aegis
aged care group

20 March 2003

Professor Warren P Hogan
Aged Care Price Review Taskforce
MDP 76 GPO Box 9848
CANBERRA ACT 2601

Dear Professor Hogan

You have written to us as an Approved Provider advising that you are calling for submissions from the Aged Care Industry.

Aegis Health Care Group Pty Ltd is making this submission on the basis of its 20 years experience as a Provider of residential aged care services in Western Australia.

We believe the current system is workable but urgently requires improvement in order to correct some obvious and some less obvious problem areas.

In summary, our submission is focused on the following key points and recommendations for up front improvements:

1. Reclassify the current system as falling into two components, Care and Accommodation.

2. Government funding of RCS as presently structured does cover the **existing** "Care costs".

3. Current funding does **not** cover the accommodation cost of new and upgraded facilities, but does cover pre 1990 facilities.

4. "User Pays" needs to be improved by eliminating the cap on the accommodation charge.

5. The means tested income received by the Government should be used to increase the Concessional Resident Fee for improved facilities.

6. Introduce accommodation bonds into high care to give a choice between accommodation bonds and accommodation charges for those who can afford to pay.

7. The five (5) year limit on accommodation bond retentions and accommodation charges should be eliminated.

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8. The Concessional Resident Ratio should be eliminated or reduced to 20%.

9. Extra Service status should be approved "On Application", subject to compliance with set agreed criteria.

10. The Viability Supplement for rural and remote areas should be substantially increased.

## 1.0 Background of the Aegis Health Care Group

The Aegis Health Care Group ("Aegis") was founded in 1982 with the purchase of 2 nursing homes with a total of 85 beds.

Aegis now has 309 high care beds including 97 Extra Service beds, 172 low care beds and 152 Approvals in Principal for high and low care beds which are in the process of being built. Aegis also has 40 Care Awaiting Placement beds with the State Government, a 20 Bed Transitional Care Pilot scheme being run as a joint venture with the Commonwealth and State Governments and manages a further three facilities with a total of 239 beds for other Approved Providers.

Our group is therefore responsible for an aggregate 932 Residential Aged Care places.

Since 1999 our Group has renovated and built 399 beds in seven facilities at a total cost of nearly $28 million (see the attached *Table 4* for detail). This expenditure does not include the cost of land for new sites and additional land adjacent to existing sites purchased at a cost of $5 million.

Aegis would not have been able to carry out this substantial capital works program without the ability to collect accommodation bonds. At the present time we have 220 Bonds representing over $18 million.

As is apparent from our track record and the level of our involvement, we are committed to the Aged Care Industry. It is our intention to continue our specialisation in only residential aged care.

## 2.0 Our Philosophy for Residential Aged Care

**Our philosophy for Residential Aged Care is that it should be divided into two components – Care and Accommodation.**

As demonstrated in the following *Table 1,* the Government is already paying for the Care of the residents.

The Government and Users are presently paying an adequate Accommodation Fee for most older facilities in the industry.

However, the Government and Users are **not** paying an adequate Accommodation Fee for residents to be in new or upgraded facilities nor to promote and support the building of new high care facilities.

**Only accommodation bond payers are paying an adequate fee for new facilities.**

Our submission establishes that there are minor changes needed to the current system to solve a lot of the problems inherent in Residential Aged Care.

## 3. Government Funding DOES Cover Existing Care Costs

We have compared the income received from RCS fees and payroll tax supplement for ten of our facilities over the past year against the cost of staffing those facilities and found the daily income per bed is very close to the staffing cost.

Staff costs include staff wages, agency wages, superannuation, payroll tax, workers' compensation insurance, laundry wages and costs, staff education and staff amenities.

**Whether the facility is totally low care, a combination of high and low care or totally high care, the income is surprisingly close to the aggregate daily staff costs.**

*Table 1* sets out the results for ten of our facilities for year 2002.

