Aged Care Association Australia

Submission

to

SENATE FINANCE

AND

PUBLIC ADMINISTRATION COMMITTEE

INQUIRY INTO RESIDENTIAL AND COMMUNITY AGED CARE IN AUSTRALIA

Introduction

Aged Care Association Australia (ACAA) welcomes the opportunity to make this submission to the Senate Finance and Public Administration Committee Inquiry into Residential and Community Aged Care in Australia.

ACAA is an industry stakeholder organization representing over one thousand aged care providers across Australia. The ACAA membership comprises both not for profit and for profit service providers with these members operating or providing services in the community, seniors housing and residential care domains.

ACAA therefore has a direct representational interest in ensuring that the Australian aged care industry is resourced to provide quality services and infrastructure within a financially sustainable, economically and socially responsible framework.

This submission responds to each of the terms of reference detailed in the Inquiry announcement whilst referring to a number of supporting documents, publications and research that may assist in a better understanding of the aged care industry and the current strengths and weaknesses of the industry.

Background

The Australian economy and broader society will face significant structural pressures over the next thirty five years. Table 1 below details the rapid change in the demographic profile of Australia. As the most resource intensive component of any part of the care continuum is in servicing the over 85s the four fold increase in this population group over the next forty years will place enormous pressure on service delivery capacity and the ability to finance this growth whilst sustaining a declining workforce with a reduced taxation contribution to Government revenues.

Table 1: Australian Population Projections

As at 30 June (millions)

Age range	*2007*	*2017*	*2027*	*2037*	*2047*
0–14	4.0	4.1	4.2	4.3	4.3
15–64	14.1	15.2	15.9	16.4	17.0
65–74	1.5	2.2	2.7	3.0	3.0
75–84	1.0	1.2	1.8	2.3	2.6
85 and over	0.4	0.5	0.7	1.1	1.6
65 and over	2.8	3.9	5.2	6.4	7.2
Total	**20.9**	**23.2**	**25.3**	**27.1**	**28.5**
Percentage of the total population					
0–14	19.1	17.7	16.7	15.7	15.0
15–64	67.4	65.6	62.7	60.7	59.7
65–74	7.0	9.5	10.6	10.9	10.7
75–84	4.7	5.0	7.2	8.5	9.1
85 and over	1.7	2.2	2.7	4.2	5.6
65 and over	13.4	16.7	20.5	23.6	25.3

Source: Treasury (2007, p. 16).

Table 2 sets out in detail The Productivity Commission costs of care projections across the various service types.

Table 2: Projected person receiving care and aged care expenditure

Persons aged 65 year or older[a]

	2006-07	*2016-17*	*2026-27*	*2036-37*	*2046-47*
Number of places/persons	'000	'000	'000	'000	'000
High care residential	108	148	205	303	405
Low care residential	58	60	82	122	162
Total residential	167	208	287	426	567
CACP	31	50	71	100	125
HACC[b]	518	697	976	1251	1448
Australian Government expenditure (share of GDP)	%	%	%	%	%
Residential	0.54	0.68	0.87	1.21	1.53
CACP	0.04	0.06	0.08	0.10	0.12
HACC[b]	0.09	0.12	0.15	0.18	0.20
Other	0.04	0.05	0.06	0.07	0.08
Total	**0.71**	**0.90**	**1.16**	**1.57**	**1.93**

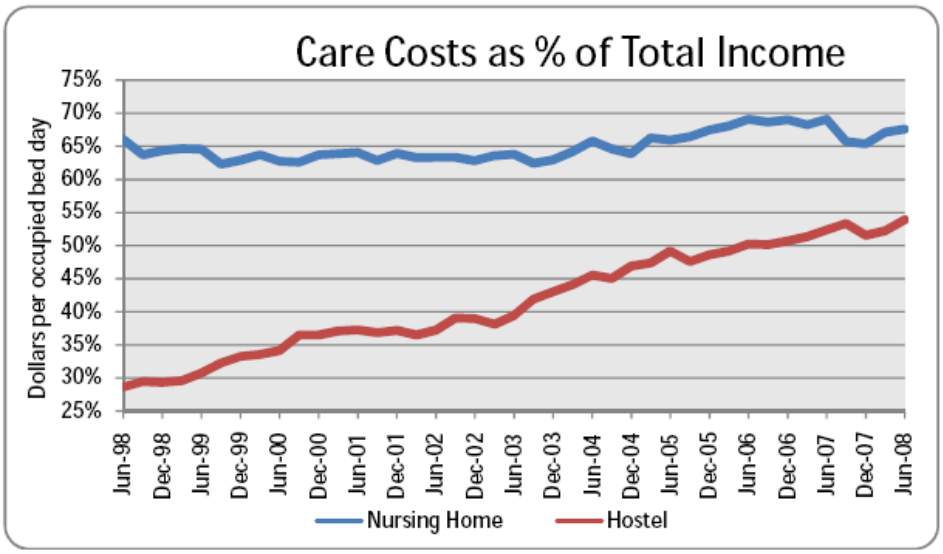
[a] These data relate to the projected demand for aged care and Australian Government expenditure on aged care programs by those persons aged 65 years or older. They are lower than Intergenerational Report (Treasury 2007) published results that include access to aged care programs by persons of all ages.
[b] Support for persons aged 70 years or older.

Source: Department of the Treasury, unpublished modelling results (2007).

If Australia is to develop policy solutions that will address these significant demographic, care cost and service volumes, it is fundamental that the current aged care system including the financial base underpinning the current system be placed on a strong sustainable basis with the real cost of care and capital being realized by Government and community. Further, if Government and community are not prepared to appropriately fund their care and infrastructure expectations then both must be prepared to adjust their expectations accordingly.

This contention is reinforced in Graph 1 which shows the movement in care to income ratio over a long period of time. During this period you can see the fairly steady and generally steep increase in the low care ratio. In contrast, the high care ratio has been relatively stable although it did see fairly constant increases in the ratio from June 2004 to June 2006.During this time increases in award rates of pay were greater than the relative increases in subsidies and residents fees.

Graph 1:



Source: Stewart Brown & Co – Financial Benchmark of aged care providers

REFERENCE 1

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

Grant Thornton recently undertook a major survey of the financial status of the residential aged care industry. This survey adds to work already undertake by Bentleys MRI on behalf of Government which reviewed the audited financial accounts for the industry.

The survey results which appear in the second set of graphs relate to the 2007/2008 financial year and has attracted in excess of seven hundred aged care facility sites. With two thousand eight hundred and thirty six aged care sites across Australia, a seven hundred plus participation rate is considered a reasonably reflective sample across size, ownership, service type and geography. The full report from Grant Thornton appears at Attachment A.

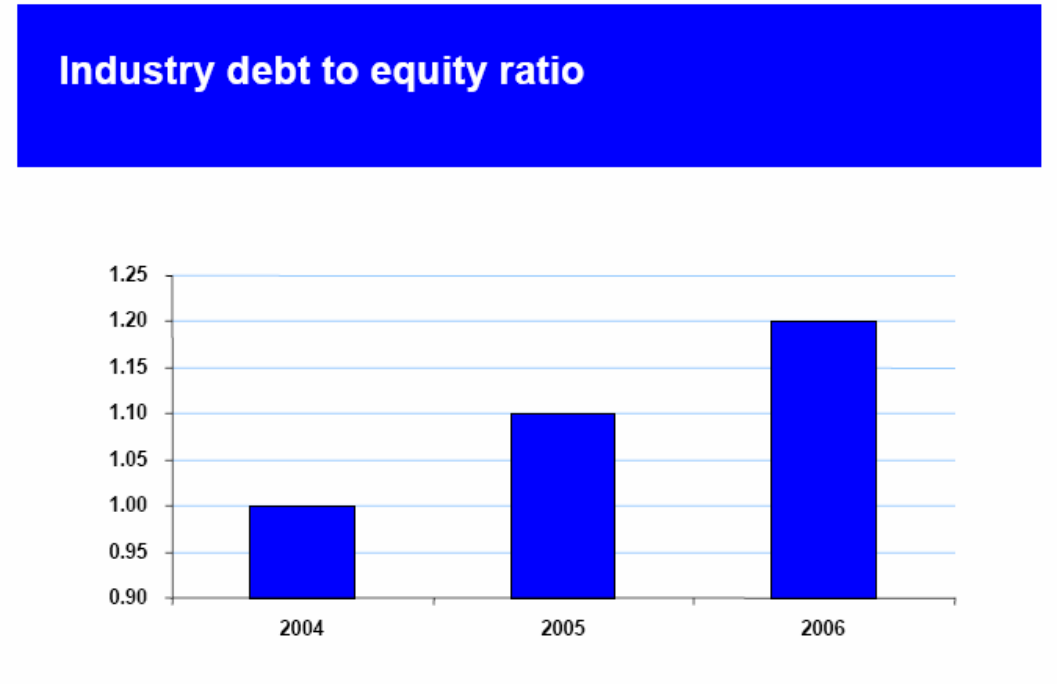
The Audited General Purpose Financial Reports are required to be submitted by aged care providers in order to maintain the Conditional Adjustment Payment (CAP) funding. Unfortunately the Department of Health and Ageing has not released the data for the years 2005/06 onwards which makes this important piece of industry financial benchmarking data unavailable to aged care providers for site specific benchmarking and to the industry more broadly.

