Finance & Public Administration Committee
Inquiry into Residential and Community Aged Care

Melbourne Hearing 20 February 2009

Replies to:
Questions on Notice to
Aged and Community Care Victoria

Question 1

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Senator CAMERON—Your submission indicates a graph on the industry debt-to-equity ratio, and your comment in your submission is that there is a gradual decline in the industry's debt to equity over the 2004 to 2006 period. Since 2006 we have had a global economic crisis. We have banks in a deleveraging situation, and we have declining assets in terms of prices for real estate. This industry debt-to-equity ratio, I would guess, has ballooned. It has gone up 10 per cent a year according to your graph, but my view would be that it would have been ballooning over the most recent period of time. Do you have any information for us on that?

Mr Mansour—I cannot update it in terms of the information that is there; we rely on other sources for that. No, I cannot update those figures.

Senator CAMERON—Do you think my proposition on that could be a legitimate proposition?

Mr Mansour—That that has peaked? It plays itself out in different ways. It is hard to work out what the factors are. In recent conversations with our members on debt-to-equity ratio, we find the changing nature of the property market is playing itself out sometimes in a negative way for us. There are a number of people that have an ACAT assessment, wanted to move into an aged care facility and are unable to sell their own home, and therefore they delay entry because of matters like that in terms of bond income. So, in terms of measures, we would suggest there are a series of financial measures, and I cannot provide any further comment on that particular one.

Senator CAMERON—Could you take that one on notice and have a look within your organisation?

Reply: Senator, ACCV did not provide a graph on the industry debt to equity ratio however, there has been one published measure that we are aware of and we therefore draw your attention to Grant Thornton's Fourth edition of the Industry Intelligence Report for Aged Case (February 2008).

Question 2

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Senator CAMERON—Do your members take low socio-economic people into your aged care centres? Do you have any beds set aside for non-profit places—people who cannot provide you a profit?

Mr Mansour—There are the application of concessional ratios and many of our members, because of the funding model, will take those. Most providers operate and work within a community and provide services very broadly. What tends to be the driver comes back to the funding model and access. If you have an individual in the future who—

Senator CAMERON—I am not asking for the driver. I am asking if you do it.

Mr Mansour—The answer is yes, it will vary from one place to another.

Senator CAMERON—Okay. Can you then give the committee details on what percentage that is in terms of your membership?

Mr Mansour—What percentage of them provide—

Senator CAMERON—What percentage of those lower socio-economic people are in—

Senator CAROL BROWN—Concessional.

Mr Mansour—Concessional—that data is available via the Commonwealth. I can have a look at that, yes.

Reply: Senators, In terms of the Aged Care Act 1997 , the test for determining "low socio-economic status" is whether or not people have assets. If a person's net assets are $91,910.40 or less, then the Act deems these people to be of low socio-economic status. These residents are called "supported residents" and are required to make up 40% of all new residents admitted into the aged care facility.

Supported residents, that is those whose net assets are $91,910.40 or less, pay neither the lump sum accommodation bond usually paid by low care residents with assets above $91,910.40 or the means tested daily accommodation charge paid by high care residents who have assets above $91,910.40.

As a consequence of a person being a "supported resident", the facility receives an accommodation supplement on their behalf. This is to make up for the income which would have otherwise been earned through the payment of either a lump sum accommodation bond paid or the daily accommodation charge.

If the 40% level of supported residents is not reached by the facility, then a 25% penalty is applied to all accommodation supplements paid to the facility on behalf of any supported residents in that facility. There are further details on this in the Commonwealth's annual report into the operation of the Aged Care Act 1997[1]

There is a sliding scales for the payment of the act supplement with the maximum supplement payment of $26.88 per day being paid on behalf of those residents with assets of less than $36,000. However this reduces at a rate of 48 cents per $1000 of assets above $36,000. Thus by an asset level of $91,910.40 the payment is nil.

