
Refundable loans - residential ($'000)	$62,836	$75,802
Refundable loans - retirement living ($'000)	$48,886	$53,701
Home care packages unspent funds liability ($'000)	$1,271	$861
Borrowings ($'000)	$13,186	$15,881
Other liabilities ($'000)	$30,809	$26,688
Total liabilities ($'000)	$156,988	$172,933
Net assets ($'000)	$58,789	$63,375
Net tangible assets ($'000)	$53,695	$56,868
Ratios (Medians):		
Liquidity	33.9%	34.8%
Capital adequacy	34.5%	33.8%
Property assets as a proportion of total assets	65.8%	64.1%

Table 7 reports approved providers' average balance sheet figures as of December 2023. It shows that providers' total asset base grew 9.5% over the last 12 months. Cash, operating assets, and property assets increased, and bed licenses continued to decline, reflecting the impairment and write-down of these intangible assets in anticipation of the discontinuation of ACAR.

Regarding providers' debt position, Table 7 shows a 10.2% annual increase in the average value of total liabilities, driven by significant increases in residential refundable loans and borrowings, which grew by 20.6% and 20.4%, respectively. The key balance sheet ratios (expressed as medians) show liquidity[128] and capital adequacy[129] remaining steady compared to the prior year. Both ratios are well above the generally expected 15-20% threshold. However, these ratios vary across different types of providers (not tabled). Large chain providers have a lower liquidity ratio (20.9%) than single-home providers (58.2%) in the first half of 2023–24.

128. Liquidity is calculated as the total of cash, cash equivalents and financial assets, divided by total liabilities minus lease liabilities.
129. Capital adequacy is calculated the net tangible assets divided by total tangible assets (i.e. intangible assets are excluded).

Residential care analysis

Overview

- Residential aged care homes continue to report poor financial performance, although with some gains compared to the prior year. In the first half of 2023–24, 51.6% of homes operated at a loss, with an average deficit of $4.02 per resident per day.
- On average, these financial outcomes are comparable to pre-pandemic results, although homes now receive substantially more Government funding for everyday living and direct care.
- There is a widening gap in financial outcomes across the sector. On average, the top 25% of homes earn an additional $70.81 per resident per day compared to the remaining 75% of homes.
- Homes' Operating Results, on average, comprised a large positive margin of $13.33 per resident per day for direct care services, consumed by larger losses for everyday living (loss of $6.96) and accommodation (loss of $10.39).
- Administration costs have grown by 11.4% for the first half of 2023–24 compared to the same period in 2022-23, averaging $51.52 per resident per day.
- Occupancy of available places has improved, with a national average rate of 92.8%.
- Direct care staffing minutes have increased and are, on average, now just over the sector-level target of 200 minutes, although the majority of homes have not staffed up to their mandated requirements. Both staffing time of registered nurses and personal care workers have increased, but enrolled nurse time continues to contract.

Residential aged care home profiles

The residential care analysis reports the average financial and workforce outcomes of participating residential aged care homes, otherwise referred to as nursing homes or residential aged care facilities. The 2023–24 StewartBrown half-year residential dataset comprises 1,187 homes and 97,960 places,[130] representing 45.0% of Australia's 2,639 residential aged care homes and 44.2% of the 221,467 operational places.[131]

Table 8: Profile of surveyed residential aged care homes

	Dec-22	Dec-23
Number of homes in dataset	1,099	1,187
Total number of places in dataset	90,215	97,960
Average home size (number of places)	82	83
Ownership:		
For profit	11.2%	6.7%
Not for profit	88.8%	93.3%
Location:		
Metropolitan (MMM1)	64.1%	62.3%
Regional (MMM2)	7.9%	8.5%
Large rural (MMM3)	10.9%	11.2%
Medium rural (MMM4)	7.3%	6.9%
Small rural and remote (MMM5-7)	9.7%	11.1%
Provider scale:		
Single home	11.2%	8.3%
2-6 homes	20.8%	18.4%
7-19 homes	27.0%	28.9%
20+ homes	40.9%	44.4%
Home size:		
Less than 40 places	9.5%	9.0%
40-80 places	42.9%	42.9%
80-120 places	30.4%	31.3%
More than 120 places	17.2%	16.8%

130. In total 1,203 residential aged care homes participated in the half-year 2023–24 StewartBrown survey, however as part of the data cleaning and analysis process 16 homes were excluded from the final sample either because of data integrity issues or because they were subject to substantial disruption to their operations, such as the case for homes that were newly built, undergoing major refurbishment or subject to sanction by the regulator. In the StewartBrown Aged Care Financial Performance Survey terminology, 'all homes' relates to the entire sample and 'mature homes' relates to the final sample, as used in the analysis in this report.

131. Department of Health and Aged Care (2023), *Aged care data snapshot—2023, Third release*, Australian Institute of Health and Welfare.

As shown in Table 8, the average size of each home in the 2023–24 half-year dataset was 83 operational places, comparable to the national average of 84.[132] Almost all (93.3%) surveyed homes are operated by not-for-profit providers.[133]

The dataset is also consistent with sector-level statistics on the overall geographic spread of homes by remoteness category (i.e. the Modified Monash Model, MMM), with almost two-thirds being located in major cities.[134]

In terms of provider scale, the dataset is weighted towards homes operated by larger providers. For example, while standalone single homes comprise 17.9% of all aged care homes nationally, they represent only 8.3% of homes in the dataset. Conversely, while homes operated by large providers (20+ homes) comprise 34.5% of all homes nationally, they account for 44.4% of the dataset.[135]

Likewise, in terms of home size, the dataset is underweighted for small homes (less than 40 places). These homes comprise 14.2% of all aged care homes nationally; however, they represent only 9.0% of homes in the dataset. Nonetheless, the proportion of homes larger than 80 places (49.0%) is similar to that in the national statistics (50.4%).[136]

132. Department of Health and Aged Care (2023), *Aged care data snapshot—2023, Third release*, Australian Institute of Health and Welfare.
133. The weighting towards non-for-profit providers is due to the absence of several large listed for-profit providers from the survey and the recent acquisition of for-profit homes by large non-profit providers. State government-operated homes are also not included in the dataset.
134. Australian Institute of Health and Welfare (2023), *Aged care service listing 30 June 2023*.
135. These statistics relate to population characteristics in June 2022, as reported in the Department of Health and Aged Care (2023), *Financial Report of the Australian Aged Care Sector 2021-22*.
136. Department of Health and Aged Care (2023), *Financial Report of the Australian Aged Care Sector 2021-22*.

Key performance indicator summary

Table 9: Key performance indicators of residential aged care homes

	Dec-22	Dec-23
Operating Result (per resident per day)	($17.47)	($4.02)
Operating Result (per bed per annum)*	($5,323)	($1,050)
Operating EBITDA (per bed per annum)*	$1,617	$5,529
Proportion of loss-making homes (Operating Result)	63.1%	51.6%
Proportion of loss-making homes (EBITDA)	43.0%	31.4%
Occupancy rate	90.9%	92.8%
Supported resident ratio	45.3%	45.4%
Average direct care revenue (per resident per day)	$208.31	$267.54
Average direct care expenditure (per resident per day)	$204.14	$254.21
Direct care expense ratio	98.0%	95.0%
Average direct care minutes (per resident day)	186.2	200.3
Average value of full RADs held at reporting date	$406,012	$427,101
Average value of new full RADs taken during period	$459,096	$475,035

*Per annum figures are the per resident per day result for 365 days adjusted for the occupancy rate.

Financial performance

The half-year results for 2023–24 show a gain in the financial performance of residential aged care homes compared to the two previous years. As shown in Figure 20, on average, homes' Operating Result[137] was a deficit (loss) of $4.02 per resident per day, up from a deficit of $17.47 per resident per day a year prior.[138] This means that fewer homes are operating at a loss at present. As of December 2023, 51.6% of homes in the dataset were operating at a loss compared to 63.2% in December 2022.[139]

It is worth remembering that these results represent the average results of only the 'mature' homes that participated in the 2023–24 StewartBrown dataset.[140] If all participating homes were included, the average Operating Result for the 2023–24 half-year would fall to a deficit of $7.77 per resident per day.

137. Operating Result refers to the Net Profit Before Tax (NPBT) earned by a residential aged care home.

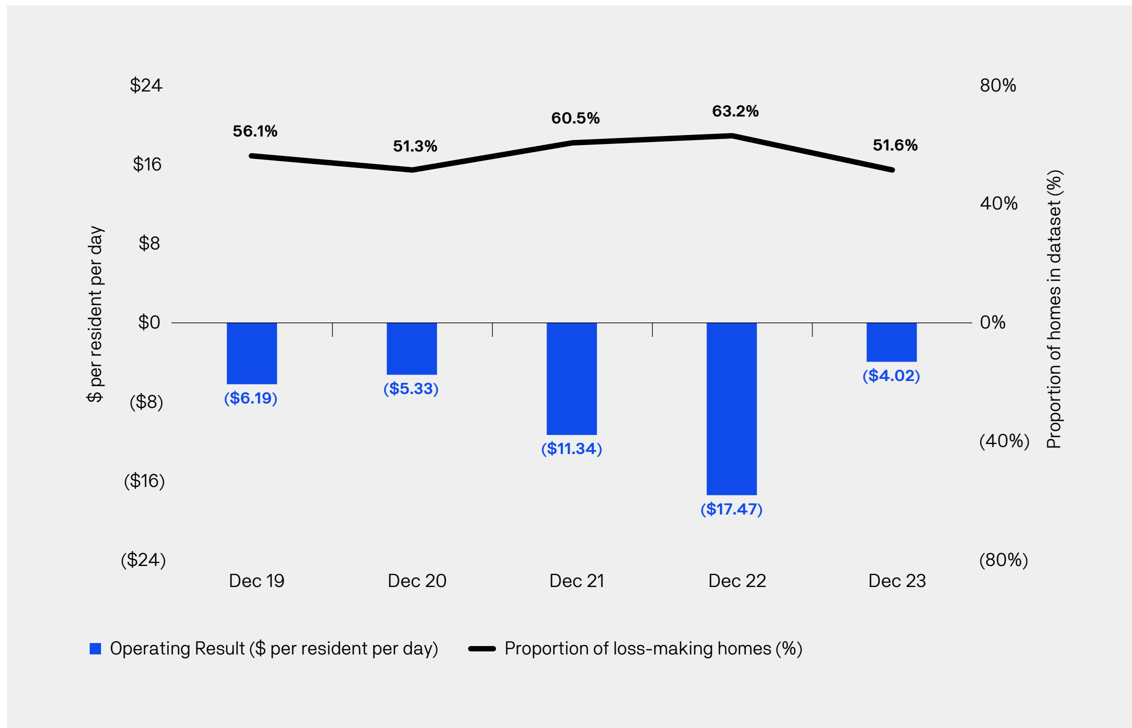
138. The UARC estimate for average Operating Result (negative $4.02 per resident per day) is $1.77 lower than the StewartBrown estimate (negative $2.25 per resident per day): StewartBrown (2024) *Aged Care Financial Performance Survey Report December 2023*. This difference arises from methodological differences in the way averages are calculated, where the UARC estimate reflects home-level average and the StewartBrown estimate reflects a place-level average. For more information, please see the methodological guidance provided in Appendix.

139. An Operating Loss occurs when an aged care home's Operating Result (i.e., NPBT) is below zero.

140. As part of the data cleaning and analysis process, 16 homes experiencing substantial disruptions to their operations have been excluded (e.g., newly built and still ramping up, undergoing major refurbishment or subject to sanction).