| Bed Size and Category | Facility | **RCS Fees** And Payroll Tax Supplement | **Staff Cost** |
|---|---|---|---|
| 25 – 45 Low Care | 1 | 41.73 | 41.32 |
| 25 – 45 Low Care | 2 | 45.79 | 45.59 |
| 25 – 45 Low Care | 3 | 40.45 | 39.07 |
| | | | |
| 80 – 100 High and Low Care | 1 | 79.37 | 79.87 |
| 80 – 100 High and Low Care | 2 | 86.84 | 85.96 |
| 80 – 100 High and Low Care | 3 | 80.31 | 80.76 |
| | | | |
| 40 – 65 High Care | 1 | 109.10 | 104.08 |
| 40 – 65 High Care | 2 | 110.38 | 102.07 |
| 40 – 65 High Care | 3 | 106.23 | 98.80 |
| | | | |
| 30 – 39 High Care | 1 | 106.23 | 100.92 |

***Table 1***

We propose that "Care Funding" does not need to be acquitted (as with previous systems) as the present RCS contributions cover the current Staffing Cost and can therefore be the base to start from.

If staffing levels or wage rates change, a commensurate change can be made to the RCS funding to maintain the equilibrium.

The indexation of the RCS should be tied to increases in the award rates of the various staffing categories used in the Aged Care Industry.

RCS validation, Accreditation and the complaints mechanism should ensure staffing levels are maintained. It is considered essential that ability to retain efficiencies needs to be left in the system. Further regulation would increase costs and probably offset any savings made.

Should the RCS system be improved as a result of the RCS Review, the care and accommodation model would still enable those improvements to be introduced.

## 4. Government Funding Does NOT Cover Accommodation Costs

The above Section 3.0 sets out the costs covered by the RCS funding and payroll tax supplement. Therefore, all other costs should be covered by the balance of funding received by the Aged Care Industry.

We have considered the funding available for a resident classified as Level 8 where the Government has determined no care is required for that resident. This being the case, that resident needs to cover all costs.

These costs are food, resident welfare (chemist, medical, incontinence pads, etc.), accommodation costs (cleaning, rates, depreciation, repairs, etc.), administration, rent and a profit return to the Provider.

As no RCS funding is received, the funding for a level 8 resident is received through the resident daily fee, rental assistance, accommodation bond retention and accommodation bond interest (or interest saving).

These income sources would cover the accommodation costs for all low care residents.

If care and accommodation fees were separated for high care, the accommodation costs would be covered by the resident daily fee, payroll tax supplement, rental assistance, and the accommodation charge or the Concessional Resident Fee.

Government statistics show that since 1997 a significant number of low care facilities have been built. There have also been a significant number of new facilities built which are a mix of high and low care.

Government statistics also show there have been almost no new high care facilities built in that time.

**Low care facilities and facilities with a mix of high and low care have been built because of access to accommodation bonds by the industry.**

The amount that can be charged as an accommodation bond is not restricted by the Government and this has enabled providers to set an accommodation bond at a level they consider to be reasonable for the standard of their facility.

**No stand alone high care has been built because there is inadequate means of accessing capital to cover the increased cost of operating and the capital cost of building these facilities.**

**For Approved Providers to be able to build new high care facilities they need the upper limit on accommodation charges to be removed.** The price an incoming resident pays as an accommodation charge should be based on the standard of accommodation they are receiving and there is no reason for the Government to set an upper limit. **The Government should also re-introduce accommodation bonds into high care** as many residents would prefer to pay an accommodation bond to access a better standard high care facility.

**If accommodation bonds were re-introduced along with an uncapped accommodation charge, potential residents who can afford to pay would have a choice between these two alternatives.**

In many instances residents of low care facilities are paying an accommodation bond of around $107,000. This amount is just below the limit to retain pensioner supplement eligibility. An accommodation bond of $107,000 is worth the equivalent of an accommodation charge of $34 per day taking into account the retention amount and interest on the bond at the current Government rate of 8.84%.

**This difference of over $20 per day between the required accommodation charge and the current accommodation charge is the reason why high care facilities are not being built.**

**There is also an inequity in low care facilities that needs to be corrected. Residents may not have the assets to pay an accommodation bond, but may have a high income, yet they are not required to pay an accommodation charge.**

To support our proposition that the accommodation charge is inadequate, we set out in *Table 2* the operating costs of the same ten facilities used in *Table 1* for year 2002 (excluding the staff costs set out in *Table 1*). *Table 2* includes the Certification Scores of each of the facilities. All of the facilities except the last one have been built since 1991. The last facility is a small high care facility and its costs per bed are higher than acceptable because it is below an economic size.

*Table 2* shows the required daily accommodation charge to range between $31.60 for a high care facility with a certification score of 83.55 and $43.80 for a low care facility with a certification score of 98.70.

