Australian Government

Department of Health and Ageing

Supplementary Submission to

the Senate Finance and Public Administration Committee *Inquiry into Residential and Community Aged Care in Australia*

from the Department of Health and Ageing

April 2009

TABLE OF CONTENTS

Executive Summary **5**

1 Are current funding levels sufficient to meet the expected quality service provision outcomes? **12**

1.1 Residential aged care 12
1.1.1 Aged care building activity 12
1.1.2 Aged care building approvals 15
1.1.3 Planned and completed building activity 17
1.1.4 Aged care construction costs 18
1.2 Community care packages 23

2 Does the current indexation formula recognise the actual cost of pricing aged care services to meet the expected level and quality of such services? **25**

2.1 Growth in Government Funding 25
2.2 Comparing growth in costs to growth in revenue 26
2.3 Methodological Discussion 27
2.3.1 Growth in unit costs 27
2.3.2 Productivity 28
2.3.3 Growth in unit revenues 29

3 How do current arrangements address regional variations in the cost of service delivery and the construction of aged care facilities? **30**

4 Are there inequities in user payments between different groups of aged care consumers and, if so, how are these inequities addressed? **32**

4.1 Residential aged care 32
4.1.1 Basic daily fee 32
4.1.2 Income tested fee 32
4.1.3 Accommodation payments 33
4.1.4 The payment of accommodation bonds 33

4.2 Community care packages 34
4.3 Other community care services 35
4.3.1 National Respite for Carers Program (NRCP) 35
4.3.2 Day Therapy Centre Program (DTC) 35
4.3.3 Residential Respite 35
4.3.4 Home and Community Care (HACC) 35
5 Is the current planning ratio between community, high and low-care places appropriate? 36
6 What is the impact of current and future residential places allocation and funding on the number and provision of community care places? 39

FIGURES

Figure 1: Building activity, Commencements, Aged care, Australia 5
Figure 2: Distribution of aged care construction costs (2009 prices) 6
Figure 3: Unit cost and revenue growth - low care* 7
Figure 4: Unit cost and revenue growth - high care* 8
Figure 5 Building activity, Commencements, Aged care, Australia 13
Figure 6: Building activity, Commencements, Aged care, New South Wales and Victoria ... 14
Figure 7: Building activity, Commencements, Aged care, Queensland and South Australia . 14
Figure 8: Building activity, Commencements, Aged care, Western Australia and Tasmania. 14
Figure 9: Building approvals, Aged care, Australia 15
Figure 10: Building approvals, Aged care, New South Wales and Victoria 16
Figure 11: Building approvals, Aged care, Queensland and South Australia 16
Figure 12: Building approvals, Aged care, Western Australia and Tasmania 16
Figure 13: Building approvals, Aged care, Australia, real and nominal prices 17
Figure 14: Number of additional residential places from building work completed, 2001 to 2008 18
Figure 15: Distribution of aged care construction costs (2009 prices) 19
Figure 16: Unit cost and revenue growth (constant frailty) – low care 26
Figure 17: Unit cost and revenue growth (constant frailty) - high care 27
Figure 18: Average accommodation bond for all new residents, by remoteness, 2007-08 30

Figure 19: Average cost of new building or rebuilding work per additional residential place in Major Cities compared with Regional and Remote areas, 2007-08 31

Figure 20: Total places required to meet targets 37

Figure 21: Operational and vacant places, residential aged care, 2001-02 to 2007-08 41

TABLES

Table 1: Summary of finding of the three surveys of residential aged care 22

Table 2: Ratio of number of applications for community care packages to number available, 2001 to 2008 23

Table 3: Growth in Government Aged Care Funding, 2008-09 26

Table 4: Community care package places, recipients and claim days, 2004 to 2008 39

Executive Summary

This supplementary submission provides responses to the terms of reference for the Senate Finance and Public Administration Committee *Inquiry into Residential and Community Aged Care in Australia*.

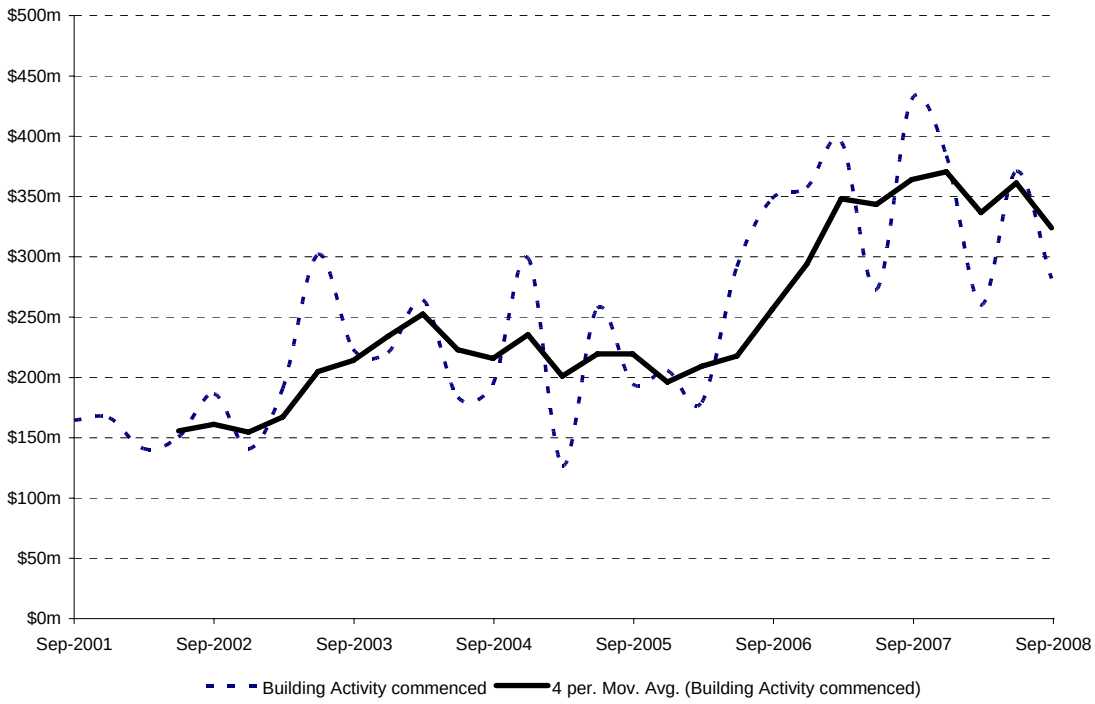
Are current funding levels sufficient to meet the expected quality service provision outcomes?

Indicators of funding levels in Residential Aged Care are examined.

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 (Figure 1).

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. In 2007-08, aged care providers indicated that 18,700 places were being planned for construction or upgrading, forming a strong pipeline of planned building activity.

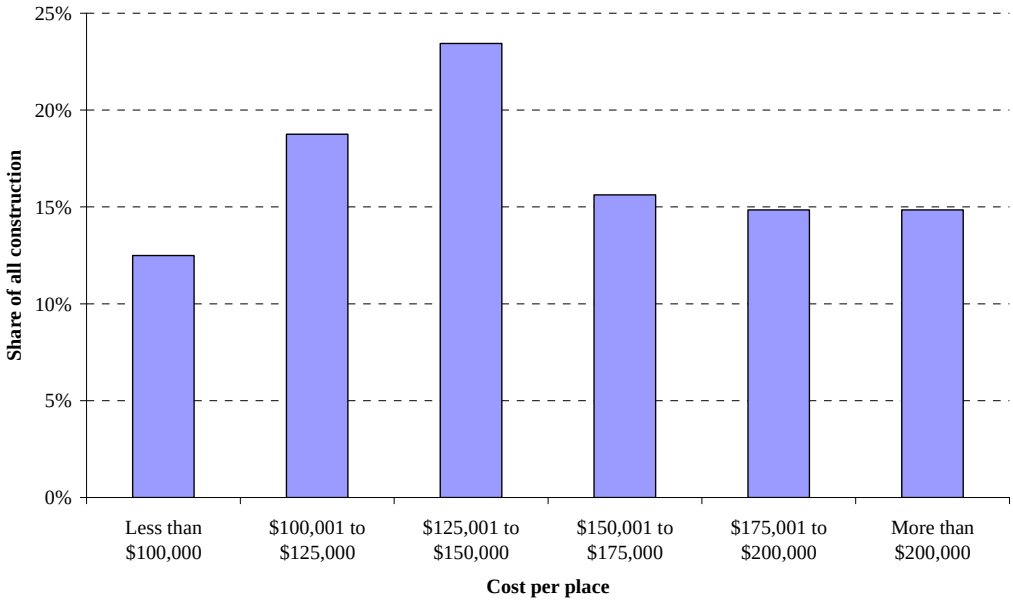
Figure 1: Building activity, Commencements, Aged care, Australia



Returns per resident for efficient providers, defined as the top quartile, increased between 2006-07 and 2007-08, supporting the evidence above that capital investment in the aged care sector is strong. The large preponderance of not-for-profit organisations may make theoretical average levels of return of questionable application for this industry.

Industry representatives have asserted that building costs in the sector are typically $180,000 per place or even higher. Figure 2 shows the average construction costs for new or rebuilt aged care homes is $155,000 per place. This cost is net of land as the Department sees this as an appreciating asset, not a depreciating capital cost.

Figure 2: Distribution of aged care construction costs (2009 prices)



The Department is monitoring the potential for the global financial crisis to weaken the aged care industry. There are a number of reasons to believe that aged care providers will be relatively (but certainly not completely) sheltered from the effects of the global financial crisis in comparison with other sectors in the economy. Impact on the aged care sector is mitigated because:

- The income stream in aged care is almost completely underwritten by government. The Government directly funds at least 82.5 per cent of all income to community care providers, and some 70 per cent of all income to the residential aged care sector in the form of subsidy payments.

- Resident contributions in residential aged care are further underwritten by the pension system and by aged care supplements.

- Demand for aged care is relatively non-discretionary.

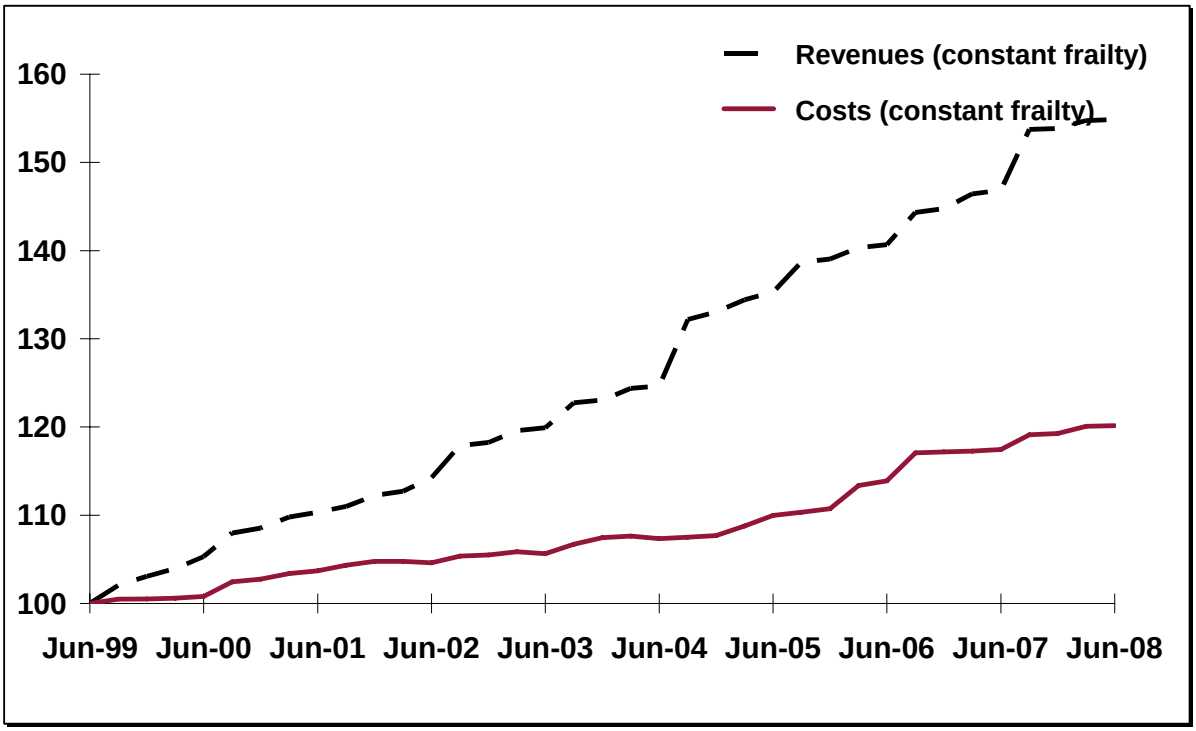
Does the current indexation formula recognise the actual cost of pricing aged care services to meet the expected level and quality of such services?

