# Ray Village Aged Services (Inc) t/a Capecare

**ABN 77 630 179 279**

# Submission to: Senate Standing Committee on Community Affairs

**APRIL 2013**

**Aged Care (Living Longer Living Better) Bill 2013**
**Aged Care Quality Agency Bill 2013**
**Aged Care Quality Agency (Transitional Provisions) Bill 2013**
**Aged Care (Bond Security) Amendment Bill 2013**
**Aged Care (Bond Security) Levy Amendment Bill 2013**

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## ABOUT CAPECARE

Capecare is proud to be celebrating 52 years of service to the regional community of Busselton, Dunsborough and surrounds in 2013 and we are one of the organisations that form part of the mission-based and not-for-profit (NFP) aged care sector, that deliver about 70 per cent of aged care services in Australia.

We were incorporated in 1961 under the name of Villa Maria Homes (Inc) and now Ray Village Aged Services (Inc) t/a Capecare.

The initial objective was to manage the 20 acre site located in Busselton, Western Australia that was donated by Jack & Maud Ray to be used for charitable purposes, especially in care for the aged.

The organisation has grown over the years to now consist of:

- a 44 bed nursing home;
- a 68 bed hostel;
- (Note: 70% of Capecare's residents have high care needs).
- a community care service that provides day centre care/respite and also assists over 400 people to continue to live in their own homes (HACC services) plus nearly 50 EACH, EACHD, CACP packages; and
- 55 independent living units with about 70 residents.

Capecare employs over 190 committed staff (110 FTE) and is assisted by 120 amazing community volunteers.

Capecare remains an organisation that is:

- Local and community based;
- not-for-profit;
- an incorporated entity; with
- Board members and management living in the local community.

When we make a return on our operations, it is invested back into providing more quality care services and facilities. It is not paid to an owner, shareholder, head office or investor.

Capecare is the largest "independent", NFP aged care provider outside of the Perth CBD.

# INTRODUCTION

Capecare is a member of Aged and Community Services Western Australia (ACS WA), which is part of Aged and Community Services Australia (ACSA).

ACSA is the leading national peak body for aged and community care providers which represents church, charitable and community-based organisations providing housing, residential and community care services to older people, younger people with a disability and their carers.

Capecare is visible and highly accessible in the community resulting in the public relying on us for service, support and care. The community has an expectation that Capecare will continue to provide for them.

Capecare recognises the need to make the aged care system more responsive, flexible and affordable by creating a balance between individual responsibility for aged care services, affordability for taxpayers and a safety net for those who require such services.

While Capecare welcomes the Federal Government making aged care reform a priority through *Living Longer Living Better* (LLLB-April 2012), in order to ensure quality aged care services are sustainable into the future there are a number of concerns that still need to be addressed.

The Productivity Commission's (PC) 2011 report 'Caring for Older Australians' presented a comprehensive blueprint for aged care reform designed to improve access for older Australians and their family and carers for better quality, more responsive and affordable aged care provision.

Unfortunately, the LLLB package fell very short of the PC's recommendations and required reform of Australia's aged care system. The LLLB package has selectively chosen aspects of the PC recommendations that, in effect, create a distorted reform agenda that is likely to be inefficient at best, or possibly ineffective in its cost effective deliverables. This must be addressed or the aged care reform agenda as recommended by the PC will not reach the desired objectives and in a worst case scenario will lead to the loss of a significant number of aged care providers, particularly in regional, rural and remote (RRR) areas.

Within reason, people should be able to age in the communities in which they live and where their families and support networks reside. To this end, noting the need to be efficient and cost effective, it is essential that regional and remote aged care providers remain sustainable into the future.

**Capecare supports the comments and submission made by ACSA to the Senate Standing Committee on Community Affairs but is also making a submission in order for a regional voice to be heard and to ensure that the reforms and changes made lead to a quality aged care system for all Australians.**

## AGED CARE BILLS: PROCESS

The Minister for Mental Health and Ageing Mark Butler introduced five Bills into Parliament in March 2013 which will enable the measures in the LLLB reform package that require legislative change, including by providing the authority for amendments through delegated legislation.