**By eliminating the upper limit on accommodation charges, Approved Providers can set an accommodation charge at a level they believe to be commensurate with the services and accommodation provided by their respective facilities.**

Approved Providers would then be in a position to determine the standard of accommodation people could pay in their particular area or region and build a facility commensurate with the size of the accommodation charge they consider to be commercial and achievable.

| Facility | Cert Score | Resident Costs | Admin Costs | Rent and Accomm Costs | Profit | Total | Less Daily Fee | Required Accomm Charge |
|---|---|---|---|---|---|---|---|---|
| 1 | 90.30 | 13.82 | 8.70 | 34.45 | 14.80 | **71.77** | 31.00 | **40.70** |
| 2 | 85.00 | 12.36 | 8.39 | 27.81 | 14.80 | **63.36** | 31.00 | **32.30** |
| 3 | 98.70 | 14.91 | 9.03 | 36.10 | 14.80 | **74.84** | 31.00 | **43.80** |
| | | | | | | | | |
| 1 | 91.0 | 17.20 | 8.12 | 28.40 | 12.40 | **64.78** | 31.00 | **35.14** |
| 2 | 87.03 | 16.12 | 8.51 | 28.73 | 11.00 | **64.36** | 31.00 | **33.30** |
| 3 | 98.80 | 14.24 | 7.95 | 32.00 | 13.35 | **67.54** | 31.00 | **36.50** |
| | | | | | | | | |
| 1 | 83.55 | 14.99 | 8.49 | 29.32 | 9.86 | **62.66** | 31.00 | **31.60** |
| 2 | 90.63 | 20.96 | 9.03 | 25.87 | 14.80 | **70.66** | 31.00 | **39.60** |
| 3 | 98.50 | 15.45 | 8.74 | 33.32 | 12.00 | **69.51** | 31.00 | **38.51** |
| | | | | | | | | |
| 1 | 58.66 | 22.58 | 8.66 | 18.08 | 9.86 | **59.18** | 31.00 | **28.18** |

***Table 2***

Unless there is access to capital through either uncapping the accommodation charge or re-introducing accommodation bonds or both, the lack of high care construction will become a significantly more serious problem than it is now. The Government is issuing more care packages, States are providing HACC and more programs are coming on stream to keep potential low care residents at home. At present, almost 64% of residents in high and low care beds are categorised as high care. As more care packages are brought on stream, fewer people will be going into low care places.

Those with "Home Packages" will be looking to move into Residential Aged Care when they become high care. Under the current system they are not **able to access the high standard of accommodation they want or expect, even if they can afford to pay for it.**

## 5.0 Adequacy of Concessional Resident Fee

The Concessional Resident Fee currently payable to a facility with more than 40% of its residents being concessional is $13.20. If a facility has less than 40% concessional residents it receives a Concessional Resident Fee of $7.70 per day.

Statistics show that approximately 27% of residents in high care facilities are concessional. This can also be supported by "The Regional Concessional Resident Target" set by the Commonwealth Government for each planning region in each state. Except for remote areas the concessional resident ratio is more like 20% to 23%. The effect of these ratios is that a large number of facilities are not able to achieve the 40% concessional resident ratio and therefore are paid the smaller amount of $7.70 per day for concessional residents.

*Table 2* in the Background Paper No. 1 shows that in year 2001only 26.6% of residents in Aged Care homes had personal weekly income of less than $200 besides the pension. Therefore, over 73% of residents earn more than $200 per week, in addition to a pension, to contribute towards their accommodation.

The Government set the higher daily fee for achieving the 40% Concessional Resident Ratio in an effort to ensure concessional residents were not discriminated against when it came to entry to an aged care facility.

**To ensure concessional residents are not discriminated against by Approved Providers, the Government should increase the concessional resident fee based on the certification score of each facility.** By doing this the Government will provide an incentive to Approved Providers to upgrade the standard of their facility and also encourage them to accept concessional residents into their facility. In any event, Providers need to meet the regional ratio to achieve Accreditation.