The Department of Health and Ageing has developed cost and revenue indices for high and low care providers to track the actual cost of pricing aged care services.

For both low and high care aged care homes, comparisons of costs and revenue indices over time show that the revenue index has increased at a greater rate than the costs index, since

1998-99. Figure 3 and Figure 4 show this comparison. The main difference between these indices and those quoted by industry is that the industry indices do not include the effects of productivity improvement, and therefore compare income with unit prices of labour rather than the sector's actual labour costs.

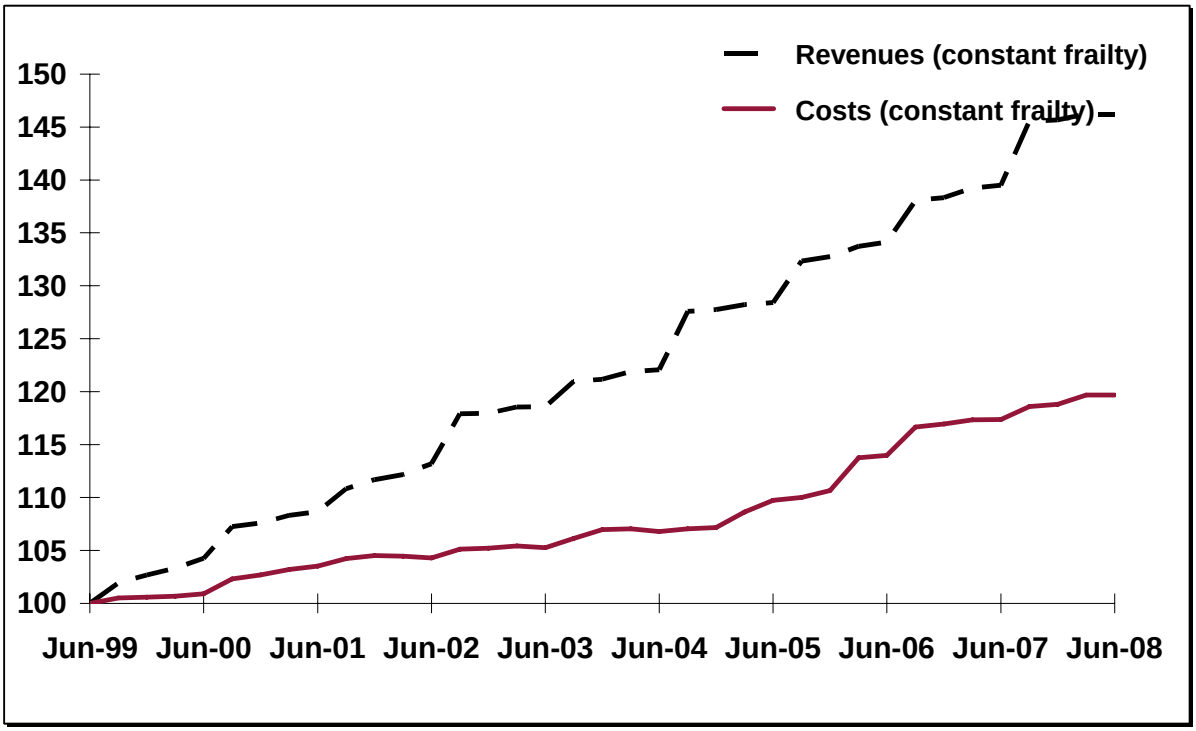
Figure 3: Unit cost and revenue growth - low care*



*The analysis is conducted on a constant frailty basis.

The data is presented on an index basis with revenue and costs levels for 1998-99 set to 100.

Figure 4: Unit cost and revenue growth - high care*



*The analysis is conducted on a constant frailty basis.

The data is presented on an index basis with revenue and costs levels for 1998-99 set to 100.

How do current arrangements address regional variations in the cost of service delivery and the construction of aged care facilities?

The Commonwealth Government provides capital funding targeted toward the development of infrastructure in rural and remote areas, including through the provision of capital grants and zero real interest loans. In 2007-08, $45 million in capital assistance was allocated to assist providers of residential care, with almost 80 per cent of this funding allocated in rural and remote areas. The 2008-09 Budget included a measure to provide $300 million in zero real interest loans.

To assist aged care services in rural and remote areas with the extra cost of delivering services, additional funding is made available through the viability supplement. In 2007-08, around $15 million was provided to care providers through this supplement.

Further details on these programs were provided in Section 4 of the Department's December submission to this Inquiry.

Are there inequities in user payments between different groups of aged care consumers and, if so, how are these inequities addressed?

The Commonwealth Government sets the maximum level of fees that aged care providers can levy on residents of Commonwealth-funded aged care homes and recipients of Commonwealth-funded community care packages. Within the regulated maximum fees, providers and residents negotiate the actual fees paid.

More equitable arrangements in relation to fees and charges for new aged care residents were introduced in March 2008. These reforms removed differentials in how fees and charges were calculated between self-funded retirees and those receiving a full or part pension. These reforms have also seen those who can afford it being asked to pay more toward their accommodation, while the level of Government payments has increased for those who cannot meet the costs themselves.

The maximum basic daily fee for all residents (post-March 2008) is 85 per cent of the single basic age pension ($467.74 per fortnight as at March 2009). An income tested fee is then paid by those with substantial income. This fee reduces government expenditure rather than accruing to care providers - it is used to make the cost of aged care more sustainable to taxpayers. This income tested fee has a maximum set equal to 5/12 of the resident's total assessable income in excess of the maximum income of a full single pensioner.

Bonds may be charged of certain residents in low care but not in high care. The payment of the bond typically requires significant rearranging of the financial affairs of the resident. This is more consistent with a longer term accommodation change than a short, health-related transition.

In relation to the differential arrangements in user charging between low care and high care, the Department submits the following facts:

- In 2007-08, over half of people that entered high care residential care for the first time came from hospital (56%). For low care this figure is around half of this level (27%).
- Of the people admitted to residential high care in 2007-08, 40 per cent had been discharged or died within six months. For low care this was significantly lower, with 17 per cent being discharged or dying within six months.

This data suggests that for many people entering high care it is at a time of health crisis rather than one which is typified by a long term accommodation choice.

Is the current planning ratio between community, high and low-care places appropriate?

The Review of Pricing Arrangements Residential Aged Care ('the Hogan Review') recommended that the Commonwealth Government increase the aged care provision ratio to reflect the increasing frailty in older populations and to re-weight the planning ratios toward community care. The ratios were revised in 2004 and again in 2007, when both the community care ratio and residential high care ratio were increased.

The current planning target ratio is 113 places per 1,000 people aged 70 years or older, comprising of 88 residential places (44 high care places/44 low care places) and 25 community care places. Community care provision continues to grow strongly.

Within residential care there is considerable flexibility between low and high care. The high care and low care ratios are used for planning purposes and seek to ensure that places are available for residents who need either high or low care on admission. Half of all residents

entering care for the first time are low care. "Ageing in place" as a policy was designed to enable residents to remain in the same environment as their care needs increased. It is evident this is occurring. As at 30 June 2008, some 69 per cent of residents in aged care homes were receiving high level care.

The implementation of the Aged Care Funding Instrument (the ACFI) ensures that providers are funded on the basis of the care needs of their clients.

Taken together, the planning arrangements ensure access for both low and high care residents, while funding arrangements give flexibility to meet the changing needs of residents who are already in care.

In summary, policy over the last decade has consistently emphasised relative growth in care at home and both flexibility and the capacity for enduring care in the residential care setting.

The Government has announced a review of aged care planning ratios that will take into account changing demographics and planning processes.

What is the impact of current and future residential places allocation and funding on the number and provision of community care places?

In recognition of the desire by frail older people to remain in their own home as an alternative to low or high level residential care, the Commonwealth Government has been increasing the number of available community care package places over the last decade, while also increasing residential care in line with growth in the older population.

The Department considers that the overriding dynamic in explaining vacancy levels in aged care currently is not one of competition between care types, but of rapid growth in care places leading to temporary vacancies.

The faster the growth in places, the greater is the vacancy rate, simply because it takes time for newly created community care places or newly built aged care homes to fill up. There is also a short-run impact on neighbouring services.

It is the Government's intention to facilitate choice and to continue to emphasise growth in care at home. Sufficient vacancies in both community and residential care ensure people can get a place in the care of their choice without undue delay; with providers competing amongst each other to attract customers on the basis of quality of care and amenity.

1 Are current funding levels sufficient to meet the expected quality service provision outcomes?

1.1 Residential aged care

This section examines several indicators of the adequacy of current funding levels in residential aged care.

The first set of indicators examine the stages and extent of capital investment in the aged care industry. The most reliable independent trailing indicator of investment sentiment is the level of building activity commencing in the aged care sector – see Section 1.2.1. A number of leading indicators of investment sentiment are also available. These include the level of building approvals in the aged care sector (Section 1.2.2) and the level of planned building activity (Section 1.2.3).

The second set of indicators describe the actual returns earned by efficient providers to determine whether those levels are sufficient to allow providers to meet expected quality service outcomes while returning a reasonable return on investment – see Section 1.2.4.

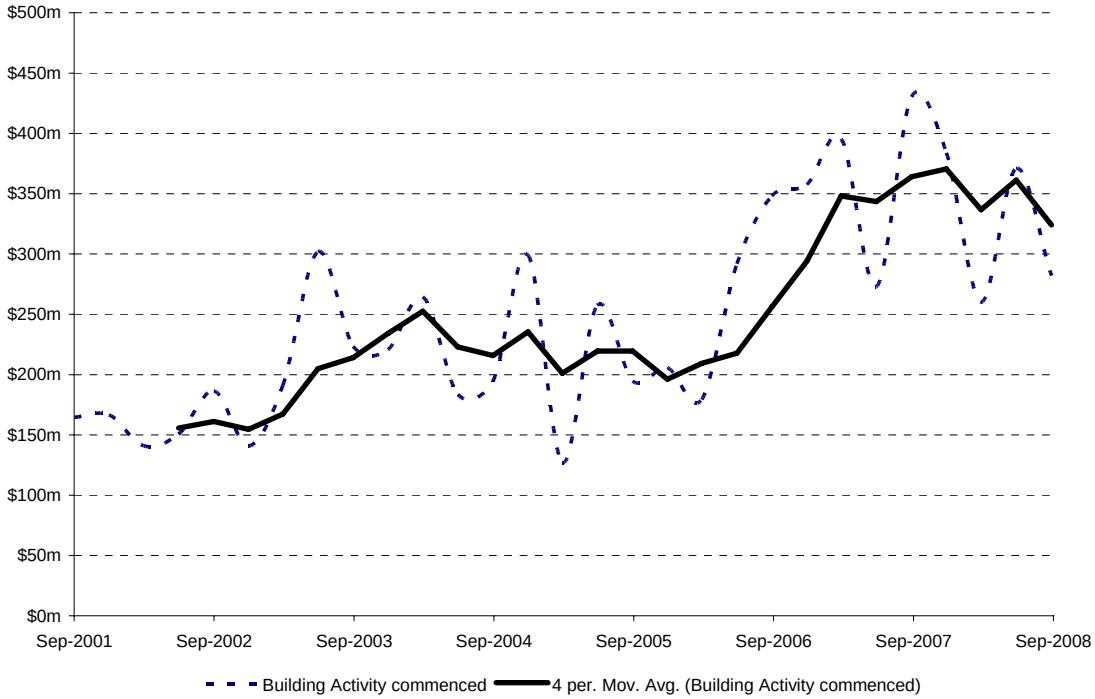
1.1.1 Aged care building activity

The Australian Bureau of Statistics (ABS) publishes quarterly estimates of the level of building activity in various sectors, based on building approval details and returns collected from builders and other organisations engaged in building activity. It has published separate statistics for the residential aged care sector since the September Quarter 2001. These estimates provide a robust trailing indicator of investment activity and sentiment.[1]

Figure 5 illustrates the level of aged care building work commenced in each quarter in Australia over the last decade. It also illustrates the trend in this activity – the trend line represents the yearly average of the quarterly levels of building activity.