Amendments to the **delegated** legislation in the form of the Aged Care Principles and Ministerial Determinations are expected to occur after the passage of the primary Bills. These will be introduced in three tranches to reflect the commencement date of the individual reforms:

- 1 July 2013;
- 1 January 2014; and,
- 1 July 2014.

It appears that it is the intention of the Government to move as much of the operational detail of aged care from the Act itself to the delegated legislation of the Principles and Determinations.

The details of the Principles and Determinations are not yet known as they have not been released for comment. This is of concern to Capecare and of equal concern is that the delegated legislation is not subject to the same level of scrutiny as the primary legislation. Our concern is heightened even more given that several significant changes will be effective from 1 July 2013.

Capecare is concerned that as the bulk of the current reform process sits in delegated legislation and is therefore subjected to less scrutiny than the substantive legislation which is, historically, rarely disallowed once it has been presented to the Parliament that further changes will be made without the opportunity for adequate provider comment.

**Requested Action:**

- **That the Senate Standing Committee Report recommends that the Minister and DoHA ensure appropriate lead in time is provided to aged care providers to review, comment and prepare for the changes that will be embedded in the Principles and Determinations.**

## Significant issues for Capecare

### Issue 1: Provider viability/sustainability is under serious threat

Capecare is concerned that the proposed changes that have already been implemented and the changes currently planned in these five bills will make many approved providers (APs) unviable. This is brought into sharp focus for smaller providers and particularly those providers in RRR areas.

As noted in our introduction, mission-based and NFP aged care organisations deliver about 70% of aged care services in Australia and there is a view that we have not been looked after at all well in the LLLB and funding reform aged care initiatives currently proposed.

There has been a history of NFP aged care providers both in the community care and residential care space actually "disappearing" totally with similar reforms in NZ, UK and Europe. If this level of consolidation/rationalisation occurs in Australia, given our great geographic spread, it will have major social, economic and financial impacts in our RRR areas.

People have a right to age in their communities rather than face a massive dislocation at a time when they are most vulnerable and need support from family and friends.

It would seem that future consolidation of providers in the aged care sector is a clear agenda and an undoubted outcome of current policy.

Meeting the challenges of developing and delivering new or expanded residential and home care options in communities where populations are small and dispersed, distances are great, building costs are higher and workforce in short supply requires a joint approach and strategies.

This collaborative approach is not only between State and Federal Governments but importantly with Local Government, Country Health Services, communities, clients and aged care providers. If these providers disappear, who will provide and pay for the services as the above organisations operate under different funding drivers and with different business models.

Capecare agrees that it is vitally important that APs operate in an efficient and cost effective manner. However, further support is needed for APs in RRR areas to ensure consumers of these services are not adversely impacted when compared to those in city locations.

Several areas have contributed to this key concern issue of APs viability/sustainability, in summary they are:

1. The actual cost of care compared to care funding – refer to Issue 3;
2. Lack of indexation in our ACFI funding – refer to Issue 4;
3. Cost imposts now being imposed to develop an Enterprise Bargaining Agreement (EBA): in Capecare's case, we may potentially have to have 4 EBA's in place – refer to Issue 2;

4. Additional cost imposts to pay higher wages, with very minor wages supplementation and no funding to cover "on costs" – refer Issues 2 and 4;
5. New supplements for Dementia and Veterans Dementia, wherein providers will be hit with a 2% levy to be then redistributed back out to providers in the form of a supplement;
6. Loss of Bond (Refundable Accommodation Deposits) retentions – refer Issue 8.

**Issue 2: Workforce Supplement** Section 44-5(1)(a)(vi)

**Capecare fundamentally disagrees with the Workforce Supplement announcements and how the current Federal Government has funded it.**

As a matter of principle, Capecare does not support a framework that diminishes aged care funding to providers in order to channel funds to supplement wage increases. Taking money from consumer entitlement to channel to staff wages is inappropriate, particularly in a consumer-focused environment.

The Federal Government has removed care funding from providers and then plans to redistribute some money back to pay for higher wages.

This will impact providers' viability as we have lost revenue that would have been available to provide care in an environment of increasing resident frailty and costs and we will then also take another hit to our financial outcomes with increased salary costs and ongoing administration and legal costs with the requirement to implement EBAs.

