Inquiry into Residential and Community Aged Care in Australia

Submission by Blue Care to Senate Finance and Public Administration Committee

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Table of contents

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1. Executive summary

Blue Care is a significant provider of aged care. We operate approximately 4,234 residential aged care beds and provide over 1.5 million days of care per annum in our residential aged care facilities. Blue Care makes in excess of 2.5 million occasions of service annually for clients in their homes along with providing many other community services.

Blue Care's submission to the Senate Finance and Public Administration Committee (the Committee) is in respect to both residential and community aged care as set out in the following sections under each term of reference. In summary, Blue Care submits:

Term of reference (a): Whether current funding levels are sufficient to meet the expected quality service provision outcomes:

- Residential aged care:
  - The current operating funding (subsidy income) ***is not sufficient*** to meet the expected quality service provision outcomes with a shortfall of approximately $5,500 per resident per annum. This amount translates to a requirement for additional operating funding in the order of $15 per resident per day.
  - The current capital funding ***is not sufficient*** to meet the expected quality service provision outcomes. An increase in the maximum accommodation supplement from $26.88 per resident per day to $62.81 per resident per day is required to adequately fund investment in new beds.
- Community care:
  - Current ***community funding levels are sufficient*** to meet the expected quality service provision outcomes. However, a number of recommendations are detailed herein regarding indexation, contract reviews, flexibility in service provision and client contributions.
  - The consequences of insufficient funding of residential aged care include increased morbidity for the frail among the burgeoning aged population and increased demand on home care services and the wider health sector. Reform of the wider sector will be inhibited as more and more elderly people fall back into doctors' waiting rooms and hospital emergency departments.

Term of reference (b): How appropriate the current indexation formula is in recognising the actual cost of pricing aged care services to meet the expected level and quality of such services:

- Residential aged care: The ***current indexation formula for residential aged care is not appropriate*** in recognising the actual cost of pricing residential aged care services to meet the expected level and quality of such services.
- Community care: The ***current HACC indexation formula is not appropriate*** in recognising the actual cost of services to meet the expected level and quality of such services.

Term of reference (c): Measures that can be taken to address regional variations in the cost of service delivery and the construction of aged care facilities:

To address regional variations in the cost of service delivery and the construction of aged care facilities, Blue Care recommends that:

- Operating costs:
  - the Australian Government explicitly adjust residential aged care subsidies, HACC unit prices and other fees according to the respective regional cost premium and mix of input costs.
- Residential aged care construction costs:
  - the Australian Government explicitly adjust the accommodation supplement according to the regional cost premia and the respective mix of input costs.

Term of reference (d): Whether there is an inequity in user payments between different groups of aged care consumers and, if so, how the inequity can be addressed:

- Residential aged care: There ***are inequities in user payments between different groups of residential aged care consumers***. These can be addressed by:
  - the Australian Government removing the distinction between low and high care and enabling providers to request an accommodation bond from all residents
  - the Australian Government eliminating the anomaly that exists in the income available to providers from partially supported residents.
- Community aged care: There ***are inequities in user payments between different groups of community aged care consumers***. These can be addressed by the Australian Government developing a national policy which includes:
  - consistency for common service types across funding programs
  - a flat fee per unit across all funding programs subject to means testing for personal care, domestic services, social support and centre based respite
  - administrative ease.

Term of reference (e): Whether the current planning ratio between community, high- and low-care places is appropriate:

- Residential aged care: Blue Care's resident ratio of 73% high care is close to the national average of 70%. The planning ratio of 44/44 explicitly assumes a ratio of 50% high care and 50% low care. Therefore, Blue Care submits that ***the current planning ratio between community, high-care and low-care places is not appropriate***.
- Community care: Blue Care considers that the current distribution of places for community services does not reflect community demand and is therefore ***not appropriate***.

Term of reference (f): The impact of current and future residential places allocation and funding on the number and provision of community care places:

- Community care:
  - funding for residential facilities ***impacts directly on the demand for community care*** because insufficient residential aged care funding results in poorly maintained buildings, resource stretched care staff and a lack of attractive residential aged care homes
  - if the current situation continues, it is likely that waiting lists for community services will grow with a consequence that people will need to be maintained within a funded service environment that is inadequate to meet their needs
  - in allocating places (and funds) there is a need to consider regional and seasonal factors.

This executive summary should be read in conjunction with the full submission.

2. Preface

2.1. Blue Care's scale of care

Blue Care is a UnitingCare agency in Queensland. An overview of Blue Care's scale of services is shown in the table below:

Table 1: Overview of the scale of Blue Care's services

Staff employed	10,153
Volunteers	3,030
Residential aged care	
No. of hostels	58
No. of nursing homes	35
No. of residential aged care beds (approx. 2.5% of funded residential aged care beds)	4,234
Days of residential aged care provided per annum	1,503,070
Provisional	442
Community care	
No. of client home visits per annum	2,180,298
No. of occasions of service per annum	2,627,386
No. of home nursing centres	77
No. of respite centres	59
No. of day therapy centres	12
No. of Cth Carelink Centres	4
Community Aged Care Packages	1,386
Extended Aged Care at Home Packages	188
No. of National Respite for Carers Programs	22

Source: Blue Care

2.2. Precarious position of residential aged care in Australia

The existence of this inquiry is evidence there are indications of the precarious financial position of residential aged care in Australia. This situation is adversely affecting the providers' sustainability and inhibiting capital investment decisions. Ultimately, this

may be expected to lead to a significant lack of capacity and shortfall in residential care for a growing number of frail, elder Australians[1].

The residential aged care industry faces several critical issues including:

- workforce ageing and shortages
- input cost increases which far exceed operational funding indexation
- a substantial capital funding shortfall
- regulation that stifles efficiency and optimal use of resources
- meeting rising consumer expectations for levels of service.

In addition, providers in both Queensland and Western Australia, in particular, face cost pressures as aged care providers compete with the mining sector for staff. At the same time the aged population is growing in Queensland at a faster rate than the national average.

In respect of workforce ageing and shortages, the Productivity Commission recently reported that the aged care workforce will need to dramatically increase but noted that aged care staff receive on average 10% less than the acute sector. The Commission noted that it would cost approximately $450 million a year to pay aged care workers at that level.

Respected chartered accountants, Grant Thornton recently released the findings of a survey of 700 nursing homes and hostels. This survey points to significant viability and capital funding issues.

Grant Thornton reported that aged care service providers' average earnings before interest, taxation, depreciation and amortisation (EBITDA) in 2008 was $2,934 per bed per annum which is a deterioration from 2007's $3,211. Modern high care facilities with single bedrooms reported the worst results, averaging $2,191. "This represents an average return on investment of approximately 1.1% for modern, single bedroom facilities".

According to a recent survey by chartered accountants, Stewart Brown for financial year 2007, on average, both high care and low facilities incurred losses continuing a downward trend that has been evident for some years, and only 18.2% achieved a break-even or better result. This situation is a clear signal of both the potential for significant financial failure among providers and a brake to new investment.

The residential aged care sector is comprised of one-third private sector providers. Financially astute members of the Senate Finance and Public Administration Committee (the Committee) will appreciate that an investment return in the order of 10% per annum would be required for private sector investment in residential aged care.

[1] The number of people over the age of 85 years will increase from about 400,000 to 1.6 million by 2047 (Trends in Aged Care Services: Some implications, Productivity Commission, September 2008).

Blue Care provides evidence later in this submission that the cost of establishing a new bed is in the order of $250,000 plus land. Simple maths suggests that the required return on investment in a new bed is $25,000 per annum. Thus the gap between the industry's current level of financial performance and the level required to sustain private sector involvement and allow all participants to expand the provision of residential aged care beds is substantial.