It is very frustrating to aged care providers to enter into an agreement with the Department of Health and Ageing regarding the obligations the industry had to meet to maintain their CAP funding one of which was the submission of audited General Purpose Financial Accounts. Whilst the industry continues to meet its CAP obligation, the Department unilaterally decided to stop providing the funding benchmark data to individual providers and de-identified data to the industry from the 2005-2006 year onwards.

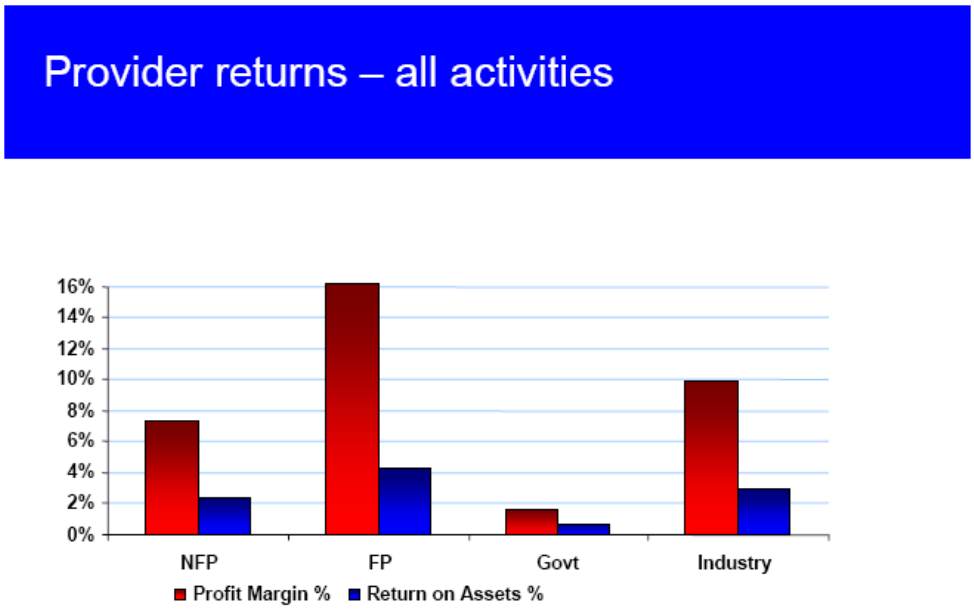
The first series of findings detailed in the following graphs are from the original analysis of the audited financial accounts submitted by the industry up to 2005/2006. This work was contracted by the Department of Health and Ageing to Bentleys MRI Perth office.

The major findings are:

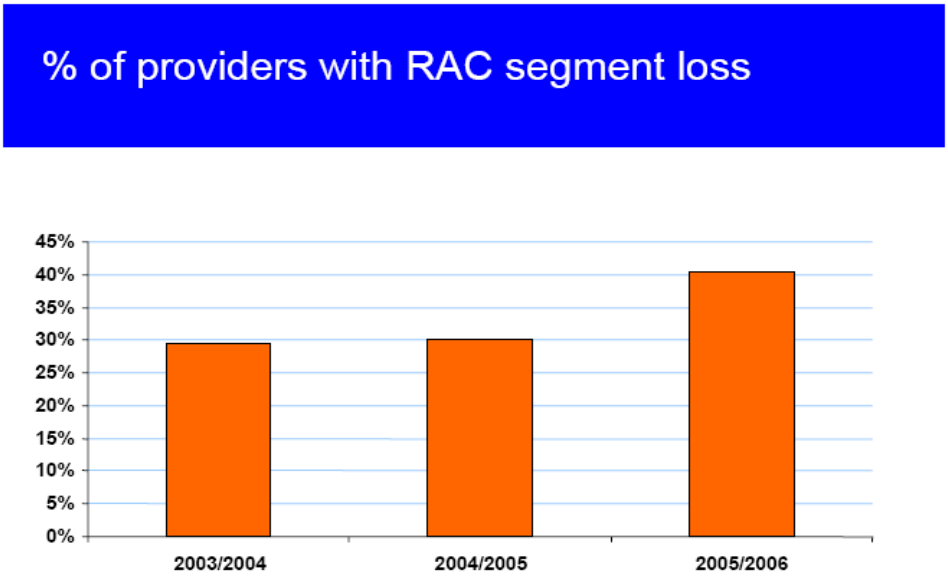
Graph 2: The graph below is concerning as it shows the gradual decline of the industry's debt to equity over the 2004-2006 period.



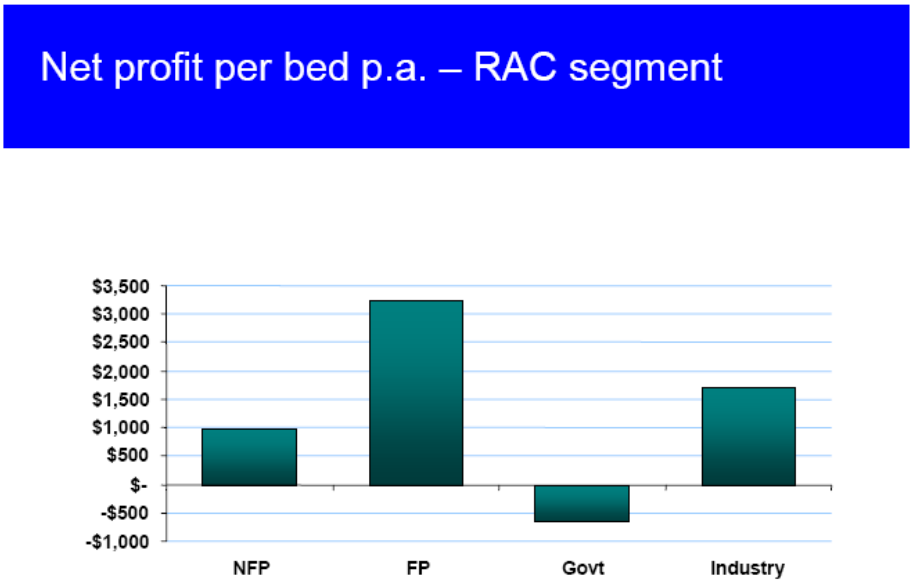
Graph 3: The graph below shows the profit margin on all activities of the participating operator. More concerning is the return on asset figure of just over two percent.



Graph 4: This graph details the aged care specific activities of the survey participants and shows when this component of the provider's business is considered forty percent of providers in 2005/2006 year were making a loss on their aged care specific operations.



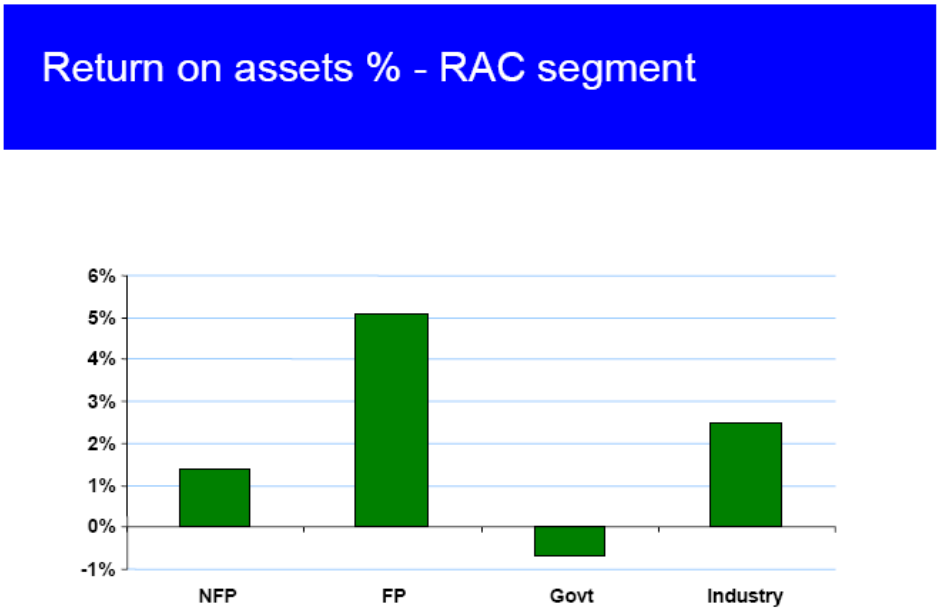
Graph 5: This graph details the net profit per bed per annum being generated by aged care providers from their aged care specific operations.



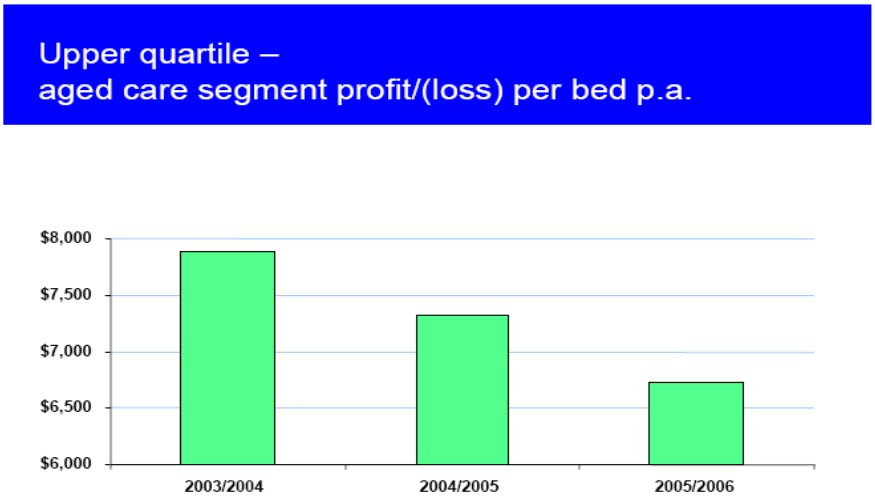
Whilst there is some contention as to what is a fair and equitable profit per bed per annum, it is universally agreed that a return per bed of $1,600.00 is entirely unsustainable.