In launching the Workforce Compact, the Minister for Mental Health and Ageing said it "will provide higher wages, better conditions and more rewarding careers for the nation's 350,000 aged care workers." Every provider I know supports those objectives.

The Productivity Commission did as well, they said: "The Commission proposes that scheduled care prices take into account the need to pay fair and competitive wages to nursing and other care staff."

What they did not propose was that the government should remove funding used for the care of the elderly, and recycle the money saved to (partly) fund wage increases. Yet that is exactly what has happened.

The government froze the rates it pays for the care of the elderly on 1 July 2012. In other words, the rates which apply today are the ones which came into effect on 1 July 2011.

Because of the compounding effect of this freezing on future years, the Workforce Supplement being offered will leave providers with only a small gain in funding by 2016-17, compared to what they would have had if the rates had not been frozen and there was no Workforce Supplement.

Firstly, all of the supplement payments must be passed on in full as wage increases, with providers being required to fund the 30 per cent or more on-costs which will flow.

Secondly, providers will be required to pay annual increases of 2.75 per cent, or the Fair Work Commission minimum wage increase, if higher. Where will that money come from? Clearly, not from the supplement and, if long-term history is any guide, not from the annual subsidy indexation either.
Capecare is already paying above award rates for all our staff and also conducting a significant level of training and professional development and we also have a highly level of work flexibility for our staff, given our regional location.

The changes proposed will simply provide another cost impost on our business, when we are already feeling and responding to the impacts on employee attraction and retention through existing market driven forces ( ie competition from other providers including the WA Health Dept.). Additionally, we are already providing ongoing training and development to many of our employees to ensure we have the requisite skills and in order to keep a competitive market position.

It is important to note that the Government have now dropped the word “Compact” from this initiative, simply because a compact could not be reached.

**Capecare rejects the Workforce Supplement as proposed in Section 44-5(1)(a)(vi).**

**Requested Action:**

- **Capecare requests that the Senate Standing Committee Report make recommendation to the Parliament that Section 44-5 (1)(a)(vi)of the Bill be deleted.**

**Issue 3: Determining the actual cost of care**

The actual cost of the delivery of aged care in various locations has never been determined and Capecare supports ACSAs call that this must be understood in order to base funding as accurately as possible to ensure ongoing viability and sustainability of aged care.

This is highlighted even more so, with the planned introduction of supplementation funding, without a good understanding of costs.

**Requested Action:**

- **Capecare requests that the Senate Standing Committee Report make recommendation that ACFA is commissioned to undertake a comprehensive and nation-wide “cost of care”study, including RRR areas.**

**Issue 4: Lack of indexation in our ACFI funding**

The government froze the rates it pays for the care of the elderly on 1 July 2012. In other words, the rates which apply today are the ones which came into effect on 1 July 2011.

In recent years the minimum wage has exceeded CPI which in turn has exceeded the COPO mechanism that drives the growth in both ACFI and packages funding.

As noted in Issue 2, providers will be required to pay annual increases of 2.75 per cent, or the Fair Work Commission minimum wage increase, if higher.

Where will that money come from? Clearly, not from the supplement and, if long-term history is any guide, not from the annual subsidy indexation either.

The ACTU has recently submitted a claim to increase the minimum wage by 4.95%.

As we move forward provider costs will grow as revenue growth in real terms lags because the index driving the growth in most of the funding, COPO, will continue to lag wage increases. It has been suggested for example that COPO for July 2013, if paid at all will likely be less than 1.5%.

**Requested Action:**

- **Capecare requests that the Senate Standing Committee Report make recommendation that an appropriate mechanism is established to compensate providers for increases in costs and that COPO be reviewed as a result of this.**

**Issue 5: ACFI appraisal**

Schedule 1 Items 35-38 – Suspending an Approved Provider (AP) from ACFI Appraisals.

**Capecare supports the ACSA submission on this matter as follows.**

This relates to amendments whereby the Secretary can suspend an AP from making ACFI appraisals and reappraisals, based on one perceived false, misleading or inaccurate information event which may have been made inadvertently on **one or more** occasions but only if after the reclassification of the appraisal/reappraisal another appraisal/reappraisal is also judged to be false, misleading or inaccurate. That is, a repeat offence occurs.

