REVIEW OF CONDITIONAL ADJUSTMENT PAYMENT

AGED CARE INDUSTRY COUNCIL

October 2008

Introduction

The ageing of Australia's population, while an achievement to celebrate, brings with it a number of challenges for public policy. These form an important part of the context for the review of the Conditional Adjustment Payment (CAP). They include the increasing numbers of older people requiring care and other services; the increasing number of Australian families whose lives are touched by the world of aged care; and the increasing complexity of care needs among the very old.

In this context, expenditure on aged care should be seen as an investment. An investment in the productivity and quality of life of increasing numbers of Australians; and an investment in the overall effectiveness of the suite of care services used by older people, extending well beyond those funded under the Commonwealth aged care program.

Getting aged care right, in all its forms, is becoming increasingly important. An effective aged and community care system forms an important underpinning for a number of key Government policy objectives including health reform, social inclusion and enhancing national productivity.

The aged care industry views the CAP Review as an important step on a longer journey. The Aged Care Industry Council would look forward to a continuing engagement with Government on what needs to be a shared goal, ensuring that aged and community care is on a sustainable footing.

Key Elements

There are three important issues to be addressed in this review.

- The additional CAP indexation must continue to be applied each year to payments to aged care providers.
- A similar provision must be made for community care services.
- A longer term solution to the financial viability issues affecting aged care services must be found.

The Industry's View of CAP

The CAP was only ever intended as an interim measure, pending the achievement of efficiencies through the implementation of certain structural reforms recommended by the Hogan review and the completion of a review to determine the long term model of recognising cost escalation on the industry. The specific 'efficiency measures' required as conditions of the payment have all been met. However, no real progress has been made on the longer term reforms and neither has a definitive case been made that these would result in a more sustainable funding system for aged care providers.

The limitation of the CAP payment to only residential aged care followed directly from the Terms of Reference of the Hogan Review but, given that the principal cost of providing all forms of care is wages, there is no logical reason to expect that similar cost pressures do not apply with at least equal force in community care.

We are aware that, since 2004 when the CAP was introduced there have been two other partial measures of a financial nature introduced into residential aged care. These were the Aged Care Funding Instrument (ACFI) and the 'Securing the Future' package (STF). We note that these set out to achieve quite distinct objectives from maintaining the viability of residential aged care in the short term which was the stated purpose of the CAP.

The additional funding applied to the ACFI was intended to cater for the increasingly high needs of high care residents, funding for which had been artificially capped under the former RCS funding system. This was an issue identified in the first of a series of review projects leading to the development of the ACFI[1]. This will not be fully implemented until the grandparenting and capping provisions associated with ACFI implementation have washed through the aged care system.

The STF package was intended as a boost to capital raising in high care facilities in the context of the then Government's reluctance to address the fundamental structural distortions in the Aged Care Act regarding user contributions in high and low care. ACIC contends that the STF package offers some providers less funding in terms of capital when the package is looked at in its entirety taking into account the losses of funding under the package and the capping of the funding until September 2010.

Adding these measures together can create a misleading picture of recent changes in aged care funding. Though ultimately they do all come together in the 'bottom line', each had a distinct purpose and cannot be assigned to a different objective without abandoning the stated one – the money can only be spent once.

It is also important to view these various measures in the appropriate quantitative context. It is too easy to recite figures of increased funding of hundreds of millions of dollars without acknowledging the scale of the issues that need to be addressed. The very welcome extension of CAP indexation in the 2008-09 budget comes at a four year cost of $407.6 million. This sounds impressive but, naturally, represents an increase of 1.75% in the first year and approximately 1.35% over the four year period covered by the forward estimates. While the amounts sound large they need to be seen in perspective against the size of the aged care program.

Evidence of Industry Maturity

The residential aged care industry has kept its side of the bargain reached with Government in 1997 by introducing a number of efficiencies over the past ten years, many of these in cooperation with the Australian Government. These include the introduction of the new ACFI funding system; the adoption of a nationally uniform entry form for residential care (the five step model); the achievement of targets for building standards including space and privacy, full implementation of accreditation and a steady increase in the use of information technology, as evidenced by the survey conducted for the Department in 2007 and released this year[2].

[1] ACEMA 2002 Resident Classification Scale Review – DoHA February 2003
[2] CHIK - IT Readiness Survey of the Aged Care Sector, 2006

The three specific CAP conditions were detailed in the 2004-05 Federal Budget and are contained in Division 4 Part 10 of the *Residential Care Subsidy Principles 1997*. These conditions provide that the CAP will be paid to the Approved Provider where the provider complies with the three requirements, namely that the Approved Provider:

- Produce a financial report for either the approved provider or the residential care service through which the care recipient receives care, for the previous financial year, in accordance with the accounting standards, have that report audited and provide a copy of that report for the financial year previous to the previous financial year to:
  - Any care recipient who received care from the entity covered by the financial report, or their representative, who requested a copy of the report; and
  - Any prospective care recipient (that is, a person approved to receive residential care) who was considering receiving care from the entity covered by the financial report, or their representative, who requested a copy of the report; and
  - Any person or agency authorised by the Secretary of the Department of Health and Ageing, who requested a copy of the report.
- Encouraged workforce training at the residential care service during the previous calendar year; and
- Participated in the most recent workforce survey and census conducted by the Department of Health and Ageing.

Whilst industry has achieved these efficiencies it should be noted the industry is unaware of any requests for copies of the audited accounts from residents, prospective residents or relatives of residents (including prospective residents). In fact the only requests have come from the authorised agents of the Department and this year, contrary to a 2004 agreement between the Department and the industry, the Department has sought the audited accounts be made available to the Department directly not a third party organization commissioned to undertake the analysis of the audited accounts and to independently report on this analysis to the Department, individual providers and the industry generally.

The requirement to provide the accounts to residents, prospective residents and relatives thereof, where requested, was to provide information about the financial stability of entities, especially where bonds were concerned. This is no longer considered necessary for the following reasons:

- Segmented accounting does not provide information relating to the viability of the total entity;
- Most people cannot read or understand audited general purpose financial reports ; and
- Legislation was introduced in 2006 to financially underpin the repayment of bonds.