Residential aged care homes

Figure 20: Operating Result, per resident per day, and proportion of loss-making homes

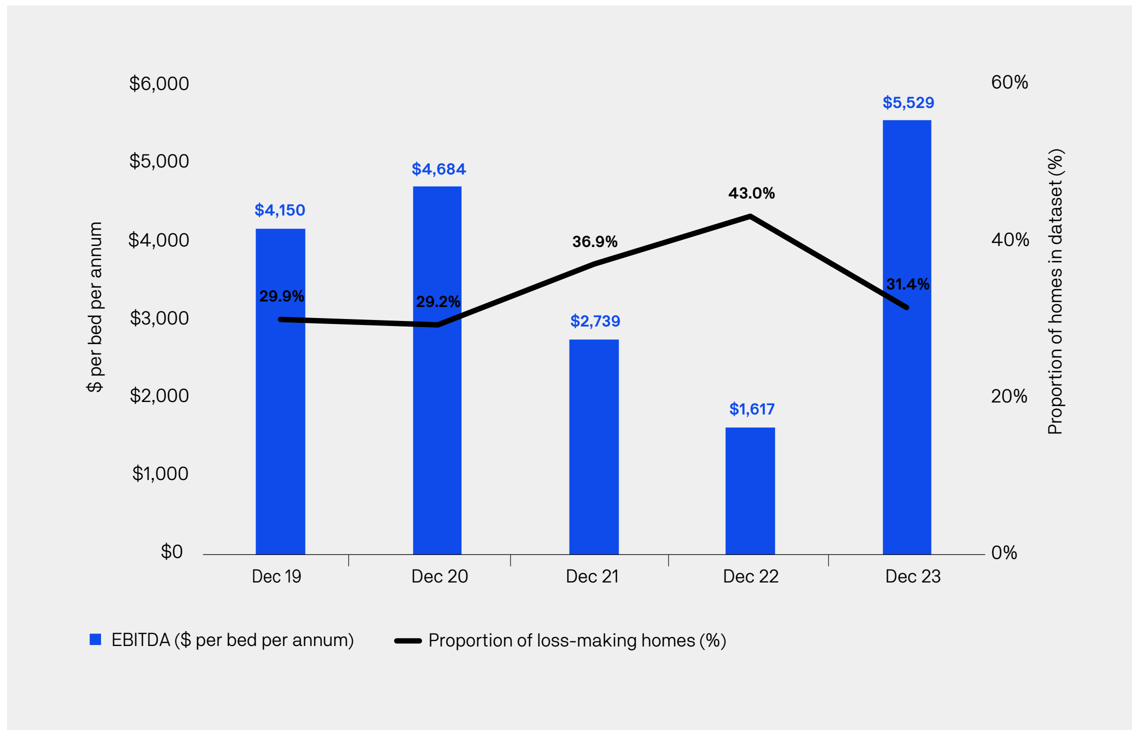


In reflecting on the longer-term trend, the 2023–24 half-year results are, on average, comparable to those reported in corresponding periods in 2019–20 and 2020-21. However, it is worth noting that homes now receive substantially more government funding through higher direct care subsidies (AN-ACC) and the hotelling supplement.

Also, while the results have improved compared to 2021-22 and 2022-23, the continued poor financial performance of many homes presents an ongoing challenge for the sustainability of the sector. Further, as detailed in Part 1, the reported improvements of some homes may only be temporary until their staffing levels (and associated costs) meet mandated requirements.

Homes experiencing sustained periods of financial distress are at greater risk of closure, which may undermine reliable access to services for older people, particularly those outside major cities. Furthermore, as outlined in Part 1, if homes cannot generate reasonable operational returns, this may undermine or stall the required investment in the sector to ensure the supply capacity to meet the needs of Australia's ageing population.

Figure 21: Operating EBITDA, per resident per day, and proportion of loss-making homes



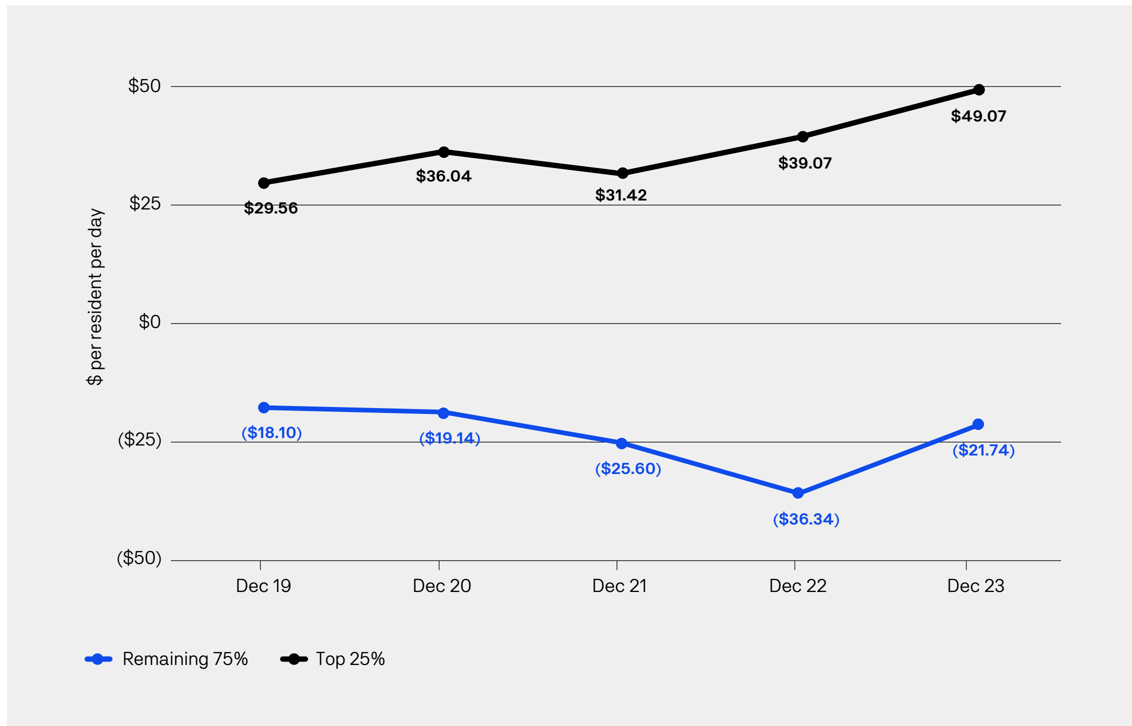
The Operating EBITDA of aged care homes[141] has exhibited a similar trend (Figure 21). Operating EBITDA improved relative to the prior year to an average of $5,529 per place per annum. As of December 2023, 31.4% of homes reported a negative Operating EBITDA result,[142] down from 43.0% in December 2022. Homes that can generate an Operating EBITDA surplus over the longer term may be considered more viable, as they are less at risk of having to draw down on their asset base.

141. In general, Earnings Before Interest, Taxation, Depreciation and Amortisation (EBITDA) is a measure of profitability that excludes several key line items relating to the corporate structure, financing arrangements and tax status of an organisation. It thus allows for a comparison of the profitability of homes operated under different corporate arrangements and financing policies. 'Operating EBITDA' also excludes all provider-level revenue and expenditure, including fundraising revenue, revaluations, donations, capital grants and sundry revenue.

142. An Operating EBITDA loss occurs when an aged care home's Operating EBITDA is below zero.

Residential aged care homes

Figure 22: Operating Result, top 25% vs remaining 75%, per resident per day



The trend in the average financial results masks the increased variation in the financial outcomes of homes across the sector. Figure 22 shows the profitability trends of the top 25% of homes each year (based on their Operating Result) compared to the remaining 75%. Five years ago (2019–20), the top 25% of homes earned an additional $47.66 per resident per day compared to the remaining 75%. The most recent half-year results (2023–24) show this gap has grown to $70.81 per resident per day.

Furthermore, while the average surplus earned by homes in the top 25% has almost doubled over the last five years (from $29.56 per resident per day in 2019–20 to $49.07 in 2023–24), the performance of the remaining 75% is still marginally lower than it was five years ago.

A key driver of this widening disparity is the variation in homes' compliance with the minimum staffing requirements. As of December 2023, only 16.8% of homes in the top 25% had met both of their service-level direct care minute targets.[143] By comparison, for the remaining 75% of homes, this rate was 32.8%. Although all homes have received substantial increases in direct care funding from AN-ACC, homes that do not meet their care minute targets have lower expenditures on direct care staff. This enables them to retain a (larger) direct care surplus, contributing to their improved bottom line.

Part 1 provides further details about this widening disparity in the financial outcomes of homes, including the results when split into quartiles and the characteristics that differentiate the most profitable homes. This confirms that the variation in homes' financial results largely stems from differences in staffing levels and direct care results.

143. The analysis was conducted using de-identified data about homes' actual and service-level targets for direct care minutes, as published in the October – December 2023 Star Ratings extract.

Operating Result breakdown

This section disaggregates the revenue and expenses that contribute to aged care homes' Operating Result into three service areas:

- **direct care** (nursing, other clinical and personal care services, including wound management, medication administration, allied health, care management and support with showering, dressing and toileting, as well as social care services such as recreational activities and emotional support)
- **everyday living** (food, cleaning, laundry, and other daily amenities), sometimes referred to as 'indirect care'
- **accommodation** (provision and maintenance of buildings, equipment and other capital infrastructure)

This disaggregation enables better identification of the revenue streams and cost components that influence the financial performance of aged care homes (see Table 10) and can indicate areas for policy and management focus.

Following the methodology used by StewartBrown, administration costs have been allocated across the three areas for a meaningful comparison between the respective revenues and costs.[144] Administration costs are allocated to three service areas according to the following proportions:

- **Direct care** – 37.0%
- **Everyday living** - 33.6%
- **Accommodation** – 29.4%[145]

This approach also accounts for the need for each revenue stream to contribute to the overhead costs of operating an aged care home, noting that no specific revenue stream is associated with administration costs.

It should be noted that the current allocation method is the subject of some debate, and further data collection and analysis is warranted.

The breakdown between revenue and costs is depicted in Table 10 and Figure 23 shows recent trends in each service area.

144. StewartBrown periodically verifies the validity of the allocation percentages with reference to data collected from participating providers, including an additional Corporate Administration survey.

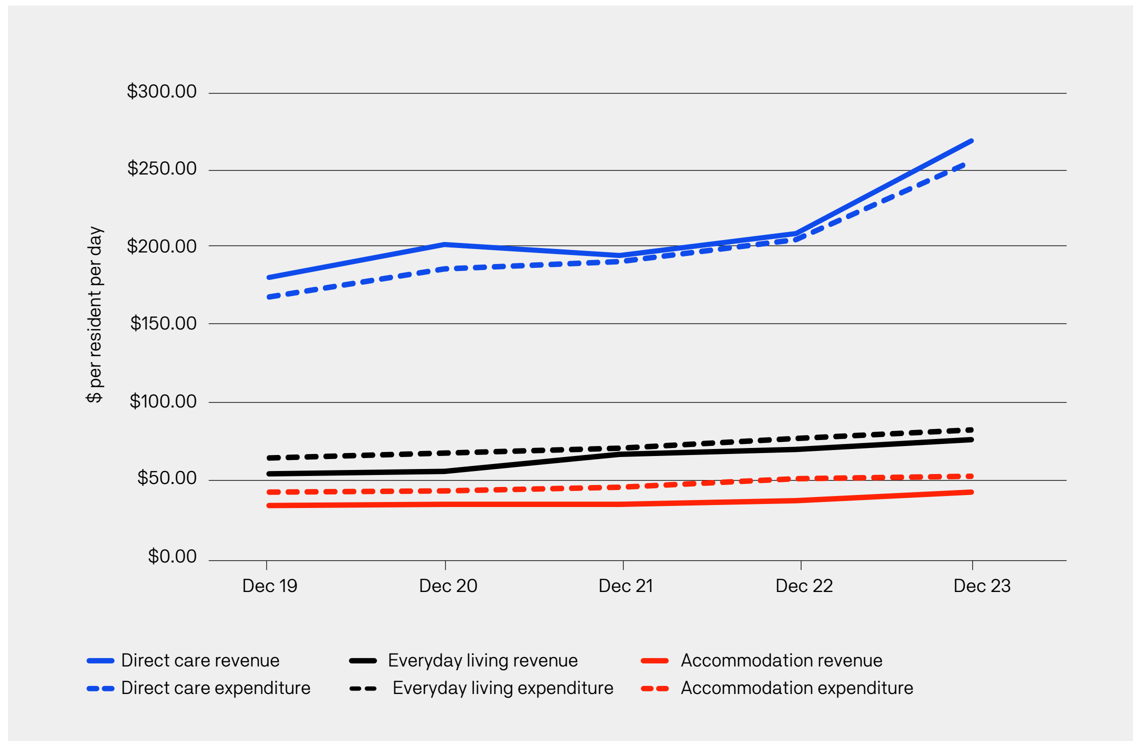
145. StewartBrown (2024) *Aged Care Financial Performance Survey Report December 2023*

Table 10: Detailed financial results, per resident per day

	Dec-22	Dec-23
Direct Care		
Direct care revenue:		
Residents	$6.82	$7.99
Government	$201.48	$259.56
Total direct care revenue	$208.31	$267.54
Direct care expenditure:		
Direct care labour costs	$153.58	$200.51
Other labour costs	$27.25	$24.90
Other direct care costs	$6.21	$9.74
Allocation of administration costs (37.0%)	$17.11	$19.06
Total direct care expenditure	$204.15	$254.21
Direct Care Result	$4.17	$13.33
Everyday Living		
Everyday living revenue:		
Residents	$58.68	$63.64
Government	$9.93	$10.94
Total everyday living revenue	$68.61	$74.59
Everyday living expenditure:		
Catering	$36.79	$39.84
Cleaning	$10.14	$10.51
Laundry	$4.48	$4.66
Utilities	$7.94	$8.15
Other	$1.09	$1.10
Allocation of administration costs (33.6%)	$15.54	$17.31
Total everyday living expenditure	$75.98	$81.57
Everyday Living Result	($7.37)	($6.96)
Accommodation		
Accommodation revenue:		
Residents*	$14.02	$16.16
Government	$23.98	$24.60
Total accommodation revenue	$35.33	$40.76
Accommodation expenditure:		
Depreciation	$21.42	$20.48
Property maintenance and rental	$12.95	$13.88
Other	$1.64	$1.65
Allocation of administration costs (29.4%)	$13.59	$15.14
Total accommodation expenditure	$49.60	$51.15
Accommodation Result	**($14.26)**	**($10.39)**
Operating Result (per resident per day)	**($17.47)**	**($4.02)**
Total revenue (per resident per day)	**$312.25**	**$382.89**
Total expenditure (per resident per day)	**$329.73**	**$386.93**

* Accommodation revenue from residents only includes daily accommodation payments (DAPs) and does not include imputed interest relating to refundable accommodation deposits (RADs)

Figure 23: Service area revenue and expenditure, per resident per day



Direct care:

The direct care results from the first half of 2023–24 were much higher than in recent years.[146] On average, homes earned $13.33 per resident per day from direct care services, compared to a more modest margin of $4.17 for the same period the year prior. This has been driven by a substantial increase in direct care revenues. In the first six months of 2023–24, homes, on average, earned $267.54 per resident per day in direct care revenue, 28.8% more than the same period the year prior ($201.48). This revenue growth is attributable to:

- Increases in the AN-ACC base price for 2023–24 to fund the Stage 2 FWC 15% pay increase for direct care workers, increases in the Superannuation Guarantee and indexation accounting for historical wage rises and inflation[147]
- Additional funding to cover the 5.75% National Wage Case pay increase
- The 24/7 registered nurse supplement for eligible homes

146. The Direct Care Result represents the net difference between revenue and costs directly associated with care services. It includes direct care subsidies, supplements and grants from the Government and means-tested care fees) revenue less total direct care costs, and this includes an allocation of workers compensation and quality and education costs, as well as an allocation of 37.0% homes' administration costs.

