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FINAL REPORT OF THE AGED CARE TASKFORCE
FINANCIAL IMPACT OF REPORT RECOMMENDATIONS

Abstract

The Government established the Aged Care Taskforce (Taskforce) to review funding arrangements for aged care and develop options for a sustainable system that is fair and equitable for everyone in Australia. The Final Report of the Aged Care Taskforce was released on 11 March 2024. (https://www.health.gov.au/sites/default/files/2024-03/final-report-of-the-aged-care-taskforce_0.pdf).

Specifically, the Taskforce was to provide recommendations on:

- Funding and contribution approaches to support innovation in the delivery of care
- A fair and equitable approach to assessing the means of older people accessing residential and in-home aged care, including the scope of income and assets included in the assessment of means
- Issues and trade-offs for including and excluding different service types in the new in-home aged care program (the service list)
- Consumer contributions for in-home aged care, and reforms that support a future transition to a single in-home aged care system
- Reforms to arrangements for pricing and funding hotel and accommodation costs in residential aged care, including the phasing out of refundable accommodation deposits.

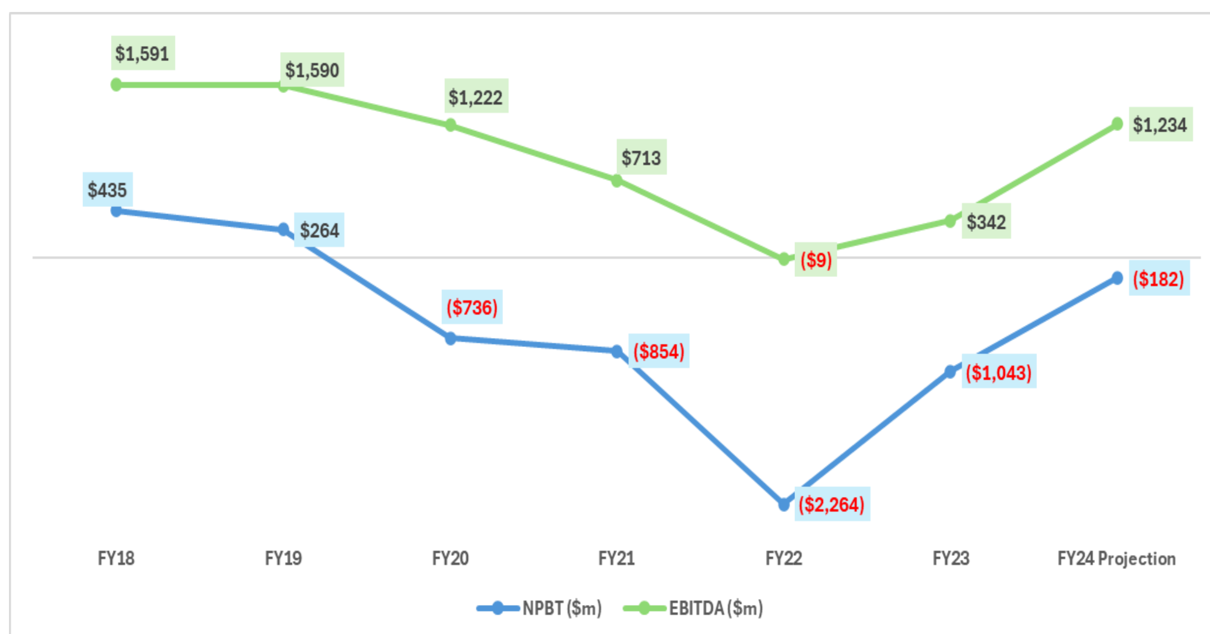
The Taskforce Report contained 23 separate Recommendations in relation to the above terms of reference.

Residential Aged Care

Current Financial Performance

The residential aged care sector has experienced aggregate financial operating deficits for each of the financial years 2020 to 2023 totalling $4.897 billion with a further forecast deficit for the 2024 financial year of $182 million.

Figure 1: Trend analysis of aggregate Net Profit Before Tax (NPBT) and EBITDA FY18 - FY24 ($ million)



Source: FY18 to FY22 Department of Health and Aged Care; FY23 StewartBrown estimate; FY24 StewartBrown Projection based on Dec-23 YTD financials

Figure 2 shows the financial performance FY19 to FY23 and for the Sep-23 quarter expressed as $ per bed day ($ pbd). The graph highlights that the Direct Care margin (ACFI/AN-ACC) has been a surplus in each period. The Sep-23 quarter AN-ACC margin is the primary reason that the overall result significantly improved in this quarter, however this margin will decrease as Providers meet the mandated minutes target and will likely drop to the $6 - $8 per bed day range.