The industry has also absorbed the impact of other Government policy changes and other non government economic events. These include, but are not limited to:

Government Policy Changes:

- Police checks
- The conversion to ACFI (incl IT conversions and staff development & training)
- Compulsory reporting of incidents
- Widening of the CRS to the Complaints Investigation Scheme
- Increased numbers of Commonwealth surveys
- Increased validation of subsidy assessments
- Additional interest on bond repayments
- Increased unannounced accreditation visits and support contacts
- Introduction of food safety standards and mandatory food safety programs
- License fees associated with food safety
- Implementation of electronic commerce with completion and lodgment of the new ACFI funding instrument
- Bond protection and prudential arrangements

Non Government Related Costs, Reforms and Efficiencies

- Increased interest rates
- The cost of recruiting staff (high)
- The increased reliance on disposable continence products
- Improved wound management techniques at considerably higher cost
- IT and assistive technologies
- Increased specialized nursing procedures (ostomy care, peg feeds, IV therapy Tracheotomy care) previously done in acute settings
- Increased evidence of residents with mental illness (requiring specialist care) previously catered for in the State health system
- Staffing efficiencies

The overall cost of the new government policies are, in some cases, greater than the income received from the annual CAP funding. ACIC estimates the costs associated with the Government initiated policy reforms at an average annual cost in excess of $200m whilst the cost impact of non government reforms and efficiencies is in excess of $300m per annum.

Possible future reform

Without the continuation of CAP indexation, other enhancements to the industry's reform capability and possible further efficiencies will not be possible. In fact a number of the following suggestions will only be possible if the CAP is maintained and Government is prepared to provide additional implementation funding for the proposed reforms. Some suggestions for reform are:

- The increased use of nurse practitioners to supplement the role of GPs in residential care;
- The advancement of the Government's Award modernisation agenda through the creation of a single aged care industry award incorporating all classifications of worker in the industry;

- Support the industry to full electronic enablement for business to business transactions with Medicare Australia;
- Enable ePrescribing for aged care facilities, GPs and community pharmacies servicing aged care facilities leading to the creation of an electronic virtual health record between aged care facilities and servicing GPs;
- Implement a single resident agreement for the industry
- Implement a single industry wide application form so prospective customers only need to complete a single application form once even though it may be lodged at a number of facilities;
- Development of a national 'working with vulnerable persons' card that could be used by aged care workers across the industry,
- Develop a national vacancy service to provide prospective clients in community and residential care a quick reference to available places within a geographic area.

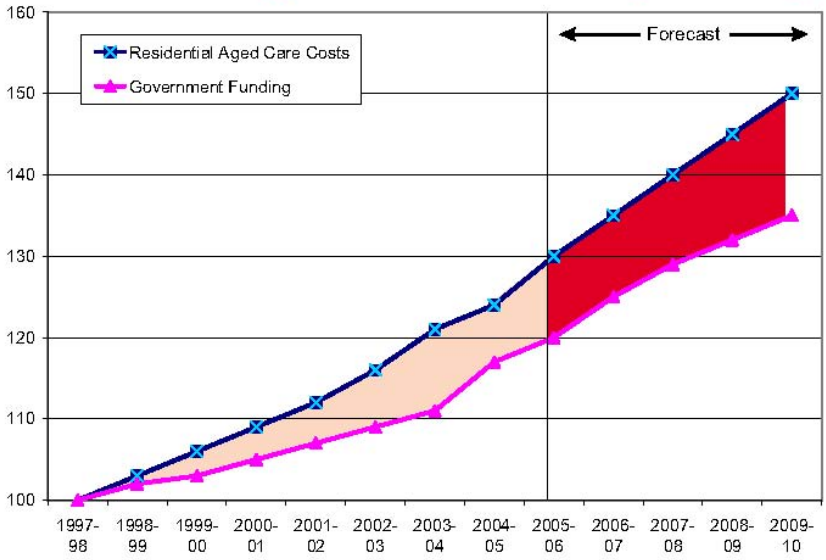
Recognising economic and social benefits

The dividend to Government of a healthy aged and community care industry extends well beyond the immediate benefits to older people in need of care. We estimate that some 3.7 million people's lives are touched by the aged care industry as clients, workers and families of both clients and workers. Aged care is a significant employer, often the most significant in many country towns[3] around Australia and contributes, in ways that have yet to be thoroughly measured to the nation's productivity by releasing carers back into the workforce. Expenditure on aged and community care should properly be seen as an investment.

Consequences of Inadequate Funding

Failing to maintain the value of care subsidies will mean a reduced standard of service to clients. If revenue continues to fall behind the increasing cost of care labour, then fewer hours of care per day, per week and per resident or client will be able to be provided. Data collected by industry benchmarking firms already shows that the number of care hours per resident has fallen

[3] CRA International 2006 – Economics Importance of Non-Hospital Health and Aged-Related Community Care Services to Regional Communities. Report prepared for Hesta.



Commonwealth Aged Care Homes Funding Shortfall (1997-98=100)

Note

The Government Funding up to 2007-08 includes the Conditional Adjustment Payment announced in the 2004-05 Budget. It is not included for subsequent years as there is no government commitment to this payment extending beyond 2007-08.

Notes on the graph

Government funding (COPO index) is based on the actual funding amount provided in 1997-98 and shows the compounding impact of providing funding which does not keep pace with the rising costs of care delivery. The Government funding index does not show actual funding which has increased as a result of factors such as increased number of places and increased complexity of care associated with those places. The Government funding index can, however, be used to show the increase in subsidy per resident of the same complexity over the time period compared to the increase in costs of providing care to that resident. The shortfall is clearly evident.

This graph is based on an original graph produced by Catholic Health Australia.

Without the small boost provided by the CAP hours of care would have fallen even more, as they have in community care which has not benefited from the CAP. Reducing the quality of the aged care product is not efficiency.

In addition aged care has significantly restructured workforce roles and functions over the last decade with substantial efficiencies being achieved from workplace restructuring whilst still increasing total care wage outlays.