ACAA would contend that a healthy aged care sector should as a minimum being aiming for an annual profit per bed per annum of between $12,000.00 to $15,000.00.

Graph 6: This graph details the return on assets for the aged care segment which industry wide stands at 2.2% and for the not for profit sector 1.1%.



Graph 7: This graph looks at the best performing upper quartile of respondents.

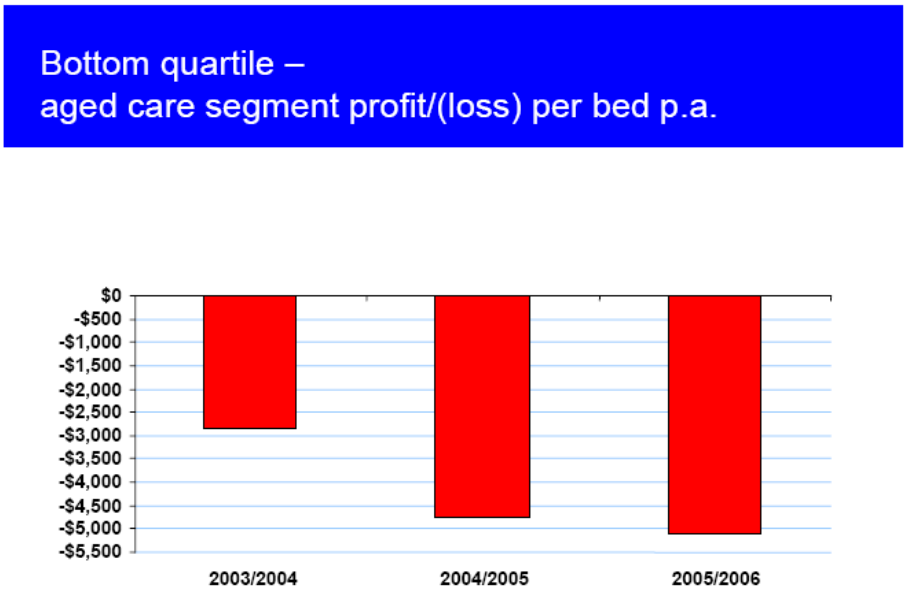


There is no doubt that an industry objective should be to move all providers into this area of return.

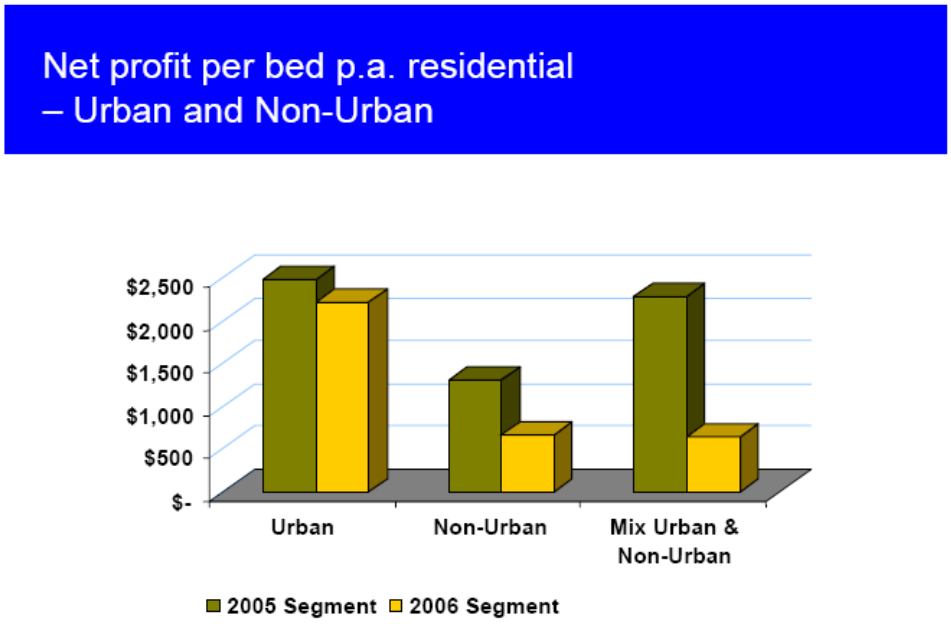
However, as the above graph demonstrates; though their performance is better than the industry overall, their performance still declined considerably during the period 2003/2004 to 2005/2006.

It should also be noted that the upper quartile is heavily weighted in favour of multi bed wards and extra service facilities which shows considerably better results than standard accommodation.

Graph 8: The graph shows a very unsatisfactory picture for those providers in the bottom quartile of performers.

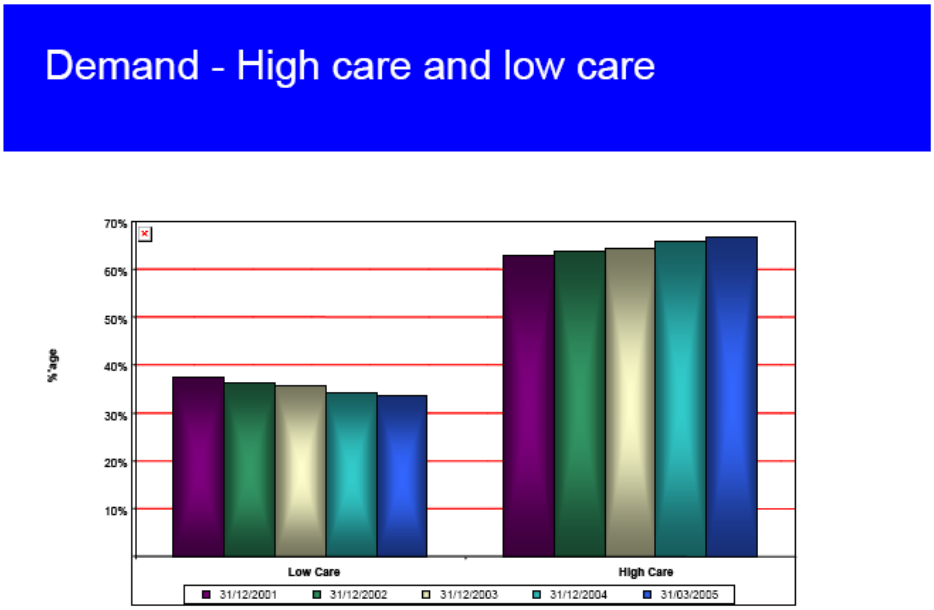


Graph 9: This graph demonstrates why aged care providers are withdrawing from capital commitments and further industry investment other than what is in the pipeline.



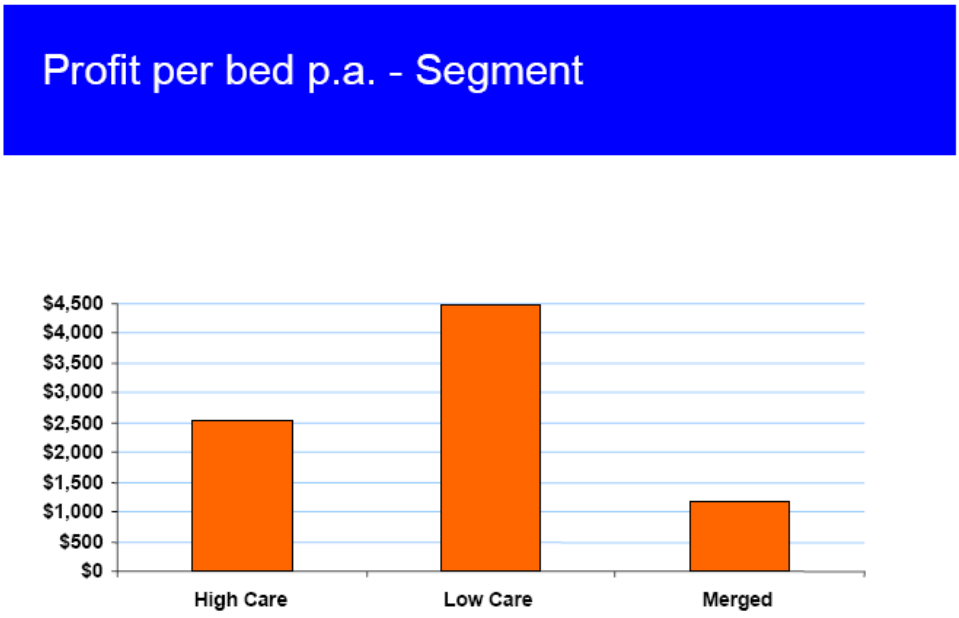
It is now costing approximately $200,000.00 to build a single ensuite unit in an aged care facility; a return of less than $2,500.00 does not support the investment risk.

Graph 10: The graph shows the continuing decline in demand for residential low care and the gradual move to residential high care.