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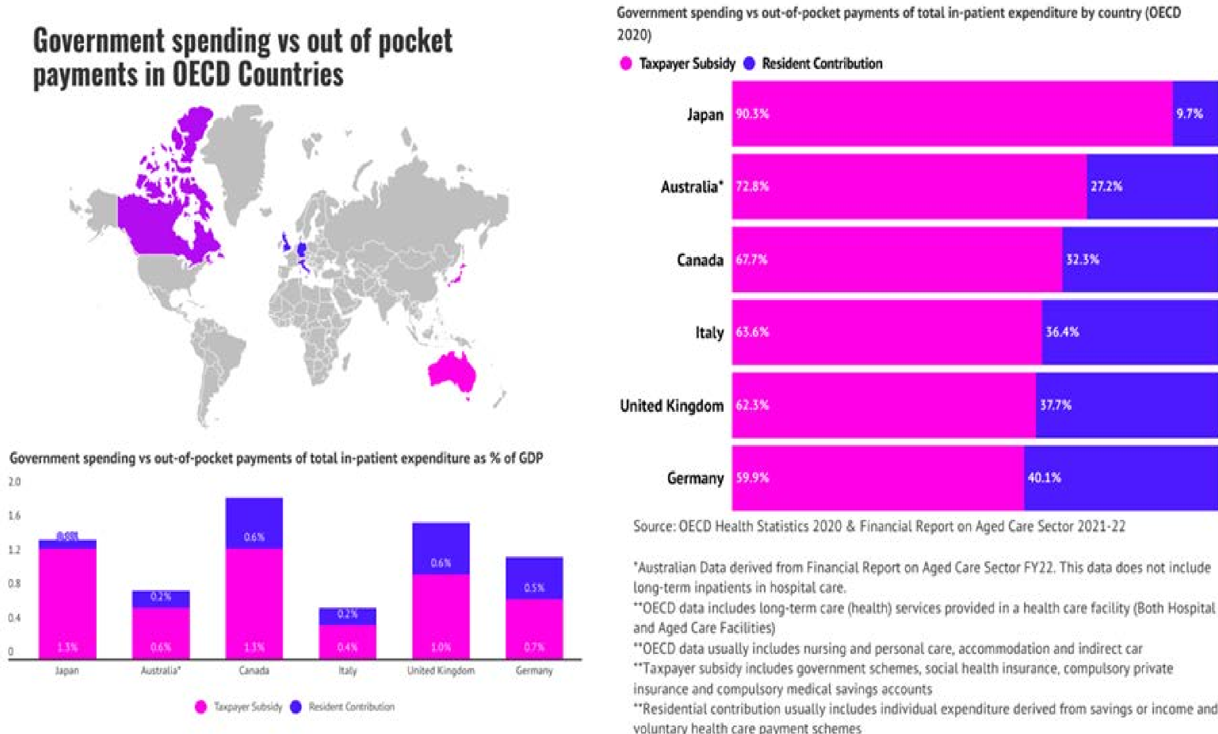
The overall operating result (losses for FY20 to FY23 and small surplus in FY19 and Sep-23 quarter is due to both the Indirect Care (hotel services) and Accommodation margins being in deficit. This was the focus of the Taskforce Report recommendations; for the residents who have the financial capacity (non-supported) to pay for the actual cost of the everyday living and accommodation services, and for the Accommodation Supplement in relation to supported residents to be increased to ensure equity.

Figure 2: Operating Results (margins) for Direct Care, Everyday living and Accommodation FY19 to Sep-23

Comparison of Consumer Contributions for Aged Care

Figure 3: Aged Care government spending vs out of pocket (consumer) payments comparison



When considering taxpayer subsidy funding for residential aged care and comparing it to comparator OECD countries Australia has the second lowest percentage of resident contribution for residential aged care services spending.

With a growth of three times the ageing population projected in the next 10 years, the Taskforce recommended a greater co-contribution with respect to the daily living costs that people have paid for throughout their adult lives. Interestingly, Japan has a low consumer contribution for those in aged care due to having a specific aged care levy for all taxpayers from age 40.

