Chapter 4

Current funding levels and expected quality service provision outcomes

> Older persons should be able to enjoy human rights and fundamental freedoms when residing in any shelter, care or treatment facility, including full respect for their dignity, beliefs, needs and privacy and for the right to make decisions about their care and the quality of their lives.
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> *Principle 14 of the United Nations Principles for Older Persons*

Introduction

4.1 The overwhelming majority of residential and community aged care providers who participated in the inquiry held that that the current funding levels for both residential and community aged care are inadequate and do not reflect the real costs of providing high quality care.[1] It was argued that this is impacting adversely on the provision of quality care and, indeed, on the viability of providers and thus on the availability of sufficient aged care services in the long term.

4.2 This chapter considers current funding levels and whether they are sufficient to meet the expected quality service provision outcomes. It explores the financial performance of aged care providers, staffing issues and capital funding.

Common concerns of residential and community aged care providers

4.3 Many witnesses stated that the aged care sector was in 'crisis' and that financial losses in the sector would see the closer of beds and the inability of the sector to meet the demand in the future through the provision of new and expanded facilities. Mr Gerard Mansour of Aged and Community Care Victoria stated:

> …there is no doubt whatsoever that our industry is just like a rubber band that is stretched near its limit. Our industry is increasingly concerned about how well we will be able to cater for our ageing population. This concern over recent years has moved to a real fear that we now face an impending crisis.[2]

4.4 Mr Martin Laverty of Catholic Health Australia (CHA), while not supporting that the sector was currently in crisis, however commented that 'if we do not make changes to capital and operational subsidies today and if we do not revise the

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1 See for example, Aged and Community Care Victoria, *Submission 89*; Management Consultation and Technology Services, *Submission 42*; Anglicare Australia, *Submission 67*; Catholic Health Australia, *Submission 75*; Kiama Municipal Council, *Submission 27*; Aged and Community Services Association of NSW and ACT, *Submission 61*; Aged Care Association Australia – SA Inc, *Submission 63*.

2 Mr G Mansour, Aged and Community Care Victoria, *Committee Hansard*, 20.2.09, p. 35.

opportunity for consumer contributions to their care we will in fact have that potential problem in the years ahead of us'.[3]

4.5 The committee heard evidence that not only residential care but also community care was facing difficulties. According to Aged and Community Care Victoria, providers of Community Aged Care Packages are:

> …"stretched" in their capacity to respond adequately to the needs of their clients due to funding levels, inability to access HACC services at subsidised rates and poor integration between programs.[4]

4.6 Mr Greg Mundy of Aged and Community Services Australia commented that 'our aged-care system is close to being broken and we need to find some fixes for some longstanding issues'. Mr Mundy argued that the current funding levels are insufficient and pointed to three principal reasons to support this claim:

> One is that, over the last decade or more, the amount of service that we have been able to provide to each of our residents and each of our community care clients has steadily declined…
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> Secondly, we have problems in competing for staff with the state operated health system. We cannot match the wages that they pay in that system, so recruitment and retention of staff is always an issue. The third aspect is that we do have great difficulty nowadays putting new high-care residential facilities on the ground. It is very difficult to make those projects come out cash-flow positive.[5]

4.7 Submitters also pointed to recent surveys of the sector, principally the Grant Thornton survey, as further indicators of the poor financial performance of aged care providers.

4.8 Mr Mundy went on to comment that the indexation formula, particularly in relation to wages, used by the Commonwealth is contributing to these difficulties. He commented that: 'It has been not a sudden development but a steady development over a long period of time that the value of the Commonwealth's subsidies for care has not kept pace with the cost of providing that care…So there has been a steadily widening gap between what it costs us to provide services and what the subsidies will cover.'[6]

4.9 Ms Mary Murnane, the Department of Health and Ageing, responded to these comments and noted that while some providers 'find the going very hard indeed for a variety of reasons', those reasons are not because of current funding levels. The funding levels have been substantially increased and the 'gross amounts that are spend on aged care are very great indeed'.[7] Ms Murnane also stated:

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3 Mr M Laverty, Catholic Health Australia, *Committee Hansard*, 123.3.09, p. 2.

4 Aged and Community Care Victoria, *Submission 89*, p. 5.

5 Mr G Mundy, Aged and Community Services Australia, *Committee Hansard*, 20.2.09, p. 2.

6 Mr G Mundy, Aged and Community Services Australia, *Committee Hansard*, 20.2.09, p. 2.

7 Ms M Murnane, Department of Health and Ageing, *Committee Hansard*, 21.3.09, p. 17.

> I would not say that there is a current and present crisis. There are certainly some organisations, some homes, that are in difficulty, and we are dealing with those…
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> The claims that we are regarding very seriously indeed are the claims about capital need into the future. As Mr Stuart said, we do listen carefully to industry. We have forums where we speak with industry groups, and those forums are not acrimonious; they are respectful where there is a respectful exchange of views. I think I have made clear that as to a crisis, we would say no. There is not a present crisis. Aged care is a key policy of government. We know that the numbers of people seeking support in extreme old age are going to increase and we are of course looking at that. We are particularly examining very proactively the claims that are made about capital needs into the future.[8]

4.10 Ms Murnane concluded:

> We are not complacent, but we are not seeing signs that there is a crisis across the industry and across the provision of aged care now. That does not mean we are complacent, but that would be our reading of the evidence.[9]

4.11 Mr Andrew Stuart of the Department of Health and Ageing also commented:

> The industry continues to deliver care every night to about 175,000 older Australians. Insolvency in this industry is extremely rare. The care continues to be delivered at a quality that is appropriate against the accreditation and certification standards. I do not see a crisis in delivery in care in residential care in Australia.[10]

Financial performance of aged care providers

4.12 A substantial number of aged care service providers raised concerns regarding their financial stability and sustainability. According to The Bethanie Group, recent reports indicate that up to 40 per cent of aged care facilities are not performing at breakeven levels.[11] The Aged and Community Services Association of NSW & ACT cited a 2008 financial performance survey to highlight that 57 per cent of residential aged care services in NSW are currently operating at a deficit.[12]

4.13 Other providers have faced substantial reductions in their surpluses. UnitingCare Australia noted that the Conditional Adjustment Payment (CAP) has been a 'critical revenue source' enabling it to continue to achieve a small surplus on residential operations and avoid losses in the four years that it has been implemented. However, UnitingCare Australia highlighted that even with the CAP, its agencies surpluses on residential aged care have fallen from $12.8 million in 2004–05 to

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8 Ms M Murnane, Department of Health and Ageing, *Committee Hansard*, 21.3.09, p. 10.

9 Ms M Murnane, Department of Health and Ageing, *Committee Hansard*, 21.3.09, p. 17.

10 Mr A Stuart, First Assistant Secretary, Department of Health and Ageing, *Committee Hansard*, 13.3.09, p. 79.

11 The Bethanie Group, *Submission 81*, p. 3.

12 Aged and Community Services Association of NSW &ACT, *Submission 61*, p. 2.

$0.7 million in 2007–08. According to UnitingCare, had the CAP not existed, these organisations would have incurred serious losses in providing residential aged care aggregating $16.25 million over this period:[13]

> The downward trend reflects factors such as increased resident acuity coupled with inability to access bonds from high care residents, input cost increases at a rate greater than income indexation, increasing compliance costs and rising repairs and maintenance costs as building stock deteriorates.[14]

4.14 According to the Grant Thornton Australia survey, the most common explanation for the declining financial performance was that 'staff and general care costs were escalating faster than increases in Government subsidies'.[15] Other witnesses also pointed to consumer demand for single room ensuite facilities.

4.15 Mr Stuart, the Department of Health and Ageing, responded that capital investment in the sector has been strong recently, with building commencements having increased since 2001 and having plateaued in March 2007. Mr Stuart also noted that returns per resident for efficient providers, defined as the top quartile, increased between 2006–07 and 2007–08.[16] The department also commented that net funding growth has been 8 per cent resident.[17]

Surveys of the aged care sector

4.16 Many witnesses pointed to the results of recent surveys as indicating the poor financial performance of the aged care sector. In particular, they pointed to the October 2008 Grant Thornton Australia Aged Care Survey which reported that providers of residential aged care services are 'experiencing low and deteriorating financial returns' at a time when there is unprecedented demand for high care services. The survey reported an average return on investment of approximately 1.1 per cent.