It is now more than five years since the Aged Care Act was introduced and aged care Providers who have done little or no work to their facilities in that time are still receiving the same concessional resident fee as Providers who have built or substantially upgraded their facilities since 1997. The problem is, **new facilities cost between $15 and $25 per resident per day more to operate.**

We propose the following Concessional Resident Fee be paid to Providers based on their facility's certification score.

| Certification Score | Concessional Resident Fee |
|---|---|
| Below 60 | $ 0.00 |
| 60 – 64 | $15.00 |
| 65 – 69 | $20.00 |
| 70 – 79 | $25.00 |
| 80 – 89 | $30.00 |
| 90 – 100 | $35.00 |

***Table 3***

The Government could even give a "star" rating from zero for a facility with a score under 60 to five star with a score of above 90. The star rating is well recognised in the tourist and accommodation industry.

We have totalled the **Means Tested Fee** paid by the residents of our facilities. Extrapolating that amount out to all facilities in Australia, **we estimate the Government is receiving about $170 million a year in means testing from residents.**

The Government is also making a substantial amount from residents who sell their homes to pay a bond to go into low care or extra services facilities and change from being a pensioner to a non-pensioner. Some of these residents are even means tested as well, so they can change from being a receiver of Government funds to a payer of funds to the Government.

Centrelink publishes a book called "A Guide to Payments and Services 2002 – 2003". On page 114 of that booklet under the heading of 'Income Assessment for Residential Aged Care Fees' Centrelink makes the following statement;

> "From 1 March 1998, new residents entering residential aged care may be asked to pay an income tested fee, based on their income and the level of care needed. This fee, which is in addition to the daily care fee, helps cover living expenses such as meals, laundry, heating/cooling and nursing and personal care. The fee is paid directly to the care services as part of the resident's aged care fee".

This is an exaggeration of the truth as the means tested amount is collected by the Approved Provider and the Government reduces its subsidy to the Approved Provider by that amount. In fact, if the resident does not pay the means tested amount the Government still reduces the subsidy payable to the facility.

Even so, **the means tested amount received annually by the Government (which will continue to increase on an annual basis) should be put back into the industry by way of increased concessional resident fees provided to subsidise the building of better standard accommodation for concessional residents.**

This would be a case of the rich subsidising the poor in aged care.

## 6.0 User Pays

As part of the Review of Pricing Arrangements in Residential Aged Care, Background Paper Number 1 was prepared and submitted to the industry to assist with their submissions.

Chapter 5 in the Background Paper, states that users can pay and their ability to pay will increase as time goes by. As that ability to pay increases, their expectations will increase and they will expect to receive commensurate services and standards of accommodation.

We have already experienced the changing consumer expectations mentioned in Section 5.6. We are also experiencing consumers' increasing ability to pay as the statistics set out in Section 5.7 relating to changing consumer resources show.

As residents' incomes rise through increased savings and superannuation, they will have a greater ability to pay for improved services and can demand those services. **They will pay for those services if the system is deregulated to enable them to pay.**

In the Review carried out by Professional Gregory from 1990 to 1992 he said the then system had no incentive for Providers to improve the accommodation or services being paid for. As has been stated from many different sources, accommodation bonds in low care have opened up that area to improvement. The regulation of the concessional resident fee and accommodation charge in high care has restricted any incentive to improve accommodation and services in high care.

The level of applications for extra service status has increased significantly over the last three to four years, particularly from the church and charitable sector. This has eventuated because it is the only means of getting bonds into high care to create the capital needed to build new stand alone high care facilities.

The National Commission of Audit in its review in 1996 also said it was critical of the highly regulated nature of residential aged care, the lack of effective choice for consumers and the inability of providers to position themselves in the market to receive additional revenues for providing a higher quality service. The National Commission of Audit suggested that means testing be introduced which the Government has done. It also called on the Government to change funding arrangements so those able to contribute more towards their own care could do so. This has not been done.

## 7.0 Other Changes

7.1 **Extra Services** applications should be made by Approved Providers on an "as required" basis.

As Extra Service Status does not impinge on Government funding and does not result in any more care places coming on stream, the Government should be able to approve or disapprove of an application at any time based on the application meeting the extra service requirements. The application would also be assessed by taking into consideration the Extra Service Ratios set by the Government for that region.

The **25% claw back of extra service fee** by the Government should be abolished. Residents are means tested and are therefore paying a means tested fee as well as a Government claw back for extra service. **This constitutes a form of double taxation.**

7.2 **Transitional** residents who have been in aged care since before 1 October 1997 are being subsidised by the Government at a much lower rate than concessional residents and those paying accommodation charges.