The recommendations only impact older people entering residential aged care and not current residents. It is important to note that persons who do not have the means to pay for the full cost of the daily services will be taxpayer subsidised.

Residential Aged Care Modelling

With respect to residential aged care the following recommendations are relevant in relation to the modelling of the financial effect.

Recommendation 10: Funding for daily living needs to cover the full cost of providing these services. It is recommended this be comprised of the Basic Daily Fee and a supplement

Recommendation 13: Require providers to retain a portion of the RAD in the near-term to make an immediate improvement to sector financial sustainability. To base the amount on the length of stay, with a cap on the number of years a RAD is subject to retention to protect residents who stay for a long time

Recommendation 14: Review the Accommodation Supplement, including improving incentives to meet the accommodation design principles

Table 1 below shows the forecast aggregate additional revenue for residential aged care if the proposed funding reforms as included in the Taskforce report are implemented. Please note that there is a lag period of at least three years for the full effect to be received, as current residents are grandfathered, and it will be the new residents who progressively pay the increased contribution.

It must be noted again that the additional consumer contributions do not apply to direct care delivery (RN's/EN's/Personal Care/Allied Health/Recreation/Medication) as these are separately funded by a care subsidy (AN-ACC and previously ACFI) with this funding being at least 94% paid by the taxpayer. The increased consumer contributions are purely in relation to everyday living services (food/cleaning/laundry/utilities) and accommodation

The increased consumer contribution amounts ($568.9m + $637.9m +$602.7m = $1,809m) have been highlighted in blue. Recommendation #14 ($844.5m) is increased taxpayer subsidy for financially supported persons accommodation (not paid by the resident) is highlighted in green.

Table 1: Financial modelling of Taskforce Recommendations (after phasing in period)

Recommendation 10: Funding Everyday Living services to cover the full cost

Everyday living cost	$80 per day
Basic Daily Fee (all residents)	$61 per day (85% of single pension) *(excludes additional services)*
Everyday living supplement	$19 per day *

* Supported residents $19 per day paid by taxpayer subsidy
* Non-supported residents $19 per day paid by resident

Benefit (additional revenue)	$8.08 per bed day (average additional revenue)
Annualised sector benefit	**$568.9 million pa** (after phasing in period)

Recommendation 13: Retention of a percentage of RAD *(3% pa over maximum 5 years)*

Accommodation (RAD) price $400k	$12,000 pa ($32.88 per day)
Accommodation (RAD) price $500k	$15,000 pa ($41.10 per day)
Accommodation (RAD) price $650k	$19,500 pa ($53.42 per day)
Accommodation (RAD) price $750k	$22,500 pa ($61.64 per day)
Benefit (additional revenue)	$9.06 per day (average additional revenue)
Annualised sector benefit	**$637.9 million pa** (after phasing in period)

Recommendation 14: Increase Accommodation Supplement

Accommodation price $450k	$98.63 per day
Current maximum accommodation supplement	$66.94 per day
Benefit (additional revenue)	$11.99 per day (average additional revenue)
Annualised sector benefit	**$844.5 million pa** (after phasing in period)

Maintain MPIR (Weighted Average Cost of Capital) at minimum 8% pa

Annualised sector benefit	**$602.7 million pa** (after phasing in period)

Aggregate Financial Effect on Residential Aged Care Viability

Figure 4 shows the forecast EBITDA financial results if the Taskforce recommendations are implemented. The projections include the phasing in period.

In summary should the full recommendations be implemented the forecast operating result after the phasing in period would result in an aggregate of $4.23 billion (representing $22,000 per bed per annum) and if the Accommodation Supplement (subsidy) was not increased the operating result forecast is $3.26 billion ($17,000 per bed per annum).