Inadequate funding also compromises the industry's ability to pay competitive wages to staff. The more generous funding increases made available to the public and private hospital systems have supported higher wage outcomes in these sectors and increased the difficulty for aged care providers to compete. Undesirable trends such as increasing casualisation with its associated risks to quality care; inefficiencies such as over use of agency staff and the reduced purchasing power of working families[4] all stem from inadequate prices paid by the Government for care.

The cost of achieving wage parity has been estimated at around $450M in 2008 (Productivity Commission 2008). Additional amounts of around $100M in subsequent

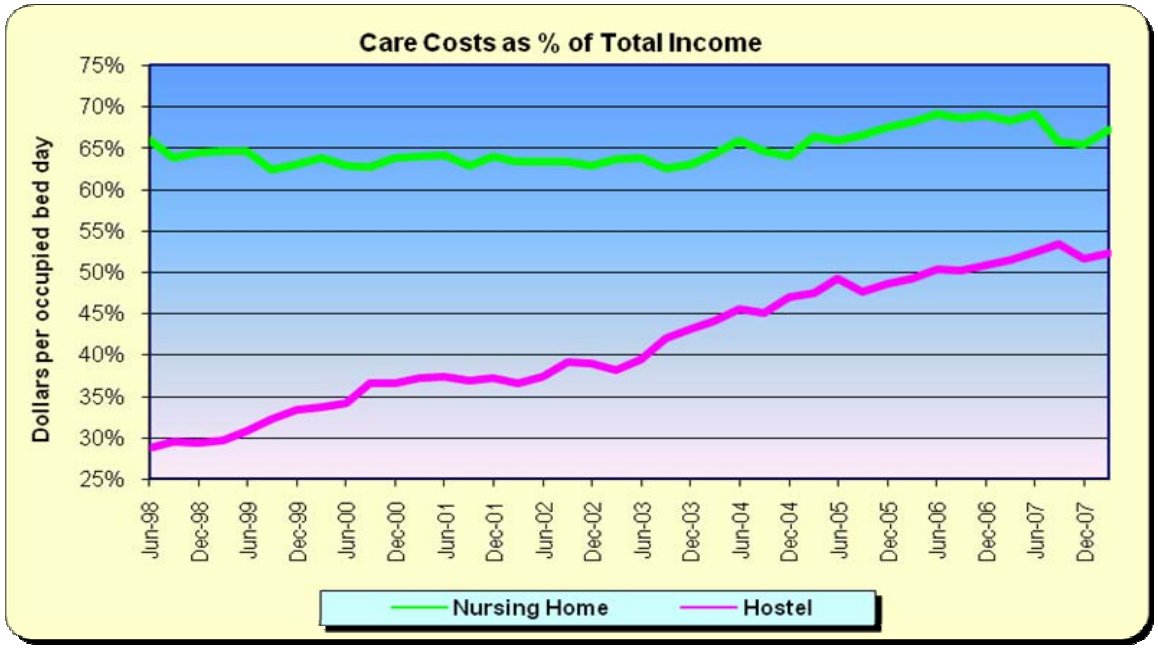
[4] Generally lower paid as a result of a decade or more of inadequate funding.

years would be necessary to maintain wage parity under the current COPO adjustment arrangements.

The introduction of CAP was:

> *"To assist aged care providers to continue to provide high quality care for older people, including assisting in paying more competitive wages to nurses and to other staff" – (2004-05 Budget Fact Sheet "Summary of aged Care Measures")*
>
> *"Real wages are expected to grow faster in residential aged care than in the economy, due to growing demand and a developing shortage of qualified staff." – ("Investing in Better Care" the Hon Julie Bishop, Minister for Ageing)*

Since the introduction of the Aged Care Act 1997 care costs as a percentage of total income have remained reasonably constant in high care facilities. In low care facilities the percentage has steadily increased and this reflects the introduction of ageing in place. The care costs as a percentage of income has steadily increased in both low and high care since the introduction of CAP and this recognises that the income from CAP is resulting in increased care for residents. This is indicated from the following graph contained in the "Aged Care Financial Performance Benchmarks at 31 March 2008" prepared by Stewart Brown Aged Care Financial Services.



Aged Care is often accused of not using additional funds to pay staff additional salary and wages. In fact, Stewart Brown has used their industry survey to track the proportion of income received that is allocated to care wages. The graph above clearly details the

ongoing growth in industry care wage outlays at a growth factor greater than increases in income.

Nursing wages in the non-aged care sectors continue to escalate and so aged care will be forced to follow or risk losing valued staff to the acute care sectors. The alternative is to decrease direct care hours which is in direct opposition to the desires of the industry. It is estimated that the non-continuation of CAP will cost the industry approximately $635,000,000 which equates to 5.69 full time equivalent positions per facility over 3 years. This directly compromises the capacity of the industry to maintain quality care delivery.

Impact of the loss of CAP

Based on the Operational and Approved Places at 30 June 2007 provided by the Department of Health and Ageing, the non-increase of CAP from the current 8.75% level will result in losses to the industry of $100 million in 2009/10, $205 million in 2010/11 and $330 million in 2011/12. The losses are more succinctly expressed as follows;