There is no reason for these residents to be subsidised at a lower rate than those paying accommodation charges and those being subsidised at the concessional resident rate. Therefore all transitional residents should be brought up to either a concessional resident rate or a charge exempt rate.

7.3 The **five year retention** on accommodation charges and accommodation bond retentions should be abolished.

There is no reason for a five year limitation to have been put on these fees.

There is no five year limit on the Concessional Resident fee. This is paid for the same reason as an accommodation charge or accommodation bond.

By having a five year limitation, those residents who have been in aged care for more than five years are receiving a benefit but then being discriminated against. We have accepted residents when other Providers have not been prepared to accept them or are looking to transfer them because the resident is no longer receiving the income relating to the five year limit.

7.4 The **Viability Supplement** for rural and remote areas should be increased to whatever subsidy is required to make those facilities viable.

In almost all instances the viability supplement is grossly inadequate. It is not possible to increase the size of the facility, particularly in remote areas, to one that would be of a viable size. Therefore the Government needs to substantially increase the viability supplement to a level that encourages Approved Providers to operate them. Otherwise access to aged care in some rural and remote regions will continue to decline.

The amount of money involved is small inn the whole scheme of things. There would probably be enough funds available from means testing to allocate to this extra cost.

## 8.0 Advantages of the Care and Accommodation Model

- The Government pays for the **care** of the residents;
- Residents who can, should pay for the services and accommodation they want and can afford;
- The Government should pay for the services and accommodation of concessional residents at an appropriate rate;
- The Approved Provider should set fees commensurate with the service and accommodation being provided to the resident;
- Residents who want higher levels of service and/or accommodation should be able to pay for them.
- The system should change more to a "user pays system" in line with the Government preference.
- Indexation could be more simply calculated for the separate care and accommodation sections.
- The choice of accommodation bonds or accommodation charges (with no cap on the charge) would enable providers to budget on an income commensurate with the capital cost of building or upgrading.
- The scaled concessional resident fee would provide the income to enable new buildings for concessional residents to become viable.
- As incomes and wealth of the aged increase over the coming years, Providers could improve the accommodation and services in line with those user expectations.

- Deregulation would bring the larger operators with more capital into the industry. This would enable facilities to be built faster as capital would be invested more readily.
- The care and accommodation model meets all of the five points the Pricing Review has to consider under its "Terms of Reference".
- This model meets all of the objects of Section 2 – 1 of the Aged Care Act 1997.
- Minimal changes would need to be made to the Aged Care Act to implement our recommendations.

We commend our submission to you and hope our pro-active approach to Residential Aged Care will influence the recommendations you make to the Minister.

Yours sincerely
AEGIS HEALTH CARE GROUP PTY LTD

GSW TAYLOR
Director

MC CROSS
Director

## AEGIS HEALTHCARE GROUP

## CAPITAL COST OF BUILDING AGED CARE FACILITIES

| Facility | Year Completed | Beds | New/Renovation | Floor Area $m^2$ | Building, Fees and Furnishing | Cost per Bed |
|---|---|---|---|---|---|---|
| 1 | 2000 (Stage 1) | 29 H/Care | Renovation | 2,990 | 1,685,000 | 58,013 |
| | | 27 L/Care | New | | 1,549,000 | 57,370 |
| | 2002 (Stage 2) | 31 H/Care | New | 1,969 | 1,548,600 | 51,620 |
| | | 16 L/Care | New | | 1,258,800 | 78,675 |
| 2 | 2000 | 36 L/Care | New | 2,331 | 2,821,131 | 78,365 |
| 3 | 2000 | 17 Low Care | New | | 1,420,000 | 83,529 |
| | | 44 H/Care | Renovation | | 2,220,000 | 50,455 |
| 4 | 2000 | 47 L/Care | New | 4,398 | 6,315,198 | 80,964 |
| | | 31 H/Care | New | | | 97,368 |
| 5 | 2003 | 45 L/Care | New | 2,678 | 4,381,578 | 97,368 |
| 6 | 2002 | 44 H/Care | New | 1,873 | 2,975,873 | 67,633 |
| 7 | 2002 | 7 L/Care | Renovation | | 652,400 | 93,200 |
| | 2003 | 25 L/Care | New | 1,170 | 1,791,170 | 71,647 |
| | | | | | 28,618,750 | |

*Table 4*