The Senate

Standing Committee on Finance and Public Administration

Residential and Community Aged Care in Australia

April 2009

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**Senator Rachel Siewert to replace Senator Hanson-Young
***Senator Gary Humphries to replace Senator Ryan
****Senator Carol Brown to replace Senator Collins for hearings on 27 March and 7 April 2009

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Recommendation 1

3.6 The committee recommends the establishment of a national aged care forum, reporting directly to the Minister for Health and Ageing and coordinated by the Department of Health and Ageing, to consider, on an on-going basis, current and future challenges to the aged care sector.

Recommendation 2

3.7 The committee recommends that the national aged care forum establish a taskforce (or equivalent body) representative of all involved aged care stakeholders including clients to action and where possible implement determinations of the national forum.

Recommendation 3

3.12 The committee recommends that the Department of Health and Ageing, in cooperation with the suggested taskforce and in partnership with all involved stakeholders including clients, undertake an all-encompassing review of the *Aged Care Act 1997* and related regulations. The review should:

- **equally examine the provision of residential and community aged care services in Australia with consideration of both current and future challenges in the provision of aged care services;**
- **provide future projections to enable both short and longer-term sectoral planning.**

Recommendation 4

3.24 The committee recommends that the Department of Health and Ageing in association with the suggested taskforce and in consultation with all aged care stakeholders including clients undertake analysis to establish benchmark of care costs.

Recommendation 5

3.30 The committee recommends that the Department of Health and Ageing recommence publication of Audited General Purpose Financial Reports as soon practicable and continue to publish such reports annually as a matter of course.

Recommendation 6

3.31 The committee recommends that the Department of Health and Ageing review the Audited General Purpose Financial Reports with an aim to identifying any necessary reporting changes to ensure that the information available provides a clear and comparative understanding of provider performance.

Recommendation 7

3.39 The committee recommends the establishment of a nationally consistent methodological approach to data gathering and research on the financial status of the residential and community aged care sector. Towards this goal, the committee recommends the establishment of a roundtable of key stakeholders engaged in such research and facilitated by the Department of Health and Ageing to discuss and agree upon common indicators and definitions to enable comparative analysis.

Recommendation 8

3.44 The committee recommends that the Department of Health and Ageing in association with the suggested taskforce (or equivalent body) and in collaboration with the Australian Institute of Health and Welfare review and address deficiencies in information in the aged care sector.

Recommendation 9

4.59 The committee recommends that the Department of Health and Ageing undertake a 'stress test' of the aged care sector in order to measure the sector's financial wellbeing.

Recommendation 10

4.78 The committee recommends that the Department of Health and Ageing, in association with the suggested taskforce, undertake a review:

- **to identify the costs and resources required to meet new regulation, accreditation and compliance measures with a view to rationalising the administrative processes as required; and**
- **to identify more cost effective means of meeting the requirements of the compliance framework.**

Recommendation 11

4.79 The committee recommends that the Department of Health and Ageing implement measures, including additional funding, to assist smaller providers to meet the requirements of the compliance framework.

Recommendation 12

4.98 The committee recommends that the issue of professional nursing and other aged care staffing requirements be considered in the overarching review of the aged care sector.

Recommendation 13

4.113 The committee recommends that the Department of Health and Ageing, in association with the suggested taskforce, review aged care staffing challenges and

identify methods of address, with particular focus on staffing requirements in rural and remote areas.

Recommendation 14

5.49 The committee recommends that the taskforce undertake a review of the indexation formula used for the aged care sector in order to identify its adequacy in relation to costs faced by the sector and to identify modifications to the formula if required.

5.50 The committee further recommends that consideration be given to an independent mechanism to continually assess the indexation formula.

Recommendation 15

6.40 The committee recommends that the all-encompassing review specifically consider the provision of aged care services in rural and remote areas and the effectiveness of the current viability supplement to support service provision.

Recommendation 16

6.43 The committee recommends that the Commonwealth and Norfolk Island Government initiate discussions in relation to a proposal to develop homecare services on Norfolk Island.