[1] See: ABS, *Building Activity, Australia, September 2008* (Cat. 8752.0), Canberra: ABS, 2009.

Figure 5 Building activity, Commencements, Aged care, Australia



The trend estimates for the value of building commencements for Australia show a rise in the value of aged care building commencements over the period from the September Quarter 2001 to the June Quarter 2003 to a plateau of about $226 million per quarter that was maintained until the June Quarter 2006. The data then shows a further increase to the March Quarter 2007 to a new plateau of about $342 million per quarter.

In general, as the following charts show, similar patterns are observed in the yearly averages of the quarterly levels of building activity in each state. In all of the states, the value of aged care building commencements has increased over the period for which statistics have been collected. Caution needs to be exercised in drawing conclusions from the smaller states given the lumpiness of building activity and for this reason the statistics for the territories are not presented.

Figure 6: Building activity, Commencements, Aged care, New South Wales and Victoria

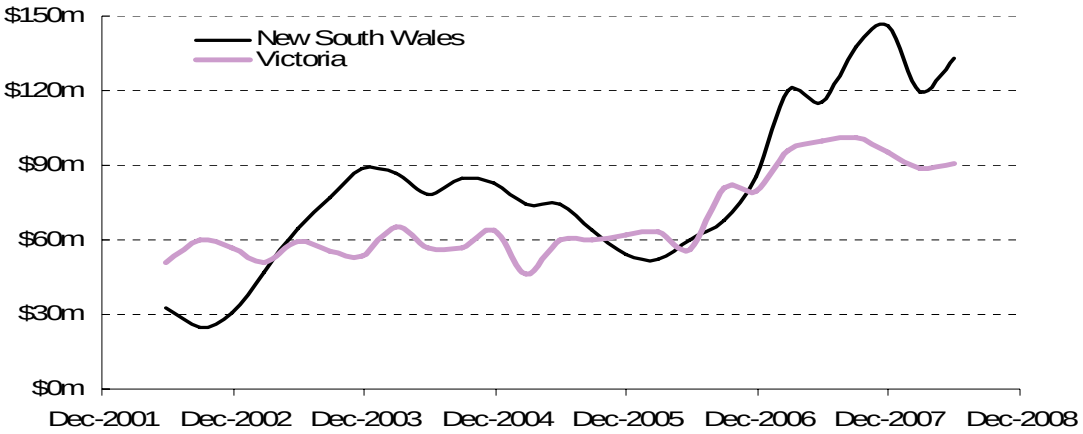


Figure 7: Building activity, Commencements, Aged care, Queensland and South Australia

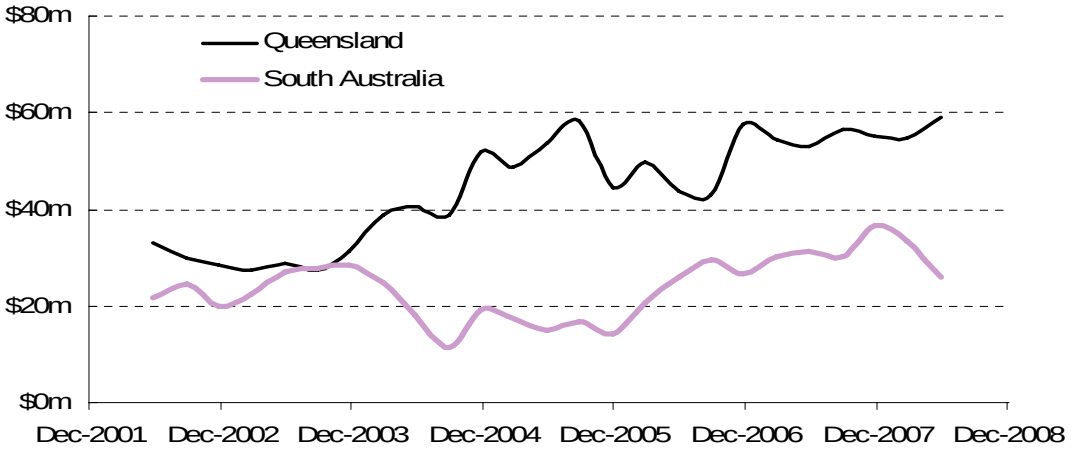
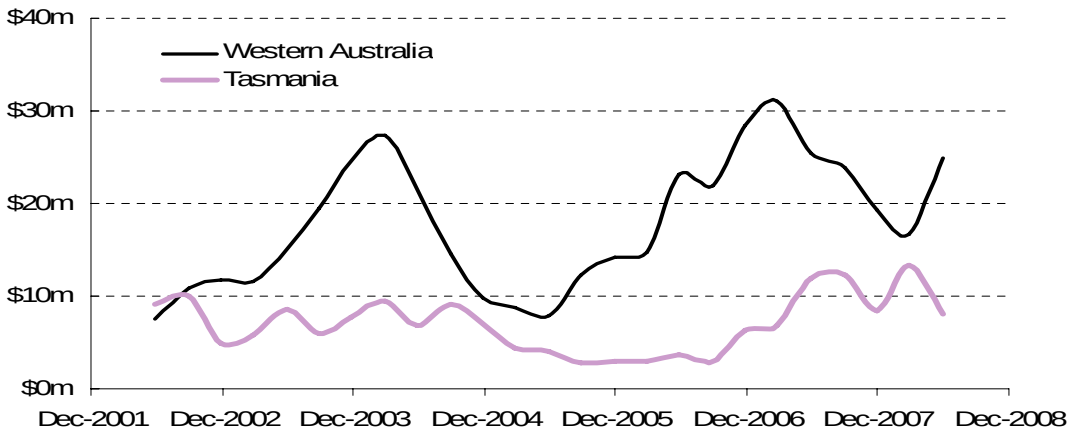


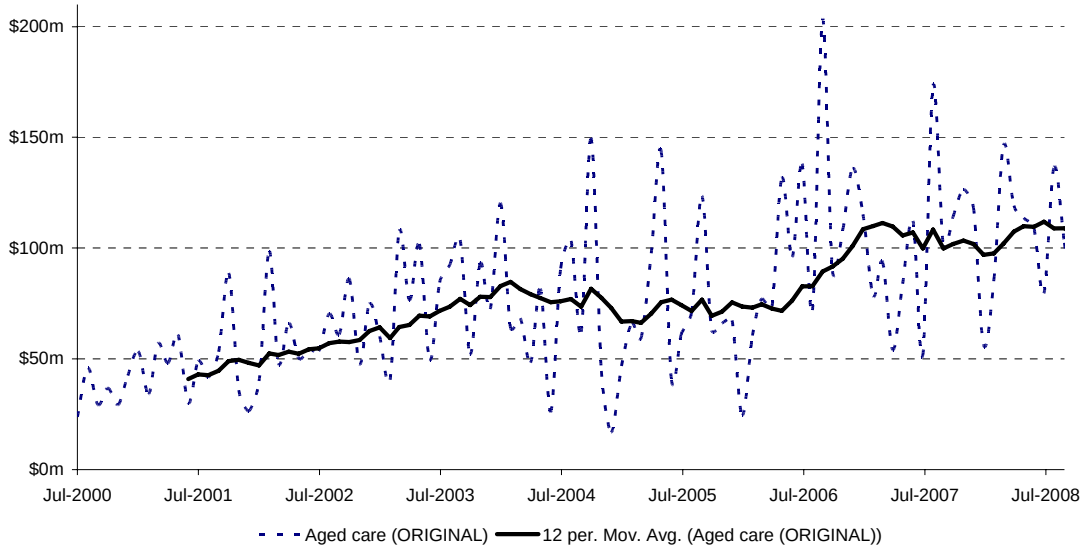
Figure 8: Building activity, Commencements, Aged care, Western Australia and Tasmania



1.1.2 Aged care building approvals

Building approvals by local councils and other authorising bodies are a leading indicator of investment activity. The ABS publishes monthly estimates of the amount of building work approved in various industries, based on permits issued by local government authorities and other principal certifying authorities. The scope of the survey includes the construction of new buildings, alterations and additions to existing buildings, approved non-structural renovation and refurbishment work, and approved installation of integral building fixtures. The ABS has published separate statistics for the residential aged care industry since July 2000.[2] Figure 9 illustrates the value of aged care building work approved in Australia over the last decade.

Figure 9: Building approvals, Aged care, Australia



The trend line, which represents the average monthly level of aged care building approvals over the previous twelve months, shows a gradual rise in the value of aged care buildings approved from January 2000 to December 2003 followed by a levelling off from January 2004 to July 2006 (with aged care building approvals averaging $77 million per month over that 24 month period). The level of aged care building approvals then rose again until July 2007 after which it plateaued again at a higher level (with aged care building approvals averaging $100 million per month over the eighteen months period from July 2007 to December 2008).

In general, as the following charts show, similar patterns are observed in the state average monthly level of aged care building approvals in each state. In all of the states, the value of building approvals for aged care has increased in the period from 2000 to 2008.

[2] See: ABS, *Building Approvals, Australia, January 2009* (Cat. 8731.0), Canberra: ABS, 2009.