147. The Independent Health and Aged Care Pricing Authority (2023), *Residential Aged Care Pricing Advice 2023–24*.

There has also been a modest increase in subsidies resulting from the gradual increase in the complexity of residents' assessed care needs over time. For example, as of June 2023, the average service-level target for total direct care time for homes in the StewartBrown survey was 197.03 minutes per resident per day. Six months later, this had grown 1.5% to 200.0 minutes (December 2023).

Homes' direct care expenditure has also grown year-on-year, albeit not at the same pace as revenue. On average, homes incur expenses of $254.21 per resident per day, equivalent to 95.0% of direct care revenue.[148] This is $50.06 more per resident per day than last year. This reflects the increase in direct care staffing to meet the care minute and 24/7 registered nurse requirements and increases in the input prices (i.e. wages) of direct care workers, including agency staff.

The wage effect is evident in Figure 24, which shows the long-term trends in the median labour cost per hour worked across all direct care staff (for normal and overtime hours).[149]

Figure 24: Median labour cost per worked hour, by direct care role

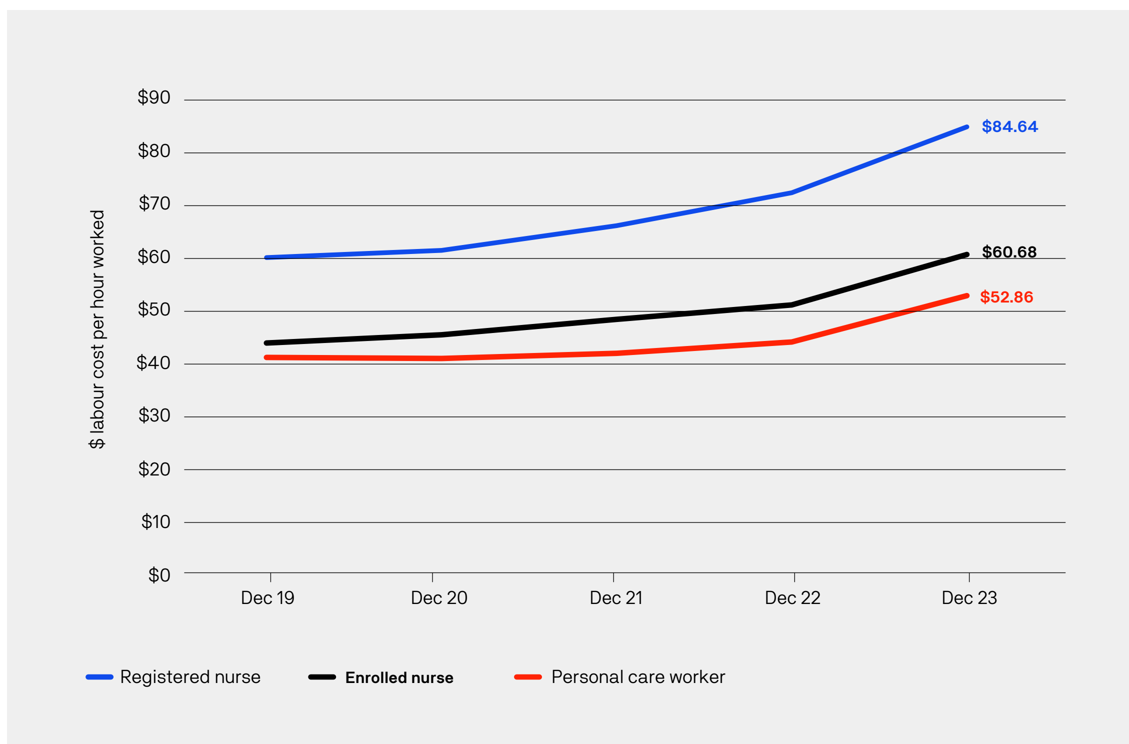


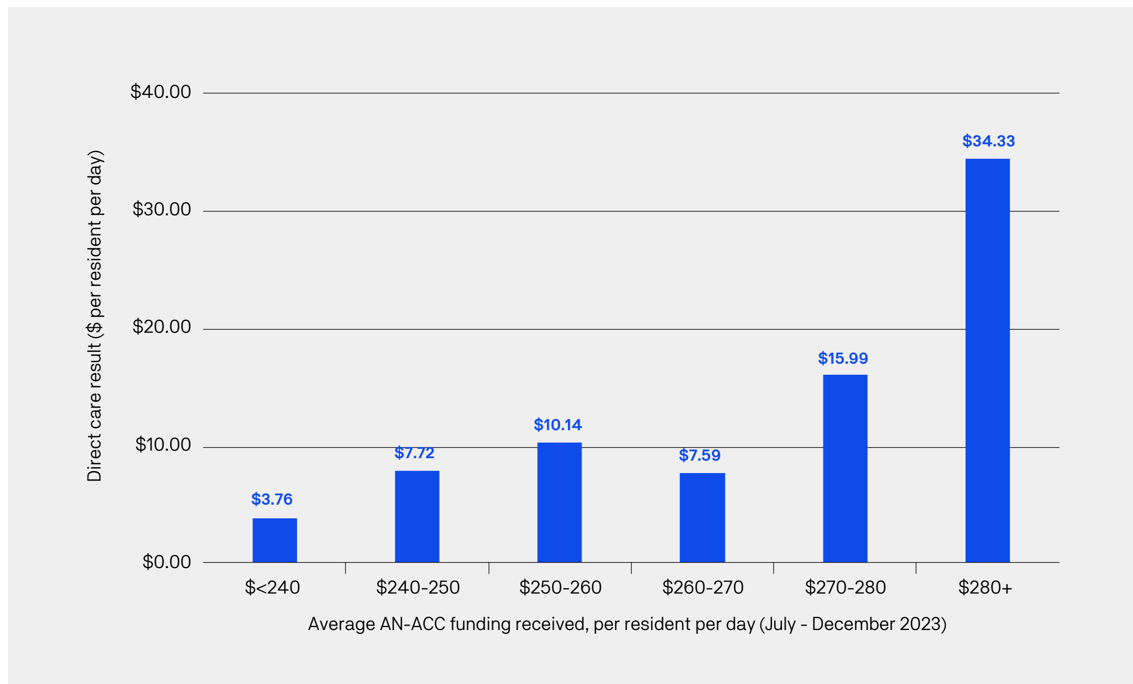
Figure 24 shows that these labour rates have continued to increase, particularly in the last year. For example, in the first half of 2023–24, the median hourly cost for registered nurses ($84.64) was 17.1% higher in nominal terms than in 2022-23 ($72.30). Over the same period, the respective growth rate of enrolled nurses was 18.7% and personal care workers was 19.9%. Noting the continued reliance on agency staff, as of December 2023, the median hourly labour rate for agency nurses ($116.78) was 44.1% more than that of internal registered nurses ($81.05).

148. The direct care expenses ratio is calculated by dividing total direct care costs by total direct care revenue.

149. These estimates include wages and salaries, on-costs, such as mandatory superannuation contributions, leave provisions and casual loadings, penalty rates paid for overtime (which, on average, represents 2-3% of internal employees worked hours) and contract costs of agency and externally contracted staff.

A final point about direct care builds on analyses presented in UARC's previous report regarding disparities in the funding outcomes of the AN-ACC model. As in our earlier analysis, the half-year 2023–24 results show that homes with lower AN-ACC funding (i.e., more residents with less complex care needs) have much smaller direct care margins (see Figure 25). In contrast, those with higher AN-ACC funding (i.e., more residents with more complex needs) earn a higher margin from direct care.

Figure 25: Direct care result, by average AN-ACC revenue, per resident per day



To some extent, the variation in direct care outcomes reflects the effect of the base care tariff. Many homes with the highest AN-ACC funding bracket (receiving more than $280 per resident per day) are in rural and remote locations (MMM5-7) and serve specialised communities. These aggregate results are also confounded by the extent to which homes are meeting their direct care staffing levels (see Part 1).

Nonetheless, a long-term aim of calibrating the AN-ACC funding model should be to ensure greater parity in the direct care outcomes of homes, regardless of their resident profile, location or specialist service offering.

A long-term aim of calibrating the AN-ACC funding model should be to ensure greater parity in the direct care outcomes of homes, regardless of their resident profile, location or specialist service offering.

Everyday living:

As shown in Table 10, the Everyday Living Result[150] has improved slightly compared to the prior year. Homes now lose, on average, $6.96 per resident per day (compared to losing $7.37 per day in the first half of 2022-23). The increase in everyday living revenue marginally outpaced growth in expenditure on those services.

The revenue growth resulted from the indexation of the basic daily fee (set at 85% of the age pension, which is indexed by the higher of either the consumer price index or living cost index) and the revision of the hotelling supplement.[151]

Regarding key expenditure items, homes have increased spending on catering and food, averaging $39.84 per resident per day. The average expenditure on everyday living for the first half of 2023–24 was $81.57 per resident per day.

As discussed in Part 1, the Aged Care Taskforce has recommended that the Government reform the payments for everyday living to eliminate the persistent deficit for this service area and thus improve the viability of homes.

150. The Everyday Living Result includes revenue from Basic Daily Fee, the hotelling supplement as well as extra or additional service fees. The main cost categories include hotel services (catering, cleaning, laundry), utilities, motor vehicles and regular property and maintenance (includes allocation of workers compensation premium and quality and education costs to hotel services staff). The Everyday Living Result also includes an allocation of 33.6% of homes' administration costs.

151. The Independent Health and Aged Care Pricing Authority (2023), *Residential Aged Care Pricing Advice 2023–24*.

Accommodation:

Turning to the Accommodation Result,[152] in the first six months of 2023–24, homes lost an average of $10.39 per resident per day in providing accommodation services. Although this represents a modest improvement compared to the same period for 2022-23 (where homes lost an average of $14.26 per resident per day), this service type represents the most significant area of concern within the business model of providing residential care. There are also long-standing concerns with how accommodation financial performance is measured, including how RADs are taken into account.

The improvement is mostly attributable to increases in average revenue due to increases in the Maximum Permissible Interest Rate (MPIR), noting that there may also be an effect from a changing payment mix between lump sums, daily payments and combinations. The MPIR rate calculates the value of newly admitted private-paying residents' DAPs. In July 2022, the MPIR was 5.00%; by December 2023, it had grown to 8.15%. The value of DAPs has also increased as providers have continued to increase the price of their accommodation.[153]

As with everyday living, Table 10 shows accommodation services generate losses because current revenue settings are inadequate to cover the total accommodation cost (including administration expenses). Also, even though depreciation is one of the most significant cost categories (averaging $ 20.48 per resident per day), it likely understates the true cost of replacing or refurbishing physical infrastructure.[154] In the future, if homes need to incur additional expenditure to replace or refurbish their physical assets, accommodation services' losses will likely grow unless providers set a price that meets the full accommodation cost, with a commensurate increase in the government-funded accommodation supplement for supported residents.

152. The Accommodation Result shows the net difference between accommodation revenue earned from either daily accommodation payments made from non-supported or partially supported residents, and government supplements for supported residents, and expenses related to capital items such as depreciation, property rental and refurbishment costs. The Accommodation Result also includes an allocation of 29.4% homes' administration costs.

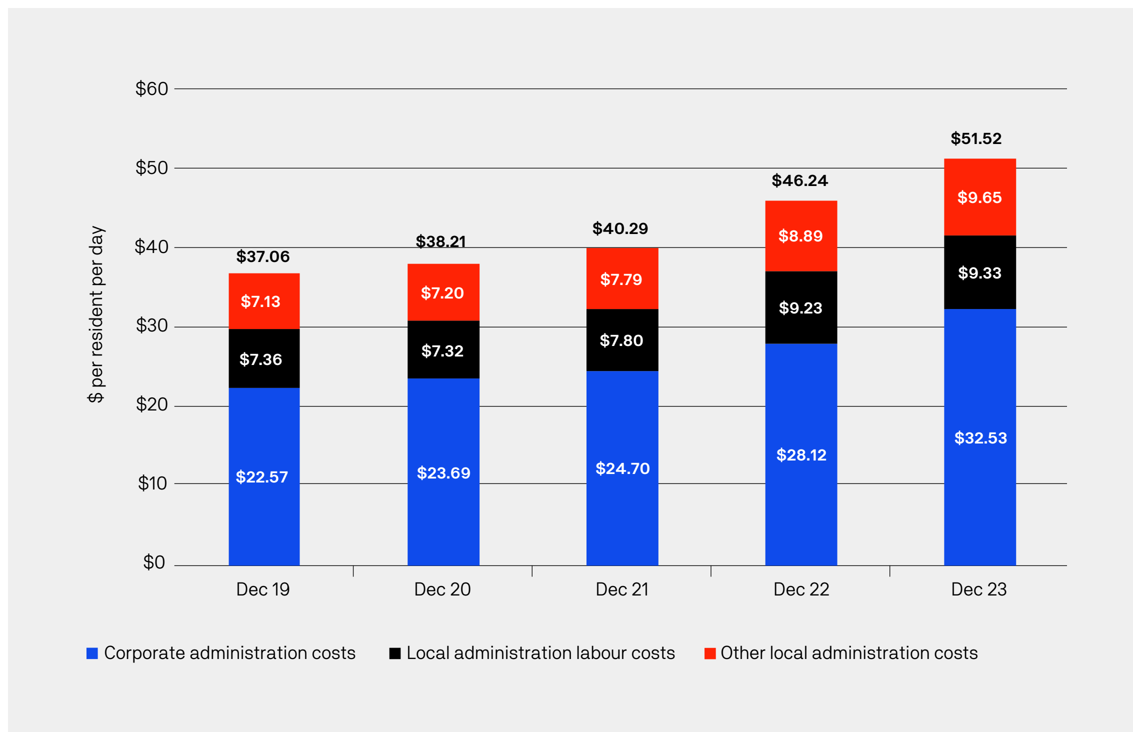
153. For example, in the first half of 2023–24, the median value of a new RADs was $475,035 compared to $459,096 in the first half of 2022-23.

154. The most significant accommodation-related cost is depreciation and amortisation, which is reflective of changes in homes' asset bases (i.e., through new or refurbished infrastructure) and accounting policies. While a minority of providers revalue their property assets, most depreciate based on cost. Of those, most providers depreciate based on 30-40 years of useful life, although a mid-life refurbishment is likely to occur after about 15-20 years.

Administration costs:

The above analysis allocates administration costs to calculate the net results for direct care, everyday living and accommodation. Figure 26 shows the trend in the underlying expense items included in this allocation. In the first six months of 2023–24, total administration costs were, on average, $51.52 per resident per day. In nominal terms, this is 11.4% higher than the average administration costs in the first six months of 2022-23, and 39.0% higher than the same period in 2019–20. This growth has occurred in both corporate and local administration costs.[155]

Figure 26: Administration expenditure, per resident per day



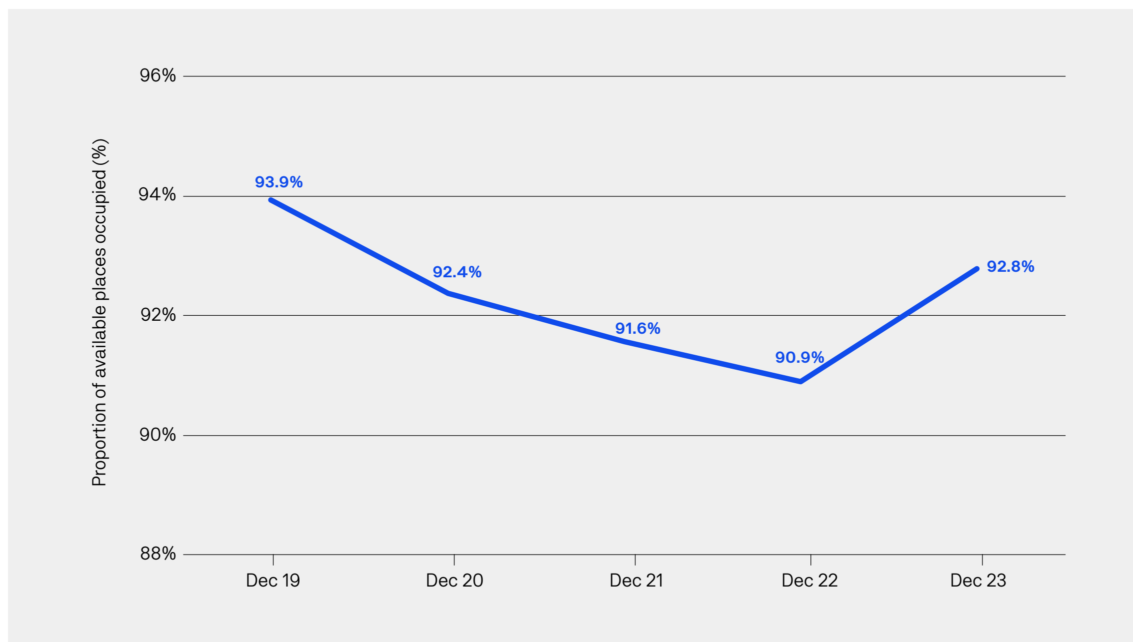
155. 'Corporate administration costs' represent an apportion of the provider's corporate head office costs or organisation-wide administration costs; 'local administration labour costs' represent the wages and on-costs for administration and clerical staff employed directly by the residential care home; and 'other local administration costs' include all other administration costs, including quality, education & compliance costs, workers compensation, other insurance, payroll tax, fringe benefits tax, advertising for staff, accounting fees, accreditation costs, audit fees, computer expenses, consulting fees, general expenses, legal fees, postage, printing, recruitment, subscriptions, telephone and travel costs.

Occupancy

Occupancy is an important indicator within the residential aged care sector, reflecting the expressed demand for residential aged care relative to its supply.

Occupancy is also a critical driver in explaining changes in the financial performance of aged care homes. This is because while homes' revenue is highly sensitive to short-term changes in occupancy and resident mix, most of the costs involved in delivering residential aged care are fixed, at least over the short to medium term.[156] This means that even a minor drop in occupancy of a few percentage points can cause a home to experience a funding shortfall (i.e. where revenue is insufficient to cover costs) and trigger acute financial pressures.

Figure 27: Occupancy rate



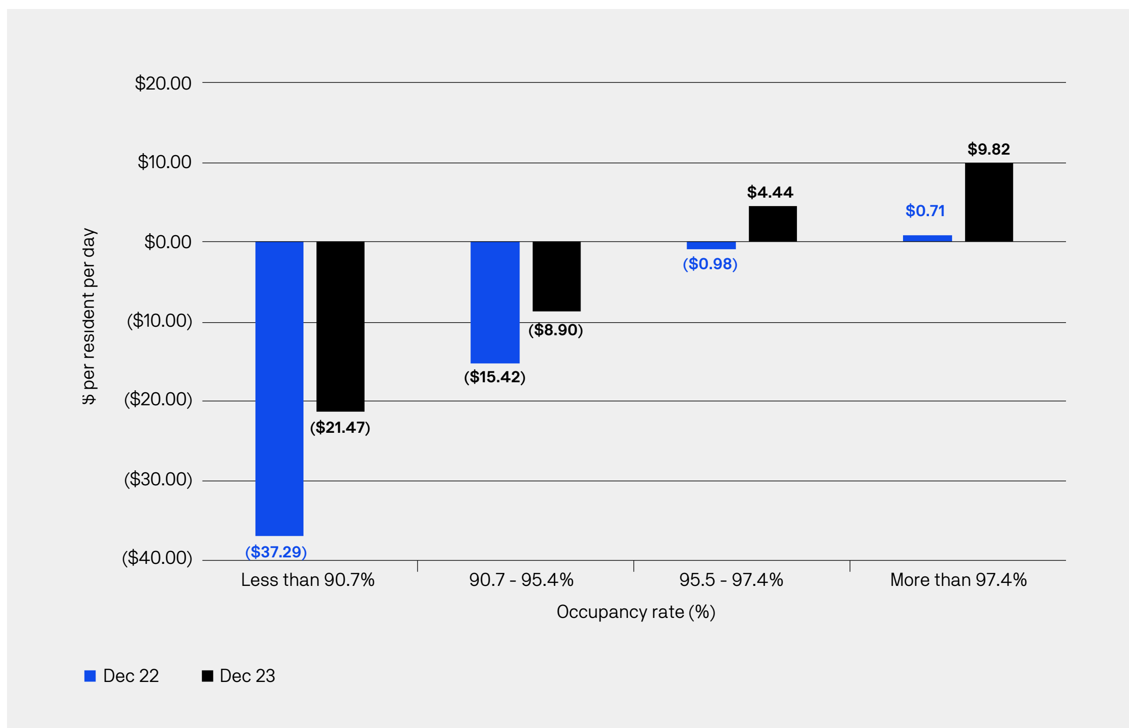
In this context, the improvement in the financial results reported in the previous section is at least partially attributable to the improvement in average occupancy rates in the first half of 2023–24.[157] It should also be noted that higher occupancy, while enabling fixed costs to be spread over more residents, also puts pressure on staffing, including meeting residents' care minute requirements.

156. These include costs of the physical infrastructure, administration and compliance, all of which must be incurred regardless of the number of places occupied. Furthermore, unless there is a significant and ongoing shift in residents' needs or occupancy, homes find it difficult to alter the configurations and costs of their staff.

157. Occupancy measures the rate in which an aged care home's places are used (i.e., occupied) by a resident. In the StewartBrown data occupancy is calculated in terms of the available places, which excludes places that have been allocated but are not operational. This measure of occupancy differs from the estimates published by the Department, which measures occupancy as the proportion of total allocated places, including those that might not be operational.

As shown in Figure 27, the average occupancy rate across all mature homes in the StewartBrown dataset has increased to 92.8% in the first half of 2023–24. Although this is still lower than rates reported five years ago, it represents an increase of almost 2 percentage points compared to the same period the previous year. The improvement in occupancy likely reflects the return of demand for residential care, potentially as negative community perceptions ease, consumer information through Star Ratings improves, and direct care staffing increases. It may also be influenced by the increased wait times for home care packages, as described in Part 1.

Figure 28: Operating Result, by occupancy rate, per resident per day



The relation between occupancy and financial performance is evident in Figure 28. This figure shows the average Operating Result (per resident per day) of homes split by different occupancy rates. In the first half of 2023–24, homes with the highest occupancy rates (above 97.4%) had an average operating surplus of $9.82 per resident per day, while homes with the lowest occupancy rates (less than 90.7%) had an average operating loss of $21.47 per resident per day.

Future occupancy rates will likely reflect the interaction between various supply and demand factors for residential care, including the increased availability of home care packages and the abolition of supply-side residential care restrictions imposed through bed licences which were issued through ACAR.

As detailed in Part 1 of this report, long-term demographic projections indicate that the demand for residential aged care will continue to grow as the number of older Australians with complex care needs, such as dementia, increases over time.[158]

158. Commonwealth of Australia (2023), *Intergenerational Report 2023: Australia's future to 2063*

Workforce

The aged care workforce is a critical factor influencing the quality and safety of residential care services. It also affects the financial performance of homes, as staffing costs account for the largest area of expenditure.

Table 11 shows the average staffing time by role, measured as minutes per resident per day. It is important to note that these results are based on year-to-date data. Thus, they represent the average staffing time across the first two quarters of 2023–24 rather than the staffing as of 31 December 2023.

There has been a 7.5% increase in direct care staffing time[159] (i.e. registered nurses, enrolled nurses and personal care workers), which on average was 200.3 minutes per resident per day. This comprised uplifts in registered nurses and personal care workers but also a further slight decline in the staffing minutes of enrolled nurses.

Table 11: Staffing time of residential aged care homes, minutes per resident per day

	Dec-22	Dec-23
Number of homes in dataset (workforce analysis)	1,093	1,178
Direct care:		
Registered nurses	31.6	38.5
Enrolled nurses	13.1	11.9
Personal care workers	141.4	149.8
Total direct care staffing time	186.2	200.3
Other care:		
Care management	6.3	4.7
Allied health	5.9	4.6
Lifestyle	6.7	7.1
Total other care time	18.9	16.4
Everyday living, accommodation and administration:		
Hotelling	41.3	41.9
Maintenance and accommodation	4.0	4.2
Administration	10.1	9.4
Quality and education	1.3	0.9
Total everyday living, accommodation and administration time	56.7	56.3
Total staffing time	261.8	273.0

159. Direct care time is a measure of the staffing hours (both normal and overtime) of registered nurses, enrolled nurses, and personal care workers. To allow comparisons between homes, it is measured as an average rate per resident per day. It does not measure the actual time spent with each resident, but provides an approximation based on the total normal and overtime hours worked by staff.

Residential aged care homes

While much policy attention has focused on direct care roles, which comprise 73.4% of total staffing time, it is important to recognise the contributions of other types of staff within residential care homes. For example, those in other care-related roles (such as allied health and lifestyle) comprise 6.0% of total staffing time (a decline on the previous year), and those in everyday living, accommodation and administration represent a further 20.6%.

Figure 29: Staffing time, by category, per resident per day

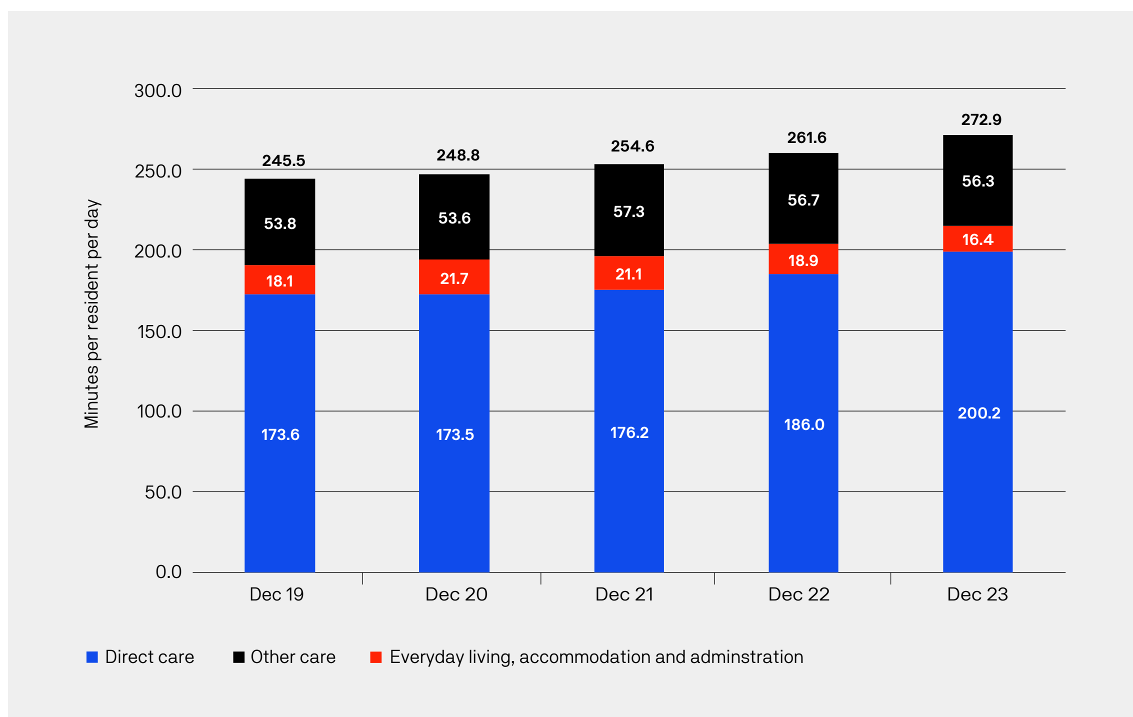


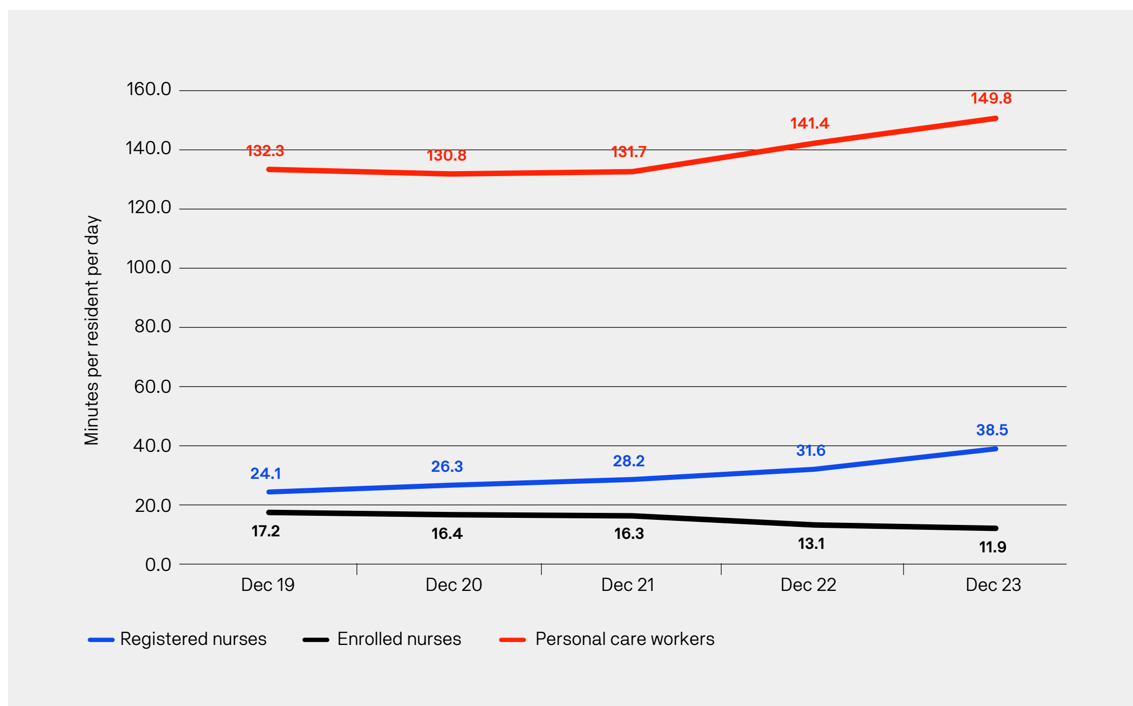
Figure 29 trend shows the long-term trend in the average composition of homes' staffing. This shows that almost all (97%) of the growth in total staffing time over the last five years has been in direct care staffing roles. On average, direct care staffing has grown by 26.6 minutes per resident per day since December 2019, while everyday living, accommodation and administration time has increased by only 2.6 minutes per resident per day. Furthermore, the average staffing time of other care roles has declined in the last five years from 18.1 minutes per resident per day in December 2019 to 16.4 minutes in December 2023. This contraction is likely to reflect, at least in part, some reassignment of care managers' time to registered nurse time.

These changes in the composition of homes' staffing models coincide with the various reforms implemented in recent years to lift direct care staffing levels, including the 24/7 registered nurse requirement (introduced in July 2023) and care minute targets (introduced in October 2023).[160]

160. From 1 July 2023, all homes have been required to always have a registered nurse on duty, with exemptions for some homes based on location and size. In terms of the care minute targets, on average, homes across the sector are expected to provide at least 200 minutes of direct care per resident per day, with at least 40 of those minutes provided by a registered nurse from 1 October 2023. Each individual home's service-level care minutes targets dependent on the relative care needs of its residents, as assessed under AN-ACC. Homes with a higher proportion of residents with more complex needs will have higher care minutes targets (for both total direct care and registered nurses), and vice versa for homes with residents with less complex needs.

Of note, in the first half of 2023–24, the homes in the StewartBrown dataset reported average direct care staffing levels on par with the sector-level averages prescribed by the minimum staffing standards. Nonetheless, as discussed in Part 1, many aged care homes still lag behind their service-level targets. Furthermore, the care minute targets will increase again in October 2024 (i.e. from an average of 200 minutes of direct care per resident per day to 215 minutes, of which registered nurses must provide 44 Minutes).[161]

Figure 30: Direct care staffing, by role, per resident per day



Disaggregating the direct care data further, the five-year trend depicted in Figure 30 shows that growth in registered nurses and personal care workers has continued since the staffing requirements became mandatory in October 2023.

However, as with previous reports, we note the continued contraction of enrolled nurse time, which has declined for the fourth year, representing an aggregate fall of 30.2% since December 2019. UARC notes that to address this issue, the Government has recently announced that from 1 October 2024, homes will be able to meet up to 10% of their registered nurse targets with care time from enrolled nurses. This measure may provide an additional incentive to retain enrolled nurses with lower award rates than registered nurses. However, it is likely to only partially offset the incentive to substitute enrolled nurses for personal care workers.

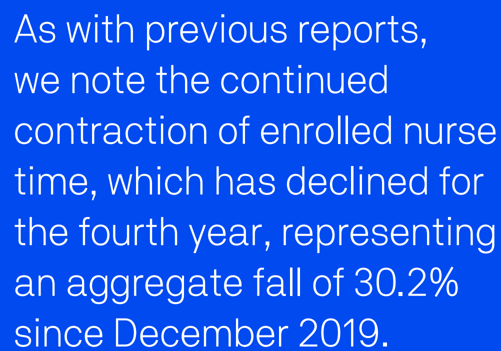
161. The Department has indicated that homes will be able to count enrolled nurse time for up to 10% of their registered nurse care minutes target.

Residential aged care homes

It is important to note that the figures above (i.e. the 200.3 in total direct care minutes and 38.5 minutes for registered nurses) represent the average staffing times across homes in the StewartBrown dataset. There is still substantial variation in homes' direct care staffing levels vis-à-vis their service-level care minute targets. Using data from Quarter 2 only (i.e. from October-December 2023), UARC analysed each home's staffing compared to their service-level care minutes targets. Only 41.5% of the homes in the StewartBrown dataset had met their registered nurse care minute target, 52.8% had met their total direct care target, and 28.9% had met both targets.[162]

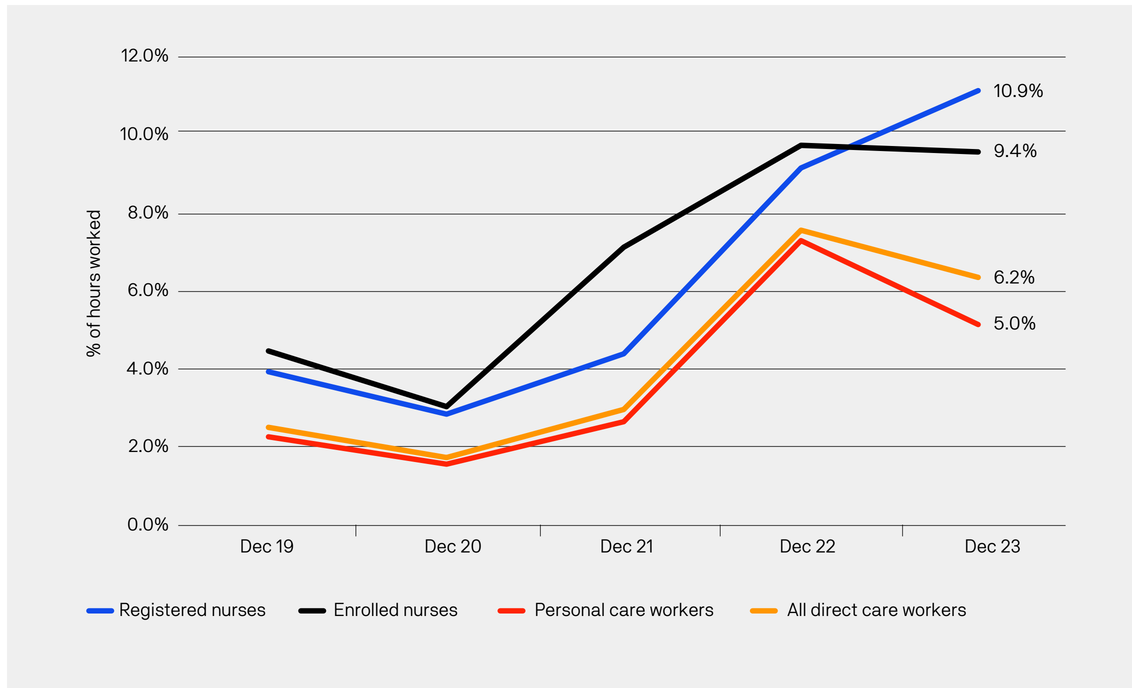
UARC's analysis of the StewartBrown dataset showed that the homes that were meeting both care minute targets are characterised by the following features:

- Smaller size, with fewer available places
- Rural and remote, located in areas MMM5-7
- Operated by smaller providers, either as standalone homes or part of small chain providers (2-6 homes)
- Slightly lower occupancy rates



162. As the StewartBrown dataset does not contain government providers (which historically have had higher direct care staffing levels), the rates for the StewartBrown dataset are lower than the sector-wide statistics reported in Part 1.