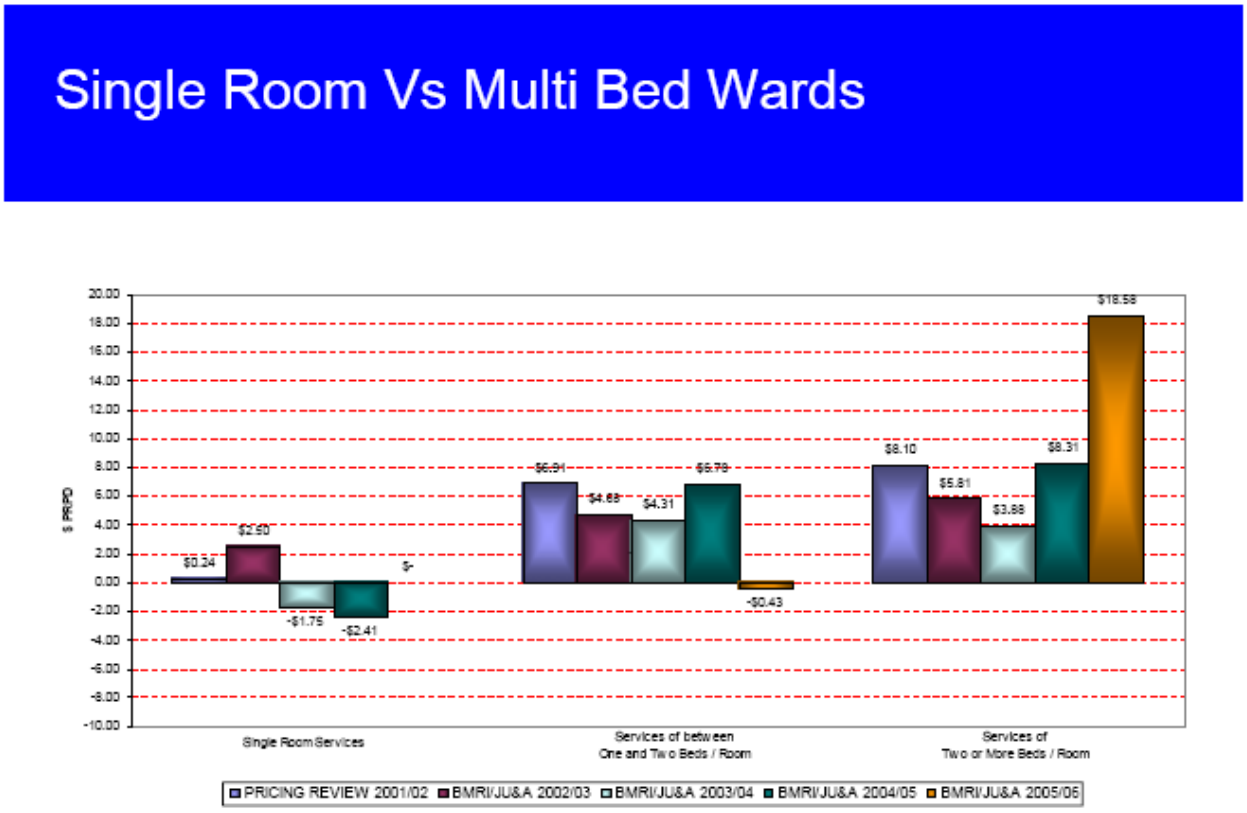


In the 2008 Report on the Operation of the Aged Care Act 1997, it was reported that forty five percent of all low care residents are classified high care.

Graph 11: The graph shows the impact of bonds on profit per bed in residential low care as compared to residential high care.



Graph 12: The graph uses a number of sources to emphasise the significantly different returns achieved from multi bed units as compared with single bed units.

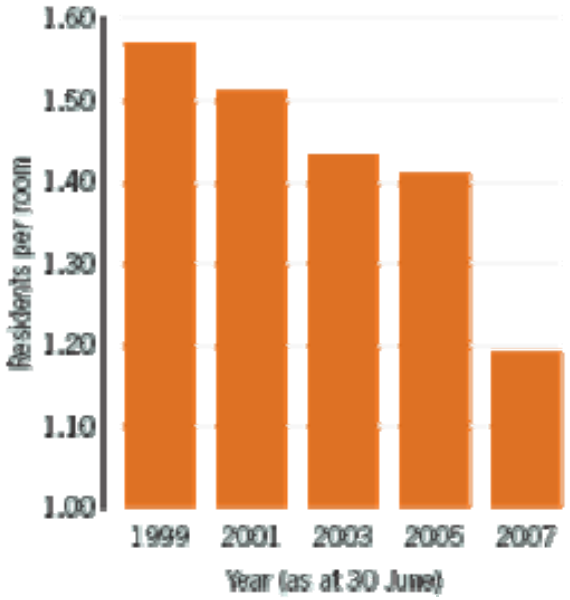


The Grant Thornton survey of the industry covering the 2007/2008 financial year (released October 2008) supports the above trend data demonstrating a continuing decline in industry profitability and an extremely poor return on investment of 1.1% which for any industry is not a sustainable position and will see many facilities eating into capital to sustain operating viability.

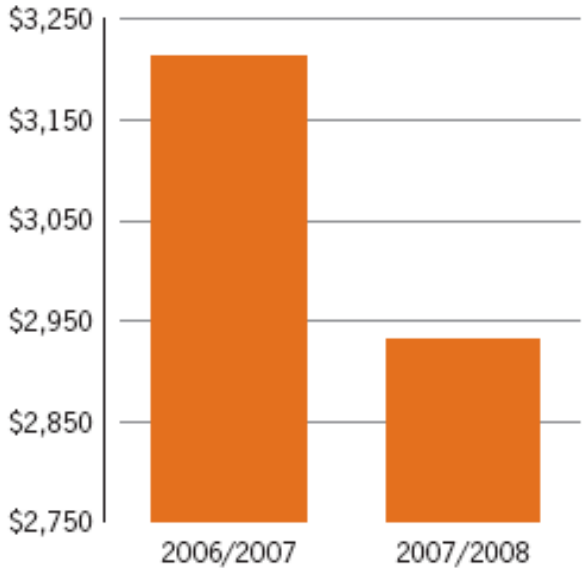
The following graphs deal with a range of issues covering industry EBITDA, number of facilities making a surplus/loss, the average return per bed per annum and the difference in return on older multi bed facilities as compared with more modern single room en suite facilities.

There is no doubt that the current funding methodology has failed to recognize that there is a significant cost in both constructing and operating residential care as single room en suited services. The current subsidy for the industry is based on meeting a clinical service need and a certain standard of hotel service but does not include any assessment of the additional staffing costs of operating single room services each with separate bathroom and toilet.

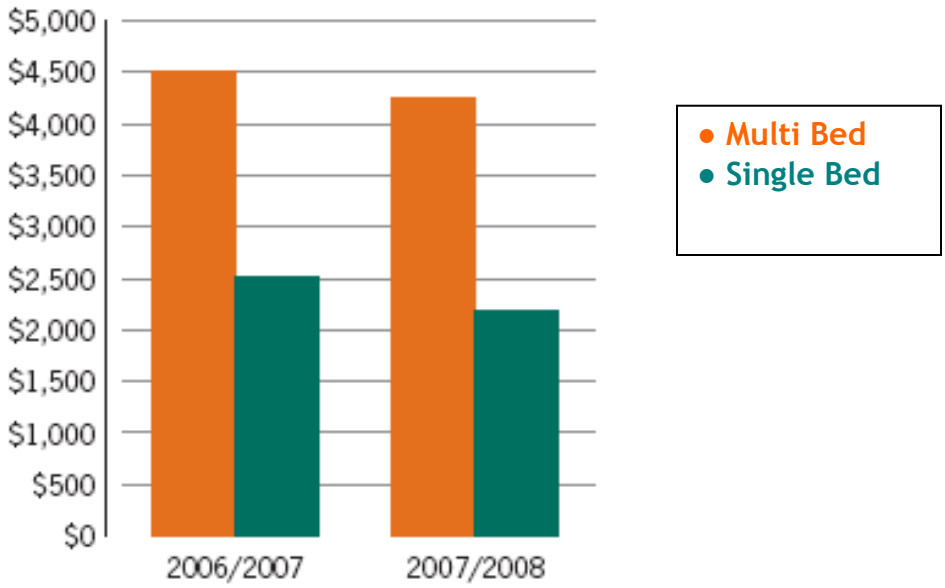
Graph 13: This graph shows the gradual reduction in the number of residents per room over the period 1999 to 2007.



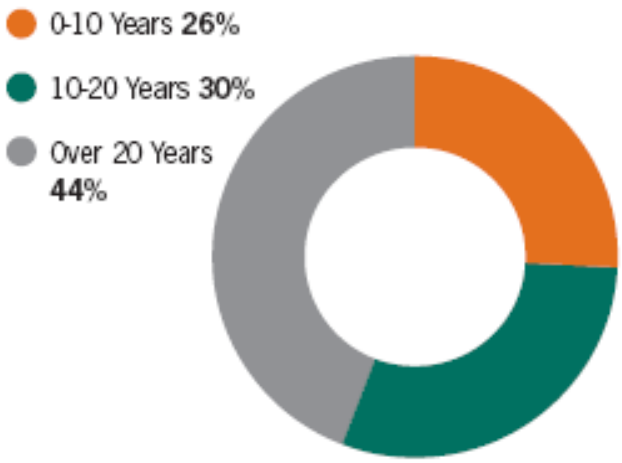
Graph 14: This graph shows the EBITDA across aged care over the period 2006/2007 and 2007/2008 and highlights the continuing decline in industry profitability.



Graph 15: This graph again emphasises the significant return differentials between multi bed units and single ensuite units.



Graph 16: This graph shows the age profile of the industry with forty four percent of facilities aged over twenty years.

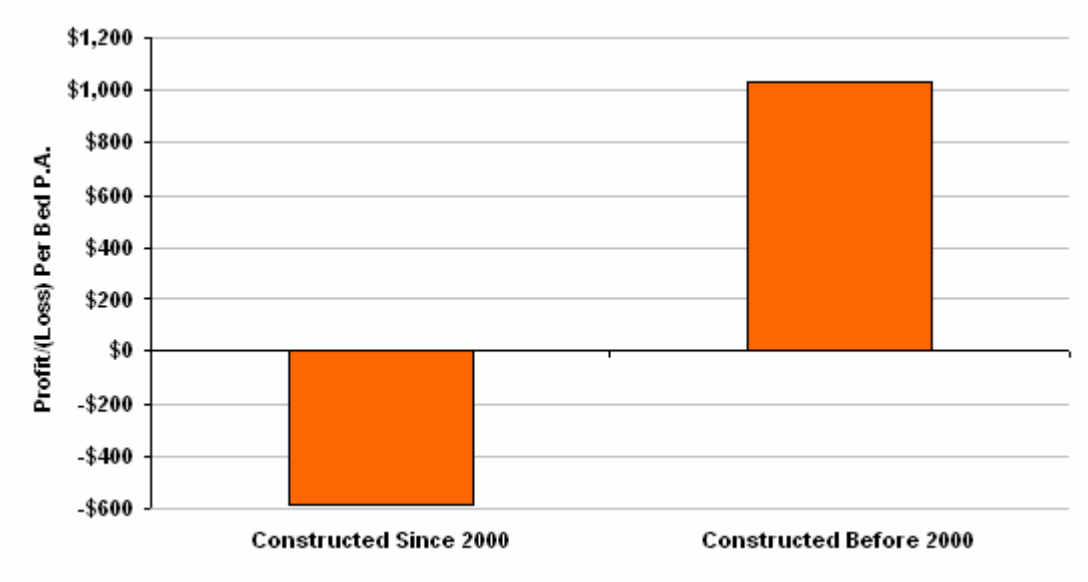


This demonstrates the need to continue investing in aged care if industry infrastructure is to be maintained. It also emphasises the substantial investment by the industry over the past twenty years and the last decade in particular. The industry spent $1.45B in financial year 2007/2008 on various building works.

Graph 17: This graph demonstrates the significant impact on viability created by the construction of single room accommodation which has been almost universally the case since 2000 onwards. This data does not include construction during the past 24 months to ensure reliability of the data outcome.

The move to single room ensuite accommodation has in part been driven by the certification requirements placed on the industry. Certification requires providers to meet certain space and privacy minimums by 31 December 2008 and certain levels of fire and safety. These requirements of certification are set at levels higher than the standards required in the Building Code of Australia (BCA).

ACAA contends that certification has achieved the objective originally intended and should be removed as the industry standard with the BCA being the standard for aged care.



RECOMMENDATIONS: ACAA would contend that the above data clearly shows this industry in considerable difficulties and will face further decline if steps are not taken soon to address the shortcomings.

ACAA therefore recommends the following actions:

1. Undertake a comprehensive analysis of the cost of care
2. Reform the capital generating capacity of the industry by allowing residents to exercise choice as to how they pay for their hotel and accommodation services.
3. Uncap the daily accommodation charge for high income older people and increase it for those on a medium income so it is equivalent to the average previous year bond. This measure has no cost to government.
4. Provide real choice to those older Australians who want to pay an upfront refundable deposit for their high care accommodation. This measure has no cost to government.
5. Link government payments for concessional residents to the average bed cost. This measure is estimated to have a cost of $280M to government.
6. If the above steps occur then ACAT assessments should apply to entry into care not level of care.
7. That the BCA be the building standard for aged care not certification.

REFERENCE 2

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;

There is little doubt that the existing Commonwealth Own Purpose Outlays (COPO) formula is totally inadequate in recognising the actual cost of pricing aged care services to meet the expected level and quality of such services. The following table drawn from the Aged Care Industry Council submission to the Review of the Conditional Adjustment Payment (CAP) (See Attachment B) shows a comparison between COPO and other indices.

Table 3: Comparison of COPO index and increases in selected classes of average weekly earnings

Year	1996 1997	1997 1998	1998 1999	1999 2000	2000 2001	2001 2002	2002 2003	2003 2004	Mean Annual Increase	Overall increase
COPO%(a)	1.7	1.7	1.4	1.5	2.1	2.3	4.8	2.2	2.2	21.6%
Earnings: Persons; Full time: Adult: Ordinary time earnings August – annual % increase	3.84	3.96	4.22	2.64	5.30	5.36	4.87	5.93	4.4	47.3%
Earnings: Females; Full time; Adult; Ordinary time earnings; August – annual % increase	3.97	4.14	4.37	3.35	4.91	5.68	4.98	5.73	4.55	49.3%

Data sources: Australian Institute for Primary Care La Trobe University, 2003, and ABS, 2005

Even when the additional CAP index of 1.75% is added to the COPO formula the industry is still well behind other possible indices and not being sustained at a level where costs increases are at least being met by the annual indexation. The following table details the shortfall between COPO/CAP and various other more appropriate indices.

Table 4: The table below shows the shortcomings of the COPO/CAP indexation when compared to other indices.

Year	COPO % Increase	CAP % Increase	COPO/CAP % Increase	SNA – Min Wage % Increase	AWOTE % Increase
1997	1.80	0.00	1.80	2.86	4.55
1998	1.70	0.00	1.70	3.90	3.62
1999	1.70	0.00	1.70	3.21	3.12
2000	2.10	0.00	2.10	3.89	4.17
2001	2.30	0.00	2.30	3.25	4.62
2002	2.40	0.00	2.40	4.35	6.16
2003	2.2	0.00	2.20	3.94	4.64
2004	2.00	1.75	3.75	4.24	5.26
2005	1.90	1.75	3.65	3.64	4.76
2006	2.00	1.75	3.75	5.65	4.49
2007	2.00	1.75	3.75	2.02	3.50
2008	2.30	1.75	4.05	4.15	4.61

Table 5: A Comparison of Cumulative Combined COPO/CAP Subsidy to SNA – Minimum Wage, and AWOTE is detailed below.

Year	COPO/CAP Based on escalation of $1of subsidy in 1996	COPO/CAP % Below SNA – Min Wage Base $1 in 1996	COPO/CAP % Below AWOTE Base $1 in 1996
1997	$1.02	1.04%	2.70%
1998	$1.04	3.23%	4.64%
1999	$1.05	4.76%	6.10%
2000	$1.08	6.60%	8.25%
2001	$1.10	7.59%	10.71%
2002	$1.13	9.63%	14.77%
2003	$1.15	11.50%	17.51%
2004	$1.19	12.03%	19.22%
2005	$1.24	12.02%	20.50%
2006	$1.28	14.07%	21.36%
2007	$1.33	12.17%	21.07%
2008	**$1.39**	**12.27%**	**21.72%**

It is interesting to note that the Commonwealth has not used the COPO formula to index the prices it charges for services, for example the fees charged by the Aged Care Standards and Accreditation Agency are indexed by the Consumer Price Index, the cumulative effect of which is much higher than COPO. The indexation which the Government puts on its no real interest loans is also based on the Consumer Price Index.

For Aged Care the COPO arrangement is a cocktail of 25% CPI and 75% based on wage increases. This is calculated as follows:

- The CPI is the March to March movement for the weighted average of the eight Australian capital cities.
- The wages figure is the annualised dollar figure of the latest Safety Net Adjustment, or Federal Minimum Wage decision of the Australian Fair Pay Commission, expressed as a percentage of the Average Weekly Ordinary Time Earnings (AWOTE) at the time of the decision.

For example; if the Federal Minimum wage decision was $22.00 per week, and AWOTE at the time of the decision was $1,000.00, then the wage increase would be 2.2%. If the March to March CPI was 3.0% COPO would be:

Wages (2.2% x 75%)	-	1.65%
CPI (3.0% x 25%)	-	0.75%
COPO	-	2.40%

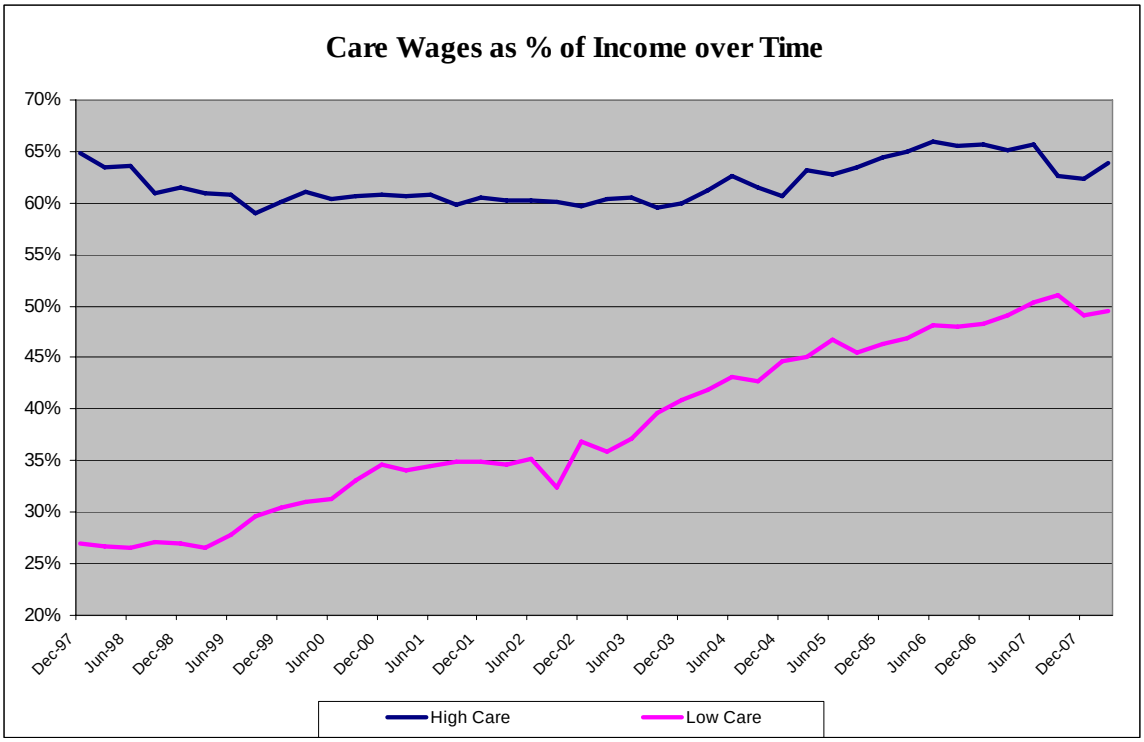
In the past it has been argued that COPO is a whole of government approach and could not be changed because of the requirements of a single department such as Health and Ageing or a program such as aged care. The Veterans' Home Care program does not use the COPO index, private health insurance premiums have had much higher increases authorised by successive Ministers for Health. COPO is not an appropriate index for the Aged Care industry. The Government has a ceiling on income streams through admission control, growth control and price control.

If the Government wants to continue to control its outlays to the Aged Care industry via the continuation of COPO indexation, the Government needs to allow the industry to charge residents who can afford uncapped fees or bonds to offset wages and operating costs that far exceed COPO.

ACAA supports the concept of paying competitive wages for aged care staff however is unable to do so within the current restrictions of the aged care funding index. The Productivity Commission in their recent report accepted that aged care funding would need a one off increase of $450m and then ongoing support to sustain a competitive environment.

Table 6 has been prepared by Stewart Brown & Co and analyses the average wage outlays as a comparison to care cost between 1997 and 2007. The Table clearly shows that providers have paid any additional income received as wages with the significant increase in low care wages being partly explained by the growth of ageing in place in low care facilities.

Table 6:



RECOMMENDATIONS:

ACAA would strongly support:

1. **Immediate**

- Continue the additional CAP indexation beyond 2008/09, pending longer term resolution of an aged care indexation formula:

- Extend similar top up indexation to community care programs from 2009 onwards;

- Review the indexation calculation so as to better reflect the increased costs in the industry. This could include the following:

  - Rolling up the CAP increases into the subsidy payments;
  - Linking the indexation to aged pension increases;
  - Allowing Accommodation charges to be based on a periodic payment up to the so-called "maximum bond" level (currently $141,000)
  - Bond retentions for those Bonds greater than the Y factor included in paragraph 23.71(4) of the User Rights Principles 1997, to be set at a percentage of the bond level; and
  - A more efficient use of the income tested fee to allow Government to partially uncap the accommodation charge.

2. Longer Term Solutions

2.1 Link to Health

Given the increasing emphasis being placed by Government on the integration of the health and aged care systems, the fact that they share a labour market and the fact that care needs in the aged care part of that system are rising, the most logical longer term option for aged care pricing is to link it with health. While a one off boost is needed to establish the basis for competitive wages, linking aged care payment rates to those applying in the broader health system would stem any future decay.

2.2 A Specific Index

Alternatively a specific aged and community care index could be developed and applied annually such that movements in the average cost of care are covered each year. This could be administered by an independent body, analogous to the Fair Pay Commission, to ensure transparency and to avoid conflicts of interest.

REFERENCE 3

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

There are certainly variations in costs of service delivery and costs of construction between states and between regions. The Grant Thornton Report also raises the issue of variations in cost of service delivery and construction costs based on the number of residents to be accommodated in each accommodation unit.

The PriceWaterhouseCoopers report which appears in full at Attachment C concentrates on the capital needs of the industry to the year 2020 and demonstrates that the current capital raising capacity of the industry is likely to be underfunded by as much as $5.6B over the twelve years to 2020.

What the PwC report also shows is the significant variation in costs in various parts of Australia.

Table 7: Original average building cost data

	Hogan Report - June 2003 dollars based on 45 m^2 $		Hogan Report - Grossed up from 45 sq metres to 62 m^2 $		Rawlinson's Cost Guide – February 2007 dollars based on 62 m^2 $		June 2006 Parliamentary Report – January 2006 dollars (size not known) $	RLB Construction Cost Estimation – November 2007 Dollars based on 62 m^2 $
	Low	High	Low	High	Low	High		
Building	60,000	65,000	82,667	89,556	106,777	115,112	144,044	154,000
Fittings	5,000	7,500	6,889	10,333	12,000	12,000		16,250
Working Capital	3,815	6,910	5,256	9,520				
External Works					8,542	9,209		15,000
Professional / Construction Fees	4,800	5,200	6,613	7,164	10,678	11,511		22,250
Land	8,300	8,300	8,300	8,300	8,300	8,300	8,300	8,300
TOTAL	**81,915**	**92,910**	**109,725**	**124,874**	**146,297**	**156,132**	**152,344**	**215,800**

Table 8: Scenario analysis results based on the estimated medium construction cost

Scenarios	Assumptions	Values	Shortfall (2008 – 2020) %	Total net cash flow (2008 – 2020) $	Shortfall (2012 – 2020) %	Total net cash flow (2012 – 2020) $
Medium Cost Model	Average Length of Stay in High Care	3 years	-27.00%	-5,667,459,422	-25.68%	-4,401,525,623
	Loan Repayment Period	10 years				
	Obsolescence Period	30 years				
	Include Surplus Bond Revenue post 1 July 2008	Not included				
	Financing Rate on Debt	8.00%				
Best Case Basis (lowest cost)	Average Length of Stay in High Care	1.7 years	-2.77%	-468,858,908	-0.63%	-85,520,698
	Loan Repayment Period	20 years				
	Obsolescence Period	40 years				
	Include Surplus Bond Revenue post 1 July 2008	Included				
	Financing Rate on Debt	7.00%				
Worst Case Basis (highest cost)	Average Length of Stay in High Care	3 years	-34.76%	-8,163,964,330	-32.99%	-6,269,646,063
	Loan Repayment Period	10 years				
	Obsolescence Period	20 years				
	Include Surplus Bond Revenue post 1 July 2008	Not included				
	Financing Rate on Debt	9.00%				

The Viability Supplement is meant to address the service costs differential between remote and rural locations as compared with metropolitan and regional centres. Unfortunately, the Viability Supplement is a poor distributor of additional subsidy to reflect cost variables in rural and remote locations.

ACAA recommends that Government develop a revised system of service cost and capital cost that reflects the significant variations that exist in rural and remote Australia.

This system would require Government being prepared to enter into regular negotiations with providers for service contracts and building contracts in rural and remote locations so that both operating and capital cost differentials could effectively reflect the real cost of service and capital.

Whatever system is operating in the broader aged care environment, Government will need to make special arrangements to meet the operational and capital needs of rural and remote Australia.

One solution ACAA believes should be explored is the creation of a rural and remote capital pool which would be preserved for the capital needs of rural and remote communities.

ACAA believes that provided rural and remote communities and a small number of socio economic disadvantaged service providers are supported, the balance of the aged care system should operate in a partial market environment.

If Government removed the restrictions on the accommodation charge, then market forces should then reflect the variations in costs particularly capital.

Similarly, if Government ceased double taxing residents with additional income and allowed those residents to exercise choice in how their income tested fee moneys are expended, then these funds would more closely reflect geographic cost variables than the application of artificial devices.

RECOMMENDATIONS:

1. Develop specific better targeted strategies to support operational and capital needs of rural and remote providers.
2. Remove the CAP on the accommodation charge to allow market forces to better reflect the cost variations between states and regions.
3. Government to stop imposing a double taxation through the income tested fee and to allow those residents with income capacity to expend their income tested fee moneys through the exercise of choice on what services and products they wish to procure.

REFERENCE 4

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

ACAA contends that there is considerable inequity between how the existing aged care system treats a person in aged care depending upon where they enter the system whether community, low care residential or high care residential.

The differences are most stark between residential low care entrants and residential high care entrants. ACAA contends that entrants into residential care should be treated the same wherever the person enters care and the current system where high care recipients receive discriminatory treatment should cease.

The reason for this is that a person who enters high care and who is not exempt from making a capital contribution will be required to pay a daily accommodation charge of $26.88 per day plus a basic daily care fee and if appropriate, an income tested fee.

If, as is often the case, a resident needs to liquidate their home to pay these contributions, then any funds held on the sale of the home will be considered when assessing income and assets for pension entitlement.