Figure 10: Building approvals, Aged care, New South Wales and Victoria

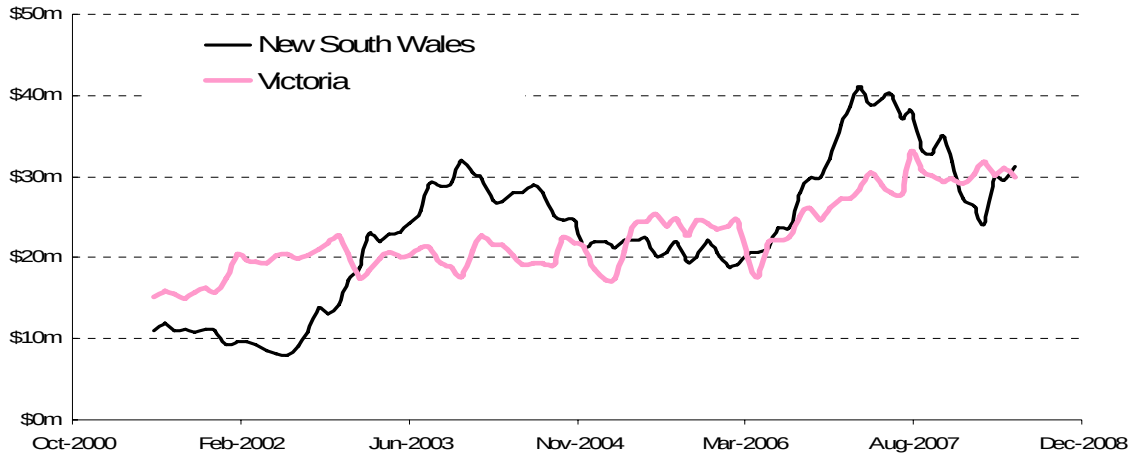


Figure 11: Building approvals, Aged care, Queensland and South Australia

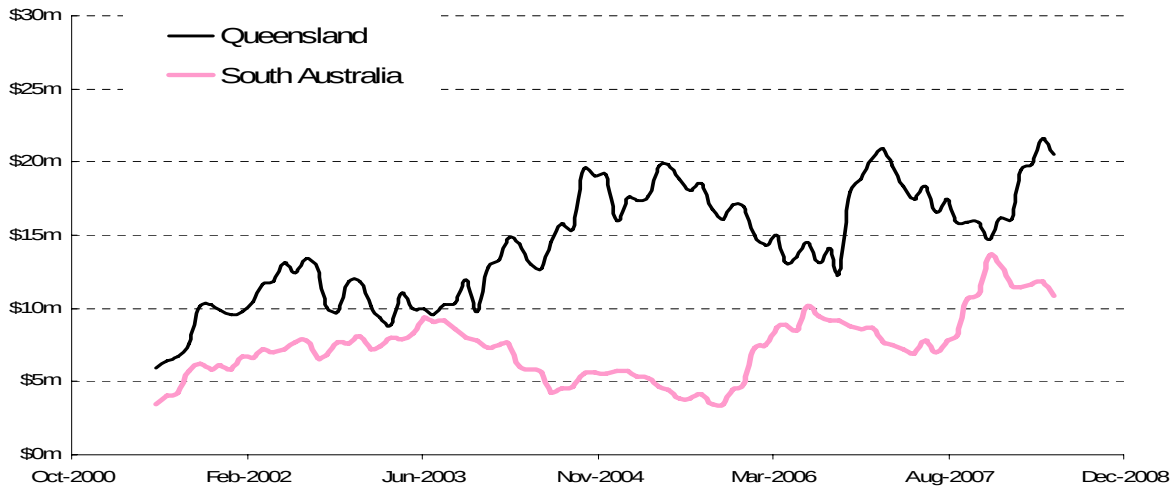
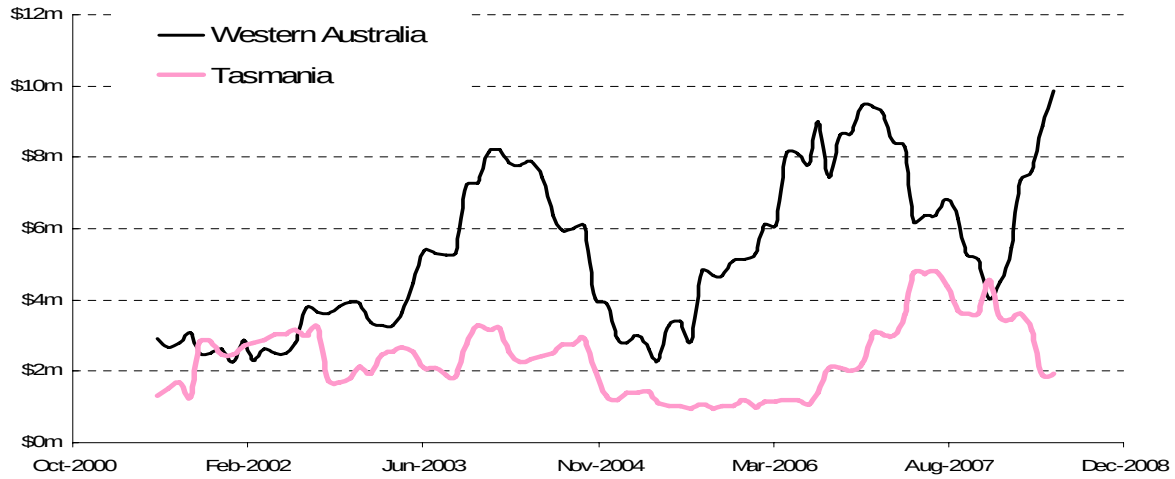
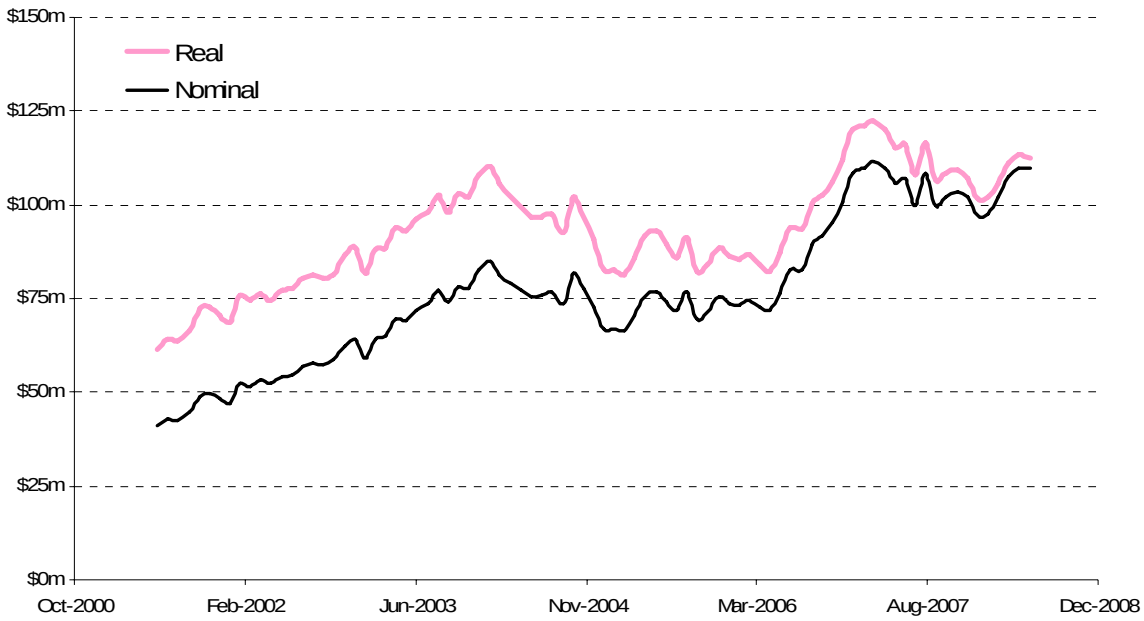


Figure 12: Building approvals, Aged care, Western Australia and Tasmania



The ABS collects its building approval statistics in nominal terms and so some of the growth in building approvals may be the result of price inflation. To address this issue the Department has developed an aged care construction cost deflator.[3] Figure 13 illustrates the growth in the level of building approvals across Australia in both nominal and real terms (with prices expressed in 2009 dollars). Even after adjusting for the increase in aged care building costs over this period, the trend estimates for the real value of building approvals still shows a substantial increase over the period from 2000 to 2008.

Figure 13: Building approvals, Aged care, Australia, real and nominal prices



1.1.3 Planned and completed building activity

The Department of Health and Ageing conducts an annual survey of aged care homes, including of building activity that has been recently completed, is underway or is planned.[4]

In the 2007-08 Survey, aged care providers indicated that 18,700 places were being planned for construction or upgrading. While this 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. Thus the planned work will form a significant pipeline of building activity in coming years.

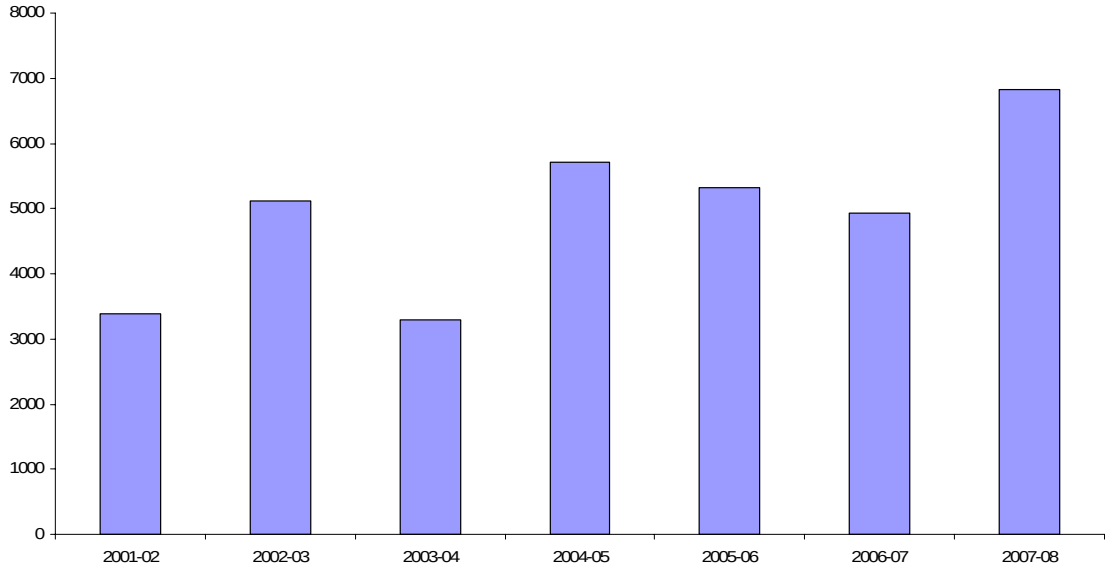
---

[3] The Department estimates that aged care building costs have risen by 5.5 per cent on average over the last decade, based on the construction costs estimates in Rawlinsons, *Construction Cost Guide*, Perth: Rawlinsons, 1993 to 2009.

[4] Department of Health and Ageing, *Report on the Operations of the Aged Care Act*, Canberra: Department of Health and Ageing, various editions, 1999 to 2008.

In 2007-08, the latest available data, the number of additional residential places coming available through completed building work was at the highest level this decade. Building work completed in 2007-08 resulted in 6,835 additional residential places for the sector, a sharp rise of 38.4 per cent on the additional places completed in 2006-07 (see Figure 14). In addition, there were an additional 8,024 residential places currently being built.

Figure 14: Number of additional residential places from building work completed, 2001 to 2008



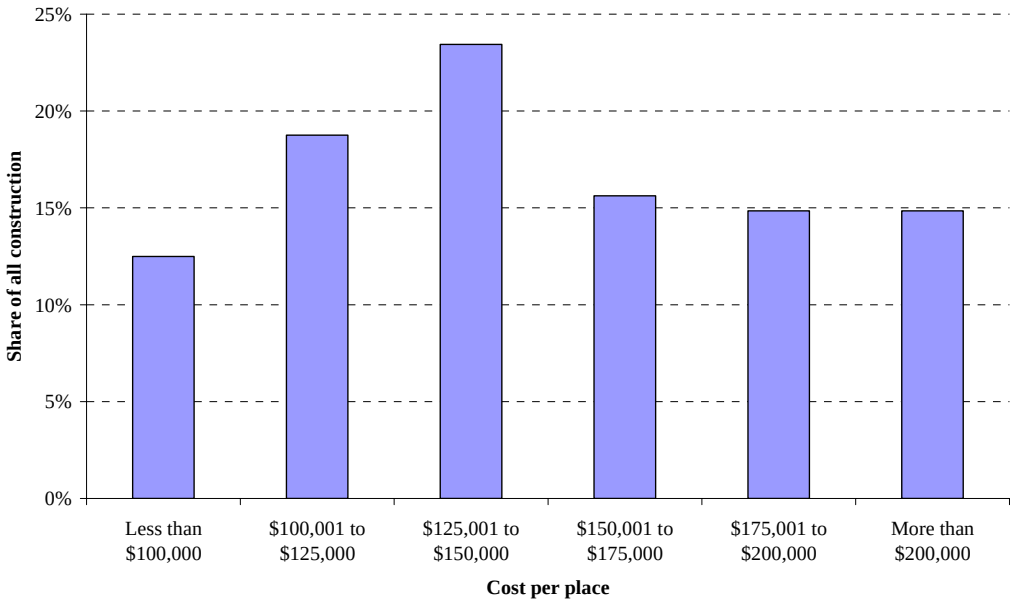
1.1.4 Aged care construction costs

Industry representatives have asserted that building costs in the sector are typically $180,000 per place or even higher.

The Department of Health and Ageing has derived estimates of the full cost of constructing an aged care home based on the results of the Department's 2007 and 2008 surveys of aged care building activity. In total, 128 construction projects for new or rebuilt aged care homes were reported in those two surveys. Figure 15 illustrates the distribution of those projects, on a cost per place basis, with all project costs converted to a 2009 cost basis. The median cost of construction of these projects was $150,000 per place.

The average construction cost of the projects is very similar to the median cost at $155,000 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, with many of these being constructed as extra service aged care homes or to a design specification well in excess of the current aged care building certification standards. 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 building certification minimum standards, including many developments composed entirely of single rooms with ensuites.

Figure 15: Distribution of aged care construction costs (2009 prices)



Independent surveys of returns earned by residential aged care providers

The following three organisations have conducted independent surveys of aged care homes:

Bentleys MRI

Bentleys / James Underwood and Associates have conducted a *National Residential Aged Care Survey* each year since 1994-95, except for 2001-02 when the *Review of Pricing Arrangements in Residential Care* conducted a similar survey. The 2007-08 Survey was conducted by just Bentley's MRI. The Surveys have had participation rate of about 240-280 services.

Bentleys provide the most detailed annual reports and data sets which can be used in longitudinal analysis of such issues as wages and other operational costs.

Bentleys have not yet published their 2008 Survey report but they have provided the de-identified data sets on the financial and staffing results for the 2007-08 financial year.

Stewart Brown & Co

Stewart Brown Aged Care Financial Services conducts a quarterly *Aged Care Financial Performance Survey* of about 280 aged care homes. Quarterly surveys have been conducted each year since 1997 and the reports are therefore able to provide a longitudinal perspective to their analysis of the data.

The June Survey of each year reports the financial performance over the previous financial year while the quarterly reports on performance for the current financial year to date.

Stewart Brown has provided de-identified Survey data which has been combined with other available data to prepare detailed performance reports for use by the Department.