4.17 The survey revealed concerns regarding the viability of both small and large operations, many of whom were incurring unsustainable losses. It found that the average earnings of aged care service providers before interest, taxation, depreciation and amortisation (EBITDA) in 2008 was $2,934 per bed per annum, a decline from $3,211 in 2007.[18] The survey also commented that older, institutional facilities with shared rooms consistently out-performed modern, single-room facilities which are most preferred by consumers. Grant Thornton Australia continued:

> Modern high care facilities with single bedrooms reported the worst results, averaging $2,191 compared to $4,233 per bed achieved in older facilities

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13 UnitingCare Australia, *Submission 76*, p. 2.

14 UnitingCare Australia, *Submission 76*, p. 16.

15 Grant Thornton Australia Ltd, *Submission 29*, p. 6.

16 Mr A Stuart, Department of Health and Ageing, *Committee Hansard*, 21.4.09, p. 1.

17 Department of Health and Ageing, *Supplementary submission 114a*, p. 25.

18 Grant Thornton Australia Ltd, *Submission 29*, p. 3.

> with shared rooms. This represents an average return on investment of approximately 1.1% for modern, single bedroom facilities.[19]

4.18 However, Grant Thornton Australia noted the following:

> The survey revealed that earnings achieved in dated, institutional facilities were almost double those achieved in the modern facilities that meet consumer demand for privacy, dignity and comprehensive care.[20]

4.19 The Department of Health and Ageing responded to evidence in relation to the surveys. Citing two surveys (not including Grant Thornton Australia), Dr David Cullen from the department provided evidence that returns were higher in 2007–08:

> Both of the benchmarking studies of the industry, which have been conducted for many years, that is, the Stewart Brown survey and the James Underwood and Bentley's MRI survey, show that the returns of providers in the 2007–08 year were higher than the 2006–07 year.[21]

4.20 Mr Stuart also commented that the general purpose financial reports that the department receives from all aged-care providers show a general improvement in financial performance to 2007–08.[22]

4.21 According to Dr Cullen, the Bentley's survey of 2007–08 established that single-bed operators made up 51 per cent of the top quartile.[23] Moreover, Dr Cullen stated that the Bentley survey demonstrated that 'efficient providers of single-bed facilities and of shared facilities make the same level of return'.[24]

4.22 However, a joint statement of James Underwood & Associates, Stewart Brown Business Solutions and Grant Thornton Australia submitted to the committee emphasised contrary findings:

> Our research confirms that modern, single-room High Care services make very poor or negative returns on average. These returns are far below the returns achieved in older, shared-room High Care services.
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> In our opinion, modern, single-room High Care services – other than those with extra service approvals – are not viable under current funding and regulatory arrangements.[25]

4.23 Ms Murnane responded to this comment:

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19 Grant Thornton Australia Ltd, *Submission 29*, p. 3.

20 Grant Thornton Australia Ltd, *Aged Care Survey 2008*, Second Report January 2009, p. 3. Document tabled during public hearing, 30 January 2009.

21 Dr D Cullen, Department of Health and Ageing, *Committee Hansard*, 13.3.09, p. 81.

22 Mr A Stuart, Department of Health and Ageing, *Committee Hansard*, 21.4.09, p. 2.

23 Dr D Cullen, Department of Health and Ageing, *Committee Hansard*, 13.3.09, p. 95.

24 Dr D Cullen, Department of Health and Ageing, *Committee Hansard*, 13.3.09, p. 95.

25 Aged Care Association Australia, Additional information received following 13.3.09 public hearing, Joint Statement of Researchers, p.1.

> What we have been saying is that, apart from the Grant Thornton data, when we looked at the Bentleys data and the Stewart Brown data, what we found was an agreement that there is an increase in revenue. They are making a different point.[26]

4.24 Grant Thornton Australia stated that the 'overwhelming majority' of those residential aged care facilities in the top quartile are 'either extra service facilities – so they are able to get bonds in high care – or they are older institutional facilities with multi-bed wards':

> So just looking at the top quartile and accepting that as being the benchmark to which everyone performs takes away from the fact that the majority of those operating in the top quartiles will be delivering a service that is not desired by the consumer.[27]

4.25 Dr Cullen also commented on the Grant Thornton survey and noted that the results are an average across the industry. However, he stated that the other two surveys, whilst also publishing an average result, make the point that it is far more appropriate to look at the result achieved by the top quartile of providers. These providers are doing the best that they can with the revenue which is made available to them, and those returns are far higher and are increasing. Dr Cullen concluded:

> What the top quartile shows you is what an efficient provider can achieve. The entire industry could be efficient if it wished to be. If the entire industry behaved efficiently, like the top quartile does, it would be able to achieve the result, and then the average result across the industry would be the average result achieved by the top quartile.[28]

4.26 Dr Cullen also stated that there are different types of providers in the sector ranging from small businesses for profit with perhaps one or two homes to large not-for-profit organisations. With the small business operator, the owner is the director and the partner is the director of nursing. They pay themselves wages, provide cars and perhaps accommodation out of the business but 'at the end of the day on their tax sheet they show either a very bare profit, a breakeven, or perhaps even a loss'. On the other hand, a not-for-profit aged care home has no need to make a surplus and may provide additional services. Dr Cullen also commented that among the larger players in the industry a number engage in financial transfers between related entities, such that the aged care provider or a number of aged care homes owned by a particular structure will make a loss, but there is another entity elsewhere, perhaps even offshore, that makes substantial profits by providing management services to those entities. Dr Cullen concluded:

> These are anecdotal representations of different parts of this sector and how it is that providers can be at once solvent and not looking like closing down, very stable, continuing to run efficient care, meeting accreditation

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26 Ms M Murnane, Department of Health and Ageing, *Committee Hansard*, 21.4.09, p. 19.

27 Mr C Ansell, Grant Thornton Australia Ltd, *Committee Hansard*, 30.1.09, p. 13.

28 Dr D Cullen, Department of Health and Ageing, *Committee Hansard*, 13.3.09, p. 87.

> requirements and at the same time there is significant data in the industry showing a lot of breakeven-type activity.[29]

4.27 The department provided the committee with a comparison of the three surveys. This is produced in appendix 3.

4.28 Much of the debate concerning research findings in relation to the financial position of residential aged care providers centred around the definition of a 'single-bed facility'. Grant Thornton Australia stated that its working definition was that of a facility with more than 70 per cent single-bed rooms and that:

> As such, modern facilities with predominantly single rooms and "a few doubles" would be included in the definition of "single bed facilities".[30]

Aged Care Approval Round applications and plans for expansion

4.29 Witnesses commented that there is evidence that providers are ceasing to bid for beds under Aged Care Approval Round (ACAR) rounds and are ceasing to invest in the new provision of services either by refurbishing their existing facilities or building new ones. In addition, a number of the new aged care places allocated by the Australian Government are unused or have been returned.[31] It was argued that this indicated the poor state of the sector.

4.30 It was noted for example, that for the first time, there was an under-subscription for residential aged care licenses in the 2007 ACAR in Western Australia and Tasmania.[32] Ms Anne-Marie Archer of the Aged Care Association commented that in 2008 there was a shortfall in bed allocations nationally and only 67 per cent of beds were available were allocated.[33] The Aged Care Association Australia WA and Aged and Community Services WA also stated that there are thousands of beds currently 'offline' for reasons including decommissioning and provisional allocation without construction. According to the organisations this has occurred in Western Australia for two reasons: first, the cost to build is prohibitive; and second, the daily funding is not adequate.[34]

4.31 UnitingCare Australia indicated to the committee that it would not be proceeding with a major development in Melbourne. Although the Victorian Government had provided land to build a 90-bed residential aged care facility to help relieve the pressure on the hospital system, financial analysis revealed that UnitingCare Australia would lose $20 million over 20 years if it went ahead with the facility. UnitingCare Australia noted that that was based on operating at the Stewart

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29 Dr D Cullen, Department of Health and Ageing, *Committee Hansard*, 13.3.09, p. 89.