Therefore facilities admitting residents with assets between $36,001 and $91,910.40 are financially disadvantaged as they are receiving nothing from the resident, and a reducing supplement from the government. This therefore can act as a disincentive to admit those residents with assets between $36,001 and $91,910.40.

Senators, a solution is to pay the accommodation supplement to facilities at a flat rate of $26.88 per day on behalf of all supported residents - all residents with net assets are $91,910.40 or less.

Question 3

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Senator CAROL BROWN—You have talked in your submission about the viability supplement, and we have talked about it previously today, so if you could just forward to the committee why you believe the supplement is inadequate, how you would like to see it work and also your views on tiered funding, please.

Mr Mansour—I am very happy to do that—tiered in terms of community care?

Senator CAROL BROWN—Yes.

***Reply*:** Senator, the essential reason the Rural Viability Supplements for both Residential and Community Care are inadequate is that they do not draw upon validated base cost price structures or indices which accurately reflect the increase cost of conducting aged care in rural and remote or small and isolated communities

[1] Report on the Operation of the Aged Care Act 1997 1 July 2007 to 30 June 2008. Commonwealth of Australia. 2008.

In an ideal world we would to "prime cost" care to establish a new base price– what we realistically could deliver as better care, not using the existing funding models or cost structures as a proxy, as we just replicate the inherent error of the current funding quanta. Only once we have done that can we actually then go forward with precise and properly weighted indices knowing what the balance of cost inputs would really be like. Any index needs to understand the base cost structure first and foremost. We use the process to drive two outcomes - a new base for aged care pricing and a new index.

Not withstanding this, and with regard to the Residential Aged Care Rural Viability Supplement, it is important to remember that the 2004 Hogan Review recommended that Government should increase the total amount available for the viability supplement for rural and remote services[2]. In spite of the some increases which started to appear in 2006-07 budget, nationally in 2007-08 476 Aged residential Care Services received just under $15.1 million of this funding as well as a further 18 National Aboriginal and Torres Strait Islander Aged Care Strategy Flexible services ($1.74 million) and all of 118 Multipurpose services ($6.5 million) In all 612 services received $23.3 million amounting to just over $38,100 per facility[3]. Clearly, an average of under $40,000 per facility over a full year is patently inadequate.

Altogether there are 1163 services in regional and remote Australia, with 420 of these in Outer Regional, Remote or Very Remote areas. The current means of determining funding is subject to three schemes, a 1997 scheme, a 2001 scheme and a 2005 scheme.

Senator, we recommend a simplification of the complexity of these schemes, a boost in the overall funding per facility to go further towards the premiums these services pay to recruit staff and purchasing a wide range of consumables, and a broadening of the net to ensure all rural services receive some benefit. Given the infinitesimal proportion this scheme currently represents as a proportion of all operational funding (0.39% of $6 billion) it should be doubled as an interim step while an appropriate costing activity is undertaken.

The Community Aged Care Rural Viability Supplement has been evaluated with some very recent evidence. Aged and Community Services Australia released their report of a detailed survey on the operation of the Rural and Remote Viability Supplement for Community Care[4]. Some of the increased costs experienced by Rural and Remote Community Care related to the very issues of distance. Community Care providers are called upon, often as the provider of last resort, to transport people hundreds of kilometres to medical appointments. In the survey report, particular emphasis was placed upon the role Community Care providers played is assisting aboriginal elders to attend "Sorry Business".

In ACSA's own words the pricing of the supplement for Community Care was not an exact science,

> *With regard to the pricing of the supplement, ACSA have emphasize that, In its 2006-7 Commonwealth budget submission ACSA argued that community care services should be compensated at the same level as their residential counterparts because they face the same cost pressures and challenges to viability. ACSA calculated that in 2006, approximately$16.8m would have been required annually to fund a community care viability supplement at the same rate*

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[2] Review Of Pricing Arrangements In Residential Aged Care WP Hogan. Commonwealth of Australia 2008.