Under-subscriptions by providers in recent Aged Care Approval Rounds (ACAR) are evidence of the lack of present viability and a lead indicator of a looming undersupply of quality facilities.

This submission provides evidence that current residential aged care funding and indexation are not sufficient to meet the expected quality service provision outcomes. Continued inaction will adversely impact doctors in general practice, hospitals and community service delivery which will compromise quality and quantity of service delivered in a period of increased demand. Those most affected are likely to be the socially disadvantaged as the charitable sector's capacity to cross subsidise disappears.

The current funding regime and the limitations on providers to access realistic fees and user contributions for service from those residents *(with a capacity to pay)* needs significant reform. In this regard, Blue Care strongly advocates removing the distinction between low and high care and enabling providers to request an accommodation bond from residents presently classified as high care. The need for liberalisation of user contributions is now greater than ever with the advent of the global financial crisis.

Blue Care's submission to the Senate Finance and Public Administration Committee (the Committee) is in respect of both residential and community aged care as set out in the following sections under each term of reference.

3. Term of reference (a)

Whether current funding levels are sufficient to meet the expected quality service provision outcomes

3.1. Residential aged care

3.1.1. Background - illustrations of current funding

An *illustrative* income stream for a high care resident including the temporary conditional adjustment payment (CAP) is shown in the table below:

Table 2: Illustrative provider's daily income - a high care resident

	Pensioner (assets < $34,500)	Non-pensioner with assets > $90,410
Resident payments		
Basic daily fee	32.95	32.95
Income-tested daily fee	0.00	56.57
Accommodation charge ('rent')	0.00	26.88
DoHA payments		
'ACFI' care subsidy (less income tested fee)*	127.35	70.78
CAP (Temporary. 8.75% of the care subsidy)	11.14	11.14
Accommodation supplement (for >40% supported residents)**	26.88	0.00
Total daily income	**$198.32**	**$198.32**

** ACFI score is based across three domains of activities of daily living, behavioural and complex health care. The illustration is an ACFI "medium, high and medium" assessment.*
*** Capital funding component*

Source: Blue Care

For most high care residents, a provider earns:

- a daily care fee from a resident equivalent to 85% of an aged pension
- an Aged Care Funding Instrument ("ACFI") subsidy (less any resident contribution)
- a daily accommodation supplement (or a 'rent') for the provision of the home
- the CAP as a percentage of the ACFI subsidy.

ACFI is the recently introduced instrument for government funding of care. In respect of the ACFI component, funding is weighted towards high care and residents with challenging behaviours. Consequences of the instrument's design include:

- increases in residents' care needs do not necessarily result in an increase in care subsidy
- providers access to resident bond income is diminished (because bonds are only available from low care residents)
- documentation requirements take qualified nursing staff away from direct and indirect nursing care.

In the above illustration, the provider earns total revenue of $198.32 for the provision of 24 hour high level care, hospitality and accommodation.

A provider's income is distinguished by whether it is providing high care or low care. A significant difference in the funding of these two levels of care is that a provider is entitled to ask for an accommodation bond from a low care resident (subject to leaving the resident with no less than $34,500 in assets). Subject to a small retention, accommodation bonds are in effect refundable deposits which entitle the provider to the interest on bond only during the period of time a resident is accommodated.

An *illustrative* income stream for a low care resident including the temporary CAP is shown in the table below:

Table 3: Illustrative provider's daily income - a low care resident

	Pensioner (assets < $34,500)	Non-pensioner with assets > $90,410
Resident payments		
Basic daily fee	32.95	32.95
Income-tested daily fee	0.00	47.94
Accommodation bond – retention (max)**	0.00	9.60
Accommodation bond – interest (say $250,000 x 7.5%)**	0.00	51.37
DoHA payments		
'ACFI' care subsidy (less income tested fee)	47.94	0.00
CAP (Temporary. 8.75% of the care subsidy)	4.19	4.19
Accommodation supplement (for >40% supported residents)	26.88	0.00
Total daily income	**$111.96**	**$146.05**

** The illustration is a "low, low and low" ACFI assessment.*
*** Accommodation bonds (or 'refundable deposits' are a critically important source of funding for low level residential aged care. This avenue of funding is not available for high care facilities.*

Source: Blue Care

In the above pensioner illustration, the provider earns total revenue of up $111.96 for the provision of 24 hour low level care, hospitality and accommodation to a pensioner or $146.05 for a non-pensioner.

Under restrictive eligibility criteria, providers may be also able to offer extra services, which can be either low care or high care and involve a higher standard of accommodation, food and other non-care services.

3.1.2. Operating funding

3.1.2.1. Approach

For the purpose of responding to term of reference (a), Blue Care has decomposed funding into operating and capital elements.

As may be noted from section 3.1.1, DoHA operating funding for providers is in the form of an ACFI care subsidy and the temporary CAP which is an 8.75% loading on the subsidy.

To assess from Blue Care's experience whether current operating funding levels are sufficient to meet the expected quality service provision outcomes, we have determined:

- whether Blue Care provides quality service; and
- whether Blue Care's operating surpluses are sufficient to provide an adequate return for risk and sustain the provision of services.

3.1.2.2. Quality service provision

Blue Care considers that the following measures are instructive in determining whether we provide quality service:

- our relative performance in accreditation
- ratings by residents in satisfaction surveys.

Accreditation

The Aged Care Standards and Accreditation Agency is the body appointed by the Department of Health and Ageing as the accreditation body under the Aged Care Act 1997.

There are four Accreditation Standards:

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

Within the four Accreditation Standards are 44 expected outcomes. These include such outcomes as continuous improvement, education and staff development, safe and comfortable living environment and infection control.

In the 2007 Round 3 accreditation, Blue Care achieved results similar to the state averages for number of 44/44 outcomes and years of accreditation received.

Resident satisfaction

Each year Blue Care undertakes an organisation-wide resident satisfaction survey to determine how satisfied residents are with the services provided to them by Blue Care staff. This survey is important because it provides residents with the opportunity to comment on how satisfied they are with the care they receive. The information gathered helps Blue Care identify what they are doing well and where service improvements need to be made, enabling the enhancement of care through quality improvement processes.

Questions in the survey are grouped into a number of key areas:

- Care delivery

- Lifestyle factors
- Staff approach
- Complaints
- Choice and information
- Support services.

A detailed survey is sent to two groups of people. The first group surveyed is cognitively able residents. The second group is the representatives of residents who were not cognitively able to answer a survey. Representatives (family members or appointed substitute decision makers) are asked to complete the survey on behalf of the resident.

Independent mail houses and survey firms are used to distribute the surveys and aggregate responses.

In 2008, the survey population comprised 413 residents, 963 resident representatives and 205 for which the respondent could not be accurately identified. The overall Blue Care satisfaction level among residents was 89%, a similar level to the prior year.

Conclusion

Blue Care provides quality service. This assertion is supported by accreditation results and resident satisfaction.

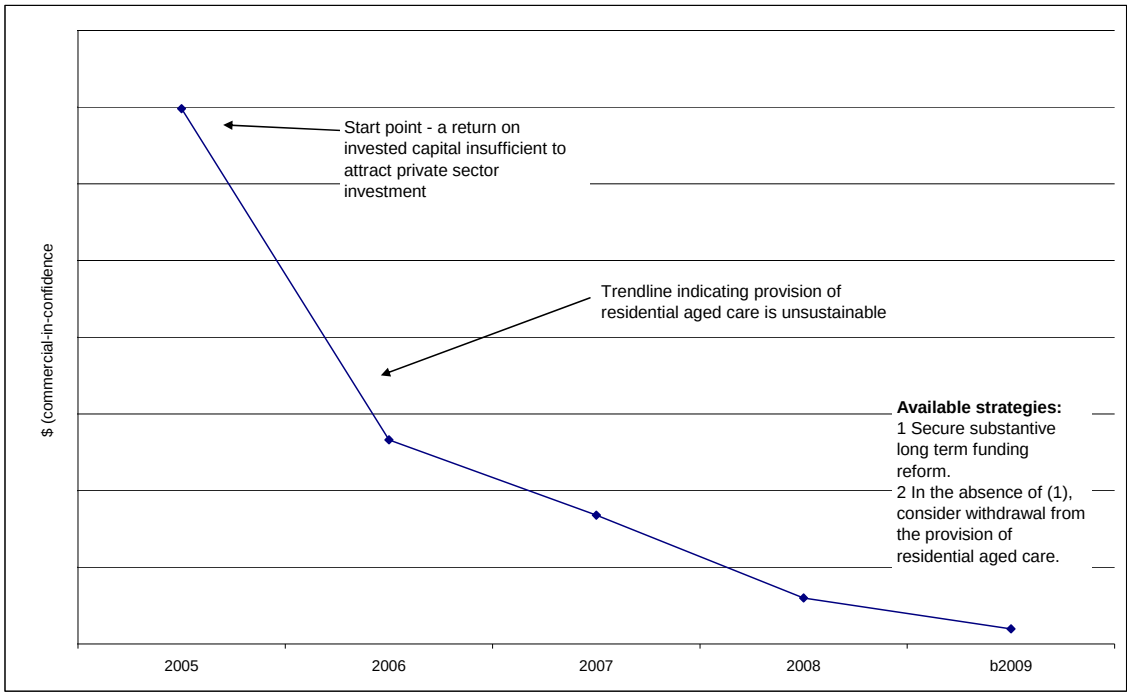
3.1.2.3. Whether Blue Care's operating results are sufficient to provide an adequate return for risk and sustain the provision of services

Blue Care's operating performance

Blue Care's operating surpluses/(deficits) across its 55 residential aged care sites are commercially sensitive and are not disclosed in this submission.

However, we note that Blue Care's operating financial performance has significantly diminished in recent years (along with the wider sector). Blue Care anticipates that operating results will further decline in financial year (FY) 2009 as a consequence of input costs increasing at a greater rate than funding. The trend of Blue Care's residential financial performance is shown in the following chart:

Figure 1: Blue Care's residential financial performance – FY2005 to budget FY2009



Source: Blue Care

The trend line shown in the above chart, does not alone demonstrate the adequacy, or inadequacy of current funding levels.

Consideration needs to be given to Blue Care's relative financial performance and to what would be level of an adequate operating surplus.

Blue Care's relative operating performance

Blue Care's relative financial performance may be considered by reference to a recent survey by chartered accountants, Grant Thornton of 686 facilities, representing almost a quarter of all Australian aged care facilities.

Grant Thornton reported in October 2008 that Aged care service providers' average earnings before interest, taxation, depreciation and amortisation (EBITDA) in 2008 was $2,934 per bed per annum which is a decline from 2007's $3,211. Modern high care facilities with single bedrooms reported the worst results, averaging $2,191. *"This represents an average return on investment of approximately 1.1% for modern, single bedroom facilities".*

Blue Care contributed to the Grant Thornton survey. Blue Care's average EBITDA per bed per annum was significantly higher than the Grant Thornton survey average of $2,934 per bed per annum. Further 69% of Blue Care's residential aged care facilities achieved an average EBITDA per bed per annum in excess of the Grant Thornton survey average.

Assuming Grant Thornton's survey results are representative of industry financial performance, Blue Care's outperforms the industry average benefiting from scale economies and a range of initiatives introduced as financial pressure has increased.

Conclusion – operating funding

The approach used in this analysis to make an indicative estimate of the shortfall in operational funding is to estimate the required level operating net income and quantify the shortfall based on Blue Care's average operating results.

As noted, Blue Care's residential aged care financial performance is commercially sensitive and is not disclosed in this submission. However, having regard to Blue Care's results and industry averages, Blue Care estimates that operating funding (ACFI subsidies in the main) are inadequate by an amount in the order of $5,500 per resident per annum. This amount translates to a requirement for additional operating funding in the order of $15 per resident per day.

Blue Care submits that ***current operating funding is not sufficient*** to meet the expected quality service provision outcomes.

This component of Blue Care's analysis does not apply to 'capital' funding which follows in section 3.1.3.

3.1.3. Capital funding

3.1.3.1. Approach

As may be noted from section 3.1.1, DoHA capital funding for providers is in the form of an accommodation supplement which is currently a maximum of $26.88 per resident per day.

The amount of $26.88 per resident per day applies to residents who have assets of less than $34,500 ('supported' residents). However, for the purpose of this analysis, the sufficiency of the maximum accommodation supplement is evaluated.

To assess, from Blue Care's experience whether current capital funding levels are sufficient to meet the expected quality service provision outcomes, we have determined:

- what constitute 'quality service provision' in terms of accommodation facilities
- what is the establishment cost of new accommodation (residential care places)
- whether the accommodation supplement is sufficient to provide an adequate return on capital invested in residential aged care places.

3.1.3.2. Quality service provision

DoHA's requirements for certification of new buildings include:

- an average of no more than 1.5 residents per room
- no individual room may accommodate more than 2 residents
- no more than 3 residents per toilet
- no more than 4 residents per bath or shower.

Residential aged care facilities are long term assets with a useful life of around 30 years. As such, a building needs to represent a competitive offering over its life to provide an adequate return on investment. Whilst the abovementioned requirements are mandated, community expectations influence Blue Care's determination of quality of new buildings.

Blue Care considers that to meet expectations of future residents, a quality residential aged care facility will contain the following minimum specifications:

- private bedrooms per resident: One
- private ensuite per resident: One
- space per resident: 55 – 60 square metres
- space per resident room: 23 square metres
- fit-out including fully ducted air-conditioning, active sprinkler systems, ceiling hoist-tracking, digital assistive aids and communication and resident recreation facilities.

3.1.3.3. Establishment cost

The establishment cost of a new place (or "bed") includes the costs of:

- land
- development and construction
- plant and equipment fit-out.

The major component is the cost of development and construction. Blue Care has considered the following sources in estimating this component:

- an assessment made by quantity surveyors, Rider Levett Bucknall in January 2008 which estimates the average building cost of a residential aged care bed at $219,611 (unescalated and does not include land or plant and equipment fit-out)
- estimates made by quantity surveyors for Blue Care's proposed new buildings.

Estimates of establishment costs per bed provided by quantity surveyors to Blue Care for proposed projects plus an adjusted Rider Levett Bucknall estimate are shown in the table below:

Table 4: Estimate of costs per bed excluding land (November 2008)

Location	Costed at	Total cost $ millions	Beds	Per bed	Escalated to Nov-08 [1]
North Queensland	Sep-06	$ 32.7	128	$255,769	$ 298,810
Brisbane	Mar-07	$ 36.4	128	$284,150	$ 320,263
Sunshine Coast	Oct-07	$ 23.2	96	$228,250	$ 246,709
Central Queensland	Apr-08	$ 12.2	64	$190,884	$ 199,047
Sunshine Coast	May-08	$ 18.5	96	$192,700	$ 199,742
North Queensland	Jan-08	$ 16.7	68	$245,397	$ 260,525
Simple average (by project)					**$ 254,183**
Rider Levett Bucknall (note 1)	Jan-08			$234,611	**$ 249,074**

Notes:

1 Escalated amounts include allowance for building cost price increases of 7.2% per annum.

2 Blue Care's adjustment of the Rider Levett Bucknall estimate includes an allowance of $15,000 for plant and equipment per bed plus escalation.