Grant Thornton Australia Ltd

Grant Thornton conducted a survey of aged care homes in 2008 with the participation of about 700 homes. This is the first time that Grant Thornton has conducted a survey of aged care homes.

Grant Thornton was asked to provide the de-identified unit record data of their survey to the Department to examine the representativeness of their survey sample, but they declined to provide that data.

Current level of average returns earned by residential aged care providers

The three surveys discussed above provide evidence on the average returns in the residential aged care industry:

- The Stewart Brown survey found that the average EBITDA (Earnings Before Interest, Tax, Depreciation and Amortisation) of the aged care homes in their survey was $3,695 per resident per year in 2006-07 and $4,020 per resident per year in 2007-08. (Sample size: 253 aged care homes in 2006-07 and 282 aged care homes in 2007-08). This equates to a 9 per cent increase from 2006-07.
- The Bentleys / James Underwood and Associates survey in respect of 2006-07 and Bentleys MRI survey in respect of 2007-08 found that the average EBITDA of the aged care homes in their survey was $4,181 per resident per year in 2006-07 and $4,952 per resident per year in 2007-08. (Sample size: 280 aged care homes in 2006-07 and 238 aged care homes in 2007-08). This equates to an 18 per cent increase from 2006-07.
- The Grant Thornton survey found that the average EBITDA of the aged care homes in their survey was $3,211 per resident per year in 2006-07 and $2,934 per resident per year in 2007-08. (Sample size: 700 aged care homes in 2007-08). This equates to a 9 per cent decrease from 2006-07.

Current level of returns earned by efficient residential aged care providers

Given the persistent high levels of inefficiency in the residential care industry, the issue is not whether average returns in the industry are sufficient to allow providers to make a reasonable return on their investment but rather whether funding levels are sufficient to allow efficient providers to make a reasonable return on their investment.

- The Stewart Brown survey found that the average EBITDA of the aged care homes in the top quartile of their survey was $9,492 per resident per year in 2007-08, some 52 per cent higher than in 2006-07.
- The Bentleys / James Underwood and Associates survey in respect of 2006-07 and by Bentleys MRI survey in respect of 2007-08 found that the average EBITDA of the aged care homes in the top quartile of their survey was $12,034 per resident per year in 2007-08, some 10 per cent higher than in 2006-07.
- The Grant Thornton survey found that the average EBITDA of the aged care homes in the top quartile of their survey was $7,247 per resident per year for high care homes and $7,513 per resident per year for low care homes in 2007-08.

These results help explain why the available empirical evidence demonstrates that capital investment in the aged care sector has been strong to date.

Comparison of findings

The Stewart Brown and Bentleys surveys both found that there was a general improvement in financial performance in 2007-08 compared to 2006-07. The 2007-08 general purpose financial reports, which have been provided to the Department by all aged care providers, have also reported a general improvement in the financial performance in 2007-08. By contrast, the Grant Thornton survey alone found a substantial deterioration in the financial performance of aged care services in the 2007-08 financial year.

Table 1 on the following page provides a summary of the main findings of each of the three surveys on the financial performance of the aged care industry.

The Department again notes its concerns with the representativeness of the Grant Thornton survey sample. The data has not been made available to the Departments for verification despite requests.

Table 1: Summary of finding of the three surveys of residential aged care

Measure	Bentleys MRI/James Underwood	Stewart Brown	Grant Thornton
All Services: 2007-08 average EBITDA per bed per annum	• $4,315 pbpa for high care • $4,963 pbpa for low care • **$4,952 pbpa for all services**	• $3,444 pbpa for high care • $4,308 pbpa for low care • **$4,020 pbpa for all services**	• $3,189 pbpa for high care • $3,331 pbpa for low care • $2,394 pbpa for mixed care • **$2,934 pbpa for all services**
All Services: Increase from 2006-07 to 2007-08 in average EBITDA per bed	• 12% increase for high care • 19% increase for low care • **18% increase for all services**	• 78% increase of for high care • 11% decrease for low care • **9% increase for all services**	• **9% decrease for all services**
Top quartile: 2007-08 EBITDA per bed per annum	• $13,838 pbpa for high care • $11,690 pbpa for low care • **$12,034 pbpa for all services**	• $9,492 pbpa for high care • $9,658 pbpa for low care • **$9,603 pbpa for all services**	• $7,247 pbpa for high care • $7,513 pbpa for low care • $5,681 pbpa for mixed care • **n/a for all services**
Top quartile: Increase from 2006-07 to 2007-08 in average EBITDA per bed	• 10% increase for high care • 15% increase for low care • **10% increase for all services**	• 52% increase of for high care • 9% increase for low care • **20% increase for all services**	• **na**
Top Quartile: Average EBITDA by Ownership	• $11,419 pbpa for Not-for-Profit homes in 2007-08. • $15,390 pbpa for For-Profit homes in 2007-08.	• na	• na

EBITDA = Earnings before interest, tax, depreciation and amortisation **pbpa** = per bed per annum

1.2 Community care packages

The level of data available on costs and income in residential care is not available for community care. The community care sector has significantly lower capital costs and its financial health is therefore more about cash flow than ability to service costs of capital. In the absence of other data, a surrogate indicator is the extent to which providers are willing to apply for Commonwealth funded aged care places. As Table 2 illustrates, the level of interest in joining the industry or in expanding current operations remains consistently high in community care.

Table 2: Ratio of number of applications for community care packages to number available, 2001 to 2008

Year	*Number of places available*	*Number of places sought*	***Ratio sought/ available***
2001	1,711	15,399	**9.0**
2002	982	8,838	**9.0**
2003	1,411	15,470	**11.0**
2004	2,920	33,038	**11.3**
2005	5,969	49,115	**8.2**
2006	3,193	3,2055	**10.0**
2007	3,993	40,185	**10.1**
2008	2,784	27,039+	**9.7**

1.3 Potential impact of the Global Financial Crisis on aged care.

The current global financial crisis is providing new challenges to all sectors of the economy.

There are a number of reasons to believe that aged care providers are relatively (but certainly not completely) sheltered from the effects of the global financial crisis.

First, the income stream in aged care is almost completely underwritten by government. The Government directly funds at least 82.5 per cent of all income to community care providers, and some 70 per cent of all income to the residential aged care sector in the form of subsidy payments.

Second, resident contributions in residential aged care are further underwritten by the pension system and by aged care supplements.

- The largest resident contribution is the basic daily care fee which is equivalent to 85 per cent of the single rate of pension. The aged pension underpins the capacity of residents to pay this fee, and also underpins the capacity to pay of residents whose private investments are affected by the global financial crisis resulting in a reduction in private income, to the extent that they may become part pensioners or see an increase in their means tested pension.

- Furthermore, in both high and low care, residents may be charged an accommodation charge or bond which is asset tested. To the extent that new entrants to aged care have reduced assets as a result of the global financial crisis, the Commonwealth Government

will pay a higher accommodation supplement. In high care, all residents are worth the same amount to the provider for accommodation related payments as a result of this system, because either the resident pays the contribution, or the government pays it, or the contribution is shared, depending on the means of the resident.

- Only in low care is there a risk of reduced bond receipts during the global financial crisis (as large bonds may return more to the provider than the accommodation supplement), but even here the supplement puts a floor under this potential impact.

- While fees may be charged in community care, not all providers choose to do so, and as the maximum fee is set at 17.5 per cent of the single rate of pension, as noted above at least 82.5 per cent of income received is directly funded by Government.

Third, consumer demand for aged care is not expected to decrease very significantly as a result of the global financial crisis. This is both because there is little effect on the access of the consumer from any changes in their income or assets, as described above, and because for many people aged care is not their first choice, but a necessary transition because of increasing care needs. Consumer demand is relatively inelastic.

Nevertheless, aged care providers will clearly be affected by a number of factors that are influencing all sectors during the global financial crisis, including access to debt financing to undertake new residential care developments and the level of income received from their investments. The Department is continuing to monitor the sector closely.

2 Does the current indexation formula recognise the actual cost of pricing aged care services to meet the expected level and quality of such services?

2.1 Growth in Government Funding

The Government has provided substantial increases in funding for residential aged care. The expenditure in 2008-09 is estimated to be $6.7 billion which represents an increase of some 10.8 per cent over the expenditure of $6.0 billion in 2007-08.

In 2008-09, Government funding for each day a resident spends in residential care will be about 8 per cent more than it was in 2007-08 for a resident of the same level of frailty. This growth reflects the increases in funding accompanying the implementation of the new Aged Care Funding Instrument (ACFI) and funding changes to accommodation charges and supplements introduced on 20 March 2008.

As well as the introduction of the ACFI, the Government made changes to enable increases in accommodation payments – both government subsidies and user contributions – particularly in high care.

Overall these changes will deliver increased revenue to the residential care sector of more than $750 million over four years, including more than $480 million in increased government subsidies. In 2008-09, the changes will result in an increase from the Commonwealth of more than $267 million in residential care funding. Once fully phased in the changes will deliver more than $350 million per year in increased revenue, mostly in respect of high care residents, to support investment in high care facilities.

The growth in Government funding to the residential aged care sector reflects indexation and the Conditional Adjustment Payment, population growth, increases in frailty and changes in policy. Leaving growth in numbers of residents assisted to one side, net funding growth has been 8% per resident. The contribution of various factors to this total growth is shown in Table 3. The component relating to new policy predominantly flows from the 20 March 2008 policy changes.

Table 3: Growth in Government Aged Care Funding, 2008-09

	2008-09 Growth
Indexation	28%
CAP	18%
Frailty growth	17%
New Policy	37%
Total	**100%**

2.2 Comparing growth in costs to growth in revenue

The issue of whether or not the revenues of efficient providers have kept pace with their costs can be resolved by comparing the growth in revenue indices with the growth in cost indices. Figure 16 compares the growth in costs (accounting for productivity improvements) and revenues for low care aged care homes. The data is presented on an index basis with revenue and cost levels for 1998-99 set to 100.