[3] Report on the Operation of the Aged Care Act 1997 1 July 2007 to 30 June 2008. Commonwealth of Australia 2008.

[4] "We make do" - A Review of the Community Care Viability Supplement. ACSA. February 2009.

as residential care. Instead, the 2006-7 Commonwealth Budget provided a total of$19.4m for the CCVS over 4 years: meeting just one-third of the calculated need (ACSA correspondence to Stephen Dellar, 18 May 2006). ACSA considers that the failure to set the levels at an equivalent level to the residential care viability supplement – which Warren Hogan already regarded as having been set too low [Hogan 2004: Recommendation 11, p22 of 397] -has seen community care short changed.

We therefore recommend that the Community Care Viability Supplement be increased threefold on its current per capita amount to meet the need already previously calculated ACSA. At the same time we note that few people, especially in Victoria and Tasmania can attract this subsidy. The ARIA is not a useful predictor of isolation in small and isolated communities. Given that one quarter of all Victorians are rural dwellers.

As such we recommend a benchmark minimum of 20% of all community clients in all states attract the supplement to ensure that they are able to receive services on an equivalent basis to their metropolitan counterparts

On the matter of Community Care potentially being tiered, we are pleased that even the National Hospitals and Health Reform Commission have recognised the need to address this issue. Chapter 6 of their recently "Interim Report" has recognised the need to introduce a more flexible range of subsidies.

In rounded figures, a Community Aged Care Package (CACP) is funded at $12,680 per annum, and Extended Aged Care at Home (EACH) package at $42,400 per annum, and an EACH – Dementia (EACH-D) package at $46,760 per annum. There is a severe disadvantage to those clients who needs are even moderately in excess of the $12,680 while they wait on a CACPs package for an EACH or EACH-D package as the gulf in finding between the two tiers is enormous.

Our own surveying of the sector, here in Victoria in 2007[5] in a provider sample representing of 3772 CACPs here in Victoria estimated that 14.2% of all clients were estimated to have needs ***well in excess*** of what a CACP can provide.

It is not assisting older people when a provider cannot increase the resources being applied to their care because they are limited to one funding level. Surely some people who are in scope for an EACH or EACH –D packages might certainly be able to be supported on a lower level of funding, but they are referred to the programs having well and truly run the gauntlet of a CAPC .

It assists no-one for older people to be moved from pillar to post between programs and organisations. Imagine if residential care dwellers had to be moved from one facility to another every time their care needs increased. This is where the "ageing in place" in residential care concept started with having high and low care under the one roof. It is now time to look at a similar approach to age in place in the community with a continuous funding model as against the vastly discontinuous model we have at present.

ACCV proposes that in the long term a continuous incremental funding model should be introduced akin to that which has operated in residential care since the 1980's with the RCS (both pre and post 1997 Aged Care Act versions) and the ACFI.

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[5] Supplementary information to the Review of Subsidies and Services in AustralianGovernment Funded Community Aged Care Programs.Building the Evidence:A survey of Victorian Community Aged CarePackages providers and the operation of their Community Aged Care Packages.ACCV. 2009

However, as an immediate measure, we believe that a further two additional tiers of funding be created above the current level of a CACP, and below the level of EACH or EACH-D and which can be accessed for existing CACP clients without requiring a further ACAS assessment.

Question 4 and 5

Additional questions on notice from Senator Carol Brown - Do you have an education and training program for your members?

ACCV's Training program is focused on developing better access to affordable and relevant training for our members. Out aim is to broaden and diversify the training our members require, whether that is through ACCV's Registered Training Organisation, Workshops or Consultancy services. Being responsive and adaptive to member requirements is our main priority.

Have you thought about a more regionally-based education and training model? If so, have you considered who would pay for it?

ACCV currently provide extensive training throughout regional Victoria. The face to face delivery method is time consuming and expensive. Government funding and strong member patronage to other ACCV programs helps supplement regional training. ACCV intend to introduce a Virtual Classroom model by the end of the 2009 business year, which will significantly lower costs.