Figure 31: Agency staffing as a proportion of direct care hours



Another critical workforce trend over the past five years has been the increased reliance on agency staffing to fulfil direct care roles. As shown in Figure 31, agency staff comprised less than 2.0% of direct care staffing time in December 2020, but it now averages 6.2%.

The increased reliance on agency staff has occurred across all direct care roles but has been most pronounced for registered nurses. This is likely symptomatic of the challenges homes have faced in recruiting and retaining enough appropriately qualified registered nurses to meet the 24/7 and care minute requirements. By comparison, over the last year, there has been a fall in the proportion of agency personal care workers, which indicates that the recent expansion of personal care worker time to meet the care minute targets has largely been filled by internal workers.

Home care analysis

Overview

- The financial performance of home care providers declined to an average Operating Result of $1.77 per client per day in the first half of 2023–24, down from $3.15 in 2022-23. This represents a profit margin of just 2.4%.

- While revenues have increased, mainly in response to price rises that reflected the increase in the Government subsidy as a result of the Aged Care Work Value case, averaging $74.04 per client per day, provider costs per client per day (including the higher wage costs) have increased, but at a higher rate, to an average of $72.27, thus resulting in a worsening of the overall financial performance.

- Revenue utilisation remains persistently low at 84.0%. Unspent funds continue to accumulate and now average $13,397 per package.

- There is an increasing use of third-parties to deliver care, with 39.1% of direct care costs attributable to third-party services in the first half of 2023–24.

Home care provider profiles

The following analysis reports on the financial and workforce outcomes of home care service providers that offer subsidised services funded through home care packages. The services can include personal and nursing care, domestic and social support activities, home maintenance, and other supports in the home and community. As noted earlier, the StewartBrown dataset does not currently extend to CHSP, STRC and other service providers. However, future changes to the dataset will align with the proposed new Support at Home program for delivering in-home care from July 2025.

Table 12: Profile of surveyed home care providers

	Dec-22	Dec-23
Number of home care providers in the dataset	87	93
Total number of packages in dataset	60,102	71,500
Ownership:		
For profit	2.3%	4.3%
Not for profit	97.7%	95.7%
Average number of funded packages per home care provider	690.8	768.8
Package mix		
% of Level 1 packages	6.3%	6.1%
% of Level 2 packages	41.5%	41.7%
% of Level 3 packages	31.6%	31.3%
% of Level 4 packages	20.6%	20.9%

The analysis reported in this section relates to 93 home care providers included in the December 2023–24 StewartBrown dataset. As shown in Table 12, this dataset includes 71,500 home care packages or approximately 26.5% of the total population of 269,573 home care clients as of 31 December 2023.[163] Most providers in the dataset are not-for-profit (95.7%). The dataset does not include home care package providers that are government agencies, which make up a substantial minority of providers in some regions.

Despite the notable increase in the total number of packages in the dataset compared to the previous year, the overall mix of packages across participating home care providers has remained relatively stable. The highest represented packages that recipients currently receive are a Level 2 package (41.7%) or a Level 3 package (31.3%). The survey package mix in the dataset is consistent with sector-level statistics of the national proportion of people with home care packages, by package level, reported by the Department. [164]

163. Department of Health and Aged Care (2024), *Home Care Packages Program Data Report 2nd Quarter 2023–24*
164. Department of Health and Aged Care (2024), *Home Care Packages Program Data Report 2nd Quarter 2023–24*

Key performance indicator summary

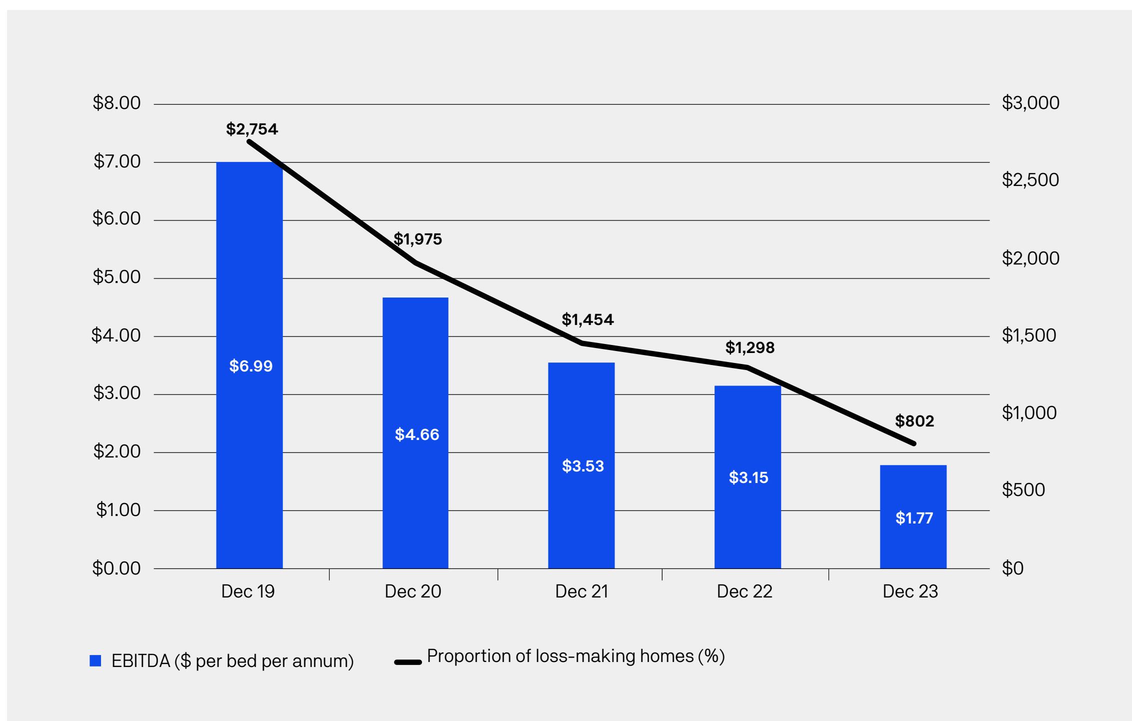
Table 13: Key performance indicators of home care providers

	Dec-22	Dec-23
Operating result per client per day	$3.15	$1.77
Operating EBITDA per client per annum	$1,298	$802
Profit margin (Operating result) (as % of revenue)	4.7%	2.4%
Revenue:		
Revenue per client per day	$66.70	$74.04
Revenue utilisation rate	82.6%	83.5%
Unspent funds per package	$10,853	$13,398
Costs:		
Costs per client per day	$63.55	$72.27
Direct care and brokered services costs (as % of revenue)	59.1%	60.9%
Care management and advisory costs (as % of revenue)	11.3%	11.4%
Administration and support costs (as % of revenue)	24.8%	25.1%
Total staff hours per client per week	5.4	5.4

Financial performance

The first half of 2023–24 results show a continued deterioration of the financial performance of home care providers. Figure 32 shows that the Operating Result[165] of home care providers has reached a 5-year low of $1.77 per client per day, down from a provider average of $3.15 per client per day in December 2022 (a decrease of 43.8%). The Operating EBITDA for home care providers in December 2023 was $802 per client per annum, down from an average of $1,298 in December 2022 (a slightly smaller decrease of 38.2%).

Figure 32: Financial results of home care providers



Provider profit margins had a corresponding decline from 4.7% in the first half of 2022-23 to 2.4% in 2023–24 (Table 13). For every $100 of a provider's revenue, only $2.40 is surplus to costs and retained as profit. This modest profit margin highlights providers' ongoing viability concerns, which pose potential challenges in funding investments, such as in technology to improve service efficiency, necessary to meet the future growth in demand for aged care services in the home and community

165. Operating Result refers to the Net Profit Before Tax (NPBT) earned by a home care service provider.

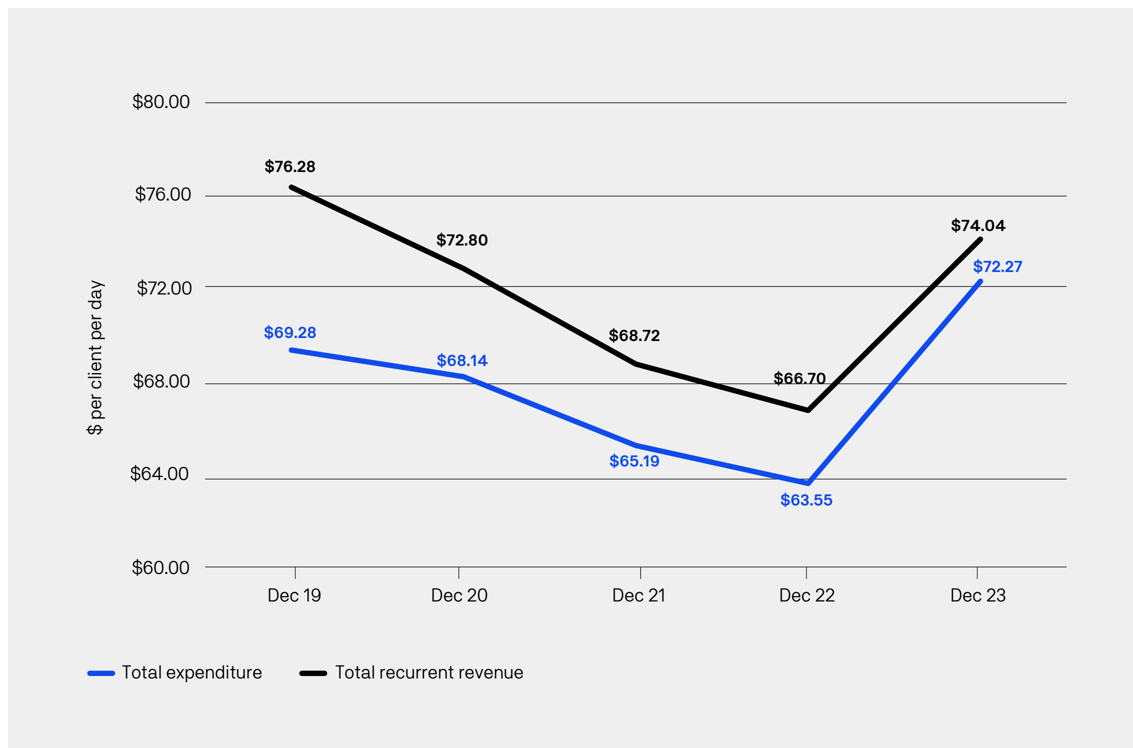
Table 14: Detailed financial results of home care providers, per client per day

	Dec-22	Dec-23
Number of providers in dataset	87	93
Revenue		
Direct service revenue	$34.66	$36.34
Sub-contracted and brokered service revenue	$11.67	$14.86
Care management revenue	$12.63	$13.61
Package management revenue	$7.72	$9.23
Exit fees	$0.02	$0.00
Total recurrent revenue	**$66.68**	**$74.04**
Expenditure		
Direct care and brokered services:		
Internal direct care:		
Staffing	$21.81	$23.89
Agency costs	$1.05	$0.64
Consumables	$0.59	$0.67
Transport	$0.97	$1.04
Other	$1.02	$1.07
Internal direct care	$25.44	$27.31
External direct service costs	$14.12	$17.57
Direct care and brokered services	**$39.56**	**$44.88**
Care management & advisory:		
Staffing	$6.92	$8.25
Transport	$0.14	$0.10
Care management & advisory	**$7.06**	**$8.35**
Administration & support services:		
Administration recharges	$6.13	$7.98
Staffing	$5.33	$6.00
Other administration	$5.06	$4.64
Administration & support services	**$16.52**	**$18.62**
Depreciation	**$0.40**	**$0.42**
Total expenditure	**$63.55**	**$72.27**
Total Operating Result	**$3.13**	**$1.77**

As detailed in Table 14, the recent decline in providers' Operating Results and profit margins has been driven by higher costs despite increased revenue. Figure 33 illustrates these as long-term trends. It shows how, on average, provider revenue per client per day had been declining but in the last year has increased while costs have increased at a higher rate, narrowing the gap between revenue and expenses in the half-year to December 2023.