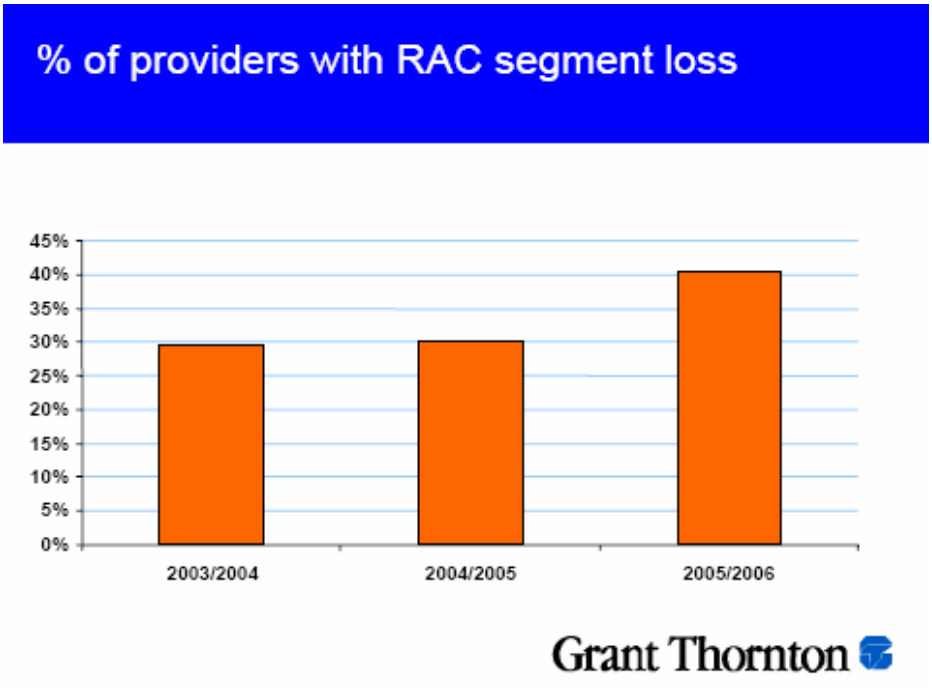
Details	NSW	VIC	QLD	SA	WA	TAS	AUST
Residents at 30 June 2007	59,500	44,000	30,500	17,000	14,500	4,500	170,000
Number of RACs	937	800	489	304	254	88	2,872
Loss of Funding – 3 years	$207 m	$177m	$108m	$67m	$56m	$20m	$635
Loss of Jobs	5,331	4,552	2,782	1,730	1,445	501	16340
Average FTE lost per RAC– 3 Years	5.69	5.69	5.69	5.69	5.69	5.69	5.69
FTE losses per RAC per year	1.90	1.90	1.90	1.90	1.90	1.90	1.90

Already the ongoing viability of the aged care industry has been compromised. As the data collected as part of the CAP conditions showed in 2005/06, 40% of providers were operating residential aged care at a loss. There will be argument about these specific figures, though they were collected and analysed by a highly-respected independent accounting firm, but no analysis is going to show that residential aged care is making healthy returns.

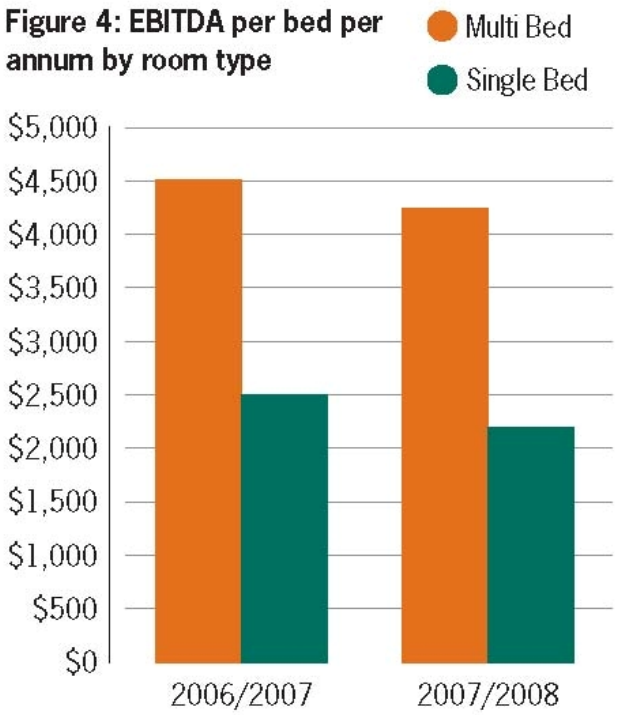
One of the efficiencies which the department stated would be provided due to the introduction of audited accounts was the provision of management efficiencies through benchmarking and in particular the financial ratio analyses for the facility and for the industry.

The industry is extremely disappointed that this information, meant to improve the financial maturity of the industry, has not been received for the 05/06 and 06/07 financial years. This has forced the industry to undertake its own financial exercise for the 07/08 financial year, the outcomes of which are attached separately to this submission. The following graph is an extract of the Grant Thornton analysis of the

industry's financial position for the 2005/06 financial year based upon their assessment of the audited accounts submitted by the industry as required for CAP maintenance.



The following graph indicates a significant difference between the returns that can be achieved in multi bed wards as opposed to single bed units.



Compromised viability is not just a problem for the organisations providing aged care services. If it is not addressed it is only a matter of time before it compromises access to care. This is likely to occur first in less well resourced parts of Australia including rural areas and poorer suburbs where client contributions to accommodation and care are at a minimum. Reduced access to care should never be regarded as improved efficiency any more than reduced hours of care can be. Reducing the efficacy of aged care services is likely to add to costs in other parts of the health care system.[5]

There are those that argue that part of the solution to the viability challenges faced by small rural aged care services may lie in their consolidation into larger organisations. To the extent that this is a viable strategy it would need to be managed strategically to ensure that local access and local input of social capital is not lost. Such a process must be resourced, including by government if acceptable outcomes for local communities are to be achieved. Resourcing the development of strategies and business plans to ensure continued access to aged and community care services would be a worthwhile investment for the Australian Government.

In 2007, according to The Grant Thornton Survey released on 14 October 2008, the average earnings (EBITDA) fell from $3,211 per resident /bed per annum to $2,934 in 2008. However, for modern high care facilities with single rooms and ensuites, the results are even worse with results of $2,191 per resident per annum compared to $4,233 per resident in multi bed rooms.

Figure 2: EBITDA per bed per annum

On a per resident per day basis the 8.75% CAP supplement equates to an average of $8.06 per day or $2,941 per annum. If the CAP was removed entirely it will push the more modern facility into a net loss of $750 per resident per annum.

[5] Refer to the recent PITCH study for data on the efficacy of community care in enhancing recipients health status.

"*One of the greatest influences in the past decade has been the preference for privacy and personal space. Single room services are a high priority for residents (and particularly their families). In response to this demand, the majority of planned facility developments in the survey had single rooms*." - Grant Thornton report.

It should also be noted that the move to single ensuited accommodation has also been driven by the agreement between government and industry to improve the overall building standard for the industry.

The Minister in media announcements stated that the value of the CAP to the industry over the next four years was $2b, therefore at constant prices and zero growth this equates to $500m a year and 1.75% equates to $100m a year.