30 Grant Thornton Australia Ltd, Additional information received following 13.3.09 public hearing, p. 3.

31 Grant Thornton Australia Ltd, *Submission 29*, p. 7.

32 Grant Thornton Australia Ltd, *Submission 29*, p. 7.

33 Ms A Archer, Aged Care Association Australia WA, *Committee Hansard*, 30.1.09, p. 38.

34 Aged Care Association Australia WA and Aged and Community Services WA, *Submission 84*, p. 2.

Brown benchmarks. However, UnitingCare Australia had concluded that 'we cannot pay for that capital when that is how much we would lose over 20 years, so we will not do that.'[35] UnitingCare Australia also commented that no-one in its network with the exception of one small facility applied for residential places in the latest ACAR round because 'we do not believe it is sustainable'.[36]

4.32 Of the consequences, Ms Anne-Marie Archer of the Aged Care Association Australia WA noted:

> This lack in demand for services is going to have an enormous long-term impact on the ability of this state to deliver services in the future, as there are time delays from allocation to actually implementing and developing these services.
>
> Some of the delays in the provision of these services can be partially attributed to the areas around zoning and development applications—in some cases up to years—and this can have a huge impact upon providers' business cases in regard to construction costs et cetera, but the major impediment is the funding that is provided for the development of infrastructure. Currently, the per bed rate allocation of funding, as you learnt before, is $109,000. Unfortunately, in WA, with our construction costs, to date providers are receiving construction quotes of in excess of $200,000, and it is—as the WA Department of Health indicated—three times that amount, if not more, in the regional areas.[37]

4.33 Mr Greg Mundy of Aged and Community Services Australia highlighted the significance of the under-subscription for licences:

> …I think we are now getting to the point where, when aged-care providers are not bidding for free resources from the Commonwealth government that they can put on their balance sheet, at no cost to themselves, then I think that should be a really, really powerful warning sign. We now have four jurisdictions in Australia—Western Australia, Tasmania, the ACT and the Northern Territory—where people are not taking these free gifts from the Commonwealth government to put on their balance sheet. The figures in Queensland and New South Wales are not actually that much better. Those states will also be undersubscribed outside the south-east corner of Queensland and outside Sydney. So I think that is actually a very powerful warning sign to us.[38]

4.34 The department argued that building activity in the sector did not support the argument that the sector was under strain. Dr Cullen commented that the level of building activity in the industry is higher now than at any stage in the decade since aged care construction statistics have been collected and concluded 'that would tend to

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35 Ms R Batten, UnitingCare Australia, *Committee Hansard*, 13.3.09, p. 26.

36 Ms R Batten, UnitingCare Australia, *Committee Hansard*, 13.3.09, p. 27.

37 Ms A-M Archer, Aged Care Association WA, *Committee Hansard*, 30.1.09, p. 38.

38 Mr G Mundy, Aged and Community Services Australia, *Committee Hansard*, 20.2.09, p. 3.

indicated that providers are more willing to make investments in care now, just on the pure statistics, than they have been at any time in the past'.[39]

4.35 The department noted that capital investment (a trailing indictor) has been strong with building commencements having increased since 2001, and then reached a plateau in March 2007 at about $342 million per quarter. Lead indicators also show that growth is strong. Between July 2007 and December 2008 building approvals have averaged around $100 million in approvals per month.[40]

4.36 The department also pointed to planned and completed building activity. The 2007–08 survey of aged care homes undertaken by the department indicated that 18,700 places were being planned for construction or upgrading. It noted that 'while there is a slight decline from the planned places from the 2006–07 survey, it is still three times the number of additional residential places delivered by completed building work in 2007–08 and over two and half times that to be delivered by building work in progress at 30 June 2008'. The department concluded that 'thus the planned work will form a significant pipeline of building activity in coming years'.[41]

4.37 Dr Cullen commented:

> As long as people are willing to enter the industry and build, then you can make a judgment that the return must be sufficient. We have provided a great deal of evidence to you to show that people are entering and building in the industry. You must be able to conclude, from the fact that all of that construction activity has occurred, that the rational beings who undertook that construction activity must have made a judgment that the return was sufficient for them to undertake that activity.[42]

4.38 Mr Stuart went on to state:

> We are listening to the sector. We are watching aged-care place applications. We are interested in all of those indicators but we also have this data that shows increases in funding in recent years, return growing faster than cost, eight per cent growth in funding into this current financial year, and aged-care providers have over the last decade substantially rebuilt the aged-care sector at funding levels lower than they are currently in real turns.[43]

4.39 TriCare commented on the use of Australian Bureau of Statistics (ABS) data concerning increased building activity for residential aged care facilities. TriCare stated:

> Our research confirms that there is no specific measure of government funded residential care facilities and no conclusion which can be reached in

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39 Dr D Cullen, Department of Health and Ageing, *Committee Hansard*, 13.3.09, p. 82.

40 Department of Health and Ageing, *Supplementary submission 114a*, p. 5.

41 Department of Health and Ageing, *Supplementary submission 114a*, p. 17.

42 Dr D Cullen, Department of Health and Ageing, *Committee Hansard*, 21.3.09, p. 22.

43 Mr A Stuart, Department of Health and Ageing, *Committee Hansard*, 21.3.09, p. 22.

relation to government funded residential aged care construction via ABS data.[44]

4.40 TriCare went on to state that is have been informed by the ABS that:

- there is no specific designation for Commonwealth funded residential aged care facilities;
- currently, the ABS relies on information from local authorities as to the purpose of the construction – it does not validate this to any significant extent and cannot be certain of what facilities are included; and
- generally, the ABS believes that the aged care grouping includes facilities where nursing or personal care and/or meals and/or resident common areas are part of the service/accommodation mix on offer.

4.41 TriCare concluded that the building statistics encompasses retirement village development and construction of which is surging 'given the lack of government restrictions on capital funding mechanisms in that sector'.[45]

4.42 Given the conflicting views on the construction statistics, the committee sought advice from the ABS. The ABS commented that it uses the Functional Classifications of Buildings (FCB) for a range of ABS publications including building activity and construction work done. For these collections the function of the completed building is generally determined at the time the building approval is lodged. The definition of aged care facilities (including nursing homes) states that they are buildings used in the provision or support of aged care facilities, excluding dwellings such as retirement villages.

4.43 The ABS concluded that it was not in a position to make comment on the claims made in the various submissions. Neither the Building Approvals collection nor the Building Activity Survey collect information on the source of the funding on any project. However, the ABS does classify a building by sector of ownership.[46]

Construction costs

4.44 Many submitters commented on the increase in costs for the construction of aged care facilities. The issues identified included the increase in costs in areas where there is competition from other sectors, high costs associated with geographical location particularly remoteness and a shift in consumer expectation towards single room ensuite accommodation. The issues of costs in rural and remote areas is canvassed in Chapter 6. The following addresses the general issue of construction costs.

4.45 In evidence, providers indicated that construction costs per bed ranged up to $180,000. Some costs were higher due mainly to remoteness. According to Grant Thornton Australia, the average anticipated building costs for new facilities was

44 TriCare, *Submission 123,* p. 11.

45 TriCare, *Submission 123*, p. 11.

46 Australian Bureau of Statistics, *Addition Submission 33a*, pp 1–2.

$176,000 per bed excluding land costs, which is a substantial increase from between $74,000 and $85,000 per bed in 2003. Of the increase, Grant Thornton Australia noted:

> The increase represents both a change in the cost of construction as well as changing expectations of consumers.[47]

4.46 The shift towards single ensuite rooms was highlighted by many witnesses as having a major impact on funding and resources. The Aged Care Association Australia commented:

> There is no doubt that the current funding methodology has failed to recognize that there is a significant cost in both constructing and operating residential care as single room en suited services. The current subsidy for the industry is based on meeting a clinical service need and a certain standard of hotel service but does not include any assessment of additional staffing costs of operating single room services each with separate bathroom and toilet.[48]

4.47 However, the aged care sector saw the shift toward single-room ensuite accommodation from multi-bed wards as a cost burden for the industry. According to Mr Young of Aged Care Association Australia (ACAA):

> In a number of the reports that are before you, particularly the work that Grant Thornton did, they have looked at the difference between single-room, ensuite accommodation and multibed wards often without ensuites. The returns that you get on those different types of accommodation run at about two to one, which is quite significant. The whole industry has or is moving to a single-room, ensuite framework, and that is considerably more expensive to operate. There is nothing in any of the subsidy reform processes that we have looked at for the last nearly 20 years now—other than the lump sum contributions in hostels—to actually reflect that changing cost burden for the industry.[49]

4.48 The department indicated that its survey of aged care facilities had shown a median cost of construction of $150,000 per place. Some 58.6 per cent of projects were completed for less than $155,000 per place, while some 14.8 per cent of projects cost more than $200,000 per place. The department concluded that the latter were constructed as 'extra service aged care homes or to a design specification well in excess of the current aged care building certification standards'. The department also noted that many facilities were built for less than the median cost and these included single room ensuite facilities:

> Many of the aged care homes with construction costs below $150,000 per place were also for design specification in excess of the current aged care

47 Grant Thornton Australia Ltd, *Submission 29*, p. 7.

48 Aged Care Association Australia, *Submission 92*, p. 11.

49 Mr I Young, Aged Care Association Australia, *Committee Hansard*, 13.3.09, p. 51.

> building certification minimum standards, including many developments entirely composed of single room ensuites.[50]

4.49 Mr Stuart commented that the Australian Government does not require single-bed facilities with ensuites. Mr Stuart went on to state:

> The Australian government policy requires for new buildings to achieve certification an average across the facility of 1.5 residents per room. That ratio permits two-thirds of the residents to be in double rooms and one-third to be in single rooms. The certification requirements also allow existing buildings to be renovated to still include some four-bed accommodation, provided it is not a sweeping refurbishment, in which case we expect them to meet the requirements for new buildings. I would submit that the industry has been, perhaps to its credit, substantially exceeding the requirements that are set in the government's certification guidelines.[51]

Potential impact of the global financial crisis

4.50 The department commented that the aged care sector is 'relatively (but certainly not completely) sheltered from the effects of the global financial crisis'. The department pointed to the sector's income stream which is almost completely underwritten by government; resident contributions in residential aged care are further underwritten by the pension system; and by aged care supplements and consumer demand for aged care is not expected to decrease very significantly as a result of the global financial crisis.[52]

4.51 Mr Stuart, Department of Health and Ageing, went on to comment:

> The other aspect is that the department adopts a risk based approach to compliance monitoring. We use a range of information sources, like complaints data, prudential returns and information coming in from other sources—media even—to identify where there may be emerging compliance risks.
>
> We also, in looking at that, try to identify whether there might be emerging financial risks. Similarly, we have been engaging more closely with the financial sector—the major banks—to talk to them about emerging developments in the sector and their attitudes to financing. At any point in time we will have at least a few approved providers about whom we may have concerns of varying degrees. There are currently one or two approved providers whom we are in discussions with on their financial position and we are providing some assistance to via consultancy services and the like to look at their operations with a view to identifying strategies to improve their situation.[53]

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50 Department of Health and Ageing, *Supplementary submission 114a*, p. 18.

51 Mr A Stuart, Department of Health and Ageing, *Committee Hansard*, 13.3.09, p. 97.

52 Department of Health and Ageing, *Supplementary submission 114a*, pp 23–24.

53 Mr A Stuart, Department of Health and Ageing, *Committee Hansard*, 21.4.09, p. 42.

4.52 However, providers stated that they were feeling the impact of the financial crisis. UnitingCare Australia for example, stated that its investment income had fallen.[54] Mr Glenn Bunney of Sundale Garden Village commented that non-operational income had 'virtually disappeared overnight'. There had also been investment write-offs and the disappearance of interest income and, at the same time, the effective interest rates that are being charged by banks have not dropped.[55]

4.53 Mr Andrew Sudholz of Japara Holdings commented that the global financial crisis has seen lending practices change dramatically:

> The banks are not lending as much, they are retreating from the industry or they are suffering from the global financial crisis. Thirty billion dollars of construction property funding is going to come out of our domestic market and be paid back to the global banks over the next 12 months.[56]

Conclusion

4.54 The committee received contradictory evidence in relation to the financial wellbeing of the aged care sector, and therefore the preparedness of the sector to meet growing demand. On one hand, providers argued that the sector is in crisis, or at the very least facing a crisis in the near future. On the other hand, the Department of Health and Ageing argued that there are significant government resources going into the sector and that there is evidence of increasing returns for providers and other indicators of strong financial viability including the level of building approvals.

4.55 The committee notes the arguments put by the department to support its view. However, in relation to the use of building activity as an indicator of the strength of the sector, the committee is of the view that the present building activity is likely driven by past allocations of beds rather than new allocations.

4.56 The committee considers that at the heart of the matter is the question of methodological approach and definitions of key terms. In the previous chapter, the committee has addressed the need for nationally consistent aged care data.

4.57 The committee also recognises that there is a need to establish a clear understanding of the financial status of aged care providers. This in turn requires insight into the funding status and needs of such providers and in this regard, the committee heard evidence of the need to establish a benchmark of care costs.

4.58 The committee also considers that, given the contradictory evidence and the emerging demands on the aged care sector as a result of the ageing of the population, a 'stress test' of the sector be undertaken to test the resilience of the sector. Such a test would measure the financial wellbeing of the sector and help to establish whether the sector is in crisis and whether it is in a position to meet future needs.

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54 Ms L Hatfield Dodds, UnitingCare Australia, *Committee Hansard*, 13.3.09, p. 27.

55 Mr G Bunney, Sundale Garden Village, *Committee Hansard*, 7.4.09, p. 79.

56 Mr A Sudhoz, Japara Holdings Pty Ltd, *Committee Hansard*, 20.2.09, p. 46.

Recommendation 9

4.59 The committee recommends that the Department of Health and Ageing undertake a 'stress test' of the aged care sector in order to measure the sector's financial wellbeing.

Costs associated with accreditation, regulation and compliance measures

4.60 The Aged Care Standards and Accreditation Agency is responsible for accreditation under the *Aged Care Act 1997* and applies four accreditation standards with 11 expected outcomes per standard:

- management systems, staffing and organisational development;
- health and personal care;
- resident lifestyle; and
- physical environment and safe systems.[57]

4.61 A number of both residential and community aged care providers were concerned with the overall increase in cost burdens associated with new regulations and compliance measures within the aged care sector. According to a number of providers, the pressure on them to meet such demands implies the diversion of staff away from meeting care needs of clients to that of administration associated with compliance. Baptist Community Services of NSW & ACT as one case in point, noted:

> The administrative load on staff is estimated to have increased by 50% over the past three years. Data from the Stewart Brown Aged Care Survey 2008 indicates that administration costs in residential aged care are now only just below the costs of feeding residents.[58]

4.62 Of these pressures, the Share & Care Community Service Group noted:

> There is pressure on all HACC providers to meet escalating demand within existing resources…The increase in quality standards, expectations of accountability and transparency, requirements for continuous consumer feedback and the massive increase of staff time to implement, monitor and evaluate all these items is in no way presently reflected in the funding. Whilst Share & Care agree these governance and operational measures are essential, there has been no increase in funding to compensate for the additional hours all these processes necessitate.[59]

4.63 The Aged and Community Services Association of NSW & ACT identified the range of increasing demands on the industry:

> Funding for aged care services is further impacted by government policy increasing demands such as police checks, compulsory reporting, increased validation of residential care funding claims, increased accreditation visits

57 Blue Care Uniting Care Queensland, *Submission 18*, p. 18.

58 Baptist Community Services of NSW & ACT, *Submission 21*, p. 2.

59 Share & Care Community Services Group, *Submission 5*, p. 3.

> and food safety standards and mandatory food safety programs. These costs have to date been absorbed totally by the industry.[60]

4.64 The ACCV noted that there are increasing costs involved in demonstrating that facilities are compliant because of an increase in the number of contact visits and documentation required under the Complaints Investigation Scheme (CIS). ACCV stated that there is a duplication of paperwork:

> Accreditation has raised the bar each time increased resources are required, as well as extra time to respond to this. As regulatory paperwork requirements extend above and beyond the ACFI in documenting care, there is a regular 'double up' in documents, assessments and records.[61]

4.65 The Shire of Kojonup highlighted the difficulties for smaller providers in covering the additional costs of administrative and compliance measures. Detailing the experience of the Springhaven Aged Care Hostel, a 22-bed low care facility, the Shire noted:

> In 2005 surveyors from the Aged Care Standards and Accreditation Agency Ltd advised management that our facility would not meet future accreditation requirements if it did not move from an overnight sleep over (on call) arrangement, to 24 hour stand up shifts. This was despite no change in the number of beds or the average RCS since the previous accreditation process.
>
> In 2007 the agency further advised that they believed there needed to be more staffing to handle administration. Between the new shifts and additional staff, required by the accreditation agency to meet the standards, and the increase in staff costs, the total staffing has increased from $441,000 in June 2005 to $568,000 in June 2008. This represents a 28% increase in costs without any increase in funding.[62]

4.66 The Department of Health and Ageing maintained that measures are being implemented to respond to the burdens associated with new regulations and compliance measures including an 'eBusiness strategy'.[63] However, concerns were raised that there remained little recognition of the time, cost and resource constraints on providers to fulfil such demands. Ms Anne-Marie Archer of the Aged Care Association Australia WA informed the committee:

> One of the biggest complaints we get from staff in the industry is the level of compliance et cetera insofar as it relates to the excessive documentation…The amount of time that they actually spend doing the

60 Aged and Community Services Association of NSW & ACT Inc, *Submission 61*, p. 2.

61 Aged and Community Care Victoria, *Submission 89*, p. 3.

62 Shire of Kojonup, *Submission 70*, p. 1.

63 Department of Health and Ageing, *Report on the Operation of the Aged Care Act 1997: 1 July 2007 to 30 June 2008*, p. 35.