The most significant driver causing the recent changes in homes' average revenue and expenditure is the increase in package subsidies and corresponding expenditure to implement Stage 2 of the FWC aged care wage case (i.e. a 15% increase in award rates for direct care workers).[166]

Figure 33: Home care revenue and expenditure, per client per day

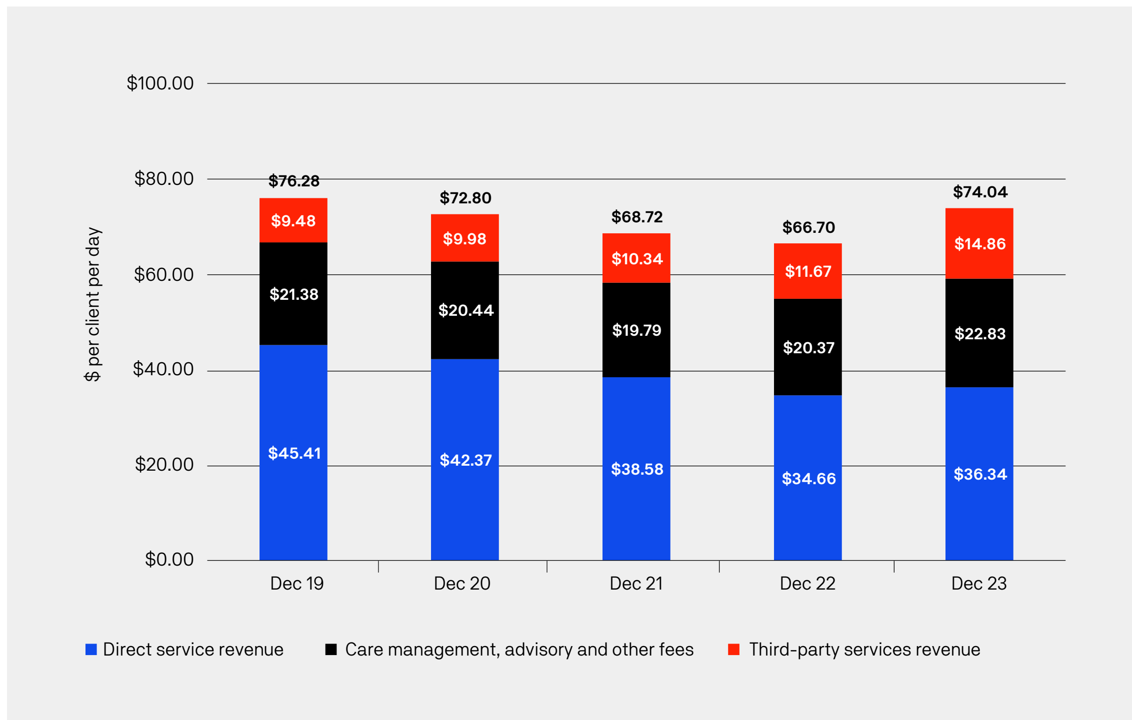


166. Wage subsidy increase in the Home Care Packages Program | Australian Government Department of Health and Aged Care

Revenue analysis

The primary funding sources for home care packages are government subsidies and a small contribution from income-tested fees and basic daily fees paid by clients.[167] Home care providers' revenue is earned as charges for the delivery of direct services, care management, and other advisory services, as well as for services contracted for clients through third-parties (also referred to as subcontracted or brokered services).

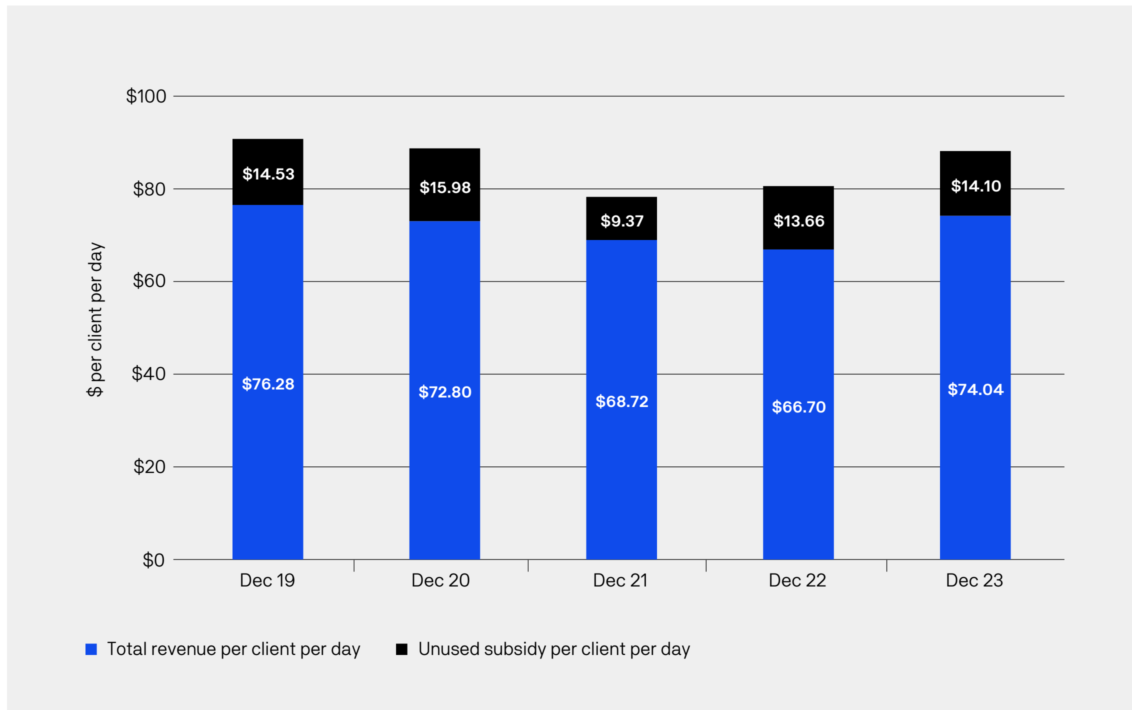
Figure 34: Home care revenue, per client per day



While Figure 34 shows that home care revenue per client per day has increased from $66.70 in the 2022-23 half-year to $74.04 in 2023–24, the revenue is still lower than five years ago. Although average direct service revenue (i.e., revenue from services the provider delivers) has increased in the last year, it is lower than five years ago. In contrast, third-party services revenue (i.e. revenue from services that third-parties deliver) has increased substantially over the past five years, signifying a growing use of external parties to deliver home care services.

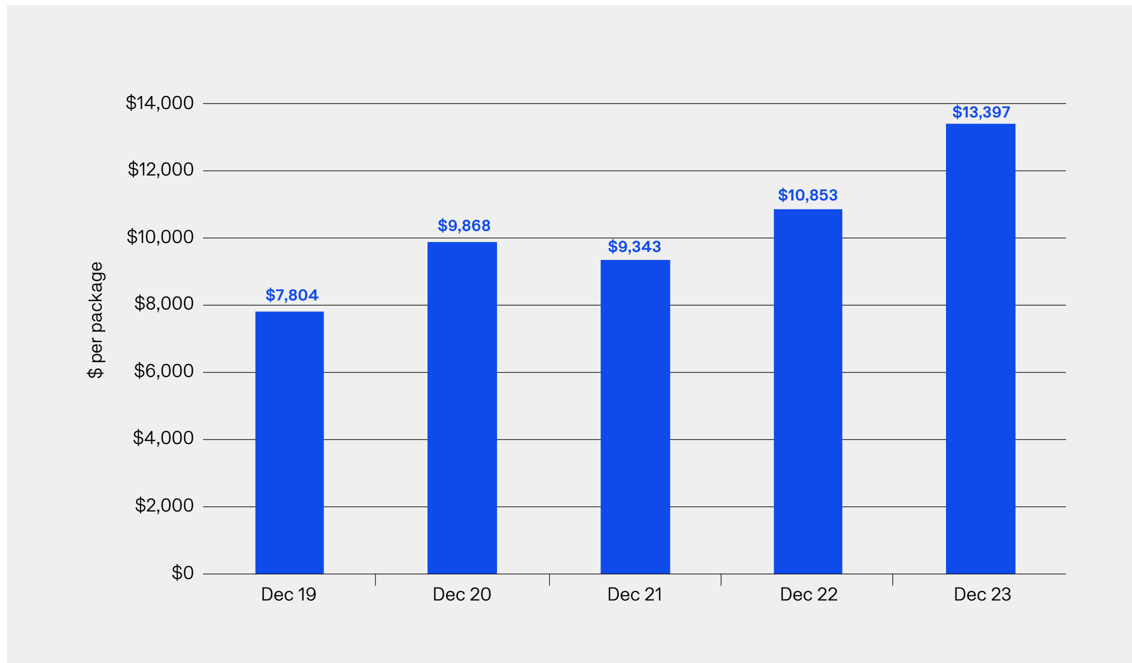
167. Providers also earn revenue from additional government supplements.

Figure 35: Revenue and unused subsidy, per client per day



Client unused subsidies continue to place downward pressure on providers' revenue per client day (Figure 35) in the context of total available package funds. The proportion of allocated subsidies used by home care clients and realised as revenue by providers can be represented as revenue utilisation. Although revenue utilisation in the first half of 2023–24 has increased slightly from 2022-23 (83.0%), it remains persistently low at 84.0%. The implication is that there continues to be a persistent proportion of home care package entitlements that go unused, equivalent to $14.10 per client per day in the first half of 2023–24.

Figure 36: Average accumulated value of unspent funds per package



A further implication of low revenue utilisation is the accumulation of unspent funds over time. Figure 36 shows the average accumulated value of unspent funds per package (i.e. per client), including unspent funds held with Service Australia and with providers. Over the last five years, the average total value of unspent funds has continued to increase and is now $13,397 per package. As discussed in Part 1, the total value of unspent funds is $3.09 billion.[168]

From a provider's perspective, these unspent funds represent unrealised revenue, a portion of which could have been additional net surplus. Furthermore, as discussed in Part 1, it is also symptomatic of broader policy issues, representing an inefficient use of taxpayer funds, particularly in the context of growing wait times for home care.

168. Department of Health and Aged Care (2024), *Quarterly Financial Snapshot Aged Care Sector, Quarter 1 2023–24*

Cost analysis

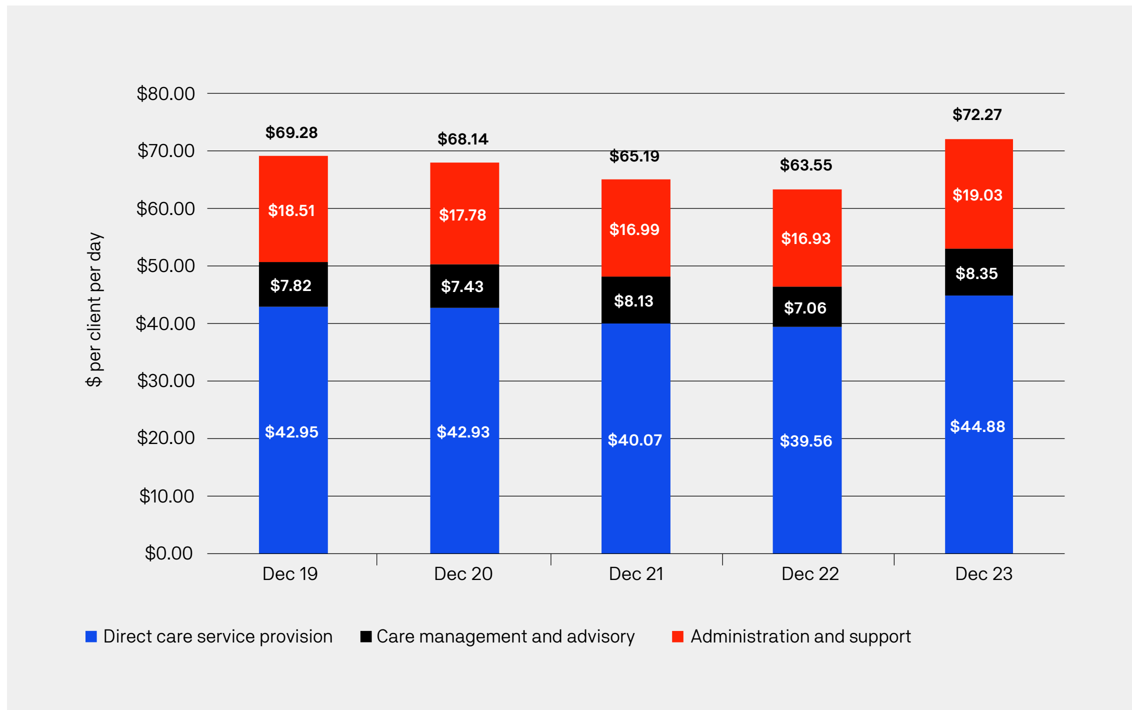
Providers' costs in delivering home care services can be disaggregated into three basic categories:

- **Direct care service provision** (including services provided by third-parties through subcontracted and brokered service arrangements).[169] This typically includes workforce costs (including personal care workers, nursing and allied health workers and other workers), consumables, travel and home modifications.
- **Care management and advisory**. This typically relates to the labour and transport costs of staff who help manage and coordinate services for clients, including managing the delivery of services from third-parties.
- **Administration and support**. This typically includes the costs of administration staff, centralised scheduling of services, education and quality control, insurance, utilities, rent, information technology, interest and motor vehicles and other 'back-office' costs relating to the provider organisation running its services.