	2008/9	**2009/2010**	**2010/2011**	**2011/2012**
8.75%	500m	500m	500m	500m
1.75%	100m	100m	100m	100m

Taking the base of 2008/2009 where the value of the 1.75% CAP increment is $100m and there are 170,000 residents allowing for growth of 2.5% the following will be the impact of having the annual increment of 1.75% denied to the industry;-

	2009/2010	**2010/2011**	**2011/2012**	**Total lost**
Funding loss pa	$101m	$208m	$321m	$630m
No of residents	174,250	178,606	183,071	
Number of Facilities	2872	2872	2872	
Av. funding loss per resident per day	$1.60	$3.20	$4.81	
Av. Funding loss per provider per day	$97.06	$199.25	$306.78	
Av. impact on bottom line per annum	$35,428	$72,727	$111,974	$220,130

The Stewart Brown, June 2007 Benchmarking Survey showed that the **net operating result** per resident per day for high care was a negative ($9.81) or $3,580 loss per resident per annum and for low care a negative ($0.01) per day or $3.65 loss per resident per annum. Removing the $8.06 average CAP funding will push the average operating result to ($17.87) per day or ($6,522) per resident per annum for high care and ($8.05) per day or ($2,938) per resident per annum for low care. This is after depreciation interest, tax and amortisations.

With High Care Capital funding at an average of half the actual cost of building, investing in capital infrastructure under the financial circumstances outlined above is for most providers hugely risky and for many impossible. With the average age of residents on entry increasing, their care needs will increase and therefore there will be fewer bond paying low care residents entering low care residential aged care facilities to fund capital building while ageing in place. Longer term there will be fewer bond paying entrants meaning that there will be a time when there will not be enough new bonds available to repay old bonds and providers will have to find cash reserves to

meet this future requirement. If providers become cash negative we may have a situation develop similar to the difficulties being experienced on global markets today.

If the aged care system had been adequately funded from 1997 when the Act was introduced and bonds and charges were tied to a resident's ability to pay, aged care providers would not be in this position. In 1997 when the Accommodation Charge was introduced it was set at $12.00 per resident per day, the average bond was $48,000 Australia wide. The average bond at 30 June 2007 was $161,000 yet the maximum Accommodation Charge is now $26.88 per day. This is effectively half of what it costs to fund and repay a loan to build a quality new facility on a per resident room basis now costing between $160,000 and $200,000 depending on the location. The maximum Accommodation Payment supplement paid by the Department for those residents who have limited assets of less than $34,500 at time of entry to residential care is also $26.88 per resident per day. An amount that will not support the cost of buildings of the quality, standard and size now required by government and expected by the community.

The effect of this unfortunate policy adjustment in 1997 is that many providers are using operational income to support capital activity, low care bond paying residents have been cross subsidising high care accommodation charge residents and fully government funded concessional residents. One perverse outcome from this policy framework is that high care accommodation charge paying residents are treated differently to bond paying residents if they sell the home, as any lump sum they hold to pay their accommodation charge is included for pension assessment whereas the lump sum bond payment made by a low care resident is exempt for pension assessment purposes.

While the CAP and capital payments are not directly linked, the impact of removing the CAP will put even greater pressure on capital funds available for building aged care facilities to cope with the growing future demands. Will negative operating cash returns be funded from capital funds? The answer is a categorical YES and that was surely not the intention of the Aged Care Act 1997.

Impact on Community Care

Addressing the diminishing purchasing power of CACPs

There is evidence to suggest that the service purchasing capacity of a CACP has diminished considerably since 1995. Whilst this does not result in fewer clients receiving care, the amount of service offered to the client has declined, with funding for packages less able to meet assessed need.

The Australian Institute of Health and Welfare's report on the 2002 census of community aged care packages (AIHW 2004) indicated that, on average, clients were receiving 6.1 hours of care per week or 52 minutes per day. A lack of historical data on the amount or type of assistance received by clients (AIHW 2000) means that direct measurements of care provided through CACPs' are not yet able to be measured over time.

Nonetheless, it is possible to use other evidence to act as a proxy. Such data suggests that number of care hours per week has decreased.

One source of evidence is that of grossed up calculations. In 1995/96 Community Aged Care Packages were allocated $9366 per annum to purchase services on behalf of clients. By 2005/06 the value of the package had increased to $11,884 (DoHA, 2005b). As the Table below shows, this amounts to an overall increase of 27.24%. During the same period, CPI, as reflected in the September quarter annual comparisons performed almost identically. However, the largest component of cost in aged care delivery is wages. Over the same eleven successive years, there has been an overall increase of 64.3% in the ordinary time earnings of full time working adults. When considering women, who comprise a large component of the aged residential care and community care workforce, the comparative figure for female adults has been 64.7%. The increase in wages measured through this national data has been more than double the increase in CACP subsidy.

Comparison of increases to CACPs subsidies, September quarter CPI, and selected average weekly earnings 1995-2005. (Data sources: DoHA, 2005b, ABS, 2005b and ABS 2005a)

Measure	**Overall increase 1995-2005**
CACP subsidy	27.24%
CPI (cumulative Sept quarter annual comparison)	27.24%
Ordinary time earnings – Persons, Full Time Adult, August measure	64.30%
Ordinary time earnings – Females, Full Time Adult, August measure	64.68%

Another proxy measure is to refer directly to the adjusted increase in CACP subsidy payments made by the Commonwealth each year using the Commonwealth's Own Purpose Outlays (COPO) index (Australian Institute for Primary Care La Trobe University, 2003). COPO is calculated using the following algorithm:

COPO% = (Annual CPI % x 0.25) + (annual *SNA % x 0.75)

*SNA Safety Net Adjustment: SNA% = Safety Net Increase per week/average weekly earnings

The same outcome is shown as for Table 1 when comparing the COPO to selected classes of average weekly earnings, as shown in Table 2 below (compared over a shorter period for which the COPO data has been able to be sourced)