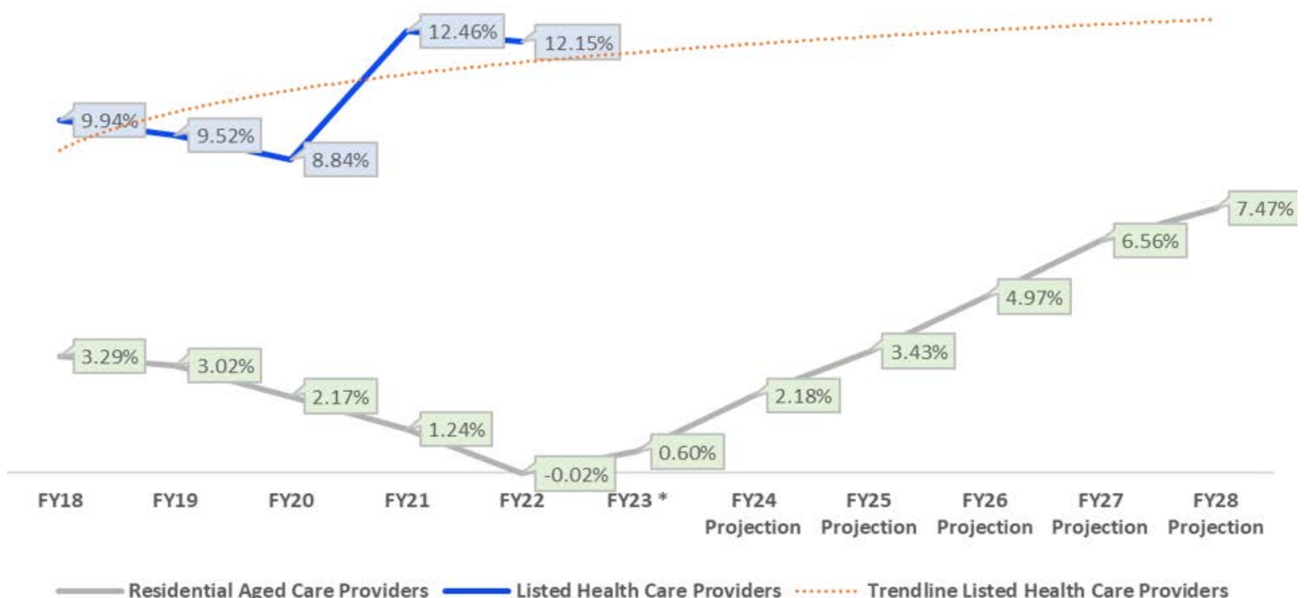
Figure 4: Projected residential sector aggregate EBITDA trend FY24 to FY28 ($ million)

Comparison to Private Health Sector

The projected operating surplus should ensure the financial viability of the residential aged care sector. The surplus will allow Providers to develop a more diverse range of accommodation options, increase spending on workforce and care outcomes and encourage significant new investment into the sector.

It also demonstrates that residential aged care is a long-term investment rather than short term speculative investment. A comparison to the return on capital for the projected residential aged care segment performance to the ASX listed private health sector Providers is shown in *Figure 5*.

Figure 5: Comparison Return on Capital for residential aged care providers to ASX listed private health providers



Cost of Increased Consumer Contributions for Residents

From a residential aged care resident perspective, the proposed increased fee (contribution) structure is below. The red highlighted areas are the proposed additional consumer contribution should the recommendations be implemented.

Briefly, a financially supported resident will incur no increase in cost (they are covered by the taxpayer subsidy). All non-supported residents (those with financial means) will pay additional $19 per day for everyday living (hotel) services (food/cleaning/laundry/utilities). The actual cost of providing everyday living services is $78 - $80 per day, so the increased contribution is in relation to the non-supported resident paying the actual cost for everyday living services and not receiving a taxpayer subsidy to supplement their contribution.

This approach is fundamentally fair and reasonable as these residents have been paying for their everyday living all their adult lives and should not expect that the taxpayer subsidises this once they enter residential aged care.

In relation to accommodation, similarly the supported resident will incur no increase in cost (covered by the taxpayer subsidy). A resident paying a Daily Accommodation Payment (DAP) has no increased cost. The resident who pays a Refundable Accommodation Deposit (RAD) will have 3% pa rental retention deducted for up to five years (noting that the average length of stay in under 3 years).

This is a new cost and will ensure more equity between residents paying a DAP and a RAD, where in the current policy setting a resident who has the ability to pay a RAD has a far cheaper accommodation cost than a resident who cannot pay a RAD and accordingly pays a DAP (current interest rate is 8.38% pa).

Table 2 provides a comparison of the current resident contribution to the proposed contribution. Comparing a DAP ($126 per day currently for a $550k accommodation price) to the proposed RAD rental retention ($57 + $45 = $102 per day) demonstrates that there is greater equity between these payment methods.

Table 2: Comparison of Current and Proposed Resident Contribution ($ per day)

	Current		Proposed		
	Supported	Non-Supported	Supported	Non-Supported	
Direct Care					
AN-ACC (taxpayer subsidy)	100%	96%	100%	96%	
Means-Tested Care Fee	0%	4%	0%	4%	
(no change to current funding)					
Everyday Living *($ per day)*					
Basic Daily Fee	$ 61	$ 61	$ 61	$ 61	
Supplement (taxpayer subsidy)	$ 11	$ 11	$ 19	$ -	
Supplement (resident)	$ -	$ -	$ -	$ 19	
(increases revenue to $80 per day)					
Accommodation *($ per day)*					
Supplement (taxpayer subsidy)	$ 67	$ -	$ 98	$ -	
Daily Accommmodation Payment (DAP)	$ -	$ 126	$ -	$ 126	*
Refundable Accommodation Deposit (RAD)	$ -	$ 57	$ -	$ 57	**
RAD 3% additional retention	$ -	$ -	$ -	$ 45	***

** Accommodation price $550k x 8.38% / 365 days*

*** Accommodation price $550k x 4.75 term deposit rate x 79% (after tax rate) / 365 days (opportunity cost)*

**** Accommodation price $550k x 3% / 365 days*

Please also note that the above contributions are not based on a normal means-testing protocol, in that if a resident is deemed to not be financially supported (ie a self-funded retiree) they then pay the additional contribution. This is not adjusted or scaled based on your means, all persons paying an increased contribution for everyday living and accommodation services pays the same amount.

In-Home Care

Taskforce Principles

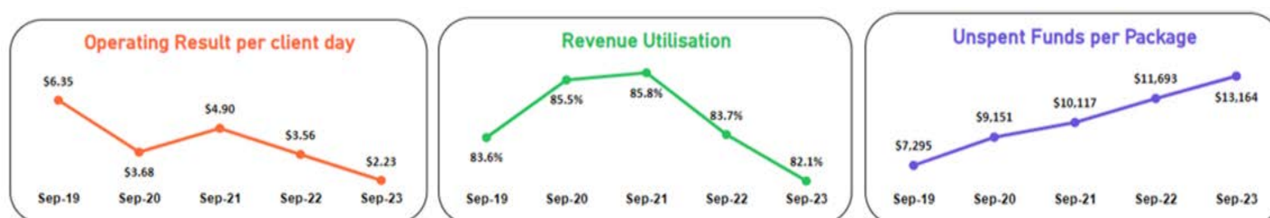
The Taskforce Aged Care Funding *Principle 1* states "The aged care system should support older people to live at home for as long as they wish and can do so safely". This is the guiding principle for the aged care sector and enshrines the policy direction that first and foremost aged care policy must continue to develop a diverse, innovative, equitable and sustainable care service delivery. This includes providing appropriate accommodation alternatives, be it in-home, affordable living, communal or institutional.

Principles 2 to 7 focus on the funding elements of the aged care sector.

Current Financial Performance

Figure 6 shows that the home care sector has declining financial performance, driven by the low revenue utilisation (the amount of services actually provided as a percentage of amount of funding allocated to each participant). This has resulted in the amount of unspent (unutilised) funds averaging $13,164 per participant (an aggregate of over $3.3 billion nationally).

Figure 6: Trend summary for HCP operating result, revenue utilisation and unspent funds Sep-19 YTD to Sep-23 YTD



Home Care Modelling

Unlike residential aged care, the current funding model for home care packages (HCP) (Subsidy Levels 1 to 4) has seen the funding allocated to participants not being fully acquitted. There are a number of varied reasons for this, and it is anticipated that the *Support at Home* model will address this.

As a result of the low utilisation of funding and concurrent high levels of unspent funds (96% of which are never utilised and return to the government when a participant leaves in-home care) there is little consumer contribution to home care, being less than 2% of the funding envelope. This detracts from participants recognising that they should co-contribute to their aged care costs.

The Taskforce proposed that home care packages be classified into three service lists with different co-contributions allocated to each:

- **Clinical supports** - government contributions would be highest, and consumer co-contributions lowest (if any) for supports that are essential to prevent decline in health (for example, nursing assistance to assess, identify and deliver care to manage health decline issues, and allied health services) *(fully funded by government – no consumer contribution)*
- **Independence** - a middle tier would include items that may support independence and reablement (for example, personal care services and assistance with food preparation) *(consumer contribution representing a part of the funding)*
- **Everyday living** - participant contributions would be highest for services that someone not in the *Support at Home* Program would typically pay for in full (for example, general house cleaning) *(consumer contribution representing a greater portion of the funding)*

Similar to residential aged care, financially supported residents would be fully funded by the taxpayer subsidy.