169. Sub-contractor and brokered service arrangements occur when third parties are engaged to provide services to the client. Common examples include when providers use a brokered labour hire company to provide client services on a permanent basis, or when gardening, home maintenance or allied health services are provided by a subcontractor. It also includes when a third party is engaged to install home modifications that support the independence of home care clients.

Home care package providers

Figure 37: Home care expenditure, per client per day

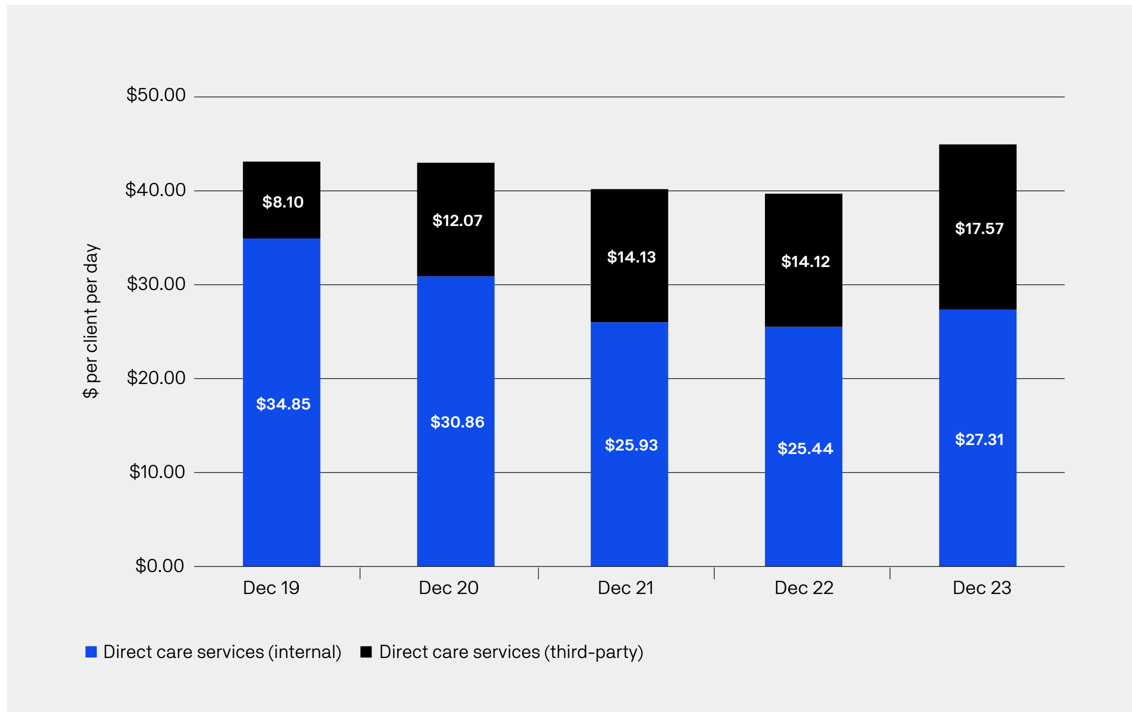


Provider expenditure in each of the three categories are shown in Figure 37. Direct care have costs have increased, mainly as a result of higher wages to $44.88 per client per day in 2023–24. Expenditures on care management and advisory, together with administration and support have also grown (although stable as a proportion of revenue).

Workforce

Home care providers continue to face substantial challenges in attracting and retaining sufficient workers with appropriate knowledge, skills and professional attributes.

Figure 38: Direct care expenditure, internal and third-party, per client per day



One of the most significant trends relating to the home care workforce is the increasing use of third-parties to deliver care services to meet the needs of their clients. Figure 38 shows a breakdown of direct care service provision costs by internal service provision (i.e. by the provider) and third-party service provision. The figure shows an increase in the cost of providing internal direct care services over the last two years from $25.44 per client per day in the 2022-23 half-year to $27.31 in 2023–24, along with a more substantial increase in the cost of providing third-party services at $17.57 per client per day in 2023–24 (an increase from $14.12 in 2022–23). Overall, this results in an increase in the proportion of direct care costs attributable to subcontracted or brokered services to 39.1% in the 2023–24 half-year from 35.7% in 2022-23.

Concurrently, the increase in the expenditure on internal staff per client per day is driven by the increase in the award wages arising from the Aged Care Work Value case before the FWC,[170] with the National Wage Case increases yet to follow. Its decision applied to residential care, home care workers, and nursing staff who delivered in-home aged care. The increased expenditure masks a continued decline in the average hours worked by internal staff. Total internal staffing hours per client per week for home care services have decreased significantly since the first half of 2019–20, from 6.64 hours to 5.36 hours in 2023–24.

170. Wage subsidy increase in the Home Care Packages Program | Australian Government Department of Health and Aged Care

One of the most significant trends in home care is the increasing use of third-parties to deliver care services.

Editorial board

Professor Michael Woods (Chair)

Professor Mike Woods is a Professor of Health Economics at the UTS Centre for Health Economics Research and Evaluation, focusing on aged care, and is a member of IHACPA's Aged Care Advisory Committee. He was a former Deputy Chair of the Productivity Commission and has held appointments to Government Boards, health and aged care policy reviews, multilateral development agencies and foreign government reform programs.

Professor David Brown (Deputy Chair)

Professor David Brown is a Professor of Management Accounting at the UTS Business School and co-director of the UTS Ageing Research Collaborative (UARC). His research focuses on the design and use of accounting systems for decision-making in organisations with a focus on business models and determinants of performance.

Grant Corderoy

Grant Corderoy is the Senior Partner at StewartBrown and leads their Consulting division. Grant has a longstanding commitment to the aged care, community service and not-for-profit sectors and regularly contributes to the financial policy, sustainability direction and viability of these sectors in consultation with the Department, peak bodies, providers and consumer advocates.

Professor Deborah Parker

Professor Deborah Parker is a Professor of Nursing Aged Care (Dementia) in the Faculty of Health at UTS and co-director of the UTS Ageing Research Collaborative (UARC). Her primary research is in palliative care for older people. She has published and is recognised both nationally and internationally. Her research incorporates her clinical background. She is the former President of Palliative Care NSW and is a member of the Palliative Care Nurses Association, the Australian Association of Gerontology and the Australian College of Nursing.

Research team

Associate Professor Nicole Sutton

Dr Nicole Sutton is an Associate Professor of management accounting at the UTS Business School, with expertise in how financial, management and performance systems influence organisations' behaviour and decision-making. Much of her current work focuses on delivering high-quality evidence that informs policy and practice across the aged care sector. She is the Treasurer of Palliative Care NSW.

Associate Professor Nelson Ma

Dr Nelson Ma is an Associate Professor of financial accounting at the UTS Business School. His research focuses on understanding the drivers of financial outcomes in organisations and the role of institutions in assuring the quality of financial outcomes of publicly listed companies. He has published research in numerous international journals.

Dr Jin Sug Yang

Dr Jin Sug Yang is a lecturer at the UTS Business School. His research interests are financial accounting, corporate governance, and aged care. He is involved in several projects investigating the business model and financial outcome of Australian aged care providers.

Eugenia Tsihlis

Eugenia Tsihlis is a Senior Research Associate within the Law, Regulation & Ethics Theme of the UTS Ageing Research Collaborative. Her key focus areas are access to legal services for older people, the prevention of elder abuse and the evolving regulatory landscape of the aged care sector.

Professor Nola Ries

Professor Nola Ries is a Professor at the UTS Faculty of Law. She leads research on law, regulation and ethics with the UTS Ageing Research Collaborative. Nola is a co-founder of the Dementia Law Network, an active member of the Australian Association of Gerontology and qualified as a lawyer in Australia and Canada.

Associate Professor Deborah Debono

Associate Professor Deborah Debono is Deputy Head (Teaching and Learning) of the School of Public Health, UTS Faculty of Health. Deborah is a qualitative health services researcher with expertise in implementation science and evaluation. She focuses on improving the delivery and safety of health and social care services, particularly for people with disabilities and the elderly.

Professor Michael Woods

As above

Appendix: Methodology

The numbers provided in this report for aged care providers or homes are calculated at the unit specified in the sample summary of each section and aggregated using averages or medians as stated. Ratios are calculated using the same methodology. Numbers applicable to all providers (e.g., service revenue) and totals (e.g., EBITDA) are averaged across only those aged care providers or homes that provide data for that line item, which may differ from the headline sample size provided. All other measures are averaged across all the homes in the particular group that incur the cost. The average by line item is particularly useful for line items such as contract catering, cleaning and laundry, property rental, extra service revenue and administration fees, as these items are not supplied by all survey participants. Below is a detailed description of the methodology for each section.

Provider analysis

For aged care providers, provider-level averages are calculated using the aggregate averages of any one line item across all providers and dividing by the number of providers in the sample.

Residential care analysis

For residential care, all home-level averages are calculated, in general, by using the aggregate of all averages of any one line item across all aged care homes in the group, and dividing by the number of aged care homes in the sample. For many line items, the home-level raw data is first transformed into a rate per resident per day. For example, the home-level average for contract catering would be calculated by first transforming the raw total amount submitted for that line item into a rate per resident per day for each aged care home, and then used to calculate the average rate per resident per day across all homes in the sample.

Home care analysis

For home care, all provider-level averages are calculated, in general, by using the aggregate averages of any one-line item across all home care providers, and dividing by the number of home care providers included in the sample. For many line items, the provider-level raw data is first transformed into a rate per client days, by dividing the raw data submitted for any one line item by the number of client days for that home care provider. For example, the provider-level average for subcontracted and brokerage costs would be calculated by first transforming the raw total amount submitted for that line item into a rate per client day for each home care provider, and then used to calculate the average rate per client day across all providers in the sample.

Methodological variation between UARC and StewartBrown

Despite using the same underlying dataset, UARC and StewartBrown analyses often return minor variations due to a difference in methodology concerning the unit of analysis in which averages are calculated.

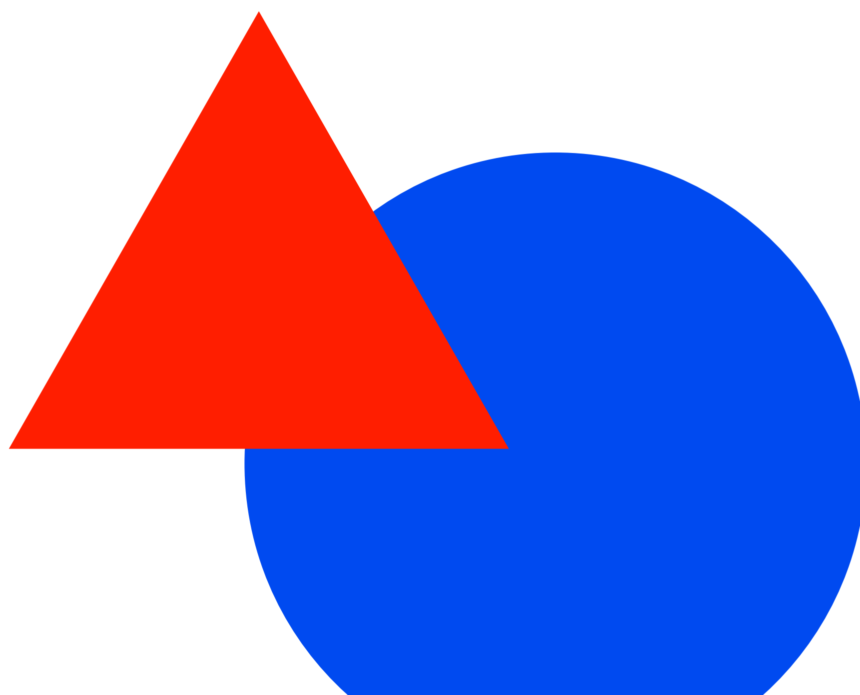
Both analyses express most items as a rate per individual, for example, EBITDA per client per annum, staffing minutes per resident per day, and Operating Result per resident per day. The intent of expressing the results as rates is to account for the effects of organisational size differences and provide comparable metrics across organisations.

In general, StewartBrown calculates these rates by taking the aggregate line item values across all providers in the dataset (e.g. the total EBITDA for all home care providers in their sample) and dividing by the aggregate of all individuals (e.g. the total number of clients for home care providers in their sample). This approach provides the average profitability of any given individual, place or client.

By comparison, UARC first calculates the rate for each organisation (e.g. EBITDA per client per annum for each home provider) and then calculates the average of that rate across all providers in the dataset. This approach provides the average profitability of any given provider or aged care home.

Owing to this methodological difference, the average rates calculated by StewartBrown and UARC will vary, particularly when there are differences in the performance of homes or providers of different sizes within the sample.

To ensure integrity in data transfer and analysis, UARC replicates the StewartBrown analysis, reconciles figures to StewartBrown's published results and reviews all line items individually to identify erroneous sources of variation.



For more information

UTS Ageing Research Collaborative (UARC)
Email: uarc_inquiries@uts.edu.au
Website: www.uts.edu.au/uarc

UTS CRICOS: 00099F