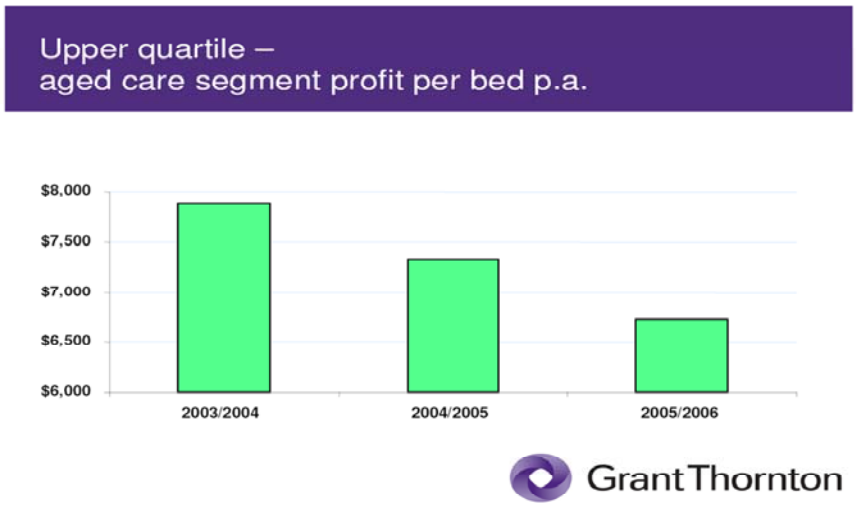
Comparison of COPO index and increases in selected classes of average weekly earnings.

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

Costs, especially wages and their on-costs, are rising at a faster rate than increases to care subsidies and care recipients' fees. The average increase in funding does not sustain the costs of the community care industry's operations. In particular, COPO which is used by Government to determine increases in subsidies, does not adequately recognise increases in wages, which often represents 70-80% of costs in the aged community care sector. Moreover, a critical factor exists in the less than adequate indexation of the wages component of COPO. The Commonwealth uses the Safety Net Adjustment, rather than actual aged care sector wage increases which have occurred as a result of enterprise bargaining, to determine COPO. This results in a method of indexation insufficient to maintain pace with real increases in the costs of running businesses and providing care.

Variations in Financial Outcomes

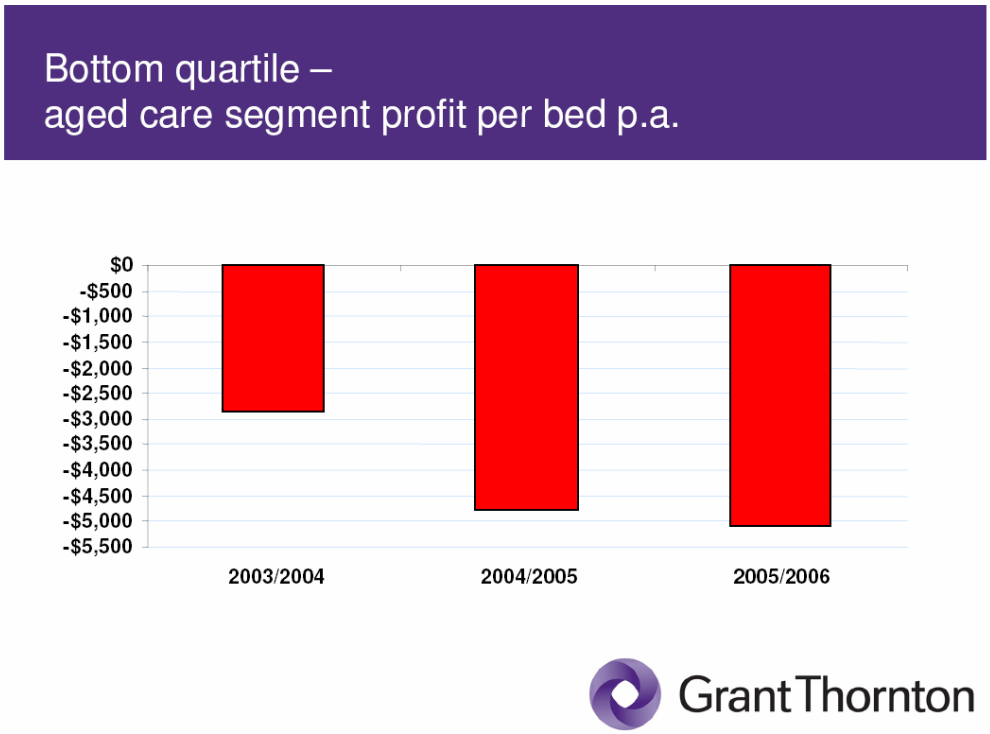


It has been argued that the top quartile of providers is doing well (it would be circular to say they are doing better!) but independently collected data shows that their results are trending steeply downwards too (see graph above). Those who cite this data as evidence that it is possible to do better in residential aged care, as was the case with Professor Hogan's assessment of relative 'efficiency,' are unable to say how these results would be achieved. The industry notes that the top quartile is not evidence of that "black box" entitled "***efficient management".*** Rather, many outcomes in this area are underpinned by either:

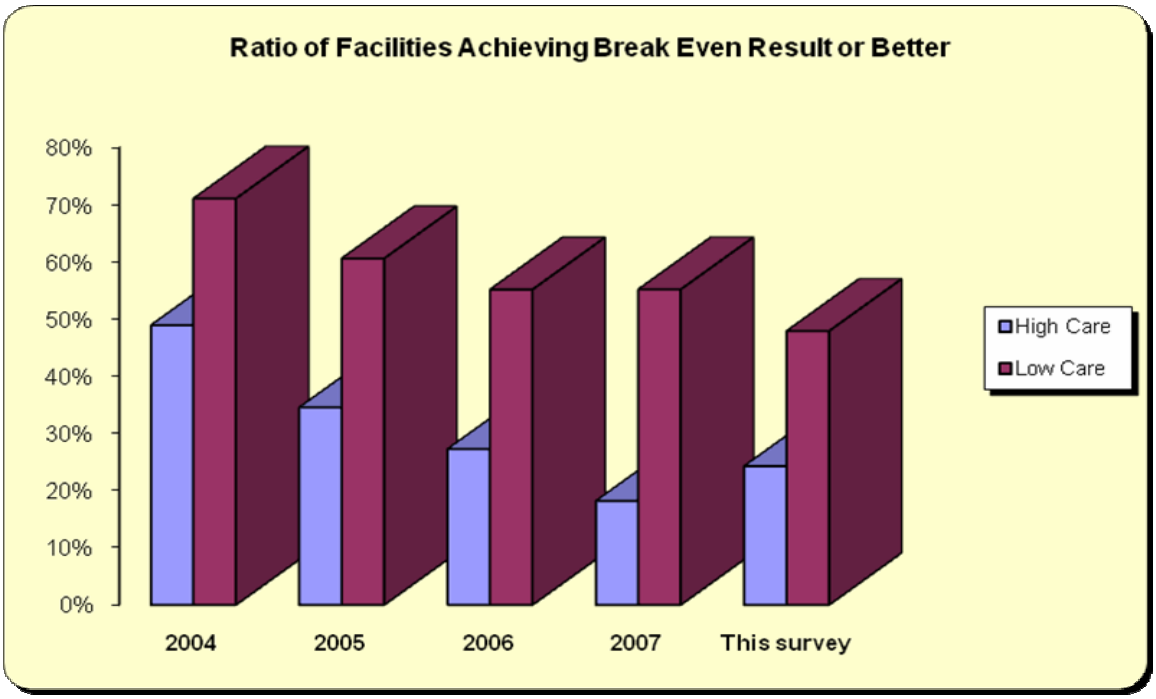
- Most facilities in this sample are extra service facilities, or offering extra service to distinct parts within the facility; or
- Are offering care in multi bed rooms which lend itself to more efficient service and capital utilisation.