Recommendation 17

6.48 The committee recommends that the all-encompassing review specifically consider and address the expectations and needs of persons from non-English speaking backgrounds.

Recommendation 18

6.60 The committee recommends that the Department of Health and Ageing conduct a review into the implications of 'elderly homeless' incorporated as a special needs category under the *Aged Care Act 1997*.

Recommendation 19

6.61 The committee recommends that the suggested all-encompassing aged care review specifically consider and address the expectations and needs of the homeless and other socio-economically disadvantaged persons.

Recommendation 20

6.71 The committee recommends that the suggested all-encompassing aged care review specifically consider and address the expectations and needs of elderly Indigenous Australians and their communities.

Recommendation 21

6.72 The committee recommends that the Department of Health and Ageing consider further initiatives to attract culturally-appropriate staff in consultation with involved stakeholders including Indigenous clients.

Recommendation 22

7.44 The committee recommends that the Australian Government implement the recommendation of the 2007 National Review of Aged Care Assessment Teams and review the legislative requirement for re-assessment of those residents:

- **moving from low to high care within an aged care complex where the low and high care facilities have separate provider numbers;**
- **entering an aged care facility with a low care approval but who require high care.**

Recommendation 23

7.51 In light of disparities in information regarding the Aged Care Assessment Team (ACAT) assessments and re-assessments between the Department of Health and Ageing and involved providers, the committee recommends that the department launch an information campaign on recent reforms to the ACAT.

Recommendation 24

7.60 The committee recommends that the Department of Health and Ageing review methods directed to affirming the ACAT as a single nationally consistent program which genuinely serves as a single entry point to aged care services. The review should entail dialogue with aged care clients and providers as well as liaison with state and territory health departments.

Recommendation 25

7.61 The committee recommends that the Department of Health and Ageing conduct a national education campaign directed at new and potential aged care clients to raise awareness of the aged care services available to them including the role of ACAT and of their rights and entitlements in relation to such services.

Recommendation 26

7.94 The committee recommends that the Department of Health and Ageing analyse decoupling of residential care and accommodation. Such a review should consider and assess the views, concerns and recommendations of involved stakeholders including the Productivity Commission.

Recommendation 27

7.112 The committee recommends that the Australian Government expand community aged care funding and services to meet growing demand and expected quality service provision outcomes.

Recommendation 28

7.122 The committee recommends that the all-encompassing review of the residential and community aged care sector take a client-based approach in order to ensure that its findings are client focused.

Recommendation 29

7.129 The committee recommends that the all-encompassing review of the aged care sector consider options to enable greater flexibility in relation to payments and services directed at providing a client-centred aged care system for Australia.

Recommendation 30

8.43 The committee recommends that the suggested taskforce undertake a review of the current planning ratio for community, high- and low-care places. Drawing on all available demographic and social information, the review is an opportunity to assess the planning ratio in light of growing and diverse demand on aged care services.

Recommendation 31

8.44 The committee recommends that the suggested taskforce review continuity of care as a potential long term solution for the aged care sector.

Abbreviations

ACAP	Aged Care Assessment Program
ACAR	Aged Care Approvals Round
ACAT	Aged Care Assessment Team
ACFI	Aged Care Funding Investment
ACSAA	Aged Care Standards & Accreditation Agency
AIHW	Australian Institute of Health and Welfare
ANAO	Australian National Audit Office
CACP	Community Aged Care Package
CAP	Conditional Adjustment Payment
CIS	Complaints Investigation Scheme
COPO	Commonwealth Own Purpose Outlays
CPI	Consumer Price Index
EACH	Extended Aged Care at Home
EACHD	Extended Aged Care at Home Dementia
GDP	Gross Domestic Product
HACC	Home and Community Care
RCS	Resident Classification Scale
RN	Registered Nurse
TCP	Transition Care Program