The estimated average establishment cost per bed of the abovementioned proposed residential aged care facilities is $254,183. This closely approximates the estimate made by Rider Levett Bucknall adjusted to include plant and equipment and escalation to November 2008.

Having regard to the Rider Levett Bucknall report and Blue Care's own experience, it is submitted that the present establishment cost of a new residential aged care place is in the order of $250,000 plus land.

3.1.3.4. Whether the maximum accommodation supplement sufficient to provide an adequate return on investment

Discounted cash flow methodology

The amount of investment in a new residential aged care place (bed) that is supported by the maximum accommodation supplement may be estimated by discounted cash flow analysis (DCF).

This methodology involves developing assumptions and projecting the cash flows from investment in a bed ie the initial investment and subsequent cash inflows and outflows. These cash flows are discounted to net present value (NPV) at the rate of return an investor would require for investment in aged care bed.

Applying the DCF methodology, the amount of initial investment (in a bed) supported by cash flow stream which includes the accommodation supplement is determined iteratively. (ie the process determines what amount of initial investment produces a zero NPV at the required investment rate of return).

Assumptions

Key assumptions are as set out in the table below:

Table 5: Assumptions

Land cost per bed $	20,000					
Land appreciation	4.0%					
Building useful life	30					
Tax rate	30%	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5
Accommodation payment prpd*	$26.88	$26.88	$26.88	$28.71	$30.54	$32.38
Occupancy	95%	95%	95%	95%	95%	95%
Annual "rent" $	9,321	9,321	9,321	9,955	10,590	11,228
Income growth (year 6 on)	2.5%					
Capital replacement (% of original capital)	35%					
Required property IRR	**9.0%**					

* *Assumes accommodation supplement payments increase in accordance with the previous government's 2007 Securing the Future package*

Projected cash flow

A projected cash flow has been developed using the above assumptions to provide an internal property investment rate of return of 9%.

To develop the cash flows to produce the required rate of return is an iterative process whereby the variable is the amount able to be invested in a bed.

The projected cash flow per bed based on the above assumptions is as shown below:

Table 6: Projected cash flow per bed (extract)

Year	**0**	**1**	**2**	**3**	**~5**	**~30**
Rent		9,321	9,321	9,955	11,228	20,816
Capital replacements						
Depreciation tax shield		1,163	1,163	1,163	1,163	1,163
Purchase land/ sell land	(20,000)					64,868
Building cost and fit-out	***(116,310)***					0
Net cash flow $	**(136,310)**	**10,484**	**10,484**	**11,118**	**12,391**	**86,847**

As indicated in the above table, an investment in a bed of $116,310 would provide an adequate return to a commercial property investor.

This calculation generally accords with information in the public domain as to the amount the previous government intended to fund.

Conclusion – capital funding

In section 3.1.3.3, Blue Care has provided evidence of the establishment of a bed as being in the order of $250,000. Applying this amount, the shortfall in capital funding is in the order of $133,690 per bed.

Blue Care estimates that an in increase in the maximum accommodation supplement from $26.88 per resident per day to $62.81 per resident per day is required to adequately fund investment in new beds.

Blue Care submits that ***current capital funding is not sufficient*** to meet the expected quality service provision outcomes.

3.2. Community aged care

Term of reference (a): Whether current funding levels are sufficient to meet the expected quality service provision outcomes

3.2.1. Expected quality service provision outcomes

Blue care receives funding from a range of community programs. For the purpose of this submission, we will focus on the Home and Community Care Program, Community Aged Care Packages (CACP) and Extended Aged Care at Home (EACH).

Blue Care meets all accreditation standards and successfully meets quality reporting and review process requirements as required by State and Federal governments with current funding levels. However the costs associated with meeting some of the quality standards, for example, HACCP food service standards, can be significant in terms of building design and staffing arrangements.

Blue Care is audited every three years for each of its 85 HACC SPID contracts as is the case for CACPs, NRCP and EACH programs. These services have met the required standards.

All Blue Care community services undertake client satisfaction surveys annually. In 2008, 3,693 clients were surveyed with an overall satisfaction rate of 97% (clients accessing HACC, DVA and VHC services). In 2008, 674 clients who accessed DTC, CACPs, EACH, NRCP and other funding types were surveyed with a 95% satisfaction rate.

3.2.2. HACC

Under Blue Care's rolling HACC contract unit prices vary across individual projects (SPIDs). The base prices for our core funding were agreed in May 2005, implemented in July 2006 (plus indexation for 2005-06). Since then base funding has been subject to annual indexation, with no opportunity for reviewing the amount or allocation of that funding nor corresponding output requirements by service type.

Due to the block funding approach used by HACC, quality of service per hour is not compromised by a lack of funds. However, as unit prices are effectively eroded by inflation Blue Care's ability to meet contracted outputs is affected. In order to maintain quality and cover unit costs, volumes of care in terms of outputs achieved, may fall.

The inability to regularly review the allocation of base funding in terms of SPIDs and service types means that services cannot respond to changes in demography, models of care or availability of resources in a timely manner.

The table below highlights the variation in unit prices received by Blue Care across the state, as at 1 July 2008:

Table 7: HACC programs – variation in units prices

Service Type	SPID	HACC District	Unit Price (per hour)	No. of Units (per annum)
Personal Care	27	Bowen	$29.10	2,495
Personal Care	929	Redcliffe / Caboolture	$37.74	12,881
Allied Health	61	Bayside	$62.01	4,518
Allied Health	12	Redcliffe - Caboolture	$73.28	5,720

Service Type	SPID	HACC District	Unit Price (per hour)	No. of Units (per annum)
Allied Health	29	North Burnett	$70.42	1,830
Nursing	60	Redcliffe – Caboolture	$62.23	13,634
Nursing	5	Townsville	$78.13	9,867
Nursing	324	Queen Elizabeth II Hospital, Brisbane	$73.60	35,808

Source: Blue Care

The wide degree of variation in prices means that some SPIDs are better able to meet contractual output requirements whilst maintaining quality care than others. Although some variation is justified by different models of care and cost structures, many variations are arbitrary and historical.

There is an increasing reliance on client contributions to maintain services given rising costs. Blue Care is keenly anticipating some clearer guidelines from government on this issue as a result of the work on the National Consumer Fees Framework, and recognition of the importance of this funding stream to ensure the future sustainability of services.

Blue Care is developing innovative models of care which will help increase the efficiency of the provision of quality care and the productivity of valuable staff, for example the use of tele-health and group based services. These developments are motivated by a desire for better outcomes for clients but also by cost and resource constraints.

3.2.3 CACPs / EACH

CACPs and EACH have a different funding model. There is a daily subsidy plus a defined client fee. The latter may be waived if clients are suffering financial hardship.

Currently the fees are $34.75 subsidy plus $6.78 client fee per day for CACPs and $116.16 plus $6.78 per day for EACH. These rates are regularly reviewed and increased. Currently Blue Care provides on average 5 visits, which equates to about 6 hours of care, per client per week for that subsidy.

The client fee is a key component of the funding which can put disadvantage programs in financially disadvantaged areas.

The fee structure also creates a transitional issue between HACC and CACPs. As there is no defined fee policy for HACC, HACC clients pay a fraction of what CACPs clients do in terms of contributions to services. Therefore, there is currently a financial disincentive for a client to move onto a CACP (even though their needs assessment may recommend this).

Blue Care is able to provide a quality service to clients at current rates, although if rates do not keep pace with costs the impact would be a reduction in hours of care provided to clients each week.