These conditions are not generalisable across the industry under current Government policy nor are they likely to be universally acceptable to consumers and their families. Only a small proportion of the older population is ever likely to afford extra service aged care and the era of four bed rooms is probably passed. It is also likely that some providers include capital gains from asset revaluations in their accounts, obscuring the real operating result from the casual observer.

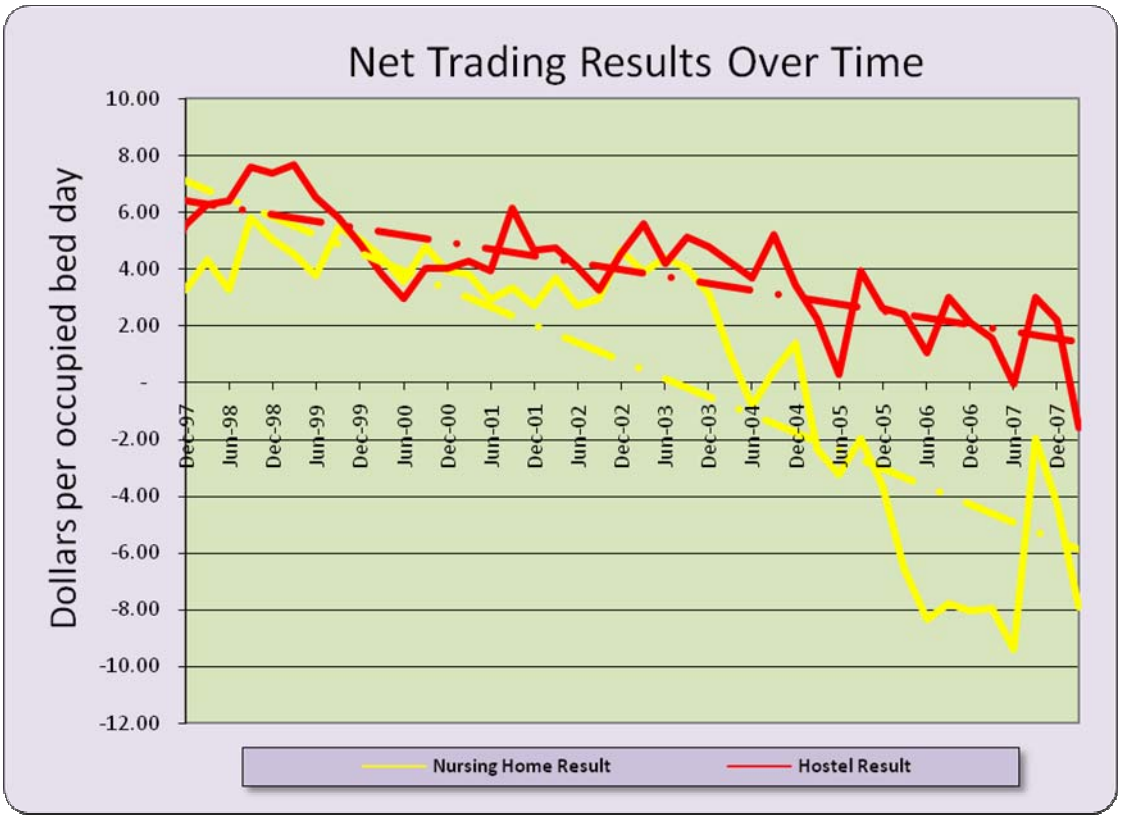
The following graph indicates the bottom quartile is in a similarly declining profit/loss position.



The Stewart Brown Aged Care Financial Services results for the nine month period to 31 March 2008 indicated that only 25% of the high care facilities achieved an operating profit compared to 49% in June 2004, prior to the introduction of the CAP supplement. Significantly there are facilities which are making a loss included in the top 25 per cent of high care facilities. Only 48% of low care facilities are showing a profit.



High Care facilities averaged an operating loss of $7.90 per bed day while low care facilities averaged a loss of $1.59 per bed day.



It has also been argued that the entry of new organisations including private equity funds, merchant banks and foreign capital into the residential aged care industry is evidence of its financial health. 'If these smart people want to buy in, things must be pretty good'. Or so the argument goes. It is disingenuous to claim that such an entry into the aged care sector is an indicator of good returns and how well the sector is going as a whole. It never ceases to amaze how silent the government is when the reverse occurs. In addition, contrary to popular belief that substantial growth has occurred in the private for profit component of the industry the reality is that over the last ten years the private for profit component has grown from 29% to 31% with most of that growth coming via new licence allocations.

The poor financial performance of residential care stemming from the failure of subsidies to keep pace with the costs of care is compounded by the inadequate capital raising strategies available under the *Act* to high care services. An independent analysis in 2007 concluded that, on conservative assumptions about capital costs, there would be a shortfall of $5.7 billion in capital over the following twelve years. This problem is exacerbated by the changing patterns of demand for residential care and may be further heightened by the incentive structure built into the ACFI which makes subsidies for many low care residents below cost.