Chapter 1

The terms of the inquiry

Background to the inquiry

1.1 On 14 October 2008, the Senate referred to the Finance and Public Administration Committee for inquiry and report by the first sitting day of April 2009:

> The funding, planning, allocation, capital and equity of residential and community aged care in Australia with particular reference to:
>
> a. whether current funding levels are sufficient to meet the expected quality service provision outcomes;
>
> b. how appropriate the current indexation formula is in recognising the actual cost of pricing aged care services to meet the expected level and quality of such services;
>
> c. measures that can be taken to address regional variations in the cost of service delivery and the construction of aged care facilities;
>
> d. whether there is an inequality in user payments between different groups of aged care consumers and, if so, how the inequity can be addressed;
>
> e. whether the current planning ratio between community, high- and low-care places is appropriate; and
>
> f. the impact of current and future residential places allocation and funding on the number and provision of community care places.

1.2 The reporting date was subsequently changed to 29 April 2009.

Conduct of the inquiry

1.3 The inquiry was advertised in *The Australian* and through the Internet. The committee invited submission from the Commonwealth Government and interested organisations and individuals.

1.4 The committee received 121 public and 4 confidential submissions. A list of individuals and organisations that made public submissions to the inquiry together with other information authorised for publication is at Appendix 1. The committee held six days of hearings in Perth on 30 January, Melbourne on 20 February, Canberra on 13 March and 21 April, Launceston on 27 March and Brisbane on 7 April 2009. Appendix 2 lists the names and organisations of those who appeared. Submissions and the Hansard transcript of evidence may be accessed through the committee's website at http://www.aph.gov.au/senate/committee/fapa_ctte/index.htm.

Department of Health and Ageing

1.5 The Department of Health and Ageing (the department) provided a written submission and appeared before the committee to provide the Commonwealth's position in relation to the inquiry's terms of reference. However, the committee wishes to express its considerable disappointment with the level of the department's assistance to the committee. Not only was the department's submission received some two months after the due date, it also provided only factual information and did not address or comment on the major issues of concern raised by providers and other interested stakeholders many of which are longstanding and well-known. At the committee's initial hearing with the department on 13 March 2009, it was obvious that the department had not prepared a response to the significant concerns raised. Senior officers also displayed a less than forthcoming attitude to the committee and as a consequence the committee required a further submission from the department and held a second hearing with officers on 21 April.

1.6 The Senate has referred significant matters to the committee which impact on a large sector of the community. In doing so, the expectation of the Senate is that the views of stakeholders will be gained, positions raised will be tested and having given due consideration to the evidence before it, the committee will in turn report its findings back to the Senate. As part of this important process, it is incumbent on officials, as the Commonwealth's representatives, to assist the committee to the best of their ability and to provide the necessary information and analysis to support the Government's policy position. In doing so, the committee is able to come to a considered position. It is unfortunate that in this instance the department's initial response to the inquiry was inadequate and its approach less than helpful. As a result, the committee's final deliberations were delayed and undermined and the capacity of the committee to effectively review the matter has therefore been compromised. The direct consequence of this has been to impede the committee's capacity to report to the Senate on the matter.

Acknowledgement

1.7 The committee thanks those organisations and individuals who made submissions and gave evidence at the public hearing

Structure of the report

1.8 The committee's report is structured in the following ways:

- Chapter 2 provides background information about Australia's ageing population and current aged care services;
- Chapter 3 considers arguments for an overall review of the aged care sector;
- Chapter 4 considers current funding levels and whether they are sufficient to meet expected quality service provision outcomes;
- Chapter 5 examines the current indexation formula;

- Chapter 6 outlines variations in the cost of service delivery and considers aged care services for vulnerable groups including the financially and socially disadvantaged;
- Chapter 7 addresses the question of whether an inequity in user payments between different groups of aged care clients exists and considers initiatives for reform;
- Chapter 8 reviews the current planning ratio for the aged care sector and explores the impact of current and future residential care places allocations on community care.