Whereas the same person entering residential low care and paying a bond will have the bond exempt from any assessment for pension entitlement.

If either the low care entrant or the high care entrant decides to rent the family home, provided some portion of the rental is applied to hotel and accommodation services in residential care, then the resident's pension status is not threatened.

Another inequity is where a self funded retiree couple have assets other than the family home and one member of the couple needs to enter residential care. Half the assets of the couple are assessed for the person entering care and brought to account and if the person is entering low care they are required to pay a bond.

If the couple's non home assets are held as superannuation, they will need to release part of their funds to pay the bond. This can on occasions leave the person not requiring care in a seriously depleted financial state.

If the person was entering high care, they would be required to pay the accommodation charge which may suit their particular circumstances as it is not a lump sum contribution.

A resident who wishes to relocate from an existing facility to a brand new facility is not permitted to renegotiate a new bond agreement with the new facility operator. The new operator must accept the existing bond contract or not admit the resident.

Family members often indicate a wish to relocate a loved one and are often able and willing to pay the additional contribution required by the new facility.

However, providers must accept the existing bond agreement and even if a relative wishes to pay a lump sum contribution on behalf of the resident, the Aged Care Act 1997 requires the provider to return these funds to the care recipient or their estate not to the person paying the bond on behalf of the resident.

One of the worst inequities in the current system is the double taxation that is applied to persons with some additional income.

If they enter standard low care or high care, they undergo an income test and pay an additional daily fee for which they receive no benefit.

The Government reduces the providers subsidy by the same amount as the income tested fee and keeps the equivalent amount in consolidated revenue.

ACAA does not consider the current arrangement to be fair nor equitable.

In addition, if the resident enters an extra service facility, the Government then claws back twenty five percent of the extra service fee.

Again, it is difficult to understand why Government will not permit extra service residents to maximise their choices by being able to spend all their financial contributions on the services and accommodation they desire.

RECOMMENDATION

1. Treat all entrants into care in the same manner. A potential care recipient is simply approved by the Aged Care Assessment Team as eligible for care. The client and the service provider then negotiate the level, type and location of service.
2. Remove the differentiation between high care and low care.
3. Maximise consumer choice and allow residents with the financial capacity to elect how they will contribute to their hotel and accommodation costs.
4. Remove the discriminatory treatment of pension eligibility depending upon whether a person pays a bond or a daily charge.
5. Amend the Aged Care Act 1997 to permit a third party to pay a contribution on behalf of a resident.
6. Amend the Aged Care Act 1997 to permit an aged care provider to refund a lump sum contribution to a third party where the payment was made by that third party.
7. Amend the Aged Care Act 1997 to permit residents to relocate to a new facility and to be able to negotiate a fresh contract.
8. Government ceases double taxing residents through the income tested fee and extra service clawback and allows these residents to exercise greater choice as to the style and type of accommodation and hotel services they wish to procure.

REFERENCE 5

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

The current planning ratio of 113 places per 1,000 people aged 70 and over is allocated as follows:

- 44 high care places per 1,000 people aged 70+;
- 44 low care places per 1,000 people aged 70+; and
- 25 (21 CACP and 4 EACH) community care places per 1,000 people aged 70+

The process of allocating new places commences with an estimation of the number of new places needed to cater for increases in the target population. Aged Care Planning Advisory Committees in each State and Territory then consider how the new places should be distributed between regions and special needs groups and advises the Secretary of the Department on the most appropriate allocation and distribution by different types of subsidy and proportions of care.

The objectives of the planning process are:

a) To provide an open and clear planning process; and

b) To identify community needs, particularly in respect of people with special needs; and

c) To allocate places in a way that best meets the identified needs of the community (Aged Care Act 1997, Section 12-2).

The Aged Care Act (the Act) (Section 11-3) defines people with special needs as:

a) People from Aboriginal and Torres Strait Islander communities;
b) People from non-English speaking backgrounds;
c) People who live in rural and remote areas;
d) People who are financially or socially disadvantaged;
e) People who are veterans;
f) People of a kind (if any) specified in the Allocation Principles.

ACAA considers the current system is very inappropriate in meeting these objectives as the ratio is not delivering a well planned and coordinated balance between demand and supply. The current operational places and allocated places are set out in Table 9 drawn from the 2008 Report on the Operation of the Aged Care Act 1997 which clearly shows the allocation formula and demand are considerably disconnected.

Table 9 also shows Allocated and Operational Residential, Community and Transition Care places at 30 June 2008 by state and Territory.

The Allocated Places Table shows that the allocated places are considerably above the target of 113 places per thousand persons over seventy years of age.

Table 9:

	Residential care - high	Residential care - low	Total residential	Community care	Transition care	Total places
Allocated Places						
NSW	50.4	49.5	99.9	22.9	1.1	124.0
VIC	47.3	52.1	99.5	23.1	1.1	123.6
QLD	46.5	51.6	98.0	22.3	1.1	121.4
SA	52.2	48.7	100.9	23.1	1.1	125.1
WA	45.6	51.4	97.0	23.5	1.0	121.5
TAS	46.5	46.5	93.1	24.0	1.3	118.4
NT	62.2	49.2	111.4	127.4	3.6	242.4
ACT	47.4	58.4	105.9	28.7	1.6	136.2
Aust.	**48.5**	**50.7**	**99.2**	**23.3**	**1.1**	**123.6**
Operational Places						
NSW	45.0	42.1	87.2	22.8	1.0	111.0
VIC	40.9	47.1	88.0	23.0	1.0	112.0
QLD	40.2	45.2	85.4	22.2	0.9	108.5
SA	49.2	46.0	95.2	22.9	1.0	119.1
WA	38.4	45.0	83.4	23.4	0.9	107.7
TAS	44.4	41.5	85.9	23.7	1.1	110.7
NT	53.5	41.5	95.0	127.4	2.6	225.0
ACT	34.4	42.4	76.8	28.6	1.5	106.9
Aust.	**42.8**	**44.5**	**87.3**	**23.2**	**1.0**	**111.5**

Note: The ratios in this table are based on population projections derived from the 2006 Census available from the Australian Bureau of Statistics. The table includes flexible care places, such as EACH packages, EACH-D packages, Multi-purpose Services places and places under the National Aboriginal and Torres Strait Islander Flexible Program attributed to residential or community care as appropriate.

It should be noted that the Government recently announced a further allocation of 37,000 places over the next three years.

Table 10 shows the Occupancy Levels as at 30 June 2007. The table shows a significant decline in occupancy with ACAA calculating that the average occupancy in the industry has declined to 93% as at 30th June 2008.

Table 10: Average occupancy rate (percent) by State/Territory and remoteness, for the financial year 2006-2007

State/Territory	Major Cities	Inner Regional	Outer Regional	Remote	Very Remote	All regions
NSW	93.84%	95.60%	95.68%	96.76%	90.41%	**94.38%**
VIC	91.95%	94.38%	95.62%	85.27%	/0	**92.70%**
QLD	94.92%	96.06%	95.06%	85.88%	75.24%	**95.11%**
SA	97.78%	98.41%	97.14%	95.47%	/0	**97.75%**
WA	95.01%	95.34%	93.94%	87.58%	81.13%	**94.78%**
TAS	/0	95.87%	96.89%	95.86%	90.54%	**96.09%**
NT	/0	/0	94.69%	95.28%	93.64%	**94.88%**
ACT	96.41%	/0	/0	/0	/0	**96.41%**
Australia	**94.05%**	**95.54%**	**95.61%**	**91.47%**	**79.97%**	**94.49%**

Source DoHA Dec 2007

At this level of occupancy it is estimated that there are 12,000 vacant places across the aged care system. From a provider perspective this disconnect between supply and demand is proving extremely costly as vacant places are a zero cost to Government while the provider must carry the full cost of construction and servicing while the place remains vacant.

Attachment D sets out the ACAA position in respect to the Aged Care Allocation Round Approval Process and the Allocation Formula. ACAA does not believe the current system is sustainable and requires a complete review as to the appropriate number of future places required to meet future demand and the appropriate mix of the ratios within the formula. The current forty four low care, forty four high care and twenty five community care places is a formula based on no scientific foundation. The original formula of one hundred places per thousand persons over seventy years of age was increased to one hundred and eight in 2004 and one hundred and thirteen in 2007.

There appears to be little or no science to the increases in the formula and only appear to be intended for one purpose namely, increasing the number of community care places. The 2008 Report on the Operation of the Aged Care Act 1997, shows that forty five percent of residents in low care facilities are actually high care classified and that sixty nine percent of all aged care residents are classified as high care.

It is difficult in these circumstances to understand why Government persists with this inefficient and ineffective formula especially as it so clearly fails to reflect actual overall demand nor components of the overall formula.

ACAA believes that a thorough review of the current formula and an analysis of the long term projected demand is essential. Aged care invested $1.45B in capital works in financial year 2007/08. This level of investment is unsustainable if Government continues to allocate places at the current rate, assumes no responsibility for the cost of maintaining vacant places but expects aged care providers to accept the cost of capital and assume all the risks of building capacity that will sits idle.

ACAA does not believe that aged care providers should have to carry the full risk of vacant places whilst the Government continues to apply the very strict controls on the

income available to providers. If Government determines that supply is to be in excess of demand to meet a public policy objective of consumer choice, then the cap on price will need to be loosened in order for aged care businesses to survive.