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**

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%				

Another indicator of the strength in the sector, which governments have used to demonstrate viability, is the Aged Care Approvals Round (ACAR) over-subscriptions. ACAR allocates aged care places to existing and prospective providers, at no cost to the operator other than the operating costs of submitting a competitive tender. Once approved, each of the places has a book value of between $10,000 and $50,000 depending on location.

Contrary to the view that ACAR round over subscription demonstrates industry viability, the following more accurately reflects the reality of what is happening:

- The 2007 ACAR Round was undersubscribed;
- A number of provisional allocations have been returned;
- Many providers have signalled that they will finish building work in progress but will not commit to further capital works beyond that which is in the pipeline.
- The devaluation of the value of secondary market places in a number of States from $45,000.00 to $0
- the fact that there are few and in many cases no prospective purchasers for places.

Recent provisional allocations handed back are as follows:

Year Returned	High Care	Low Care	Community	Total
05/06	236	479	45	760
06/07	163	286	0	449
07/08	105	166	0	271
Total	504	931	45	1,480

Links to Other Government Objectives

The Australian Government has recognised the strategic importance of aged care in the overall health system. Initiatives such as the recent expansion of transition care places are but one example of the potential to improve overall system effectiveness and efficiency by enabling people to receive treatment and care in the most appropriate setting. Much has been made of the relative costs of nursing home as opposed to hospital care. These arguments have been exaggerated since they accept costs of aged care service which are unsustainable and have sometimes been taken to imply that older people have lesser rights to public hospital services but they are not without fundamental substance. Aged and community care could play a larger role in ensuring the optimal functioning of the overall system of care for older people provided that they are properly resourced to do so and provided that they survive.

The success of the Government's welcome commitment to social inclusion also rests to some degree on the capacity of an effective community care system to enable older people to remain living in their communities, a capacity which is compromised by inadequate levels of funding for these services.

We cannot afford for aged and community care to be the weak link in these flagship Government strategies by underfunding its operations.

Links to other Government Aged Care Objectives - Implications of the ACFI

The introduction of the ACFI has been referred to above as an industry efficiency. This is true but the ACFI has other implications too. Early indications are confirming the industry's view that the ACFI will result in a re-targeting of residential aged care to people with higher care needs. People who until this year may have been admitted at the lower end of the low care spectrum (as RCS Category 6s or 7s) are unlikely to gain access to residential care under the ACFI. This outcome was acknowledged in passing in the Hogan review report but will require a rapid and substantial policy response if the care needs of affected people are to continue to be met. One important component of this will be bolstering the community care system which would be assisted by the extension of CAP like indexation to these services.

Secondly the upwards targeting of residential care will have implications for the skills mix of staff required to cater for older people with more complex care needs. We will need more skilled nurses thus heightening the competition for staff with the hospital sector and underscoring the need for aged care to be able to compete more effectively in terms of remuneration.

Under current policy settings this re-targeting of the residential care program is likely to cause liquidity problems as exiting low care residents who paid a bond are replaced by incoming high care ones who are denied the option of paying a bond even if they wanted to.

Shortcomings of COPO

Before the CAP was introduced aged care subsidies were indexed by one of the Commonwealth Own Purpose Outlays formulae. The CAP recognised the manifest inadequacy of this form of indexation, which continues for community care to this day. The table below shows the shortcomings of the COPO 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

A Comparison of Cumulative Combined COPO/CAP Subsidy to SNA – Minimum Wage, and AWOTE is

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 8 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 – fuelling wages growth as we have seen above. It is understood that the Government may be reviewing the COPO methodology; this is long overdue in aged and community care. 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 the 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.

Conclusion and Recommendations

The aged and community care industry argues that the funding issues threatening the ongoing provision of care to older people require two sorts of action, immediate short term measures to ensure services do not collapse and longer term solutions to avert future or recurrent crises.

Action Required

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.

2.3 User Pays

There is greater scope for user pays contributions to residential aged care should the Government wish to avail themselves of it. The majority of care recipients are pensioners and thus income poor by any reasonable standard. Some however, own substantial assets in the form of a family home that they may no longer need, in a capital city that has experienced substantial price inflation over the past decade. Current policy only provides for these assets to contribute to capital in low care but the option exists for Government to harvest contributions from this source by establishing a 'fair rental' for aged care accommodation, ideally reflecting the radically different property costs in different localities around Australia, and applying this to all pensioner residents together with an assets test. Allowing market forces to determine rental rates for non pensioners, as they do in the wider property market, would further relieve the cost to taxpayers.

Separating accommodation, which everyone in the community has to pay for, from care which rightly is regarded as a universal service obligation for government has been supported by many analyses of the Australian aged care system.[6]

2.4 Long Term Options - Care Insurance and Superannuation

The Hogan review examined the potential of long term care insurance as an alternative basis for financing aged care reducing the reliance on current year tax revenue. Professor Hogan concluded that commercial or voluntary insurance schemes were unlikely to be successful however compulsory schemes – effectively hypothecated taxes – have been the backbone of many aged care systems in other countries. The fact that hypothecated taxes have not been used much in Australia should not be taken to mean that they cannot be.

Some commentators have argued that future generations of older people, in receipt of superannuation, will be in a position to contribute more to the costs of their care. To the extent that this is true this potential would be much more likely to be realised if controls were to be placed around the payment of superannuation in lump sums. This significantly decreases the likelihood that there will be any funds left by the time they could be used to contribute to the costs of care.

[6] See for example The Myer Foundation 2002 '2020: A Vision for Aged Care'

Some of these longer term options may lack short term political attractiveness but the composition of Australia's population is changing and policy settings may need to change with it. The consequences of doing nothing may prove even more unattractive in the future.

Other Options

We recognise the short term focus of the CAP review but would urge consideration of the development of longer term, lasting and sustainable solutions to the funding issues besetting aged care. These should be developed in partnership with all the key stakeholders in the aged care system consumers, providers, staff and governments. All have a stake in the future of aged and community care and all have much to contribute to the identification of workable solutions.