Existing legislation states that a '**substantial** number of appraisals must be involved before suspension will occur'. The proposed reform removes the word substantial from the legislation.

Of concern to Capecare is the change in relation to the current need for substantial non-compliance in the assessment and reappraisal of residents to 'merely being an incident'

which could see an AP's ability to make claims suspended. The reforms allow any suspension to apply to a particular service, or services, rather than the entire AP portfolio.

Capecare believes that 'procedural fairness' is not maintained via the suggested amendments. Also this clause appears to give additional weight to the power of DoHA in what may be inadvertent circumstances. If the intended purpose of the proposed changes is to deal with potential rorting by APs, DoHA already has the authority to investigate such claims but has not had reason to activate those current powers.

**Requested Action:**

- **That the current wording and intent of the existing legislation be retained.**

**Issue 6: Refundable Accommodation Deposit (RAD) and Daily Accommodation Payment (DAP)**

**Capecare supports the ACSA submission on this matter as follows.**

The LLLB introduces common **accommodation payment** and **contribution** arrangements across all residential care.

LLLB includes the requirement for a prospective resident to be informed about prices before entry to a residential aged care facility (RACF) and to have choice of payment method. The choices are for either a daily accommodation payment (DAP) or a refundable accommodation deposit (RAD) or combination of both, determined by the consumer.

Before entry to an RACF the consumer and AP must agree on the maximum accommodation price that an understanding of the methods of payment, either as a RAD, or a DAP or a combination of the two. If the payment method is not agreed on at entry the consumer has 28 days to identify the preferred method. In that 28 day period the consumer is charged a DAP.

A number of aspects of the proposed RAD/DAP arrangement and relationship are a cause for concern for ACSA membership.

**28 days period to decide payment option - Schedule 3 Section 52-F** – The legislation states that if a person does not decide how to pay within 28 days, a daily payment (DAP) regime will apply (52F-3(f)).

This implies that that DAP is the default method and the Government's preferred option.

The difficulty for providers is that the Government has indicated that both payment options are of equal value. That being said Capecare understands that there needs to be a default position in place when agreement cannot be reached. However our preference is for the RAD to be identified as the default position because the RAD is clearly more beneficial to the consumer and to the AP as it is the source of financial investment for the AP from which improvements and refurbishment to the RACF can be made to improve the quality of service to the consumer.

Under the present arrangements greater than 90 per cent of residents agree to pay a bond. This has provided a stable base for both lenders and borrowers to structure the APs capital expenditures. By setting the DAP as the preferred payment option it takes the focus away from the PCs recommendation for a sustainable and strategic aged care system derived from the investment of the RAD, in favour of a 'hand to mouth' process of daily 'rental' charges. Capecare would argue that the latter is commercially irresponsible. Banks are unlikely to finance major refurbishments on the basis of daily rental transactions. They will however provide finance when it is underpinned by a reasonable RAD held for a predictable period of time.

In October 2012 the Aged Care Financing Authority (ACFA) recommended to the Minister the RAD as the primary price point and the periodic payment equivalent, the DAP, was the derived outcome based on the Maximum Permissible Interest Rate (MPIR) applied to the RAD.

The rules about resident payments and the introduction of a 28 day cooling off period to decide payment options together with the six month period to actually pay a RAD further creates an unstable platform for planning capital expenditure and debt/equity decisions within the sector.

If DAPs are the preferred baseline, APs most likely will be more exposed to debt/defaults without adequate protections derived through stronger **security of tenure** provisions which means the obligation remains with the AP to find alternative accommodation for the debtor (while still accruing debt). Similar arrangements will exist for home care providers who will have to call in debt recovery processes. There is a requirement for the AP and resident to enter into an agreement within 28 days of entry. Capecare would argue that this is not always achievable if the person has not been able to decide on the payment method because of delays with Centrelink and/or ACAT appraisals. Therefore this section of the Bill requires adjustment to ensure the preferred baseline becomes the RAD.