RECOMMENDATIONS:

1. ACAA believes a thorough review of the Aged Care Approvals process and the planning ratio formula needs to occur.
2. The review should investigate:
   a) a more open and transparent methodology for allocating places
   b) how to ensure all relevant data to assist applicants in preparing applications is in the public domain, especially planning data at local government level
   c) moving the allocation process to a five year timeframe
   d) developing a formula that more closely tracks future demand
   e) ensure that any future methodology for calculating place requirements actually reflects broader service offerings and changing service patterns being provided from service sources other than Commonwealth funded aged care programs
   f) review the expected need for community, residential low and residential high care and the interface between the three types of service

3. ACATs should in future approve a potential care recipient for care. The care recipient and service provider should determine the type, level and location of service to be provided.

REFERENCE 6

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

Prior to 1 October 1997, places were allocated as either nursing home, hostel or CACPs and these services could only admit care recipients approved by the Aged care Assessment Teams as eligible for that level of care.

Since that date places have been allocated as either High or Low care, CACP or in latter years EACH or EACH Dementia. These places are restricted also as to the care recipients that they can admit, but the pre 1 October 1997 places can admit either High or Low care.

Prior to the 1997 Act, a small number of nursing homes were designated as Exempt Nursing Homes. These homes offered a superior standard of accommodation and hotel services and could charge a higher fee to residents but in return the Commonwealth reduced the care subsidy payable under the Resident Classification Assessment Instrument (RCAI).

With the advent of the 1997 Act, these homes were called Extra Service and the Act extended to Low care the opportunity for allocated places to be classed as Extra Service. These places must be either all of the places in the approved service or in a distinct part of the facility providing it is physically identifiable as separate from the rest of the service. There must be at least five places in the distinct part and it must include sufficient living space, including dining and lounge areas, for the exclusive use of the residents living in it.

As with the Exempt Nursing Home, Extra Service places can charge a higher daily fee in return for receiving a lower care subsidy. The major difference is that, in addition, Extra Service operators may also charge an Accommodation Bond regardless of their level of care. These Extra Service places will generally not need to meet the concessional ratio requirements.

With the 1997 Act the number of Extra Service places could not exceed twelve per cent of places allocated, but this was subsequently increased to fifteen per cent. Despite this target, only around six per cent of all places are so designated.

ACAA has been concerned for a long time that the decision made by Government in 2004 to expand the number of places from 100 places per thousand persons aged 70 years and over to 108 and then to increase that number to 113 in 2007 without any verifiable scientific study surrounding the impact that this increase in planned places would have upon the overall system or the components within the system was dangerous and likely to lead to unintended consequences for aged care providers.

ACAA is now particularly concerned that this unilateral decision by Government has lead to a major impact on the occupancy levels of the industry and is now severely affecting the capacity of the industry to build additional places given that the occupancy rates are now running at approximately 93% which is making aged care facilities less and less viable.

Whilst dependency may be a better measure for place demand, the current ratios of 88 residential places and 25 community care places are a questionable proxy. What is out of step is the way the 88 residential places are split equally into 44 High and 44 Low Care. As 69 per cent of all residents are assessed as High Care, the continuation of the High/Low Care split is irrelevant.

The Government contends that it is increasing the overall ratio to meet the growing demand for home care and thus providing greater choice to consumers. However the increase in the community care planning ratio and the consequent potential for higher levels of vacancies to occur within the Industry has the risk of reducing the number of operators in the field and may, in the end, have the consequence of actually reducing the choices available to consumers. In addition, government takes no risk when aged care places are vacant as government pays no price for a place that is not occupied in either an operating context or a capital context. The full risk of having a place vacant in the current scheme is totally borne by aged care providers.

ACAA would strongly recommend a thorough review of the aged care planning ratios occur with the objective of establishing a more effective tool that reflects current and future projected demand especially the locale and type of service likely to be sought by future clients. ACAA would also recommend that any future planning of aged care service needs, must include consideration of factors that may impact demand but be external to the Commonwealth aged care funding program.

ACAA is also concerned at the continuing obligation placed on aged care providers to achieve a forty percent concessional resident ratio or suffer a reduced concessional resident supplement.

The Securing the Future Package announced by Government in February 2007 claimed it would raise the potential number of concessional residents from the then thirty three percent to a potential fifty percent.

The reason for concern regarding the concessional resident ratio is the perverse impact it can have on access to services. Providers often struggle to achieve the forty percent target and are faced with the financial penalty applied to all their concessional residents. The alternative is taking none at all. Given the perverse nature of the existing scheme and current financial pressures taking none is then the only option.

In the 2008 Report on the Aged Care Act, the concessional resident availability rate had increased to approximately thirty six percent.

It is accepted that Australians want to stay in their independent accommodation for as long as possible.

The planning formula should therefore be geared to support that community based independence for as long as possible whilst recognizing that the growth in residential care driven by the growth in the over eighty five group will need to be sustained.

A major advertising campaign needs to occur which will try to convince Australians that a single stand alone suburban dwelling may not be the most effective or efficient housing to sustain independence in the future.

Pressures on workforce and the availability of voluntary carers are likely to lead to reductions in home based care unless future potential care recipients can be located in congregate communities.

In addition, assistive technologies will be fundamental in maintaining independence for the maximum period.

Australia currently has no organized system or funding strategy to support the roll out of assistive technologies in domestic settings.

The average length of life for an Australian has expanded by approximately eight years in the past thirty five years.

If this trend continues, you would expect the average length of life for Australians to grow to about eighty seven years by 2030.

If average length of life is eighty seven years, the average Australian will therefore be in retirement from sixty five to eighty seven years, a total of twenty two years.

It is imperative that Australians be convinced to consider different and more appropriate housing. More particularly, that they be educated about the advantages of moving to housing which will more adequately sustain long term independence rather than the limitations of large stand alone suburban blocks.

To achieve better housing and support for independent and community care services, Australia has to rethink the structure and systems surrounding service delivery and seniors accommodation and housing.

The integration of the Community Aged Care Program and the Home and Community Care Program to better service home based services for seniors is considered an essential pre requisite.

The removal of barriers to better integration of seniors housing such as retirement villages, independent living, supported accommodation and residential care should be seen as an integrated offering. Unfortunately, the excessive Commonwealth regulation and compliance of residential care together with excessive legislation acts as a significant barrier to the integration of seniors housing in its various forms.

RECOMMENDATIONS

ACAA would recommend the following;

1. ACATs to approve assessment of care.
2. Care recipient and care provider to determine the level, type and location of care service to be provided.
3. That the Aged Care Allocation Ratio be completely reviewed as per recommendations in Reference 5.
4. That the concessional resident ratio obligation of forty percent be removed and that providers only be required to meet the regional concessional ratio.
5. Government undertake a major advertising campaign to persuade older Australians to move to more appropriate accommodation that will sustain long term independence.
6. That Government instigate a funding strategy to support the installation of home based assistive technologies.

7. That Government reforms the Aged Care Act 1997 to enable better integration of all forms of seniors housing into continuing hosing and care communities.
8. That Government integrate the Commonwealth controlled Community Aged Care Program and the Home and Community Care Program to ensure a continuous care system servicing the needs of all older Australians.
9. That Government consider the creation of a seniors housing and care capital pool that would be exclusively allocated to services that develop fully integrated models of housing and aged care services.

Rod Young
CEO
ACAA
3 December 2008

REFERENCE INDEX

Tables 1 and 2	Productivity Commission's Research Paper 'Trends in Aged Care Services – Some implications' http://www.pc.gov.au/__data/assets/pdf_file/0004/83380/aged-care-trends.pdf
Graph 1	Stewart Brown and Co survey 'Aged Care Financial Performance Survey – Year ended 30 June 2008' ACAA can provide this report
Graphs 2 to 12	Grant Thornton (then Bentleys MRI) analysis of audited General Purpose Financial Reports of all aged care providers 2005/2006 financial year http://www.agedcareassociation.com.au/content/Ansell%20Congress%202007.pdf
Graphs 13 to 17	Grant Thornton – 'Aged Care Survey 2008 – Summary of Findings' http://www.grantthornton.com.au/files/aged_care_survey_2008-final.pdf
Tables 3, 4 and 5	ACIC Submission - Conditional Adjustment Payment Review 2008 Copy attached
Table 6	Stewart Brown and Co survey 'Aged Care Financial Performance Survey – Year ended 30 June 2008' ACAA can provide this report
Tables 7 and 8	PricewaterhouseCoopers report – 'Aged Care Industry Council's – Estimation of capital needs for the high care residential aged care sector' Copy Attached
Table 9	2007-2008 Report on the Operation of the Aged Care Act 1997 http://www.health.gov.au/internet/main/publishing.nsf/Content/44AC5B9CB3577BD0CA256F19001013FE/$File/ROACA08.pdf
Table 10	Department Health and Ageing Dec 2007 ACAA can provide this report

Aged Care Association Australia

Attachment A

Grant Thornton Report

Aged Care Survey

2007/2008

Aged Care Association Australia

Attachment B

ACIC Submission

Conditional Adjustment Payment

Review

Aged Care Association Australia

Attachment C

PriceWaterhouseCoopers
Aged Care Industry Council's
'Estimation of capital needs for the high care residential aged care sector'

Aged Care Association Australia

Attachment D

ACAA's
Aged Care Planning
Allocation
and
Approvals Processes