Figure 16: Unit cost and revenue growth (constant frailty) – low care

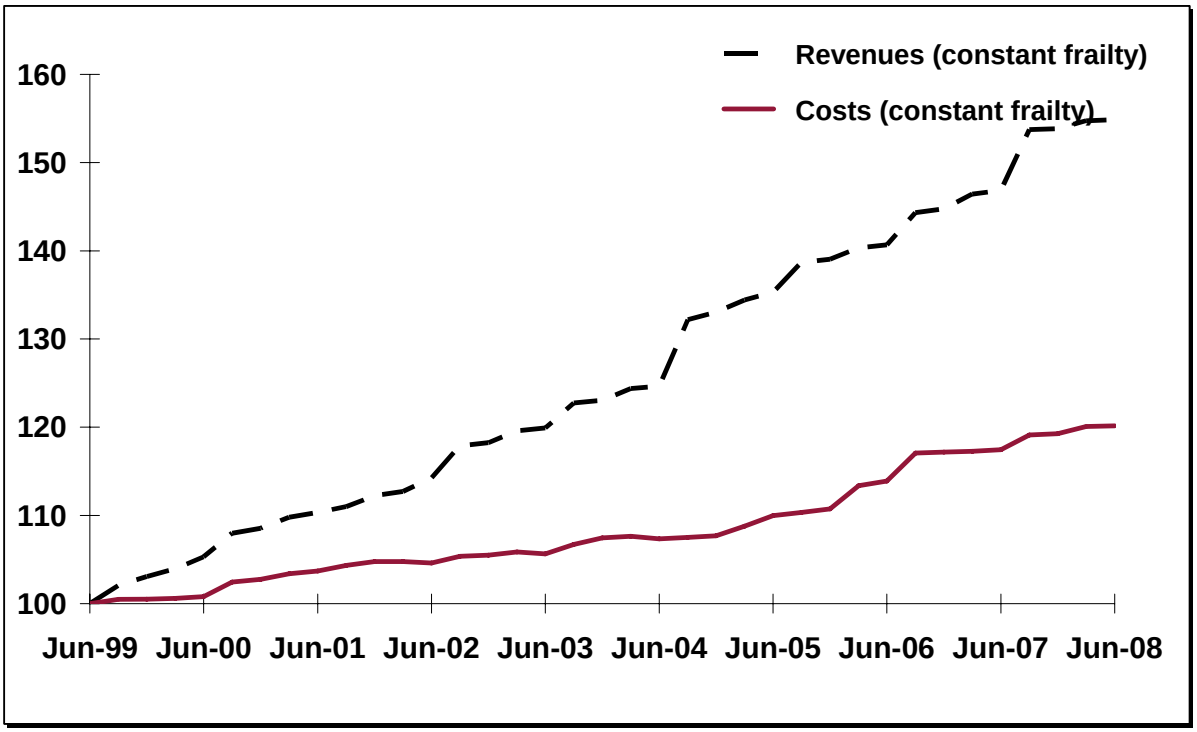
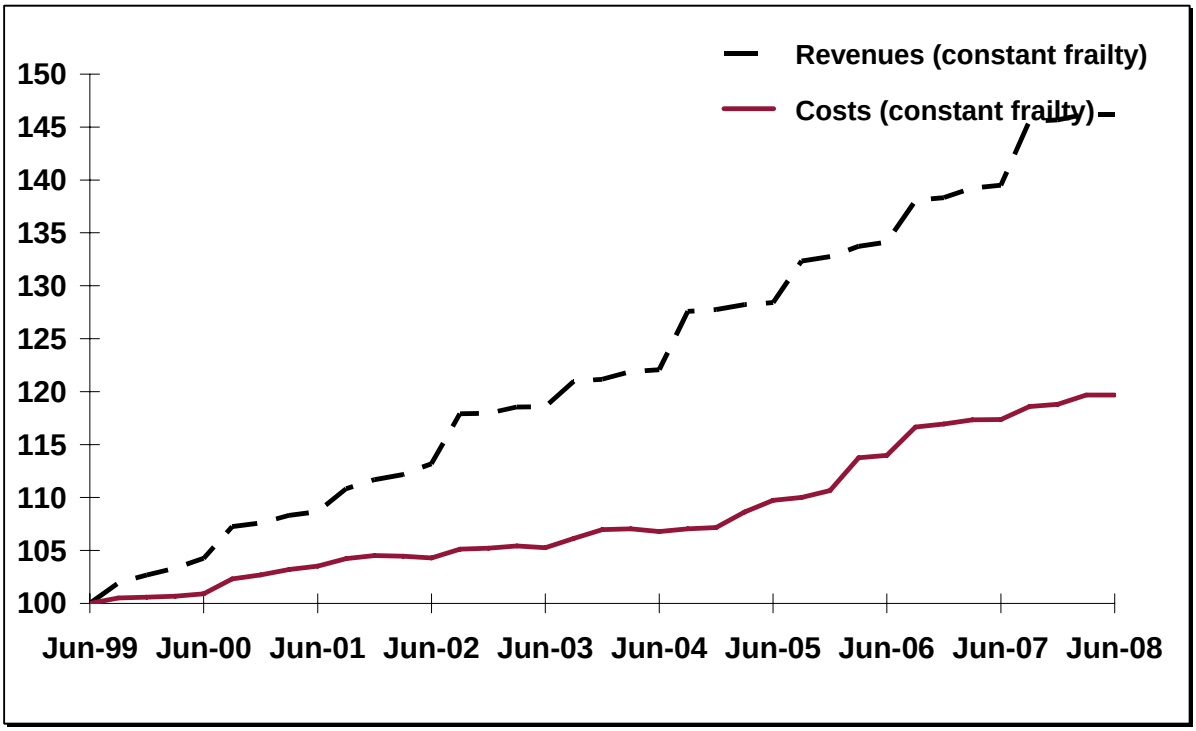


Figure 17 similarly compares the growth in costs (accounting for productivity improvements) and revenues for high care aged care homes. The data is again presented on an index basis with revenue and cost levels for 1998-99 set to 100.

Figure 17: Unit cost and revenue growth (constant frailty) - high care



The methodology behind the cost and revenue indices used in these figures is described below.

The main difference between these indices and those quoted by industry is that the industry indices do not include the effects of productivity improvement, and therefore compare income with unit prices of labour rather than the sector's actual labour costs.

2.3 Methodological Discussion

2.3.1 Growth in unit costs

The Department has developed unit cost indices that track typical growth in residential aged care costs. These indices reflect weighted averages over time of costs incurred by residential aged care providers from estimates of the cost structure of delivering residential care (both levels and changes over time) and changes in costs over time for various types of goods and services (including various labour costs).

The cost indices are about the cost of producing a day of care and not about the prices for the inputs required to produce that day of care. The indices are on a per resident basis, which removes any issues arising from change in client numbers. The indices also hold frailty constant so as to ensure that costs or revenue are not affected by changes in frailty.

2.3.2 Productivity

As noted above, the growth in unit cost must be moderated by growth in productivity to determine the actual labour costs. Therefore the Department has also constructed labour costs indices to estimate the labour productivity.

Averaged over the nine years to June 2007, the Department estimates that labour productivity in residential aged care has risen by 1.7 per cent per annum. This is considered to be a conservative estimate of labour productivity as the apparent decline in productivity in the year to June 2007 is likely to be due to a sampling error and is not consistent with the estimates of labour productivity growth that can be derived from the 2003 and 2007 workforce surveys.

An analysis of the two surveys of the residential aged care workforce conducted in 2003 and 2007 by the National Institute of Labour Studies shows that:

- the number of employees grew by 11.5 per cent (from 156,823 to 174,866);
- the number of full-time-equivalent direct care workers (including personal carers, allied health workers, and enrolled and registered nurses) grew by 3.7 per cent (from 76,006 to 78,849), while the total number of direct care workers employed rose by 15.3 per cent (from 115,660 to 133,314); and
- the number of full-time-equivalent nurses employed in the industry declined by 15.1 per cent (from 27,210 to 23,103), while the total number of nurses employed declined by 2.3 per cent (from 39,623 to 38,692).

At the same time the number of residents in care grew by 9.9 per cent (from 143,965 to 158,233) and the proportion of residents with higher levels of frailty rose substantially.

These movements over the four years can be quantified as a decline of two per cent in the weighted mix of labour inputs and a rise of five per cent in the weighted mix of outputs – an overall increase in productivity of seven per cent in total, or an average rise of 1.7 per cent per annum.

There is no evidence that this adjustment to a less costly workforce was at the expense of the quality of care. No negative trends in compliance or quality of care have been detected despite the increase in the number of visits, both announced and unannounced, to aged care homes in recent years. Nevertheless, there must be a limit to the extent of such substitution that can occur in the industry so that it is possible that growth in labour productivity will begin to mitigate at some time in the future.

The labour productivity achieved in the residential aged care industry can be compared with labour productivity growth in other sectors. Over the equivalent time period, labour productivity growth across all industries averaged 1.8 per cent per annum, while labour productivity growth in the health and community services sector averaged 1.1 per cent per

annum.[5] That is, labour productivity growth in residential aged care has been a little below the all industry average in Australia, but the sector has performed better than some other elements of health and community services industry.

2.3.3 Growth in unit revenues

The Department has also developed indices that track typical growth in residential aged care revenues. These indices have been designed and calculated to monitor changes in revenues over time in the residential aged care industry. They reflect weighted averages over time of all revenues earned by residential aged care providers that are directly relevant to the provision of aged care services. Revenues that do not directly relate to providing aged care (such as renting out for some other purpose property owned by the providers) are not included in the indices.

The revenue indices are derived from two broad sets of information: revenue levels over time for government subsidies and resident fees and relative contributions over time of different revenue streams in the delivery of high care and low care services. The bulk of data on revenue levels is obtained from Departmental data sources. Some data has also been sourced from the Bentleys MRI Survey.

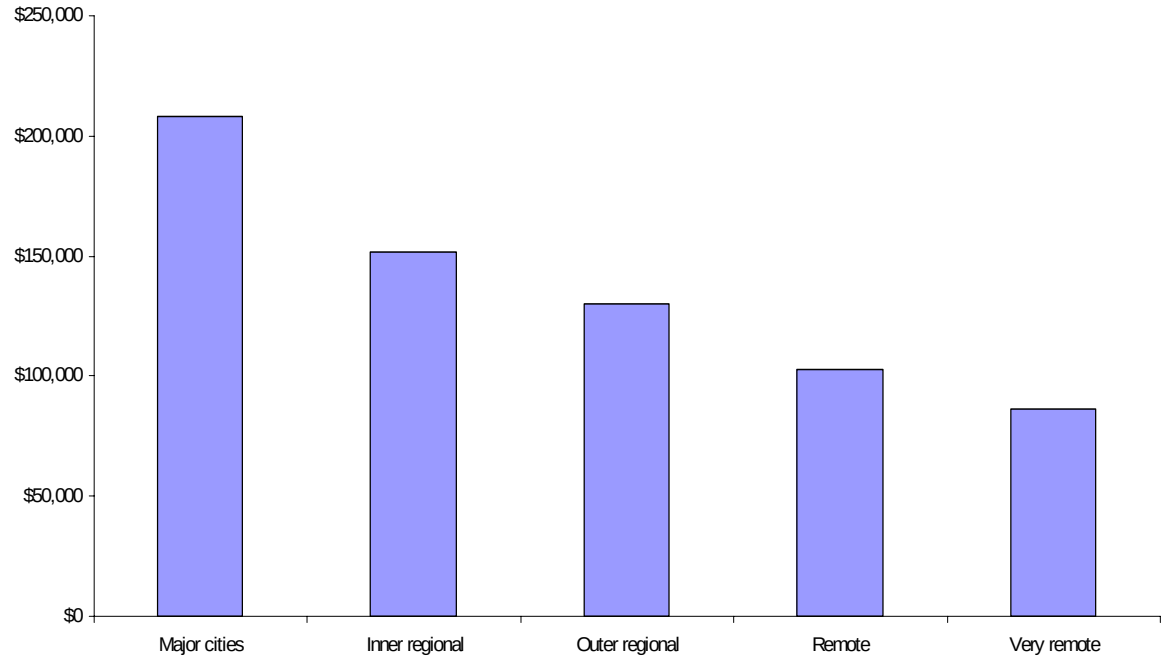
[5] Australian Bureau of Statistics, *5204.0 - Australian System of National Accounts, 2007-08*, Labour Productivity and Input, Hours worked and Gross Value Added (GVA) per hour worked - by Industry, Canberra: Australian Bureau of Statistics, 2008.

3 How do current arrangements address regional variations in the cost of service delivery and the construction of aged care facilities?

Accommodation bonds, along with accommodation charges, provide aged care homes with a capital stream to upgrade and maintain buildings. Residential care facilities that are located in regional or remote areas are not able to attract the same level of accommodation bonds as providers located in major cities. This limits access for providers in these areas access to these capital streams.

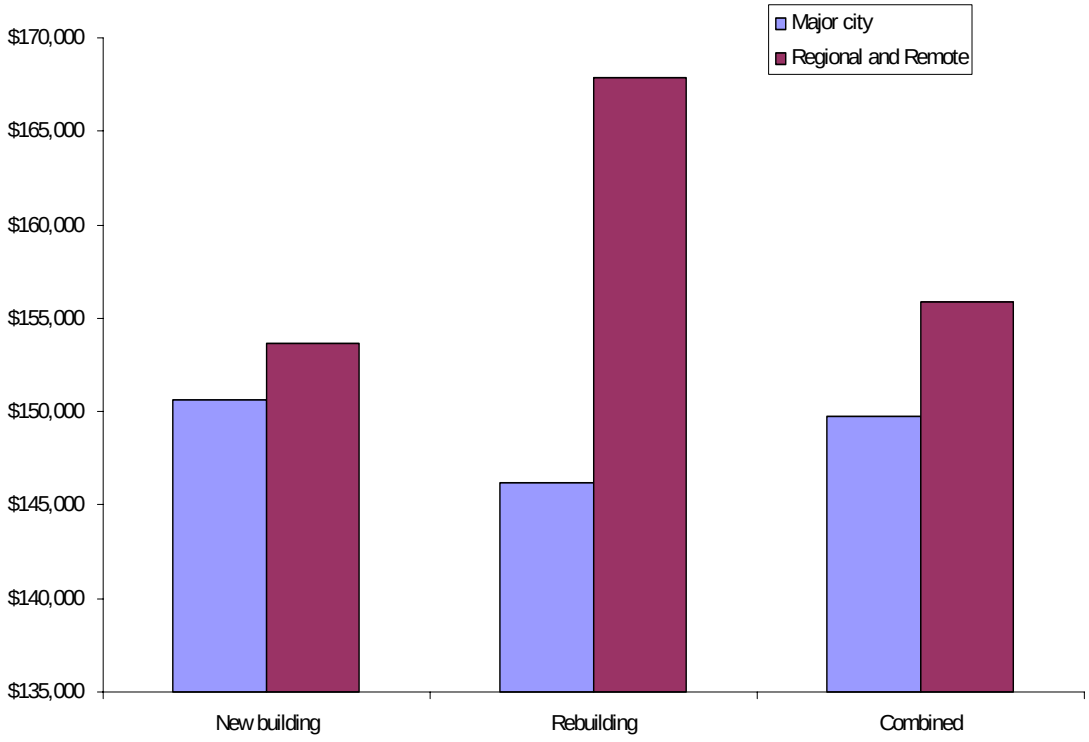
In 2007-08, the average accommodation bond for a new resident in a major city was $207,806. By contrast, providers in outer regional areas could only attract bonds of around two-thirds this amount and those in remote areas less than half (Figure 18).

Figure 18: Average accommodation bond for all new residents, by remoteness, 2007-08



The costs of construction in regional and remote Australia is higher than in major cities. In 2007-08, the cost of new building and rebuilding work was $150,000 per additional residential place in major cities, in contrast for regional and remote areas this was $156,000 per additional residential place (Figure 19).

Figure 19: Average cost of new building or rebuilding work per additional residential place in Major Cities compared with Regional and Remote areas, 2007-08



In order to address the reduced access to a capital stream from accommodation bonds or charges for providers in regional and remote areas, the Commonwealth Government provides capital funding targeted toward the development of infrastructure in these areas, including through the provision of zero real interest loans (up to $300 million in loans is available) and annual capital grants of over $44 million per annum. Further details on these programs were provided in the Department's December submission to this Inquiry (see Section 4).

Viability Supplement

Recurrent costs for service provision in regional and remote Australia may also be higher due to the increased costs of recruitment and retention of staff, the higher costs associated with temporary or locum staff (particularly relating to nursing and allied health staff), and the costs of transport. To assist aged care services in rural and remote areas with the extra cost of delivering services, additional funding is made available through the viability supplement. In 2007-08, around $15 million was provided to care providers through the viability supplement. Further details on these programs were provided in the Department's December submission to this Inquiry (see Section 4).

4 Are there inequities in user payments between different groups of aged care consumers and, if so, how are these inequities addressed?

The Commonwealth Government sets the maximum level of fees that aged care providers can levy on residents of Commonwealth-funded aged care homes and recipients of Commonwealth-funded community care packages. Within the regulated maximum fees, providers and residents negotiate the actual fees paid. The Commonwealth Government also has guidelines for the fees charged for other Commonwealth-funded community care services, such the National Respite for Carers Program and the Day Therapy Centre Program. States and Territories have policy responsibility for the fees levied by providers of Home and Community Care (HACC) services, which are jointly funded by the Commonwealth and the States and Territories.

4.1 Residential aged care

The *Aged Care Act 1997* specifies the types of fees and charges that residential aged care providers can levy on their residents. These fees fall into five categories, noting that not all residents pay all types of fees: basic daily fees, income tested fees, asset tested accommodation payments, extra service fees, and additional service fees.

The new arrangements introduced by the *Aged Care Amendment (2008 Measures No. 1) 2008 Act* significantly improved the equity of these arrangements.

4.1.1 Basic daily fee

The maximum basic daily fee for all post-2008 reform residents is now 85 per cent of the single basic age pension ($467.74 per fortnight as at 20 March 2009).[6]

The fee is paid to the aged care provider. This arrangement is more equitable that the arrangements that obtained prior to 20 March 2008, where there was a separate and higher maximum basic daily fee for self funded retirees and pensioners who paid an accommodation bond above a set threshold.

4.1.2 Income tested fee

The income tested fee is paid by those with substantial income and is used to make the cost of aged care more sustainable for taxpayers. The fee reduces government expenditure rather than accruing to care providers. The maximum income tested fee payable by all post-2008 reform residents is equal to 5/12 of the resident's total assessable income in excess of the maximum income of a full single pensioner. This income test free area is currently $713.80.

However, a resident's income tested fee cannot be greater than the lesser of:

[6] Residents in designated remote areas may be asked to pay an additional $14.84 per fortnight. This amount is equal to 85 per cent of the Remote Area Allowance (less the GST compensation component of that allowance) that is paid to pensioners in those areas.

- 150 per cent of basic age pension. This cap is currently $825.45 per fortnight and applies to residents with total assessable income in excess of $2119.08 per fortnight; and
- the value of basic subsidies and primary supplements paid by the Commonwealth to the provider of the residential aged care services in respect of the resident.

This arrangement is more equitable than the arrangements that obtained prior to 20 March 2008. Under those arrangements, self funded retirees were subject to higher maximum income tested fees than pensioners with the same level of total income because the income test was based upon the resident's non-pension income rather than on the resident's total assessable income.

4.1.3 Accommodation payments

From 20 March 2008 the Concessional Resident Supplement and Pensioner Supplement were combined into the single asset-tested Accommodation Supplement. Under these arrangements self funded retiree (SFR) residents with few assets became eligible for accommodation assistance from the Commonwealth Government.

Changes implemented in 2008 have also seen those who can afford it being asked to contribute more towards their accommodation, while the level of Government payments has increased for those who cannot meet the costs themselves. Fees paid by existing residents were not affected by the changes.

From 20 March 2008, daily payments for accommodation for new residents entering high care increased. Some new residents with sufficient means make all of the new payments themselves. For those new residents without sufficient means to make any of the payments themselves, the Government pays the increased amount in full. For those without the means to make all of the payment, they pay some and the Government pays the remainder.

Under these arrangements, providers receive $26.88 per day in accommodation payments for all new residents entering high care, either as a Government payment or a resident contribution, or a mixture of the two, depending on the value of the new resident's assets.

The accommodation payment is paid by Government for all new residents entering high or low care who have less than $34,500 (indexed) in assets. For those with more assets, the payment from Government reduces, with the subsidy cutting out altogether for those with more than $90,564 (indexed) in assets. This system replaced a number of existing accommodation supplements paid for pensioners, including those currently paid for people with low assets.

4.1.4 The payment of accommodation bonds

Entrants to residential low care may be asked to pay a bond, which is nominally uncapped, but there is a requirement that the new resident be left with a minimum level of assets (currently $36,000). Entrants to high care are required to pay a charge which is capped and its value is set at the time of entry.

The Government assists those residents who do not have sufficient means in the payment of their accommodation payments. Full pensioners are not required to pay either accommodation bonds or accommodation charges.

The difference between the payment of uncapped accommodation bonds in low care and capped accommodation charges in high care is a consequence of the evolutionary history of the aged care sector. High care has grown out of the nursing home sector, which was closely associated with the health sector, whereas low care has grown from hostels which had roots in accommodation programs for the aged. Although the 1997 reforms removed the distinction between these to some extent to allow effective ageing in place, the Aged Care Act and Principles have ultimately preserved a distinction in user charging between high and low care, which has since been maintained by all governments.

The payment of the bond typically requires significant rearranging of the financial affairs of the resident, including sale or rental of the person's home, unless that asset is protected under the Aged Care Act. This financial vehicle is more consistent with a longer term accommodation change than a short, health-related transition. In recognition of this, the Aged Care Act gives up to six months for the bond to be paid.

In relation to the differential arrangements in user charging between low care and high care, the Department submits the following facts:

- In 2007-08, well over half of the people that entered high care residential care for the first time came from a hospital setting (56%). For low care this figure is significantly lower (27%).
- Of the people admitted to residential high care in 2007-08, some 40 per cent had been discharged or died within six months. For low care this is significantly lower - 17 per cent of low care residents were discharged or died within six months.

This data suggests that for many people entering high care, more than for low care, the transition into residential aged care occurs at a time of health crisis rather than as a long term accommodation choice.

4.2 Community care packages

Programs falling under the Commonwealth Aged Care Act 1997 such as Community Aged Care Packages (CACPs) and Extended Aged Care at Home packages (EACH) have a fee policy which is determined by the legislative framework. CACP, EACH or EACH Dementia (EACHD) recipients may be asked to pay a fee to contribute to the care provided as part of these programs. For care recipients on the maximum basic rate of pension, fees must not exceed 17.5% of that pension. People on higher incomes may be asked to pay additional fees (limited to 50% of any income above the maximum pension rate). No one, however, will be denied a service they need, based on an inability to pay fees.

4.3 Other community care services

4.3.1 National Respite for Carers Program (NRCP)

Under the NRCP, there is no specific fee schedule. The NRCP guidelines do support user pay arrangements, but there is a lot of provider discretion to charging recipients of care. The Guidelines only state that 'all carers using Commonwealth Government funded respite services are encouraged to contribute to the cost of respite care when they can afford to'. Importantly, the Guidelines are clear that no carer is to be refused respite services due to an inability to pay fees. There are new NRCP initiatives targeting employed carers, with an expectation of a higher client contribution, but this is not specified formally. Fees may also vary depending on the type and cost of service provided, for example in home respite and centre based respite.

4.3.2 Day Therapy Centre Program (DTC)

Day Therapy Centres are more prescriptive on fees. The Guidelines recommend that a fee of $5 per service be applied, with an upper limit of $15 per week for clients receiving multiple services. However, the Guidelines go on to say that 'the actual charging of fees is a matter for each DTC to decide', so again there is a lot of provider discretion.

4.3.3 Residential Respite

Residential respite involves the mandatory collection of fees. Providers charge up to $33.41 per day (this is 85% of the Aged Pension) which is met either by the care recipient or carer or subsidised fully or partly by brokerage funds from NRCP funded Commonwealth Respite and Carelink Centres, according to capacity to pay.

4.3.4 Home and Community Care (HACC)

The HACC Program is jointly funded by the Commonwealth and state and territory governments. States and territories are responsible for program management, including the approval and funding of individual HACC services in their jurisdictions, and determine the fee policy for the HACC Program in their jurisdictions. Although these are underpinned by broad national program guidelines, there are different polices in operation across the country. Queensland Government does not charge fees for HACC services as a norm, but even where HACC fee policies are operational; these are generally set lower than Commonwealth Government packaged care programs. A national project has commenced to examine user charging in HACC and to consider doing so on a more consistent national basis.

5 Is the current planning ratio between community, high and low-care places appropriate?

Background

In the 2002-03 Budget, the Commonwealth Government commenced a comprehensive review of pricing arrangements in residential aged care. The final Report of the Review of Pricing Arrangements in Residential Aged Care ('the Hogan review') was received in April 2004.

The first recommendation of the Hogan Review was that the aged care provision ratio should be increased to take account of increasing frailty in older populations, and that the balance of places within the ratio should be re-weighted towards community care in line with the preferences of older Australians to receive care in their own homes for as long as possible.

The Government responded to this recommendation in 2004 by increasing the operational provision ratio from 100 to 108 places for every 1000 people aged at least seventy, to be achieved in 2007. Further review in 2007 resulted in this ratio increasing to 113 places (88 residential and 25 community care) for every 1000 people aged 70 years or older by December 2011. The balance of places within the provision ratio was also adjusted to increase the number of community care places from 20 to 25 places for every 1000 people aged at least seventy; four of these are for high level community care in the form of EACH or EACH-D packages. Adjustments were also made within the residential care target ratio of 88 places per 1000 people aged 70 years or over to increase the provision of high care from 40 to 44 places.

These adjustments to care ratios over time have made available additional aged care places, at additional cost to Government, and consistently resulted in growth in community care, which is clearly the consumer preference. The growth of Extended Aged Care at Home (EACH) packages has enabled the development of high care in people's own homes where this is appropriate.

Strengths of the aged care planning arrangement

The very considerable strengths of the planning arrangement that have been relied on by governments for over two decades are that it:

a) keeps growth in care provision in line with growth in the ageing population; and

b) directs new aged care places to those areas with the greatest need.

Consequently it is one of the few areas of public policy in which growth in expenditure is driven directly by population growth.

It is also one of the few areas of public policy in which rural and regional provision of care is at a level that matches the relative demand in those areas. Some 34 per cent of all Australia's elderly live in regional or remote areas, and some 33 per cent of all aged care places are delivered in those areas.