> documentation is time taken away from care, and that amount of documentation is increasing.[64]

4.67 Ms Lin Hatfield Dodds of UnitingCare Australia highlighted the tension between the compliance burden and meeting care needs:

> The tragedy is the burden of administration and compliance on our care staff. All of us want better quality of life outcomes for the people we are providing services to. That is the motivator for a very punitive compliance burden we carry. It means that our care staff are diverted from care. There is a very perverse outcome in terms of real quality of life outcomes for Australians.[65]

4.68 Whilst providers recognised the need for regulatory and compliance regimes, concerns focused on the rigidity of the system. Mr Martin Laverty of Catholic Health Australia argued in this regard:

> We think there should be a greater opportunity for incentives for good performance balanced with the requirement for strong accreditation standards. But we have swung too far in favour of heavy compliance rather than looking at innovation and incentives for good provision of quality care.[66]

4.69 Mr Rod Young of the ACAA expressed a similar view:

> In respect of compliance and overregulation, we believe that the accreditation agency has shifted from its educative and support function. As an industry we have been highly supportive of the whole accreditation process to achieve and maintain quality in the industry, but we feel that the balance between compliance, regulation and quality improvement in the industry has shifted too far to the compliance framework.[67]

4.70 Ms Hatfield Dodds of UnitingCare Australia shared the same concern:

> The need for regulatory controls is not disputed. We are absolutely committed to a transparent system that ensures that all citizens get the care they need and that all taxpayers can see where their money is going, but our current system of regulation is expensive and cumbersome and has perverse outcomes in terms of quality of life and priorities for staff time and effort. We believe the purpose of a regulatory system should be to support the policy intent of legislation, protect citizens and ensure accountability. We need clear guidelines both as providers and consumers for identification and management of risks and clear indicators of quality of life. We need a respectful and cooperative working relationship between the department and providers built on recognition of the negative impacts of regulatory and

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64 Ms A-M Archer, Aged Care Association Australia WA, *Committee Hansard*, 30.1.09, p. 39.

65 Ms L Hatfield Dodds, UnitingCare Australia, *Committee Hansard*, 13.3.09, p. 36.

66 Mr M Laverty, Catholic Health Australia, *Committee Hansard*, 13.3.09, p. 2.

67 Mr R Young, Aged Care Association Australia, *Committee Hansard*, 13.3.09, p. 47.

> accreditation and complaint systems that are built on negative determinants.[68]

4.71 Similarly, Mr Bryan Dorman of the ACAA also highlighted:

> My objective in my organisation is to have 24-seven continuous improvement. But we still have this punitive process where you are either wrong or you are right. There is no value adding. There is no educational component to it all. We are ready for a next-generation compliance process. The next generation is where the staff engage with getting better at what they are doing and the system works in favour of that, not just whether you are good or bad. There are a lot of other industries that work it very effectively. There is no reason why it would not work in our space.[69]

4.72 Such views are consistent with those of the Productivity Commission. In its 2008 report on aged care services, the Productivity Commission noted that:

> Over coming decades, pressures on the demand-side of the aged care market are expected to accentuate a number of weaknesses in the current policy framework, including:…inefficiencies arising from excessive government regulation…[70]

4.73 Dr Lynn Arnold of Anglicare Aged Care Association South Australia affirmed that in addition to the difficulties involved in regulation itself, the federal and state regulatory burdens conflict:

> We are not asking for a deregulated approach, we are simply asking for a re-examination of the array of regulations, if you like, micro-regulatory reform, that will prevent regulations conflicting with each other and actually result in the outcome that they ostensibly seek not being able to be achieved. We do have examples of that between state and federal regulations that make the working environment not able to provide for the aspirations of residents because of conflict between the two.[71]

4.74 Ms Derryn Wilson of the Municipal Association of Victoria identified initiatives in place between councils to address the challenges of meeting the administrative requirements:

> In some regions the bigger councils supported the smaller councils by sharing their paperwork and working together. In a few instances the state also paid for a support worker consultant to go and work alongside a small group and help them get their processes in place, and they also provided some general education and training in the area.[72]

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68 Ms L Hatfield Dodds, UnitingCare Australia, Committee Hansard, 13.3.09, p. 26.

69 Mr B Dorman, Aged Care Association Australia, *Committee Hansard*, 13.3.09, p. 58.

70 Productivity Commission, *Trends in Aged Care Services: some implications*, Research Paper, September 2008, p. xx.

71 Dr L Arnold, Anglicare Aged Care Association South Australia, *Committee Hansard*, 13.3.09, p. 63.

72 Ms D Wilson, Municipal Association of Victoria, *Committee Hansard*, 20.2.09, p. 17.

4.75 Mr Stuart of the Department of Health and Ageing commented that the aim of the ACFI was in part to reduce paperwork:

> ...the government, in introducing the ACFI, had several objectives, one of which was a radical reduction in paperwork and nurse time. We are getting a lot of feedback to the effect that that is certainly being experienced.[73]

Conclusion

4.76 The committee considers that compliance measures are essential in the aged care sector. The committee acknowledges that the concerns of aged care providers in relation to accreditation are not grounded in a belief that the outcomes for residents in aged care facilities should be watered-down.

4.77 The committee appreciates that meeting regulatory obligations including accreditation standards is creating tension for providers who must balance the administration requirements with meeting care needs of clients. The compliance regime is a particular impost on smaller providers. For these reasons, the committee recommends that a review of costs and resources (borne by providers) required to meet such measures is undertaken. In addition, the committee considers that there is a need to identify and implement more cost effective measures of meeting compliance measures and to put in place support for smaller providers in relation to the compliance regime. It believes that the recommended advisory taskforce in association with the Department of Health and Ageing could undertake such a review.

Recommendation 10

4.78 The committee recommends that the Department of Health and Ageing, in association with the suggested taskforce, undertake a review:

- **to identify the costs and resources required to meet new regulation, accreditation and compliance measures with a view to rationalising the administrative processes as required; and**
- **to identify more cost effective means of meeting the requirements of the compliance framework.**

Recommendation 11

4.79 The committee recommends that the Department of Health and Ageing implement measures, including additional funding, to assist smaller providers to meet the requirements of the compliance framework.

Reduction in the provision and quality of services

4.80 Of particular concern to providers was the issue of the provision and quality of services within the aged care sector. Many witnesses commented that the quality and quantity of services has diminished and that this was further evidence of the crisis within the sector.

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73 Mr A Stuart, Department of Health and Ageing, *Committee Hansard*, 21.4.09, p. 35.

4.81 Witnesses argued that present funding arrangement, including the indexation formula, are impacting adversely on provider viability and service provision. For example, Bromilow Home Support Services stated that there has been a reduction in services hours provided to clients and commented that 'it is impossible for service providers to maintain consistency in the service levels provided to clients form one year to the next when subsidy levels continue to fall in real terms'.[74] Aged and Community Services Australia (ACSA) commented that the hours of service per client has declined in both residential and community care, reducing the quality of life of clients and increasing the risk of more intensive and expensive interventions being required. According to the ACSA, the impact is most acute in high care residential care as ageing in place tends to mask the same phenomenon in low care.[75]

4.82 Aged and Community Services SA & NT commented that not only were there less after hours service provision and a loss of real hours of direct care, but also a loss of diversity, loss of matching and 'cherry picking' of waiting lists.[76] Anglicare noted that the rationing services impacts particularly on older people with limited means and limited alternative supports.[77]

4.83 The Australian Medical Association took the view that older Australians in residential aged care facilities 'do not have access to medical care equal to the standard enjoyed by the rest of the population' and that the Australian Government, as the funder of aged care, should 'provide specific funding to approved aged care providers to enable them to secure appropriate medical care and supervision on an ongoing basis for their residents'.[78]

4.84 The Committee’s attention was drawn to innovative models of health service provision within aged care facilities to secure more holistic tracking of the health status of residents and their subsequent treatment.[79] Such models may benefit in the medium term from demonstration funding to explore their efficacy.