Note on references

1.9 References to the Committee Hansard are to the proof Hansard: page numbers may vary between the proof and the official Hansard.

Chapter 2

Overview of residential and community care in Australia

2.1 This chapter considers the ageing population of Australia and estimated projections in relation to demand on residential and community aged care. It also provides an overview of residential and aged care services and respective funding.

Ageing population

2.2 An estimated nine per cent of Australia's population or approximately two million people are aged 70 years or older. Those aged 80 years and over comprise around four per cent of the population and this number is expected to increase to 10 per cent by 2051.[1] Over the next four decades, the number of people aged over 85 years will quadruple to approximately 1.6 million.[2] According to the Department of Health and Ageing (the department), the ageing of the population will lead to increasing demand for care and support services for the elderly with government expenditure on aged care potentially rising from the current three per cent of total government revenues to be nine per cent by 2050.[3] The Aged Care Association Australia highlighted the impact of increase in persons over 85 years of age:

> 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 taxable contribution to Government revenues.[4]

2.3 Grant Thornton Australia noted that, with increased services provided in the community, residents are entering residential care with higher care needs and concluded:

> The ageing of Australia's population can be expected to greatly accelerate these trends which will require significant investment in modern high care facilities. Many existing Australian aged care facilities are not designed to support high care residents.[5]

2.4 According to the department, approximately four in every 10 older people (those 70 years and over) are accessing some aged care services. Of these, most are

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1 Australian Bureau of Statistics cited in Department of Health and Ageing, *Ageing and Aged Care in Australia*, July 2008, p. 1.

2 Australian Institute of Health and Welfare, *Australia's Welfare 2007*, p. 82.

3 Department of Health and Ageing, *Ageing and Aged Care in Australia*, July 2008, p. 2.

4 Aged Care Association Australia, *Submission 92*, p. 2.

5 Grant Thornton Australia Ltd, *Submission 29*, p. 4.

receiving care provided in their own homes.[6] Of the move from community to residential aged care, the department noted:

> At any one time, about one in 13 people over the age of 70 years have left their home to receive care in a residential care facility. However, for people who reach age 65, a third of all men and half of all women will go into permanent residential care at some time later in their lives. The average age on entry to permanent residential aged care is 82 for both men and women.[7]

2.5 According to the department, more than 300,000 people received aged care services provided under the *Aged Care Act 1997* during 2007–08.[8]

2.6 A number of witnesses highlighted the growing complexity of aged care needs of consumers. This is partly a result of increased longevity, the number of older people with chronic illness and associated co-morbidities, and growing demands and expectations in relation to residential and community aged care.[9] The Productivity Commission noted in 2008 moreover that:

> Over the next few decades, older Australians are expected to become more diverse in terms of their care needs, preferences, incomes and wealth. This will have important implications for the qualitative aspects of aged care services (such as the range of services needed and the flexibility of service delivery) and the cost of these services.[10]

2.7 It was recognised that complex and diverse care requires specialised nursing procedures and the involvement of other qualified health professionals which further impacts on expenditure and the nature of care provided.

Residential and community aged care services

2.8 According to the department, approximately 4.2 per cent of Australia's population (or 800,000 older people in 2006–07) currently receive subsidised aged care services in Australia.[11]

2.9 There are two types of aged care services in Australia: residential and community aged care. According to the department, as of 30 June 2008, there were

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6 Department of Health and Ageing, *Ageing and Aged Care in Australia*, July 2008, p. 7.

7 Department of Health and Ageing, *Ageing and Aged Care in Australia*, July 2008, p. 7.

8 Department of Health and Ageing, *Report on the Operation of the Aged Care Act 1997*, 2008 p. iii.

9 See for example, Aged and Community Services Association of NSW & ACT, *Submission 61*, p. 2.

10 Productivity Commission, *Trends in Aged Care Services: Some Implications*, Research Paper, September 2008, p. xvii.

11 Department of Health and Ageing, *Submission 114*, p. 6.

223,107 operational aged care places across the country. