SUBMISSION TO

The Senate Standing Committee on Finance and Public Administration

Inquiry into Residential and Community Aged Care In Australia

Thursday 2nd April 2009

TriCare Limited

About TriCare

TriCare Limited is a privately owned residential aged care and retirement village provider with 1350 residential aged care beds (high and low), at 16 facilities located throughout South-East Queensland.

We also own and operate 7retirement villages, a home care business and a food catering company specialising in nutrition for the frail aged.

TriCare's core business has been residential and retirement living for nearly 40 years and in that time we have established a reputation for quality care, professional management and sound business practices.

We have a record second to none in respect of accreditation and regulatory compliance and have participated enthusiastically in and funded various independent aged care related research projects, sponsorships and other community investments over many years.

In 2005, TriCare was selected from among a number of organisations throughout Australia to partner with Macquarie Bank to acquire , manage and turn around one of the largest charitable sector providers in Australia which required substantial capital investment and management reengineering over a period of three years.

In this time, TriCare successfully brought all of these multi-state residential care and retirement facilities from loss-makers to achieving modest surpluses ,negotiated a single national Enterprise Agreement covering all staff, relocated hundreds of elderly residents from old , substandard facilities for re-building and achieved full accreditation status and regulatory compliance for all facilities over the same period.

TriCare's residential care staffing arrangements have been recognised by Human Resources Monthly as groundbreaking in the aged care sector.

Our single enterprise bargaining agreement negotiated with staff and relevant unions pioneered aged care specific competency standards , abolished seniority-based progression and demarcations and introduced unique career path incentives.

The Agreement provides for fully paid external training for staff who wish to invest in gaining further skills and competencies and recognizes these skills via our unique career progression model.
We are pleased to appear before the Senate Committee and provide our input on the critical matters under consideration.

Approach

TriCare believes it would be particular benefit to the Senate Committee if we confined our submission to clarifying previous testimony which we believe has not accurately characterized the serious regulatory and funding challenges facing providers and residents.

We particularly are concerned that some testimony concerning the independent financial reviews of the sector, ACAR rounds, business inefficiencies and the impact of overregulation, may mislead the Committee about what is actually happening on the ground.

TriCare's individual experiences of the matters listed above differ very little from virtually all other providers who have testified.

The Submission is made up of 7 key sections;

1.Independent reviews of the sector – Stewart Brown , Bentleys and Grant Thornton
2.ABS aged care building statistics
3.Bed allocations for new developments
4. Other funding increases
5. Budget Initiatives – Capital Funding
6. Sufficiency of funding in relation to the real costs of providing care
7. Enterprise Bargaining Agreements

TriCare has always been a vocal participant in public discussions of aged care policy development, regulation and funding regimes.

We do so naturally because we have an interest in ensuring policy, regulation and financial regimes encourage and provide incentives for quality care provision, development of modern, first-class aged care facilities and greater research and consequent understanding into the needs of aged care consumers of the future.

We also believe that though well represented by industry organizations, many individual providers have in the past been reluctant to assume prominent roles in these debates as a common view is that such investments are of little value given the monolithic and pervasive control exercised by federal regulators and following from that, a reluctance to draw attention to themselves .

Unfortunately, such concerns can be well founded as TriCare discovered late last year when as a consequence of unremarkable and commonly held views we expressed publicly, we were referred to the Australian Competition and Consumer Commission - an action we regarded as an attempt to ensure we were more circumspect in the future.

We should make clear that the very real problems in aged care presenting now, cannot be laid at the feet of the current government nor exclusively of the previous government - we arrived at this position because of an accumulation of many years of risk averse, short-term policy decisions based on unfortunate misconceptions

about the needs and desires of aged care consumers and the motivations of aged care providers.

The negative impacts of these policy deficiencies have gone undetected because of a lack of oversight of financial viability and medium term investment needs which is surprising given the almost complete control over income exercised by government (the only exception being the levels of bonds provided in low care and extra service and extra service fees).