3.2.3. Summary and recommendations

Current funding levels are sufficient to meet the expected quality service provision outcomes. However, we note:

- There is currently limited capacity to regularly review base funding. It is essential that indexation keeps pace with costs or else volumes of care will be compromised.
- Regular review of HACC contracts is necessary:
  - to provide some flexibility in service provision so output requirements can be responsive to changes in demography and models of care, and encourage innovation
  - to avoid perpetrating historical variations in prices across the state which may no longer be relevant
  - to ensure indexation has kept pace with changes in real costs so projects remain viable into the future.
- The increasing reliance on client contributions needs to be recognised and clearer national guidelines issued as soon as possible to assist providers in developing appropriate policies and transitioning clients from HACC services to packaged care.

4. Term of reference (b)

How appropriate the current indexation formula is in recognising the actual cost of pricing aged care services to meet the expected level and quality of such services

4.1. Residential aged care

4.1.1. Economic analysis

On 22 September 2008, a submission was made to the Department of Health and Ageing (DoHA) in respect of a review of the Conditional Adjustment Payment (CAP) by Access Economics Pty Limited for Baptist Care Australia, Catholic Health Australia and Uniting Care Ageing NSW & ACT. That submission assessed whether subsidy rates have grown faster than input costs. Key findings of that submission included:

- *'Basic subsidy rates are adjusted annually in line with movements in the COPO index formula. The particular index used for residential aged care is Wage Cost Index 9 (WCI_9), which is weighted at 75% for wage costs and 25% for other costs. WCI_9 uses the growth in the Safety Net Adjustment (SNA) for indexing wage costs and the growth in the CPI for non-wage costs.*

- *The annual increase in the CAP (has been an) additional 1.75% increase in the adjusted basic care subsidy, making the real annual indexation factor a combination of WCI_9 and the CAP increase.*

- *Over the four years following the introduction of (the temporary) CAP in 2004-05, . . . increases in both high care subsidy rates (average of 3.5% per annum) and low care rates (average of 3.7% per annum) only kept pace with CPI growth and, indeed, slightly exceeded it when topped up by the CAP.*

- *The (temporary) CAP on top of basic subsidy rates has meant that the growth of Government funding for residential aged care has slightly outpaced CPI growth since 2004-05. However, even with the inclusion of the CAP, subsidy increases have been 0.7% to 0.9% less than the increase in the LPI (health and community services) cost growth over this same period.*

- *Nurses' wages have lifted notably in recent years thanks to strong demand, and the above trends suggest that demand will remain strong going forward.*

- *Going forward, the sector's funding needs will continue to rise as a result of cost pressures arising from the growing demands and complexity of aged care needs. Increasing frailty will be compensated by movement towards higher subsidy rates, but the strong demand may result in continued strong growth in wages for nurses and personal care attendants.'*

The Committee may access the abovementioned submission at:

http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-cap-submissions-received-2008.html

On the basis of the abovementioned analysis prepared by Access Economics, Blue Care submits that:

- The current indexation formula is not appropriate in recognising the actual cost of pricing aged care services to meet the expected level and quality of such services.
- Future indexation formulae should:
  - reflect aged care providers' input cost increases as measured by industry specific indices
  - recognise regional input cost disparities such as staff cost imposts present in mining areas.

4.1.2. Blue Care's input cost analysis

Input cost analysis

Evidence of increases in Blue Care's input costs may be obtained from a period on period comparative analysis. This analysis has been conducted over the periods from FY 2006 to FY 2008.

In conducting comparative financial analysis it is necessary to consider:

- the effect of differences in volume of inputs and outputs: Blue Care records costs on a per resident per day basis. This largely eliminates the effect of volume differences and allows comparison of costs between financial periods
- differences in the mix of services: Blue Care's resident acuity levels, as measured by the now superceded Resident Classification Scale (RCS), are not significantly different over the periods being analysed. Likewise, the ratio of high care/low care residents is similar
- differences in efficiency: Blue Care is engaged in continuous improvement and has made many initiatives to improve effectiveness and efficiency during the period being analysed. Blue Care considers that there has been no diminution in efficiency during the period being reviewed that would explain unit cost increases.

Blue Care has analysed facility operating costs which constitute between 97.3% and 101.4% of operating income. This analysis is further detailed in the table below:

Table 8: Analysis of Blue Care's residential aged care input costs FY 2006 to FY 2008

	Notes	FY 2006	FY 2007	FY 2008
Key residential indicators				
No. operating beds	1	*4,198*	*4,121*	*4,118*
Occupancy	1	*98.0%*	*98.4%*	*98.2%*
Average RCS	1	*3.3*	*3.2*	*3.2*
HC/LC ratio:				
High care	1	*71%*	*73%*	*73%*
Low care	1	*29%*	*27%*	*27%*
Operating costs as a % of operating income		*Not disclosed*	*+0.7%*	*+3.0%*
Analysis of input cost increases:	2			
Client staff care costs	3		6.2%	7.0%
Kitchen and catering			8.6%	6.3%

	Notes	FY 2006	FY 2007	FY 2008
Laundry and cleaning			5.4%	1.3%
Property maintenance			6.8%	14.0%
Utilities			10.7%	7.5%
In-facility administration and information technology			(2.2)%	8.1%
Training			5.2%	7.2%
Total operating costs (excl. central admin)			6.1%	7.1%

Notes:

1 As is evident from these indicators, Blue Care's resident mix and service output volumes are similar over the three years subject to analysis.

2 This measures the percentage increase or decrease in costs per resident per day over the prior year.

3 Client staff care costs represent approximately 60% of operating income.

As is evident from the above table, Blue Care's input costs per resident per day have increased by 6.1% in FY 2007 over 2006 and by 7.1% in FY 2008 over FY 2007. Most major cost captions have increased by more than 5%.

Operating income

As noted in section 4.1.1, Access Economics have reported that high care subsidy rates have increased annually at an average of 3.5% per annum and low care rates at an average of 3.7% per annum including CAP (since the introduction of CAP).

Conclusion

The above analysis shows that Blue Care's unit input costs to service a similar resident base have increased by 6.1% in FY 2007 and by 7.1% in FY 2008. Access Economics report subsidy increases of around 3.5% during this period (including the temporary CAP). Blue Care's input costs have increased at almost double that rate.

On the basis of input cost analysis, Blue Care submits that ***the current indexation formula for residential aged care is not appropriate*** in recognising the actual cost of pricing services to meet the expected level and quality of such services.

4.2. Community aged care

How appropriate the current indexation formula is in recognising the actual cost of pricing aged care services to meet the expected level and quality of such services

The economic analysis included above in section 4.1.1 is largely relevant to community services.

In 2005, Blue Care renegotiated our contract with HACC. In the process, contracted output requirements were amended, SPID by SPID, to more manageable levels given our allocated funding. This had the affect of increasing the effective unit price whilst we were able to reallocate funding between service types to better reflect community need.

These rates have been rolled forward since then subject to annual indexation. Indexation has not kept pace with the CPI nor with increases in wage costs. This is illustrated in the following table:

Table 9: Comparison of HACC indexation with other cost indices and Blue Care's input cost increases

	2005-06	2006-07	2007-08
HACC indexation	**2.20%**	**2.10%**	**2.30%**
Contrasts with:			
Other indices:			
Consumer price index (CPI)	4.00%	2.10%	4.50%
LPI *	4.70%	4.10%	3.80%
Blue Care's estimated cost increases:			
Wages and salaries under EBAs			
Personal Care	4.10%	4.05%	4.00%
Allied Health	4.00%	4.00%	7.00%
Nursing	3.25%	4.75%	8.50%
75% EBA + 25% CPI:			
Personal Care	4.08%	3.56%	4.13%
Allied Health	4.00%	3.53%	6.38%
Nursing	3.44%	4.09%	7.50%

*LPI – Labour Price Index; Financial Year Index ; Total hourly rates of pay excluding bonuses ; Australia ; Health and community services ; Private ; All occupations

Source: Blue Care and Australian Bureau of Statistics

The above table highlights the disparity between HACC indexation and other relevant indexes and rates of cost increase.

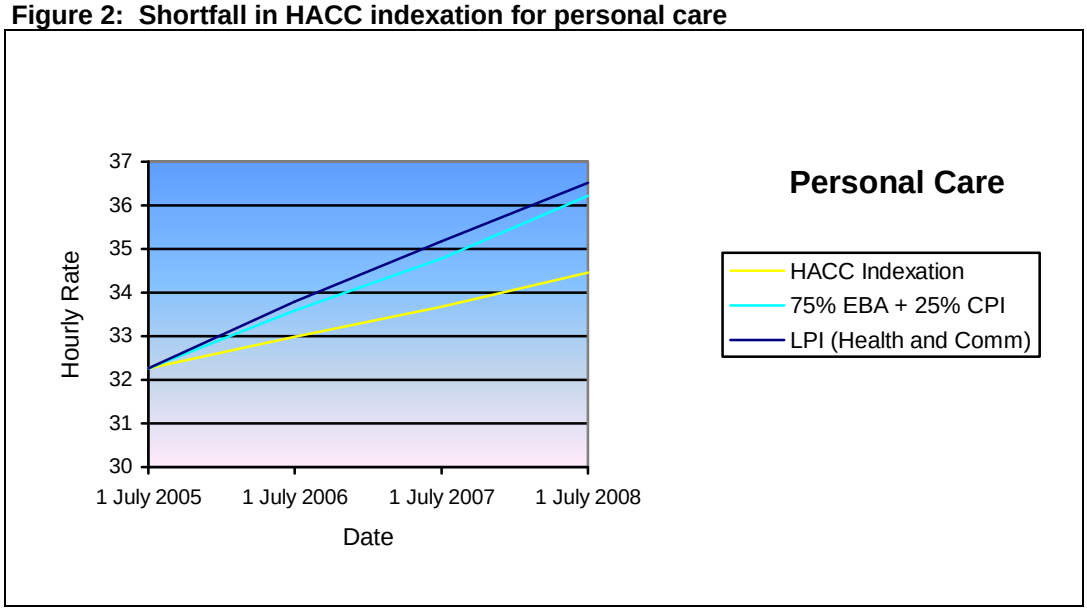
The Enterprise Bargaining Agreements (EBA) shown in the table are those agreed between Blue Care and the respective unions during the period. The real increase in costs to Blue Care can be approximated by taking 75% of the EBA rate of increase, and 25% of the CPI. This proportion does reflect the split of our costs, 75% staff, 25% other.

Real costs have been affected by increasing difficulty finding and retaining good staff which results in the need to remunerate competitively, combined with significant recent increases in food and fuel costs.

The EBA increases for nurses, health professionals and care workers have been driven by the public sector. Non-government organisations, such as Blue Care, are competing with public sector employers for the recruitment and retention of appropriately trained staff, and therefore have to match their pay scales. Significant recent wage inflation is putting pressure on services to be more creative with their capped funds, which then tests commitment to quality.

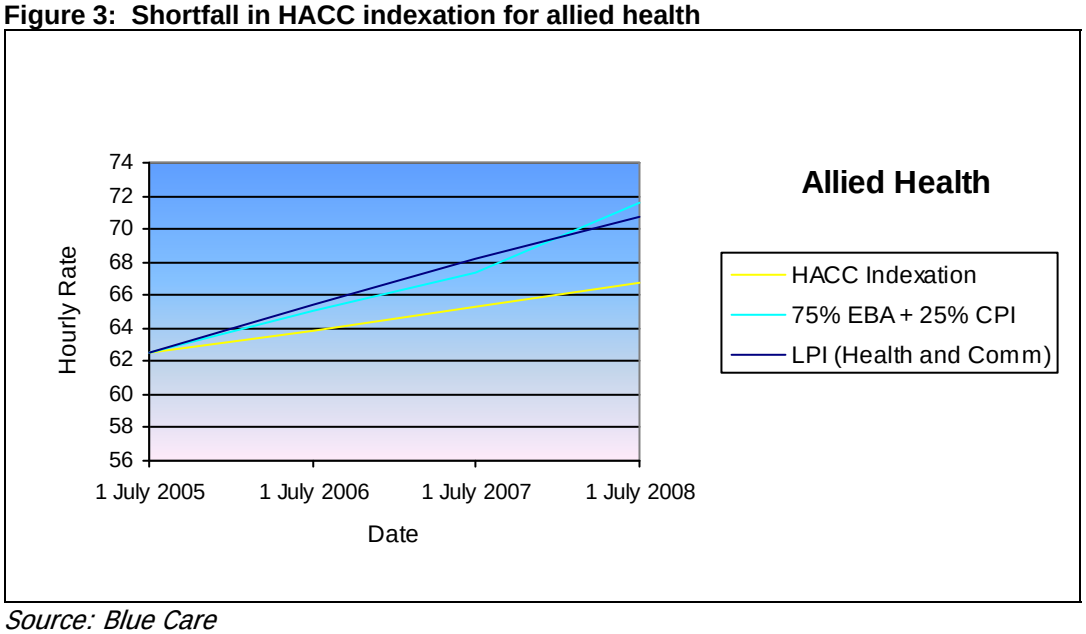
The charts below illustrate how HACC indexation has failed to keep pace with real increases in underlying costs since the contract was renegotiated:

Figure 2: Shortfall in HACC indexation for personal care



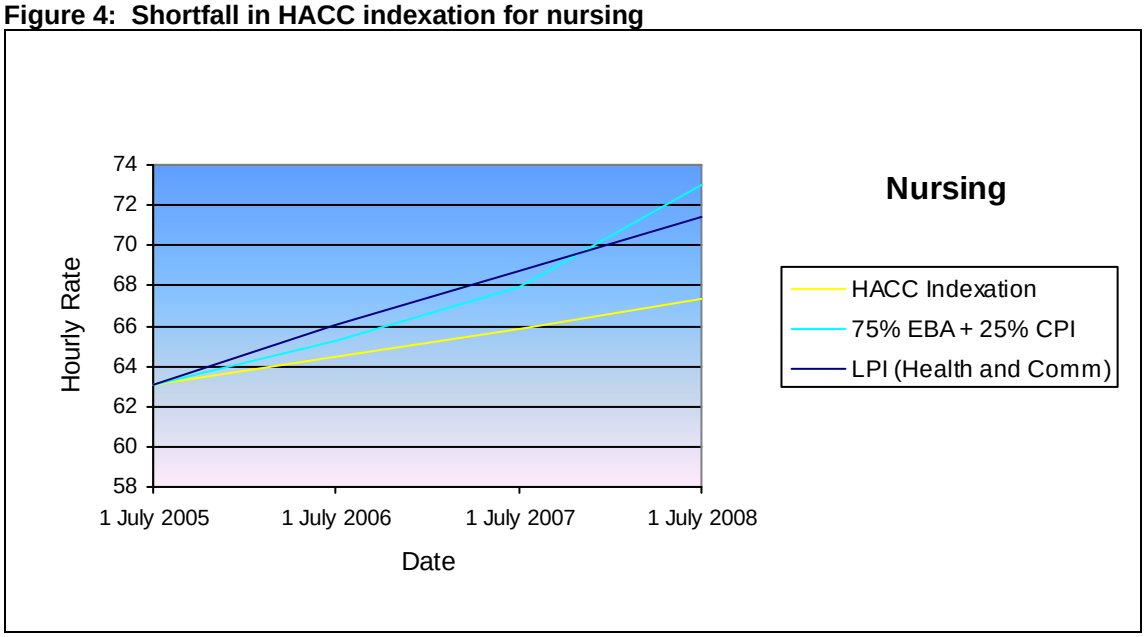
Source: Blue Care

Figure 3: Shortfall in HACC indexation for allied health



Source: Blue Care

Figure 4: Shortfall in HACC indexation for nursing



Source: Blue Care

The above analysis clearly illustrates the impact of insufficient indexation on base funding which will result in a decrease in volumes of service provision in order to maintain quality and viability over time.

On the basis of input cost analysis, Blue Care submits that the current HACC indexation formula is ***not appropriate*** in recognising the actual cost of pricing aged care services to meet the expected level and quality of such services.

5. Term of reference (c)

Measures that can be taken to address regional variations in the cost of service delivery and the construction of aged care facilities

5.1. Adverse variations in regional Queensland

5.1.1. Residential aged care

Blue Care incurs higher operating costs in regional areas. Examples include:

- in small facilities serving rural, but not remote, areas
- in the town of Emerald in inland central Queensland the demand from the mining industry for staff and residential housing make it necessary to fly-in/fly-out staff and bear the cost rental accommodation for those staff
- fruit and vegetables in Queensland are mostly sourced through the Brisbane market. Additional transport costs are incurred in distributing these to regional areas.
- electricity costs are up to 60% higher in North Queensland than in Brisbane
- liquid petroleum gas costs of up to 31% higher in some of Blue Care's regional locations compared to Brisbane.

It is noted that the Australian Government pays a viability supplement to improve the capacity of small rural aged care homes. However, the emphasis on remoteness denies small aged care homes in rural, but not remote, areas of needed funding.

Construction costs are also higher in regional locations. For example, quantity surveyors' estimates provided to Blue Care for proposed new building costs include the following regional cost premia over the south east Queensland: Rockhampton: 5%, Cairns: 10%, and Roma: 15%.

5.1.2. Community aged care

Recruitment, retention, and flexibility of employment conditions for rural staff are especially costly, examples include:

- several Blue Care services in the Central Queensland Wide Bay area have recruited from overseas to fill long term vacant positions
- in recent recruitment drives, some Blue Care services have had to offer to provide vehicles, return trips to town of origin in Australia, relocation expenses and rental assistance
- the Allied Health Service in Rockhampton continues to have a vacancy for a physiotherapist after four years of advertising
- in rural mining areas, Blue Care has to bring in administrative staff from some distance to support the service as local people choose to work in the mines where pay is substantially higher.

5.2. Measures

To address regional variations in the cost of service delivery and the construction of aged care facilities, Blue Care recommends that:

- Operating costs:
  - the Australian Government collect data on regional premia applying to the major input costs for residential and community aged care
  - based on this data, the Australian Government identifies specific regions where cost premia apply
  - the Australian Government explicitly adjusts residential aged care subsidies, HACC unit prices and other fees according to the regional cost premium and respective mix of input costs
  - the viability supplement be reviewed with a view to providing more assistance to small rural, but not remote, aged care homes.
- Construction costs:
  - the Australian Government collects data on regional construction cost premia applying to residential aged care facilities
  - the Australian Government explicitly adjusts the accommodation supplement according to the regional cost premium and respective mix of input costs.

6. Term of reference (d)

Whether there is an inequity in user payments between different groups of aged care consumers and, if so, how the inequity can be addressed

6.1. Residential aged care

6.1.1. User payments and inequities

6.1.1.1. Differences between low care and high care

Illustrations of user payments for high care residents are shown in the table below:

Table 10: Illustrative user payments - high care

	Pensioner (assets < $34,500)	Non-pensioner with assets > $90,410
Resident payments		
Basic daily fee	32.95	32.95
Income-tested daily fee	0.00	56.57
Accommodation charge ('rent')	0.00	26.88
Total resident payments	**$32.95**	**$116.40**

Source: Blue Care

The above table deals with residents with assets of less than $34,500 (supported residents) and residents with assets greater than $90,410. Residents with assets between $34,500 and $90,410 are described by DoHA as 'partially supported' and are discussed later.

For high care residents, it is notable that user payments include:

- a daily care fee from a resident equivalent to 85% of an aged pension
- an income tested daily fee. The amount of the Government paid ACFI subsidy reduces by the amount of any resident payment
- depending on asset levels, a daily accommodation charge (or a 'rent') for the provision of the home (maximum of $26.88).

Illustrations of user payments for low care residents are shown in the table below:

Table 11: Illustrative user payments - a low care resident

	Pensioner (assets < $34,500)	Non-pensioner with assets > $90,410
Resident payments		
Basic daily fee	32.95	32.95
Income-tested daily fee	0.00	47.94
Accommodation bond – retention (max)*	0.00	9.60
Accommodation bond – interest (say $250,000 x 7.5%)*	0.00	51.37
Total resident payments	**$32.95**	**$141.86**

** Accommodation bonds (or 'refundable deposits' are a critically important source of funding for low level residential aged care. This avenue of funding is not available for high care facilities.*

Source: Blue Care

The above table illustrates the accommodation bond retention and interest available to a provider of low care. This contrasts with high care admissions where bonds are not available.

The maximum accommodation charge of $26.88 per resident per day in high care can be matched by income from a bond of $105,120 as shown below:

Table 12: Bond amount required to provide income equiv. to the max. accom. charge

		$ Per Day
Bond	$105,120	
Retention (per annum)	$3,504	9.60
Interest (say, 6.0%)		17.28
Income per day		**$26.88**

Source: Blue Care

In Blue Care's experience, many prospective residents have a capacity to pay a bond in excess of $105,120. Consequently, the prohibition of bonds in high care severely constrains providers with access to much needed capital which could be used to fund high care facilities (and consequently deprives older Australian of potential new high care homes).

Differences between supported residents and partially supported residents

As noted, the DoHA capital funding for providers is in the form of an accommodation supplement which is currently a maximum of $26.88 per resident per day.

The amount of $26.88 per resident per day applies to residents who have assets of less than $34,500 (supported residents). This amount in fact diminishes as residents assets increase above this threshold.

For residents with assets above the threshold, the amount of the daily supplement will be reduced by 1/2080th of their assets over the threshold. (On this basis, the supplement will reduce to zero where residents' assets exceed $90,410). An illustration of the reducing amount is shown below:

Table 13: Illustration of the diminishing accommodation supplement

Resident's Assets	Accommodation Supplement*
$34,500	$26.88
$45,000	$21.83
$50,000	$19.43
$60,000	$14.62
$70,000	$9.81
$80,000	$5.01
$90,410	$0.00

** Assuming the residential aged care facility maintains a ratio of supported residents of 40% or more*

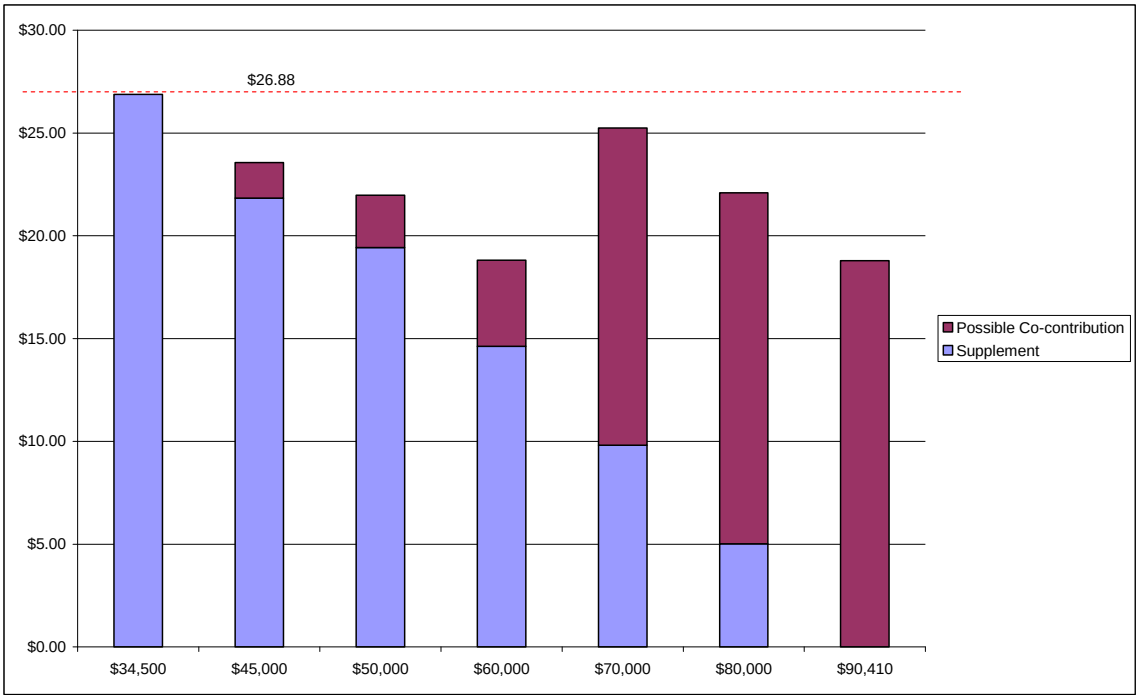
Source: DoHA New Accommodation Supplement

There is an anomaly in this sliding scale as co-contributions, if any, from residents with assets between $34,500 and $90,410 are unlikely to make up the difference in the supplement where a partially supported resident's assets exceed $34,500.

The chart below illustrates for low care residents:

- the declining amount of the DoHA paid supplement for partially supported residents (blue shaded component of the bars)
- the possible co-contribution/user payment by way of retention and interest from a bond made up the amount of a resident's assets minus $34,500 (interest at 6%) (the maroon shaded component).

Figure 5: Partially supported residents – DoHA accommodation supplement and possible user co-contributions (low care)



Source: Blue Care

As is evident from the above chart, a provider's income from a partially supported low care resident is likely to be less than from a supported resident even with a co-contribution.

As noted, for a high care resident, a provider is not entitled to obtain a bond and the income received for a partially supported high care resident in Blue Care's experience may be as little as the reduced amount of the accommodation supplement (blue shaded component of the above chart).

Summary

In summary, there are inequities in user payments between different groups of aged care consumers. The major inequities are:

- Accommodation bonds are not available from high care residents. The national resident population is comprised approximately 70% by high care residents and 30% by low care residents. In Blue Care's experience, the prohibition of bonds in high care severely constrains access by:
  - residents to better quality high care facilities

  - providers to much needed capital which could be used to fund high care facilities.

- A provider's income from a partially supported low care resident is likely to be less than from a supported resident even with a co-contribution.

6.1.2. How these inequities can be addressed

The abovementioned inequities can be addressed by:

- the Australian Government removing the distinction between low and high care and enabling providers to request an accommodation bond from residents presently classified as high care

- the Australian Government eliminating the abovementioned anomaly that exists in the income available to providers from partially supported residents. This may be done my mandating a user co-contribution such that the combination of accommodation supplement and co-contribution equal the maximum supplement available from fully supported residents.

6.2. Community aged care

Whether there is an inequity in user payments between different groups of aged care consumers and, if so, how the inequity can be addressed

6.2.1. Inconsistency in user pays arrangements between funding bodies

The absence of clear guidelines on HACC service client contribution and the fees associated with CACPs, EACH, and NRCP often mean that the decision about how people's needs are best met are driven by what they can afford or are prepared to pay.

This puts pressure on clients, clinical staff and service providers involved in care planning decisions about quality service. This is further exacerbated by the services available to clients who have DVA funding and rarely pay any fee.

6.2.2. Measures

Blue Care considers that there is a need for a consistent national policy on client contributions for community care which includes:

- consistency for common service types across funding programs eg domestic assistance under DVA, HACC and CACPs (whether provided by Blue Care or another agency)
- a consistent process across funding programs for assessment of hardship
- a flat fee per unit across all funding programs subject to means testing for personal care, domestic services, social support and centre based respite
- administrative ease.

7. Term of reference (e)

Whether the current planning ratio between community, high-care and low-care places is appropriate

7.1. Residential aged care

7.1.1. Background - planning ratio

According to DoHA , the planning framework for services provided under the Aged Care Act aims to achieve and maintain a national provision level of 113 operational residential places and community aged care places per 1,000 of the population, aged 70 years and over, by June 2011.

Within this overall target provision ratio, 44 of the total 113 places per 1,000 should be residential high care places, 44 should be residential low care places, and 25 places should be community care places (of which four will be Extended Aged Care at Home or Extended Aged Care at Home-Dementia packages).

7.1.2. Blue Care's and Australia's resident ratios

The ratio of high care and low care places in Blue Care's residential aged care homes is shown in the table below:

Table 14: Blue Care's residential aged care ratios FY 2006 to FY 2008

Notes	FY 2006	FY 2007	FY 2008
No. operating beds	4,198	4,121	4,118
HC/LC ratio:			
High care	71%	73%	73%
Low care	29%	27%	27%

Source: Blue Care

At 30 June 2007, there were 170,071 residential aged care places. According to The Australian Institute of Health and Welfare , residential aged care is meeting the care needs of an increasingly more dependent group of people. The majority of residents at 30 June 2007 were assessed as high-care (70%).

7.1.3. Whether the current planning ratio between community, high-care and low-care places is appropriate

Blue Care's resident ratio of 73% high care is close to the national average of 70%. The planning ratio of 44/44 explicitly assumes a ratio of 50% high care and 50% low care. Therefore, Blue Care submits that ***the current planning ratio between community, high-care and low-care places is not appropriate***.

7.2. Community aged care

Whether the current planning ratio between community, high-care and low-care places is appropriate

Blue Care considers that with increased demand from clients to stay at home for longer there will need to be increased funding at the higher end of community packaged care, i.e. the EACH program.

EACH programs are carrying long waiting lists, so by the time clients are admitted to the program they are already at the higher needs end of the EACH spectrum and require high levels of care and support. This creates a false step between CACPs and EACH, and means clients are staying on a CACP for too long with their needs not being sufficiently catered.

Clients would be better serviced by a review of the definition of a CACP with a resulting increase in the level of care available so the gap between EACH and HACC is better bridged. In addition a greater number of EACH packages is required to meet the demand.

8. Term of reference (f)

The impact of current and future residential places allocation and funding on the number and provision of community care places

8.1. Community aged care

In Blue Care's experience families now leave admission to residential facilities as long as possible. Potential factors in this decision include philosophical reticence about the step to leave the community, concern about service delivery and funding as frequently portrayed in the media, and concern about the built environment.

Funding for residential facilities impacts directly on the demand for community care because insufficient residential aged care funding results in poorly maintained buildings, resource stretched care staff and a lack of attractive residential aged care homes.

If the current situation continues, it is likely that waiting lists for community services will grow with a consequence that people will need to be maintained within a funded service environment that is inadequate to meet their needs.

In allocating places (and funds) there is a need to consider regional and seasonal factors. For example, the needs of elders forming part of the transient population that visit Queensland as part of the "north for the winter" migration.