The Taskforce did not specifically state whether the consumer contribution should be fully acquitted, but StewartBrown recommends that this should be the case. In this context, the consumer contribution is the first amount that is paid to the Provider for services delivered, and this will create a stronger interaction between Provider and consumer where the actual service delivery is under greater scrutiny and should lead to a more diverse and quality driven service.

Should the Taskforce recommendations be enacted together with compulsory consumer contributions, participants receiving home care services would pay a fixed consumer contribution depending on the service actually received in line with the service lists as shown above.

Similar to residential care, direct care (clinical) services are by majority taxpayer subsidy funded (98%) and it is the other services such as lifestyle, independence safety and everyday living (cleaning/maintenance/food) that the consumer contributions are levied. Should this reform be implemented the aggregate cost to consumers (after the three year phasing in) would amount to $1,017m annually.

Table 3: Additional Consumer contributions for Home Care Packages ($ per participant per day)

HCP Funding Level	BDCF	Participants
Level 1	$11.22	14,255
Level 2	$11.87	107,489
Level 3	$12.20	85,909
Level 4	$12.53	56,507
		264,160

Basic Daily Care Fee (BDCF)	$12.08	
Current BDCF *(2% of HCP funding)*	$1.53	
Difference (BDCF not recouped)	**$10.55**	$ per day
Annualised increased BDCF	**$1,017,448,114**	$ per annum

The additional consumer contributions would allow subsidy funding to be expanded as the number of persons who have been assessed for HCP funding but have not received funding has been steadily increasing.

Fair Work Commission - Work Value Case

The FWC Commission is expected to make a further ruling on the *Work Value Case - Aged Care* on 15 March 2023. Whilst the details of the likely award increase will need to be worked through, the financial effect will ultimately be passed on to consumers and increased government subsidy.

In the aged care setting, award increases are essentially "input costs". With respect to direct care workers the increases will form part of IHACPA's calculation for the AN-ACC subsidy, as were the last award increases. With respect to non-care workers, IHACPA will also include the additional staff costs to calculate the amount of the everyday living supplement. Supported residents will still be fully covered by the taxpayer funded everyday living supplement which will incorporate the increase, and non-supported residents will have a higher supplement to pay.

This is the same as any increase in supplier costs that exist in society which have to be met by the consumer, with private health insurance premiums being the latest such increase.

The important point is that this confirms the significant role of IHACPA in calculating the direct care subsidy (AN-ACC) and everyday living supplement to ensure all costs are included.

StewartBrown Commentary

The release of the Taskforce Report has created significant interest and analysis within the aged care sector and the broader media and public. This is positive as the Taskforce and the accompanying report and recommendations must also be open to scrutiny and critical assessment. This will lead to bipartisan support to progress the recommendations that have been mutually accepted and to commence the very important process of designing the legislation, guidelines and policy to support the initiatives.

StewartBrown supports the overall intent of the Taskforce recommendations and note that the financial policy reforms have been advocated by StewartBrown for a number of years. There are little differences in what StewartBrown has been advocating in this time and what is contained within the relevant Taskforce recommendations.

If the reforms are implemented, we would be confident that this will place the residential aged care sector in a significantly more stable financial position. Of equal, if not greater importance, it will drive the sector to adopt innovative care solutions that enable elderly persons to receive care in a variety of accommodation settings that also cater for dementia, disability, social and cultural needs. This will represent an exciting opportunity for the sector to move well beyond its traditional approach to care delivery.

The most important first step is to have a strong community education program as the aged care system is very complex and mis-understood by most. People enter aged care, and in particular residential aged care, in a very vulnerable time of their lives which is an emotional period for themselves and family alike. Planning for aged care and understanding and planning for the financial cost are critical in alleviating some of the anxiety.

In this context, some responses to comments that have been observed in the media and social media since the Taskforce report was released have been provided below to give some balance.

The Recommendations are in reality a form of "wealth tax"

This has been the most common public comment. The adage "I have paid taxes all my life, so why should I pay more for aged care" and "because I have worked hard and created personal wealth I am disadvantaged as I am now expected to subsidise others" are regular themes.