This has resulted in record numbers of insolvencies amongst aged care providers in recent times, which if this continues, could have dramatic consequences.
If regulatory scrutiny of the financial health of one of the largest service sectors in Australia was just a fraction of that applied to staff in their dealings with residents, the current problems would have been detected long before.

One of our sincere hopes is that the current policy of short-term , knee jerk policy formation and politically inspired censoriousness when it comes to providers, gives way to genuine good faith consultation and policy formation to meet the unprecedented challenge facing an ageing, active and demanding cohort of Australians in the near future.

1. Independent Financial Reviews of the Aged Care Sector

There are currently four major data sets available to the Commonwealth which track financial trends in residential aged care in Australia.

*Stewart Brown Aged Care Financial Performance Survey
*Grant Thornton Aged Care Survey
*Bentleys 08 National Residential Aged Care Survey
* General Purpose Financial Statement Analysis

The first three are self-selected financial surveys of individual aged care facilities measuring a variety of indicators and trends.

The reviewers are all well respected aged care specialists who conduct the survey for the benefit of participants and other interested stakeholders.

Grant Thornton has the greatest number of participants (more than the other two combined) and also importantly, is the only survey which measures exactly the same cohort of providers over a two-year period.

There has been much discussion about the appropriateness of which individual measures should be used to gauge financial performance including return on investment, EBITDA or net profit before tax much of which is largely irrelevant to the clear and consistent picture presented by all three surveys.

In the words of the reviewers themselves;

We advise participants that our data analysis indicates that, on a macro level, profitability for the sector is trending downwards when compared to last year. We will further expand on this analysis in the industry report (due for release in the near future).

We also urge participants to exercise caution when comparing data between this year's survey benchmarks and previous years. Due to changes in the participant pool in 2008, and as a result of adjustments to our classification scales for services, direct comparison from year to year for some items may be misleading at first glance.
Bentleys Chartered Accountants

Providers of residential aged care services are experiencing low and deteriorating financial returns at a time of unprecedented demand for high care services. This is particularly the case for the modern, single room facilities most preferred by consumers.
Grant Thornton Aged Care Survey

The report for the year ended 30 June 2008 shows a fairly dismal picture for operators. The average operating result for both high care and low care facilities is an operating deficit.
Stewart Brown Business Solutions

The fourth data set available to the Department are the mandatory (in that provision is a condition of CAP funding) audited General Purpose Financial Accounts submitted by providers each year.

Little is known about the trends demonstrated by these reports as no analysis has been provided for the 06/07 or 07/08 financial years with 08/09 now less than 90 days away.

To be fair, these reports are largely useless in terms of detailed financial trend analysis. In many instances they do not differentiate between government funded residential care and other business operations, they do not provide specific information about changing proportions of cost or income, they do not include critical analyses of performances between old and new and single and multi-bed ward facilities etc.

The only compare favourably with the other reviews in that participation is virtually 100% and they are audited.

There are some issues concerning these surveys which have arisen in previous testimony which should be addressed;

Differences between the various surveys

It was suggested that the both Stewart Brown and Bentley's surveys show improved returns in the most recent editions.

This is incorrect – Bentleys does not compare the SAME providers from the previous survey ; it is a different mix with a different proportion of high, low, new and old (multi-bed ward) facilities so this conclusion cannot possibly be made. In fact, Bentleys actually warn against making this assumption for precisely that reason.

Similarly, Stewart Brown have confirmed that they do not compare exactly the same group of providers from one year to the next. They believe they have a significant number of repeat participants and their assertion is that across the spectrum of indicators , the conclusion that financial returns have improved is not borne out.

Stewart Brown's position is best summarised by the statement made in the executive summary;

"*While high care has seen an improvement in operating results the average result still remains a significant operating loss"*

Further evidence of a deteriorating financial position is found in the most recent (Dec 08) Stewart Brown survey.
Other testimony suggested that the Grant Thornton survey was "highly skewed".

It is in fact remarkably similar in both methodology and findings to the others.

GT's survey compares exactly the same group of providers over 2 consecutive financial years and has the largest participation of the three.

Facility Lay-out and Resident Density

Since most new , purpose built facilities are all single room and the older the facility, the greater the preponderance of mixed rooms, the definition of single room and multi-bed ward is important. Grant Thornton defines "single bed" facilities as those with more than 70% singles – despite assertions made to the contrary previously.

All three surveys find that older, multi-bed ward facilities (wards up to 4 beds are still allowable) generate better returns (including smaller operating losses) than newer, modern , purpose built facilities. Extra service facilities are obviously an exception.

For example, from the Bentley's 2008 survey;

- 77% of High Care services in the top EBITDA quartile were multi bed not 49% as represented previously to the Committee. Grant Thornton's definition of multi-bed wards as those with fewer than 70% single rooms. Half of the top quartile facilities had 3 or more residents per room

- The bottom quartile is dominated by single bed facilities.

The difference in returns in the 2007 survey is set out below

	EBITDA	Net Profit
All Single Rooms	$ 737	-$ 3,351
Mix - Single and Doubles	$ 3,073	-$ 2,234
More than Two per Room	$ 6,077	$ 2,562

Indeed, all surveys are clear on this point;

Bentleys MRI 2007 Survey ;

> *"There is strong and continuing evidence from the survey results that single-room High Care services (other than ES) are non-viable and that multiple-occupancy room High Care services achieve much better returns.*
>
> *As High Care services across Australia are rebuilt to include more single rooms, then more loss-making High Care services appear inevitable under current income arrangements, unless more services take up full or partial ES arrangements or find some other sources of income or cross-subsidy."*

The Stewart Brown Business Solutions June 2008:

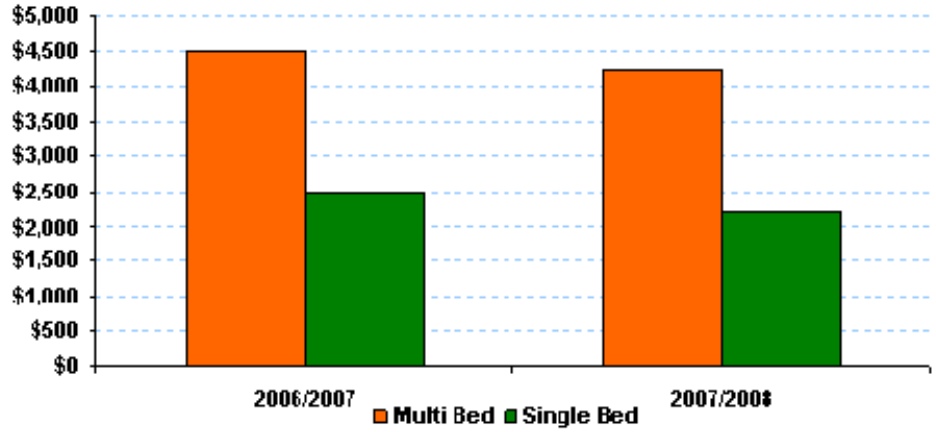
"The operating result and overall net profit of facilities with a predominance of multiple bed rooms is better than those with a majority of single rooms. This is going to continue to create a dilemma for providers. Building standards and resident choice is pushing providers to build more single room facilities, however this will tend to have the effect of adversely affecting the bottom line"

The Grant Thornton 2008 survey report:

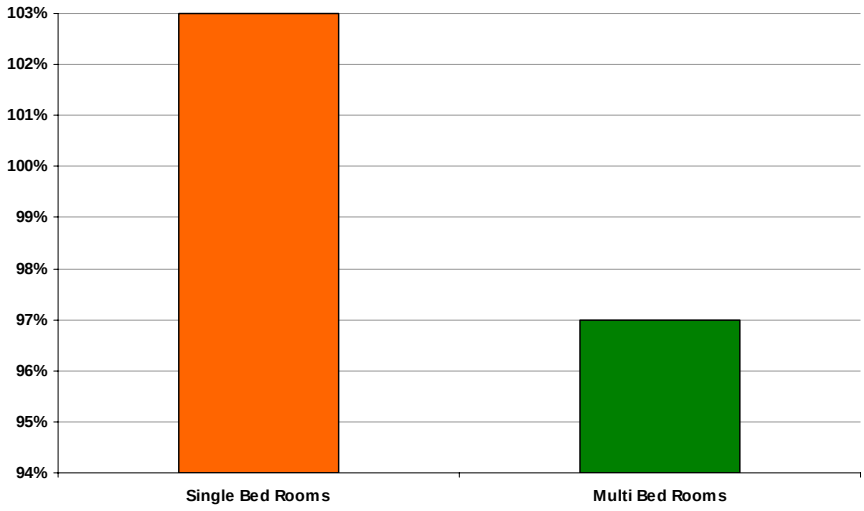
"Modern high care facilities with single bedrooms reported the worst results, averaging $2,191 compared to $4,233 per bed achieved in older facilities with shared rooms. This represents an average return on investment of approximately 1.1% for modern, single bedroom facilities."

"The regulatory and pricing framework now threatens the viability of the aged care sector by suppressing incentives to invest in modern aged care infrastructure. This decline in investment severely limits choice for consumers of aged care services."

Further, the following show this in stark reality;



Wage Costs as a Proportion of Government Subsidies – Facility Design

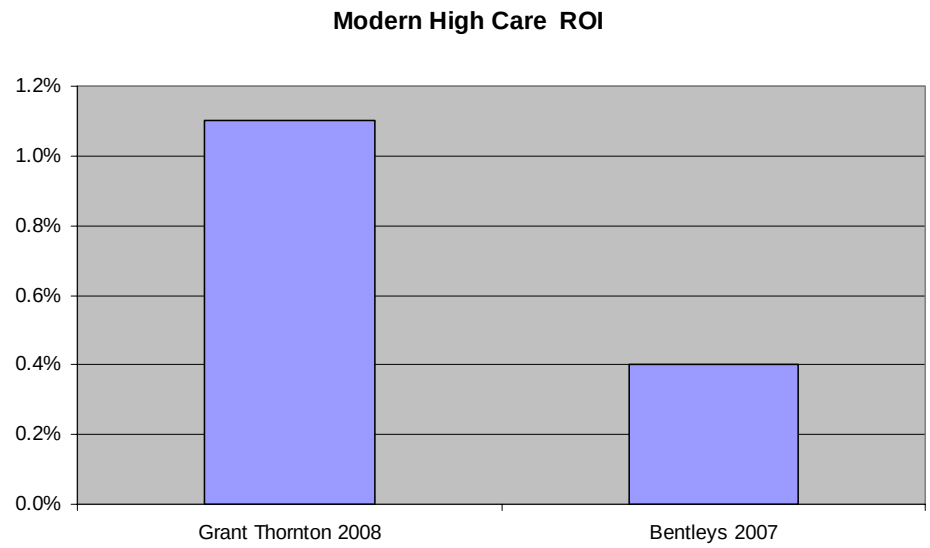


The i e sector are to be m (the top extra are not cons licy objectives.

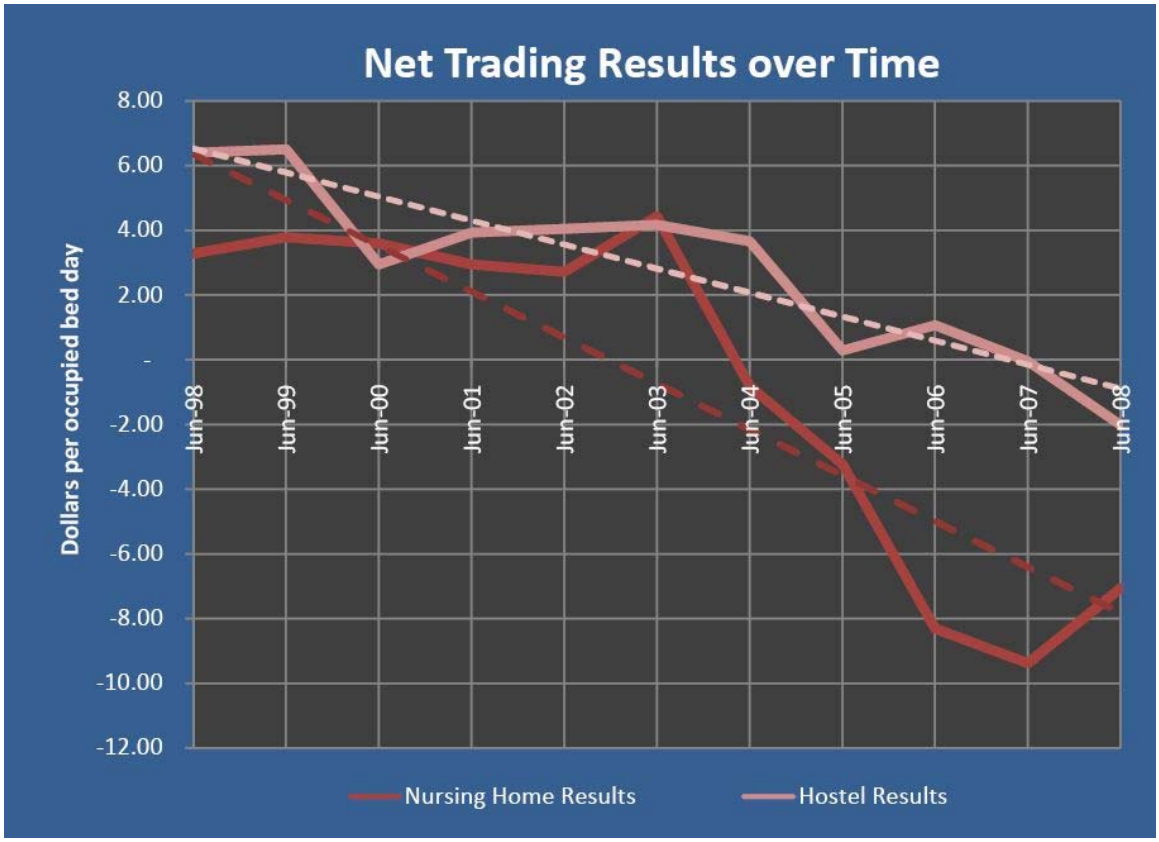
A further point is that even the top quartile providers are not showing returns which justify rebuilding or constructing new single bed, modern purpose-built non-extra service facilities. As Professor Hogan noted, providers would need to be making returns from accommodation and care to the tune of 10% and the findings of the largest survey show an average across the sector of 1.1%.

Ordinary high care providers presenting to commercial lenders with operating surpluses of $6 - 9K per bed (the high upper range of the top quartile) to service debt of $150 – 200K per bed will be unable to convince banks to advance funds.

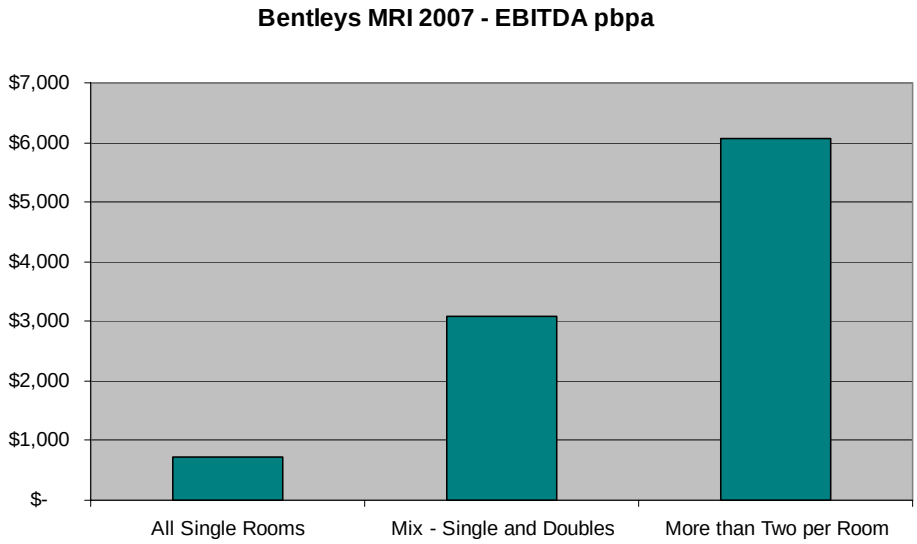
Page 18 of the 2007 Bentleys report states that EBITDA for single room facilities was $2.02 per day or $737 per annum. Their assumed building cost is $175,000. This gives a return on 0.41% before land costs – less than half of those estimated by Grant Thornton. Their average EBITDA for all high care facilities is higher because they have many old, multi-bed facilities.

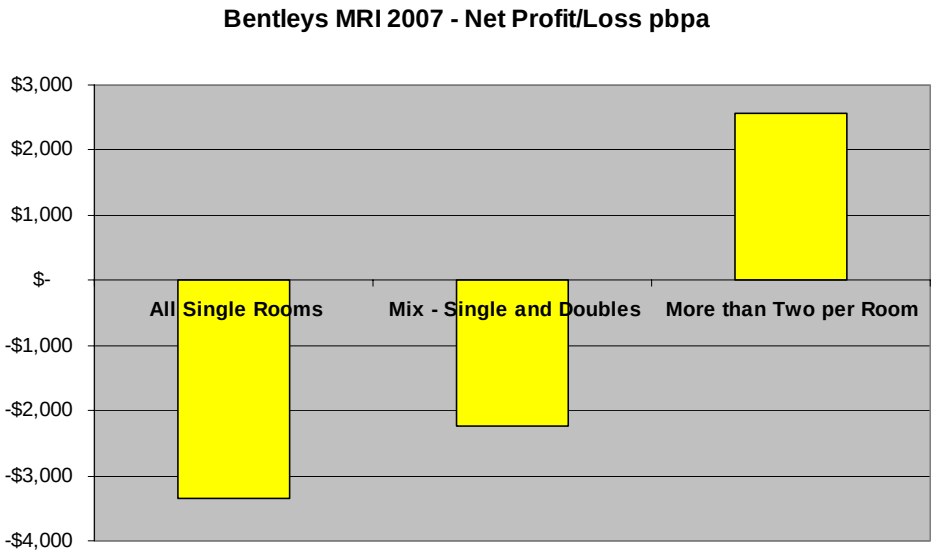


Stewart Brown does not make the same kind of quartile comparisons but the graph below demonstrates the trend clearly:



There is a great deal of testimony about "efficiency" but the statistics bear out the conclusion that the highest returns correlate best to older multi-bed ward facilities and not the particular efficiency of providers.





2. ABS building activity statistics

Previously, statements were made in respect of ABS data concerning increased building activity for residential aged care facilities.

Our research confirms that is no specific measure of government funded residential care facilities and no conclusion which can be reached in relation to government funded residential aged care construction via ABS data.

TriCare has previously had cause to examine the ABS data via participation in a Brisbane City Council initiative aimed at removing some of the barriers to new residential aged care facility construction in the inner-city suburbs of Brisbane. The BCC researchers advised the task force which included a number of aged care providers, that the ABS does not keep statistics specifically for residential aged care.

To ensure this was correct, prior to the tendering of this submission, TriCare contacted the ABS directly and was informed on the 26th March 2009 by the officer who collates the aged care building statistics of the following;

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

As is obvious to those who work in the sector, this description encompasses the vast majority of retirement villages and retirement village development and new construction is surging given the lack of government restrictions on capital funding mechanisms in that sector.

3. Bed allocations for new facility developments

The following information was provided by the Aged Care Association of Australia relating to the numbers of applications made for each available place over the last eight years.

* in 2001 there were 11 applications for each available place

* in 2004 there were 4 applications for each available place

* in 2007 there were 2 applications for each available place

*in 2008 there were 1.5 applications for each available place, and if you remove Victoria from the calculation (it is an extraordinary anomaly which bears investigation) we would have approximately 1 to 1 .

A close examination of the most relevant press release from the Minister detailing numbers of high/low applications per state indicates that unlike previous years, applications were accepted after the cut-off date provided they were postmarked prior to it. To the best of TriCare's knowledge, this has NEVER occurred before - usually the cut off is very tightly controlled. If the application is not at the Department by the required time it is not accepted.

Such a change allowed for many more applications to be registered than in previous years.

The following excerpt is from page 10 of the **2008 -- 2009 Aged Care Approvals Round Essential Guide**

All applications for:
• Community Aged Care Packages;
• Extended Aged Care at Home packages;
• Extended Aged Care at Home Dementia packages;
• Community Care Grants;
• Flexible Care Grants;
• Residential aged care places and/or Capital Grant; and/or
• Extra Service.
must be received within the Department of Health and Ageing by:
5.00pm Friday
19 December 2008
There is no extension to this closing date or time.

PLEASE NOTE: It is important for you to be aware that you have the responsibility for ensuring your application is received by the due closing date. It is not sufficient to simply have mailed your application by the due closing date, as it is highly unlikely that your application will be received within the Department by the prescribed time and date.
If you are aware of any matter that may adversely affect the timely receipt

of your application you will need to factor this into your mailing or delivery arrangements.

No explanation was provided for the sudden and unprecedented reversal in policy .

In addition, the numbers of beds allocated but subsequently returned by aged care providers is at levels not seen previously in the sector.

In Queensland, one of the largest and most respected providers returned hundreds of beds because of lack of project viability.

Catholic Health Australia earlier this year advised the Government in writing that it will not be constructing new high care facilities until a realistic capital funding model is established.

The overwhelming evidence is that there is a dramatic but hardly unsurprising decline in take-up of new places – particularly by organizations with actual experience in constructing and operating aged care facilities.

4. Other funding increases

Comparisons of annual increases in funding need to be analysed carefully so that the Committee understands the quantum and effect of these changes.

Annual COPO adjustments + CAP in comparison to CPI and Wage movements

	COPO	CAP	COPO + CAP%	CPI	AWOTE
June 04	2.00	1.75	**3.75**	2.5	5.26
June 05	1.90	1.75	**3.65**	2.5	4.76
June 06	2.00	1.75	**3.75**	4.0	4.49
June 07	2.00	1.75	**3.75**	2.1	3.50
June 08	2.30	1.75	**4.05**	4.5	4.61

NB – In only one year (June 2007) does the combined COPO + CAP exceed Average Weekly Overtime Earning increases which relate to + 70% of our cost base and actual wage increases in the health sector have exceeded AWOTE adjustments for several years. It should also be remembered that the CAP increases are not related to the entire quantum of funding but only to basic subsidies. Applied to the entire funding package CAP equates to about 1.2%.

It should also be remembered that private health insurance premiums - driven by many of the same costs impacting on aged care - have risen at levels significantly above this for over a decade, according to the Federal Health Minister.

Increased frailty amongst residents

Increasingly frail residents require higher levels of care which predominantly equates to additional staffing. The current and previous funding models attached higher levels of funding to higher acuity. Increases in subsidies to cover greater resource allocation don't represent funding boosts. This mechanism simply

recognises that more frail residents require more hours of care. This is irrelevant when considering the sufficiency of funding to meet rising costs. It's like 2 motorists comparing the expense of filling their petrol tanks when one has an 80 L and one a 60 L capacity.

ACFI changes
There appears to be an as yet unrealized expectation that changes flowing from ACFI will improve high care funding (ACFI guts low care funding). Whilst these increases may be **projected** ,they are certainly not translating uniformly into improvements on the ground and this is a widespread view amongst the sector.

5. Budget Initiatives – Capital Funding

Last year some new initiatives were announced which, when rolled out over a period of four years will increase the funding available for capital expenses.

While this is heartening in that it puts lie to the assertion that current funding initiatives are adequate –additional funding would not have been provided if government believes the current system is working well - the paucity of these measures in comparison to the real world movement in construction costs is easily demonstrated.

In essence,; over the next 4 years there will be an additional $11.38 per resident per day ($4153 per annum) or a 54% increase to cover construction costs which have risen 250 - 300% since the current funding system was introduced in 1997. Or to put it another way, in 4 years time, providers will be paid $11 818 per annum to cover capital costs which are **CURRENTLY** $16 000 per annum ($200 000 per bed X 8% interest).

So 4 years into the future, there will still be a $4k per annum shortfall on current costs with no allowance for future construction cost increases. And this doesn't allow for land costs.

This is tinkering around the edges not serious f reform

6. Sufficiency of funding in relation to the real costs of providing care

This is a critical question. It is incontrovertible that funding increases over the last 12 years have not been sufficient to keep wages at levels comparable to market rates of pay pertaining to staff with the same skill levels working in other sectors.

Given the overwhelming control of income exercised via legislation and regulation , the Committee and the Australian community should be able to satisfy themselves that the quantum of funding provided per resident is sufficient to ;

1. meet residents ongoing care needs
2. provide a high standard of accommodation and hotel services
3. properly reward staff and encourage retention
3. allow for a sufficient return on capital to attract investment

To the best of TriCare's knowledge, there is no detailed and dedicated study/research which addresses these questions.

7. Enterprise Bargaining Agreements

Testimony was provided to the effect that EBA's are largely similar across the sectors. This is not consistent with the TriCare's understandings over many years following discussions with large numbers of providers. Generally, the differences between the church and charitable private sectors come down to the following;

1. Church and charitable organisations have access to salary packaging and tax exempt arrangements not applicable to private sector providers

2. Church and charitable organisations **may** have access to higher income via bequeaths and donations

3. According to the Australian Institute of Health and Welfare, the use of volunteers in the charitable sector is greater than the for-profit sector

Conclusions

The current "debate" about aged care funding and policy direction has unfortunately become overtly adversarial with current and future cohorts of frail aged in the middle.

Whilst differences of interpretation of complex data sets are to be expected and robust discussion of policy settings are essential, when overwhelming ,unequivocal and independently verified evidence of a serious problem is ignored, the consequences for the frail aged and the wider Australian community could be catastrophic.

The truth is that residential aged care in Australia today is subsidised not just by the taxpayer but also by providers and staff whose contributions are undervalued.

TriCare submits that a "do-nothing" approach in the face of the evidence submitted is simply not an option.

Recommendations

Consumer choice and influence are paramount to future policy development. Currently, providers focus primarily on meeting the expectations of regulators ; if residents made a greater financial contribution they would likely be more discerning and discriminating and providers would have a much more healthy direct relationship – which would do more to drive accommodation and service delivery innovation than any government initiative.

1. Increased accommodation and hotel service payments by residential aged care facility residents assessed by Centrelink as having sufficient income and assets to pay, be introduced for all new residents from 1 July 2009
2. That the option of payment of an accommodation bond with agreed draw-downs as an alternative to regular payment of accommodation charges be permitted
3. That mandatory concessional resident places and subsidies be set at levels to ensure access, quality of care and minimum acceptable accommodation and service standards are guaranteed
4. That annual accommodation draw downs be re-established over an acceptable time frame to a level commensurate with 10% of average bond payments allowing an increased income stream for increased wages to aged care staff and improved returns for providers
5. That providers are free to negotiate additional fee-for-service arrangements with residents above the minimum required standard