The proposed legislation also allows for the **drawdown of daily payments** from the RAD. An approved provider must agree to any drawdown from the RAD if a resident makes the request in writing. The amendment sets out the arrangements that apply, including having the details included in the Accommodation Agreement.

If the care recipient has chosen the drawdown option, the care recipient must continue to maintain the previously agreed RAD, either by topping up the RAD (from other sources) or by paying higher daily payments.

Amendments also allow that, when the consumer leaves the RACF, the AP can deduct from the RAD other amounts agreed to in writing and specified in the Fees and Payments Principles, and any other amounts agreed to in writing between the care recipient and the AP. This will mean that a care recipient may have their care fees deducted from their RAD if both the care recipient and AP agree.

**Requested Action:**

- **That the RAD be identified as the default payment method.**
- **That a DAP, if in place, be determined from the baseline RAD.**
- **That the Security of Tenure guidelines within the Principles be revisited to create a more equitable approach that protects both the consumer and the provider.**

**Issue 7: MPIR v's WACC in determining equivalence**

**Capecare supports the ACSA submission on this matter as follows.**

The PC recommended 'limiting accommodation bonds to no more than the equivalent of periodic accommodation charges but uncap such periodic accommodation charges to reflect differing standards of accommodation'. Capecare notes that the PC's intent was that consumers be offered a periodic payment (rent) equivalent in value to a bond.

The Minister for Health and Ageing has stated that the Maximum Permissible Interest Rate (MPIR) is to be used in determining this equivalence. This method was also recommended by the ACFA because the interest rate referred to in the MPIR appeared significantly less than the rate that appears using the alternative measure. However the MPIR approach fails to recognise that in the absence of a stable lump sum (RAD), an AP may need to commit capital (both equity and debt) to fund investment in residential aged care as a result of the RAD movement via MPIR utilising DAP as the baseline.

The risks an AP must consider in determining the cost of business include: factors such as the relative quality of the offering, management expertise, care risk management, marketing expertise and competition. The underlying business risk is reflected by the cost of invested capital. The measure of that cost of capital is the Weighted Average Cost of Capital (WACC) not MPIR.

The effect of using the MPIR will be to lower the equivalent periodic payment relative to one determined by pre-tax WACC thus resulting in market distortion by increasing the attractiveness to consumers of (low impact) periodic payments relative to a RAD. RAD pools will fall (all other things being equal) as a consequence. This is not a desirable outcome from a provider's perspective or from the perspective of increasing essential investment in residential aged care or for stability in a sector that requires careful policy planning in the area of capital investment and expenditure.

Finally, the MPIR is volatile, changing quarterly which will result in erratic price movements in RADs and equivalent charges for beds in residential aged care which may not serve consumers interests and impose compliance burdens on APs.

**Requested Action:**

- **That the MPIR/ WACC issue be referred to the ACFA for consideration. ACFA should consult with acknowledged experts in the determination of cost of capital (as is the case in other sectors, such as electricity pricing).**

**Issue 8: Bond Price Controls**

On 21 December 2012, the Minister for Mental Health and Ageing outlined the regulatory framework that will apply for accommodation payments for residents entering residential care on or after 1 July 2014. The key aspects of the announcement were the classification of accommodation prices into 3 levels:

- Level 1 – up to the level of the maximum Government accommodation supplement ($50 per day (2012 prices))

- Level 2 – Prices between Level 1 and an upper threshold of $85 per day (2012 prices)

- Level 3 – Prices above the Level 2 threshold

There is a requirement for all APs to publish prices in advance in the form of a daily accommodation payment (DAP), refundable accommodation deposit (RAD) and examples of combination payments.

The PC did not recommend the implementation of price controls. Indeed it recommended 'limiting accommodation bonds to no more than the equivalent of periodic accommodation charges but uncap such periodic accommodation charges to reflect differing standards of accommodation'. ACSA notes that the PC was proposing uncapped accommodation charges, not explicit price controls as proposed under LLLB.

In Recommendation 7.2, the PC said the Government should mandate that residential aged care providers offer and publish periodic accommodation charges and any combination thereof.

The clear intent was that offering choice of payment mode and publishing of prices would serve the interests of consumers.

The Government's response has been to impose additional price controls when the evidence indicates that RADs are negotiated.