The means-testing of assets and income is predominantly relevant in determining the Means-Tested Care Fee (MTCF), which has an increasing scale of personal contribution to the direct care funding envelope based on this means test. However, this is in relation to the AN-ACC subsidy, where the MTCF represents between 4% - 6% of the overall care funding, and it actually reduces the AN-ACC subsidy component and therefore does not add to the overall direct care funding bucket.

The Taskforce was not tasked, appropriately, with consideration of the direct care funding, as this comes under the domain of the Independent Hospital and Aged Care Pricing Authority (IHACPA) whose charter is to determine the correct AN-ACC subsidy that is required to provide the necessary care needs. We are very supported of the role of IHACPA and feel that having this independent authority will be of great benefit to the aged care sector.

Everyday Living and Accommodation Services are Means-Tested

Unlike the means-testing regime for direct care where the greater the residents financial means the greater the Means-Tested Care Fee (MTCF), this is not the case for everyday living and accommodation daily services. The means-testing in this respect is simply to determine whether a person is classed as being financially supported (typically a full pensioner or partial pensioner) or are classed as being financially non-supported (typically self-funded retirees).

If classified as being non-supported, all persons pay the same amount for equivalent everyday living and accommodation, and no hierarchy exists for persons to pay more as a result of their financial means.

Indexation of the Basic Daily Fee

The Basic Daily Fee (sometimes incorrectly referred to as the Basic Daily *Care* Fee as it does not relate to direct care) relates to everyday living (hotel) services and is the same fee for all residents, irrespective of their financial position (currently 85% of the single pension). As it is aligned with the pension, it is indexed with the pension.

Should the Basic Daily Fee (BDF) be deregulated without reference to the pension, this will create considerable issues for supported residents who would not have the means to pay an amount greater than the pension and would require assistance. The Taskforce has recommended a clearer solution, being every resident pays the same BDF and the Everyday Living Supplement (the additional amount required to meet the actual costs of providing these services) is paid by a taxpayer supplement for supported residents and by the resident if they have the financial means (non-supported).

This also avoids the current situation where a non-supported resident receives a taxpayer subsidy (hotelling supplement) of $10.92 per day. Why should the taxpayer subsidise a resident with financial means for everyday living services that they have paid for all their lives.

RAD Retentions - "Back to the Future"

This is a fairly simplistic comment when making such a statement. Prior to July 2014, a retention regime was in place for residents who paid an Accommodation Bond. This only applied to low care (hostel) residents and not to high care (nursing home) residents and was a maximum retention of $323 per month ($3,876 per annum) at the time of its cessation.

One of the primary reasons it was discontinued was that it was an inducement for Providers to accept low care residents in preference to high care residents so they could receive an accommodation bond. The implementation of the ACFI in March 2008 was designed to change the cohort of residents in residential aged care from being low care to high care. This was the commencement of providing greater care services to low care persons in their homes rather than hostel institutional care. Because of this changing environment, retentions on Accommodation Bonds became redundant.

The current circumstances are entirely different with all residents with financial means paying a RAD, DAP or Combination and there is no distinction between low care and high care. Length of tenure in aged care homes has dropped significantly. As noted earlier, there is an equity disparity for residents who choose to pay (or have no alternative) a DAP as compared to a RAD.

The recommended retention (our preference is the term “deferred rental”) negates this inequity and is a substantially higher amount than the previous retention (being $1,375 per month for an accommodation price of $550k).

Use of RAD Retention

The Taskforce Report was silent in this regard, and it is a legitimate question. The RAD retention (deferred rental) is part of the overall accommodation revenue requirement to build and maintain the aged care accommodation. It also is required to repay borrowing and investment debt. For this reason, it should not be specifically quarantined.

There are options that could be considered to demonstrate that Providers are appropriately recognising the requirement to use a portion of the RAD deferred rental to regularly refurbish and maintain the accommodation to the highest standard.

Some State jurisdictions have requirements for Retirement Villages, under the *Retirement Villages Act* to establish a form of Capital Works Fund. There are some issues with this from a residential aged care perspective and there would be resistance to additional regulatory requirements.

It would be beneficial to continue to explore mechanisms to demonstrate that Providers have set aside funds or have lines of credit as required for the purpose of refurbishment and major maintenance. This would provide further comfort for residents (and intending residents) as to ongoing quality of accommodation and use of the RAD inflows.

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