Issues raised in submissions

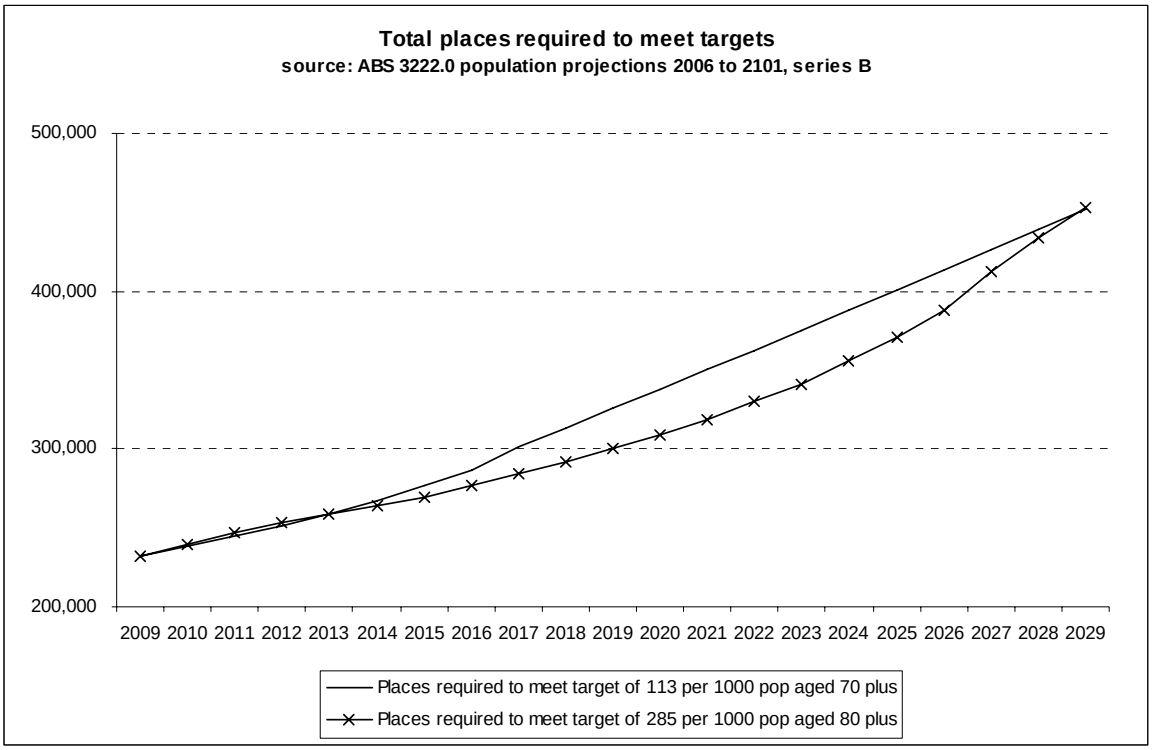
Submissions to the enquiry have argued that it is time to move to a planning arrangement based on age eighty rather than seventy years of age, as this more closely reflects the average age of aged care residents (82 to 83 years). This issue has also been raised in the National Health and Hospital Reform Commission's interim report.

While it is not appropriate for the Department to prejudge this policy matter, two issues are relevant to consider.

First, a very good forward predictor of *future* demand is the population aged over seventy. Despite impressions to the contrary, older people are not highly mobile[7] (ABS) and they want to access care where they have been living.

Further, as Figure 20 shows, to move from a ratio based on seventy years of age to one based on eighty years would soon (from 2013) produce a reduction in the release of new places, and a concomitant saving in government expenditure, because growth in this population will be less rapid than the total growth in those aged over seventy. From the year 2021 there would then be a rapid surge in the number of places required. This surge may challenge the industry's capacity to meet it since it would produce a release of aged care places which is higher than any release to date. The ratio based on those aged over seventy produces a steadier growth path.

Figure 20: Total places required to meet targets



[7] Australian Bureau of Statistics, 2003, Population Growth and Distribution, 2001. ABS:Canberra

Submissions to the enquiry have also questioned whether there is an ongoing need for a distinction between low care and high care, and have cited the increasing utilisation of low care places by high care residents as evidence that the distinction is no longer useful.

In considering this issue, a distinction needs to be made between *access* and *ageing in place*.

Taking *access* first - the current aged care planning ratio for residential aged care is 44 places for low care and 44 places for high care for every 1000 people aged 70 years or over. These ratios are used for planning purposes and seek to ensure that places are available for residents who need either high or low care on admission. Currently, admissions are distributed evenly between high and low care (49.97 per cent entered as low care in 2007-08). To remove the ratio distinction between low and high care could result in reduced access for low care residents.

"*Ageing in place*" as a policy was designed to enable residents to remain in the same environment as their care needs increase, in those facilities which could offer appropriate accommodation and care. Following reforms introduced in 1997, and continuously supported since, once a resident has entered care they are now generally able to remain in the same residential care service as his or her care needs increase.

As a result of ageing in place, the number of care recipients who are actually receiving high level residential care is significantly higher than 50 per cent. As at 30 June 2008, some 69 per cent of residents in aged care homes were receiving high level care.

Ageing in place is supported by the funding system. On 20 March 2008 a new funding instrument – the Aged Care Funding Instrument or ACFI – has now been implemented to allocate funding. The ACFI is a better and more objective measure of a residents' care needs.

With the introduction of the ACFI, the government has allowed care needs to be reassessed at any time, so that significant increases in frailty can be funded immediately. This further supports the policy objective of ageing in place.

Both *access* and *ageing in place* remain relevant as policy goals. Ageing in place and the ACFI enable a resident to be cared for within their residential setting as their care needs increase and to attract a care subsidy appropriate to their needs. The planning distinction between low and high care is only important to ensure access for a range of resident frailty, not to determine the care levels, or funding levels, of those already in care.

In summary, policy over the last decade has consistently emphasised relative growth in care at home, access to both residential low care and high care, and the capacity for enduring care once a resident is in the residential care setting.

The Government has announced that it will review aged care planning ratios and regular aged care allocation process taking into account demographic changes and changing patterns of use of aged care service.

6 What is the impact of current and future residential places allocation and funding on the number and provision of community care places?

Recent growth in community care packages

For many people, living in the comfort of their own home is an important part of growing older, but for some older people this may become difficult without extra help. The Commonwealth Government funds and regulates some community care directly, mostly in the form of Community Aged Care Packages (CACP) and Extended Aged Care at Home (EACH) Packages, including EACH-Dementia (EACH-D).

In recognition of the desire by frail older people to remain in their own home as an alternative to low or high level residential care, the Commonwealth Government has been rapidly increasing the number of available community care package places.

Table 4: Community care package places, recipients and claim days, 2004 to 2008

	2003–04	2004–05	2005–06	2006–07	2007–08
CACP					
Operational places (as at 30 June)	28,646	30,503	34,868	37,391	39,638
Recipients (as at 30 June)	27,618	28,854	31,755	34,826	36,929
Total claim days	9,874,764	10,185,175	10,884,362	12,540,906	13,840,579
EACH					
Operational places (as at 30 June)	860	1,673	2,580	3,307	4,244
Recipients (as at 30 June)	707	1,227	2,136	3,001	3,894
Total claim days	160,532	333,090	621,709	991,466	1,326,663

The number of operational CACP places has increased from 28,646 in 2003–04 to just under 40,000 in 2007–08, representing a 43.6% increase over five years, or an average annual increase of 7.5%. The number of package recipients grew at a similar rate. Subsequently, the number of days for which a CACP service was claimed, increased by over 40% for the same period (Table 4).

Since the introduction of EACH high care packages in 2003–04, the number of operational places has increased nearly five-fold. The number of days for which an EACH service was claimed rose from 160,532 in 2003–04 to 1,326,663 in 2007–08, which equates to an average annual growth of 69.6% over the period (Table 4).

Issues raised in submissions

There is a common view, which has also been expressed to the Senate Committee, that growth in community care places is leading to excess vacancies in residential aged care. The Department has been unable to produce analysis which either supports or denies this view, despite attempts. This is because there is no "natural experiment" available in which some areas have growth in community care and others do not, to see whether there is a differential

impact on residential care. Growth in community care has been nation-wide and of a reasonably consistent size in every aged care planning area over the last decade.

Intuitively, *at some level*, providing older people with greater choice in care modality (in their own home or in an aged care home) will lead to some reduction in interest in residential aged care. However,

a) choice in care setting is an explicit goal of policy; and

b) there is evidence to show that people with high level needs who are living alone and have no carer are more at risk of admission to residential care[8] (Australian Institute for Primary Care). Consequently there is only a partial overlap between those who choose care at home and those who need residential aged care.

The Department considers that the overriding dynamic in explaining vacancy levels in aged care currently is not one of competition between care types, but of rapid growth in care places leading to temporary vacancies.

The faster the growth in places, the greater is the vacancy rate, simply because it takes time for newly created community care places or newly built aged care homes to fill up. There is also a short-run impact on neighbouring services.

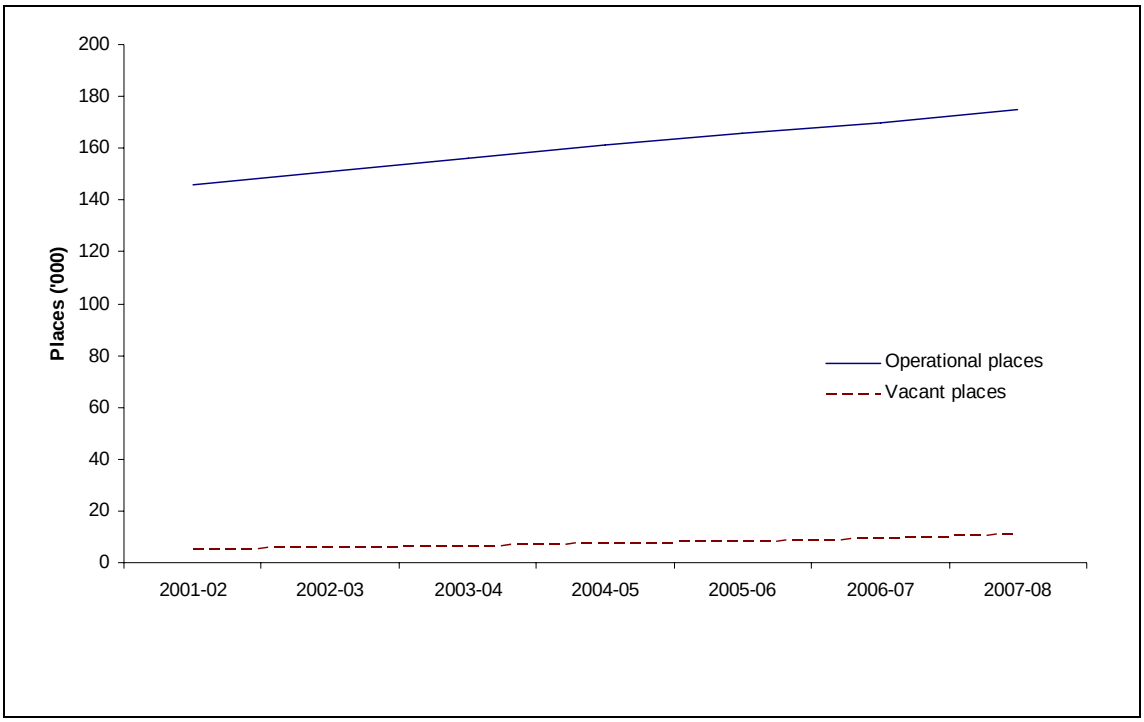
Consider, for example, a local area with three existing aged care homes, each of sixty beds. There will be, on average, sixty vacancies a year in this area, based on industry averages (on average residents live for three years in aged care homes so that each home has one third of its beds becoming vacant at some time each year). If a new sixty bed home is built in this area, there will be 120 vacancies in the area in the year it is completed – sixty in the existing services and sixty in the new home. This will be a temporary effect relating to growth. In the medium term the new annual level of vacancies in this area will be around eighty per year.

In situations like these, not all providers welcome the expansion of aged care places but this expansion is essential to meet the overriding public policy objective of meeting the growing demand of the ageing population, which is expected to double in the next twenty years.

Figure 21 shows the growth in both residential aged care places and vacancy levels from 2001-02 to 2007-08.

[8] Australian Institute For Primary Care March 2007 Targeting in Community Care: Analysis of HACC MDS and ACAP MDS and Implications for Targeting

Figure 21: Operational and vacant places, residential aged care, 2001-02 to 2007-08



It is the Government's intention to facilitate choice and to continue to emphasise growth in care at home. Sufficient vacancies in both community and residential care ensure people can get a place in the care of their choice without undue delay; with providers competing amongst each other to attract customers on the basis of quality of care and amenity.