ACSA members consider that this response may be the Governments reaction to so-called 'super bonds'. It is however evident from the data that the incidence of these bonds is very low and there is no widespread problem. Presently, there are in the order of 21,127 accommodation bonds in Australia. The incidence of so-called 'super' bonds is very low with 124 bonds between $750,000 and $1million and 33 in excess of $1 million which represents approximately 0.7 per cent of all residential aged care accommodation bonds[1].

ACFA identified that 95 per cent of all refundable deposits are less than $500,000.

The best anyone could say about it, is that a whole new set of red tape, caps and government approvals is being imposed on all providers, to fix a problem which is completely unrepresentative of the system. Why?

Finally, the new system removes a long-standing and uncontroversial consumer payment, a fixed and time-limited draw-down from deposit balances, known as a retention.

Retentions are an important source of funding for all providers who take refundable deposits, and the lower the deposit level, the more important they become.

Capecare considers that the implementation of price controls of bonds under LLLB will introduce compliance complexity and constrain the supply of new residential aged care facilities. Capecare also shares the view of the PC that publishing of prices for accommodation and choice of mode of payment will provide a significant boost to price transparency, increase competition and serve the interests of consumers.

[1] 2010-11 Survey of Aged Care Homes, bonds paid by new entrants 2010-11, sourced from Department of Health and Ageing

To further highlight why the LLLB could be considered questionable public policy, for providers in regional, rural and remote (RRR) locations, sustainability issues are further compromised by low RAD values.

Bond values in RRR locations are significantly lower (about half on average) than the national average bond. This is because of lower real estate values, often lower wages (and the compromised opportunity to save and/or invest) and higher overheads in RRR locations. Many RRR providers are forced to use the interest derived from the RAD to maintain service delivery, which does not leave a great deal to be spent on facility improvements and capital expenditure.

Despite assurances that the AP can charge higher RAD (and DAP) to offset the lost retentions, many consumers cannot pay the current advertised bonds. Through negotiation, bonds are then reduced by the AP in order to ensure service is provided in the community. This is reflected in the average bond being much lower in RRR locations. The reforms provide the option to increase costs to consumers, either in RAD/DAP combinations or as community co-payments, however if the market is not financially able to bear those costs the mechanism must be revised. Additionally, community cohesiveness in RRR often limits decisions that might be commercially viable, but in terms of community service by mission based providers, an outcome that may not be commercially viable is often implemented in the public interest.

**Requested Action:**

- **That the Minister's powers under the legislation to impose price controls be removed.**

**Issue 9: Community care co-payments**

The marked increase in community co-payments is detrimental to the objective of supporting and enabling people to stay independently in their homes for as long as possible.

Capecare believes the level of co-contribution to be excessive and the scaling of fees for part pensioners too uncompromising which will result in consumers being unable or unwilling to access community care and therefore refuse services. If consumers refuse services they will often require greater assistance via the acute health care services (at an average cost of $1500 per day) or require admission to an RACF sooner. This is a false economy and therefore very poor public policy made at the expense of Australia's ageing community.

**Requested Action:**

- **Co-payments for community care be removed from the current reform process and re-introduced over a much slower phasing in period, as part of the prescribed review processes for the legislation. As a minimum, partially supported pensioners in the community should not be asked to pay any more than 17.5 per cent of the pension towards their community care costs.**

**Issue 10: Delays with means testing especially in RRR**

Capecare is aware that consumers are experiencing considerable delays in receiving Centrelink assessments of income and assets. This delay is negatively impacting on the APs cash flow especially in RRR locations where such assessments are slower than in metropolitan locations.

**Requested Action:**

- **Means tests via Centrelink need to be timely and accurate with reportable timelines and accountability.**

**Issue 11: Lifetime contribution caps**

The proposed amendments authorise the Minister to set annual and lifetime caps on aged care contributions. As this will be done through the Determinations the process will not be scrutinised adequately and is at risk of being at the recommendation of DoHA alone. The lifetime caps on contributions should be increased from the current $60,000 to $80,000 to make allowance for increased costs and longer life spans and projected longer periods in home and residential aged care.

**Requested Action:**

- **That the lifetime cap be increased to $80,000.**