4.85 Mr Stephen Teulan of UnitingCare Australia commented:

> Given what is happening with the lack of indexation of subsidies, if we look at residential care but particularly community care, which has not had the benefit of the conditional adjustment payment, the additions to the subsidy in recent years, what is impacting there is that providers are just providing fewer services under the same packages to the community than they were previously because when salaries are going up at four to five per cent and the subsidy increase is two per cent there is no choice. The people who lose

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74 Bromilow Home Support Services, *Submission 49,* p. 5; see also Boandik Lodge Incorporated, *Submission 80*, pp 1–2.

75 Aged and Community Services Australia, *Submission 72*, p. 2.

76 Aged and Community Services SA & NT, *Submission 90*, p. 8 and p. 2.

77 Anglicare, *Submission 67,* p. 3.

78 Australian Medical Association, *Submission 14*, p. 1.

79 See for example, HealthCube, *Submission 122,* p. 5.

> out in the community are those who receive the services. They just receive less.[80]

4.86 Other witnesses also supported the view that the service purchasing capacity of a Community Aged Care Package (CACP) had diminished.[81] The ACSA maintained since 1995 funding has resulted in packages less able to meet assessed needs.[82] Perth Home Care Services held the same view, detailing the decline in the service purchasing capacity of CACP program:

> Our own experience is that since...2000 a CACP package was able to provide an average of seven hours per week with the capacity to increase to 10 hours per week for short periods of increased need. In 2008 this has reduced to five hours per week with limited capacity to increase hours to seven per week for increased need.[83]

4.87 Aged and Community Care Victoria (ACCV) held that the 'failure of funding levels to match identified care needs now fundamentally threatens the capacity of the industry to continue to provide its high standard of care'.[84]

4.88 A similar sentiment was also expressed by AMANA Living, which stated that the disparity between the amount of funding provided by Commonwealth, and the actual cost of aged care services (in this case residential care), will have negative long term consequences if the problem is not addressed:

> While the Commonwealth funds residential aged care to the tune of $114 per day (Minister Elliot's own data), an acute care bed costs $1,000 per day. The future lack of adequate residential care provision will impact very seriously on the already overstretched acute health system with serious ramifications for older people and for the overall cost of providing care.[85]

Workforce issues

4.89 One of the key issues of concern amongst aged care providers in relation to their financial position and thus ability to provide quality services is that of the recruitment and retention of staff. The difficulties in retaining aged care staff in a context in which the sector is unable to match let alone compete with the wages and conditions offered by other sectors was highlighted in evidence.[86] It was recognised, moreover, that the growing complexity and diversity of care needs require specialised

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80 Mr S Teulan, UnitingCare Australia, *Committee Hansard*, 13.3.09, p. 29.

81 Care Connect, *Submission 71*, p. 2.

82 Aged and Community Services Australia, *Submission 72*, p. 2.

83 Perth Home Care Services Inc, *Submission 32*, p. 1.

84 Aged and Community Care Victoria, *Submission 89*, p. 4.

85 AMANA Living, *Submission 3*, p. 1.

86 See for example, Mr D Kelly, Liquor, Hospitality and Miscellaneous Union, *Committee Hansard*, 30.1.09, pp 29–30; Mr J Toohey, Aged Care Alliance, *Committee Hansard*, 7.4.09, p. 23.

nurses and other qualified professionals which further impacts on expenditure and the nature of care provided.

Recruitment and retention of profession nursing and aged care staff

4.90 A substantial number of submitters raised concerns regarding the challenges of recruiting and retaining professional nursing staff in residential aged care facilities. Citing statistics from the Australian Institute of Health and Welfare, the Australian Nursing Federation (ANF) stated:

> At the same time as there are growing numbers of residents and their dependency is also increasing the numbers of registered and enrolled nurses employed in aged care has fallen from 38,633 in 1995 to 34,021 in 2005 a decline of 4,602. Over the same time the number of residential aged care places has increased from 134,810 in 1995 to 161,765 an increase of 26,955.[87]

4.91 The Aged Care Standards and Accreditation Agency (ACSAA) reported in August on staffing issues within aged care facilities found to be non-compliant:

> Among those homes found to be non-compliant in 1.6 Human resource management, it was found that a significant proportion did not maintain appropriate numbers and types of staff, with many of them not being able to ensure that staff skills and qualifications were the right fit for the work required and to reflect their residents' needs.[88]

4.92 The ACSAA went on to state that:

> …in homes where workloads are unrealistic, or where staff are unqualified, poorly trained or poorly deployed, then process malfunctions will occur across a wide range of expected outcomes.[89]

4.93 The ANF highlighted in its submission that the work of 'registered and enrolled nurses is progressively being substituted by unlicensed carers, which now represent the bulk of the workforce providing aged care services'.[90] Yet, recent evidence suggests a correlation between skills mix and patient outcomes. Citing a 2007 Australian study which reinforced findings of a number of international studies, the ANF noted that

> …[a] skill mix with a higher proportion of registered nurses produced statistically significant decreased rates of negative patient outcomes such as decubitus ulcers; gastrointestinal bleeding; sepsis; shock; physiologic/metabolic derangement; pulmonary failure; and failure to rescue.
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> The study found one extra registered nurse per day would reduce the incidence of decubitus ulcers by 20 per 1000 patients, of pneumonia by 16

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87 Australian Nursing Federation, *Submission 94*, p. 2.

88 Aged Care Standards and Accreditation Agency, *The Standard*, August 2008, p. 2.

89 Aged Care Standards and Accreditation Agency, *The Standard*, August 2008, p. 3.

90 Australian Nursing Federation, *Submission 94*, p. 4.

per 1000 patients, and of sepsis by 8 per 1000 patients. Patients are also less likely to fall and suffer injury as registered nursing home hours increase.[91]

4.94 A number of providers held that the ACFI had 'skewed' funding towards high residential care at the expense of low care funding which was creating dependence on specialist nursing services. In Western Australia, as one case in point, 72 per cent of all new admissions were of persons into high residential care requiring a high concentration of nurses.[92]

4.95 According to other evidence, problems in recruiting and retaining professional nursing staff also extended to care workers. The Australian General Practice Network (AGPN) highlighted that there was a workforce shortage affecting all care providers including personal care workers, general practitioners and allied health professionals as well as nurses.[93]

4.96 The Liquor, Hospitality and Miscellaneous Union (LHMU), whose members comprise approximately 75 per cent of the aged care workforce, stated that there was an annual turnover of direct care workers of 25 per cent.[94] Citing a 2008 National Institute of Labour Studies report, the LHMU noted that the high turnover rate was related not only to low remuneration but also work conditions. According to the report, 26 per cent of personal carers felt that they were able to spend sufficient time with residents whilst 36 per cent did not fell under pressure to work harder and 43 per cent found their job more stressful than they imagined.[95]

Conclusion

4.97 The committee acknowledges the concerns of providers in relation to the recruitment of professional nursing and other aged care staff and recognises that the issue must be addressed if the sector is to meet growing demand on its services in both the immediate and longer term. For this reason, the committee holds the view that the issue of staffing requirements must be considered in the recommended overarching review of the aged care sector. This will enable immediate and longer term projections in terms of staffing requirements and complement work currently undertaken to address aged care workforce challenges.

Recommendation 12

4.98 The committee recommends that the issue of professional nursing and other aged care staffing requirements be considered in the overarching review of the aged care sector.

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91 Australian Nursing Federation, *Submission 94*, p. 4.

92 See for example, Aged Care Association Australia WA and Aged and Community Services WA, *Submission 84*, p. 1.

93 Australian General Practice Network, *Submission 68*, p. 8.

94 Liquor, Hospitality and Miscellaneous Union, *Submission 112*, p. 2.

95 Liquor, Hospitality and Miscellaneous Union, *Submission 112*, pp 2–3.

Wages

4.99 A considerable number of submissions highlighted the problems with nurses' wages which, according to some evidence, are at least 10 per cent below that of equivalent staff in the acute care sector with some submitters commenting that the difference was up to 20 per cent.[96] According to Murchison Community Care, this disparity remains despite wage increases of 4 per cent a year for the past 6 years.[97] Aged and Community Service Australia stated that wage levels for aged care staff continue to lag behind those paid by other employers in the same labour market, further exacerbating the difficulties experienced in recruiting and retaining skilled staff.[98]

4.100 Mr Dave Kelly, Secretary of the Liquor, Hospitality and Miscellaneous Union, made the following comments in relation to wages:

> I have got a rate down there at the bottom for zookeepers. The LHMU also has the privilege of negotiating on behalf of staff at the Perth Zoo. A zookeeper under the EBA that we have negotiated with the state government gets $27, almost $28, an hour. I do not provide that just for a bit of humour: it is serious. This is what we pay people to care for animals at the Perth Zoo. What we pay staff to care for the elderly is significantly less. You would have to ask yourself, 'What does that say about the value that we attribute not only to the staff but to the elderly?'[99]

4.101 In a 2008 report on aged care services, the Productivity Commission commented on wages in the sector and noted:

> It is not uncommon for nurses employed in aged care to be paid at least 10 per cent less than their peers in the acute care sector for performing similar or equivalent work. For nurses in most settings, there has been a general trend, over the last 10 years, to adopt enterprise bargaining agreements and move away from award wage structures…the median real wage gap between aged care nurses on enterprise based agreements and those working in public hospitals has been maintained since 2005. As a result of the comparatively low wages in aged care, registered and enrolled nurses continue to be attracted to other parts of the health and community care sectors.[100]

4.102 The Valley View Aged Care Facility also raised the issue of disparity between nursing staff salaries in the private and public sectors:

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96 Murchison Community Care Inc, *Submission 36*; Management Consultant and Technology Services, *Submission 42*; Tongala and District Memorial Aged Care Service Inc, *Submission 83*; Baptcare, *Submission 59*; Valley View Aged Care Facility, *Submission 60*; Hotel Group of Companies, *Submission 79*.; Brotherhood of St Lawrence, *Submission 12*, p. 2.

97 Murchison Community Care Inc, *Submission 36*, p. 2.

98 Aged and Community Service Australia, *Submission 72*, p. 2.

99 Mr D Kelly, Liquor, Hospitality and Miscellaneous Union, *Committee Hansard*, 30.1.09, p. 30.

100 Productivity Commission, *Trends in Aged Care Services: some implications*, Research Paper, September 2008, p. 144.

> Salary sacrificing in public and not for profit sectors leaves the private sector at a severe disadvantage. The private sector is expected to provide the same standard of care as the not for profit and public sectors without being about to provide wage parity for the top quality nursing staff due to lack of finances.[101]

4.103 Wages account for a large proportion, 70 to 80 per cent, of total costs for aged care providers. According to the Darlingford Upper Goulburn Nursing Home, 87 per cent of its non-negotiable expenditure comprises staffing costs.[102] Similarly, Havilah Hostel stated that wages contribute up to 80 per cent of operating costs.[103] The House Group of Companies commented that the high turn over of nursing staff required the use of nursing agency staff and led to the expenditure of more than $750,000 on agency casual staff in 2007 which 'had a serious effect not only on the stability of our organisation and quality of care, but also on our profitability'.[104]

4.104 Providers argued that funding was insufficient for the wage gap to be closed. Mr Martin Laverty of Catholic Health Australia commented that changes need to be made to either the fringe benefits tax concessions or the care subsidies aged care providers received in order to provide parity with the acute sector.[105] UnitingCare Australia highlighted that the National Aged Care Alliance estimated in 2006 that $250 million per annum was required to achieve and maintain comparable wages and working conditions with the acute health sector.[106]

4.105 Mr Rod Young of the Aged Care Association pointed to the Productivity Commissions 2007 report and noted that the report 'accepted an industry estimate that the cost of putting aged care in a position to pay wages similar to those in the acute hospital sector would be a one-off payment of $450 million and an annual additional payment of $100 million to maintain parity between the two systems'.[107]

4.106 However, the ANF argued that there is capacity in the sector to improve wages. The ANF noted for example, that in 2005 the NSW Industrial Relations Commission awarded a significant pay increase (23 per cent) to nursing staff in aged care which bought wages close to parity with the public sector. While providers argued an incapacity to pay, the Commission stated that 'we consider that nothing the employers have put regarding their capacity to pay would prevent an increase in wages for nurses in the aged care industry that achieves fair and reasonable pay rates that properly reflect the work value of nurses'. The ANF concluded that 'to our

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101 Valley View Aged Care Facility, *Submission 60*, p. 1.

102 Darlingford Upper Goulburn Nursing Home, *Submission 19*, p. 1.

103 Havilah Hostel, *Submission 86*, p. 1.

104 House Group of Companies, *Submission 79*, p. 2.

105 Mr M Laverty, Catholic Health Australia, *Committee Hansard*, 13.3.09, p. 11.

106 UnitingCare Australia, Submission 76, pp 17–18.

107 Mr R Young, Aged Care Association Australia, *Committee Hansard*, 13.3.09, p. 47.

knowledge the pay increases did not result in a comprehensive collapse of the sector in NSW causing nursing homes to close as was the dire prediction of the provider'. [108]

4.107 The ANF went on to comment that the wages gap has developed between aged care nurses and nurses in other sectors is a consequence of enterprise bargaining agreement outcomes:

> While the content of federal safety net awards covering nursing staff in both the acute and aged care sectors remains broadly comparable, enterprise bargaining outcomes have let to significant differences in remuneration levels. The difference is primarily due to the inability to secure comparable enterprise bargaining outcomes to those in the acute sectors.[109]

4.108 The ANF also noted that Commonwealth funding initiatives implemented since 2002 to enhance the capacity of aged care employers to offer competitive salaries were not tied to wages and that 'much of the money was used for other purposes'. According to the ANF:

> The parlous state of bargaining in the sector has led to an inability of employers to fully complete in the labour market and they have struggled to recruit and retain nurses and other health professionals.[110]

4.109 The Productivity Commission noted that despite Commonwealth initiatives wage differences between the aged care and acute sectors have not narrowed. The Commission concluded that there were two main reasons for this: first, the extra funding is broadly similar to funding increases in the acute care sector; and second, there is no requirement on aged care providers to direct the extra funding towards paying higher wages to their workers.[111]

4.110 The ANF stated of a possible solution:

> It is recommended that a nursing occupational award covers all health sectors including aged care. Bargaining mechanisms need to be strengthened and stringent accountability requirements be placed on the providers to show that funding is expended on care in such a manner that provides for commensurate wages and conditions.[112]

4.111 In response to such concerns and suggestions, Dr Cullen of the Department of Health and Ageing argued of the salaries paid by the top quartile of aged care providers:

> I know of some of the providers. I know their enterprise bargaining agreements and I know that they are generous compared with the award and at a benchmark of what is done elsewhere. I do not want to be misquoted.

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108 Australian Nursing Federation, *Submission 94*, p. 6.

109 Australian Nursing Federation, *Submission 94*, p. 6.

110 Australian Nursing Federation, *Submission 94*, p. 6.

111 Productivity Commission, *Trends in Aged Care Services: some implications*, Research Paper, September 2008, p. 146.

112 Australian Nursing Federation, *Submission 94*, p. 6.

> There is no evidence that I am aware of, and I do not believe any evidence has been given to the committee, that the top quartile achieved that by cutting costs.[113]

Conclusion

4.112 The committee acknowledges that the Department of Health and Ageing has undertaken a number of initiatives to attract professional staff. The committee also recognises that the issue of attracting and retaining adequate aged care staff (including that of professional nursing staff) is complex and that there is no single solution. It therefore calls on the suggested advisory taskforce in consultation across the sector to identify the key challenges in relation to staffing and to identify a range of methods of address, particularly in rural and remote areas.

Recommendation 13

4.113 The committee recommends that the Department of Health and Ageing, in association with the suggested taskforce, review aged care staffing challenges and identify methods of address, with particular focus on staffing requirements in rural and remote areas.

Capital funding of residential aged care facilities

4.114 A number of aged care providers highlighted the lack of capital funding available to ensure that the sector is able to provide the services required in the future. Whilst accommodation bonds and charges provide aged care facilities with a capital stream to upgrade and maintain buildings, some providers may not attract sufficient residents who pay accommodation payments. For this reason, the costs of capital works are covered by an ongoing program of targeting capital assistance for such providers.

4.115 According to the department, in 2007–08, $45 million in capital assistance was allocated under the Capital Grants for Residential Aged Care program to assist providers of residential care to improve and upgrade 30 aged care homes, of which 80 per cent of the funding was provided to services in rural and remote areas:

> Of this, $12.5 million was allocated as Residential Care Grants, to support fire and safety related improvements and other works required for accreditation and certification, as well as the construction of new accommodation. The remaining $32.5 million was provided through the Regional and Rural Building Fund to assist rural and regional aged care homes to upgrade the quality of their buildings or to expand, thereby increasing access to aged care places for rural communities.[114]

4.116 In addition, the 2008–09 Budget included a measure to provide $300 million in zero real interest loans to assist in expanding the availability of residential aged care beds. Such loans are available to build or expand aged care facilities in non-metropolitan regions where there is a shortage of beds for permanent and respite care.

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113 Dr Cullen, Department of Health and Ageing, *Committee Hansard*, 13.3.09, p. 88.

114 Department of Health and Ageing, *Submission 114*, p. 25.

According to the department, the loans will provide up to an addition 2,500 aged care beds in areas of need. Loan recipients will pay interest at a rate equal to the Consumer Price Index.[115] Zero Real Interest Loans are administered through two rounds with $150 million worth of loans distributed in the first round in April 2008 allocating 1,348 aged care beds and 107 community care places in areas of high need.[116]

4.117 For providers not entitled to capital grants or zero real interest loans, capital funding is derived from the accommodation charge, currently a maximum of $26.88 per resident per day or where residents enter low care only, the retention and interest derived from a refundable accommodation bond.[117] Many residential high care providers maintain that as they have to pay more for their capital than the bond system in low care, they have lower rates of return. In addition to this, their staff costs are higher because high care demands a greater number of nurses and other care staff than low care.[118]

4.118 A number of providers maintained that funding levels were inadequate and as a consequence, construction of new high care facilities and redevelopment of existing high care facilities was non-viable.[119] According to Aged and Community Services Australia, current payments for capital purposes do not cover the costs of expanding residential care facilities, particularly high care, and to meet contemporary standards.[120] Similarly, Japara Holdings stated:

> Firstly, new aged care facilities (high care) are not being built because the cost of building new high care facilities far exceeds the end value, based on current government funding arrangements.
>
> Secondly the cost of upgrading older style existing high care facilities to best practice standards and 2008 compliance is significant, however as no additional revenue is obtained to provide a return on this capital expenditure, Approved Providers cannot under take these essential upgrades.[121]

4.119 The Western Australian Government recognised the establishment of a viable capital funding stream for infrastructure as the primary difficulty regarding aged care funding:

> Since the introduction of the Aged Care Act 1997, the residential age care sector has been troubled by the inability to establish a viable capital funding

115 Department of Health and Ageing, *Submission 114*, p. 26.

116 Department of Health and Ageing, *Submission 114*, p. 26.

117 Aged Care Association Australia – SA Inc, *Submission 63*, p. 2.

118 Mr Mundy, Aged and Community Services Australia, *Committee Hansard*, 20.2.09, p. 9.

119 Aged and Community Services Australia, *Submission 72*; Japara Holdings Pty Ltd, *Submission 74*; Aged Care Association Australia – SA Inc, *Submission 63*.

120 Aged and Community Services Australia, *Submission 72*, p. 3.

121 Japara Holdings Pty Ltd, *Submission 74*, p. 1.

> stream to finance the construction of new facilities or upgrade and maintain existing facilities in order to operate.
>
> Concomitant to this problem is the absence of a planning and/or monetary mechanism to quickly operationalise beds leading up to three-year time lapses between allocation and operationalisation.[122]

4.120 Villa Maria, Murchison Community Care Inc and Capcare maintained that they utilise their capital funding to contribute to operational costs, leaving the respective provides to source additional funding for the development and maintenance of the building and its infrastructure.[123] According to Villa Maria, this requirement typically resulted in the facility going into a 'deficit position'.[124]

4.121 The position of many providers in relation to capital funding is contextualised by the Aged and Community Services Association of NSW & ACT:

> The current capital and operational funding levels do not adequately take into account current economic variables such as building maintenance, wages, petrol etc. The inability to charge bonds in ordinary high care (nursing home) and the capping of the accommodation charge significantly impacts on capital funding streams. Currently a bond with the interest and retention amount far exceeds the worth of a daily accommodation charge. Many approved providers have recently put expansion plans on hold as the capital costs of providing new places as well as the ongoing maintenance of buildings and amenities are exceeding current funding.[125]

4.122 A Grant Thornton Australia 2008 survey of 700 nursing homes and hostels throughout the country recognised increasing costs of construction and low returns as the principal impediments to the re-development of aged care facilities whilst noting that much of Australia's building stock remains dated:

> Providers of residential aged care services are experiencing low and deteriorating financial returns at a time of unprecedented demand for high care services. This is particularly the case for the modern, single room facilities most preferred by consumers. Older, institutional facilities with shared rooms consistently outperformed new services. These results reveal a lack of incentive to renovate old facilities, or to build new ones, representing a threat to the viability of the residential aged care sector.[126]

4.123 Of the consequences, the survey noted:

> The regulatory and pricing framework now threatens the viability of the aged care sector by suppressing incentives to invest in modern aged care

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122 Western Australian Government, *Submission 111*, p. 1.

123 Villa Maria, *Submission 38*; Murchison Community Care Inc, *Submission 36*, Capecare, *Submission 13*.

124 Villa Maria, *Submission 38*, p. 1.

125 Aged and Community Services Association of NSW & ACT, *Submission 61*, p. 2.

126 Grant Thornton Australia Ltd, *Submission 29*, p. 6.

> infrastructure. This decline in investment severely limits choice for consumers of aged care services.[127]

4.124 Mr Stephen Teulan, UnitingCare Australia, informed the committee that the organisation's return on investment is currently under 2 per cent and that as a consequence there is little incentive to recreating services or rebuilding services in the future and 'what will happen in the absence of anything else is that people will not apply for new places; they will not build and the services available to Australian community will diminish'.[128]

4.125 Mr Rod Young of the ACAA emphasised the need for urgency in addressing capital funding needs:

> But there is no doubt, given the current trends in the industry, that repairing the capital capability for residential high care is certainly an absolutely urgent priority. If you look across the industry and talk to providers, the number of them who are completing construction work that is in train but who have clearly indicated they will not continue to invest any more until there is restitution to some sort of financial viability is alarming. In my opinion, we will see an almost total halt in the industry over the next two years if that is not repaired. So you would have to say that is fairly urgent; nonetheless, the operating income for the industry, given the current level of returns, is of almost equal importance. However, I think capital needs to be addressed as the first priority.[129]

4.126 According to the ACAA, during the 2007–08 financial year, $1.45 billion was spent by the industry on building works.[130] At the same time, a 2007 analysis by PricewaterhouseCoopers cited in a number of submissions to this inquiry established that on conservative assumptions regarding capital costs, the capital raising capacity of the industry is likely to be under-funded by as much as $5.7 billion in capital over the next 12 years.[131] Yet the Grant Thornton Australia survey established that 44 per cent of Australia's aged care facilities are more than 20 years old.[132] However, according to the body:

> Many operators have deferred or abandoned plans for the redevelopment of their aged care services because of the level of investment required and low returns generated from facilities that meet preferences.[133]

127 Grant Thornton Australia Ltd, *Submission 29*, p. 3.

128 Mr S Teulan, UnitingCare Australia, *Committee Hansard*, 13.3.09, pp 29– 30.

129 Mr R Young, Aged Care Association Australia, *Committee Hansard*, 13.3.09, p. 49.

130 Aged Care Association Australia, *Submission 92*, p. 13.

131 Aged and Community Services Australia, *Submission 72*, p. 3.

132 Grant Thornton Australia Ltd, *Submission 29*, p. 8.

133 Grant Thornton Australia Ltd, *Submission 29*, p. 7.

Conclusion

4.127 The committee received evidence and submissions from aged care providers and stakeholders from all parts of Australia which put a similar view: that the aged care sector is facing difficulties with the level of funding that it receives. That level is viewed as being inadequate to provide the services required, to meet increased costs such as wages and to implement the expansion needed to meet future demand. The Department of Health and Ageing's evidence did not accord with the provider's view of the sector. The committee considers that given the importance of the issues raised, that it is time for an all encompassing review, as recommended by the committee, to be undertaken.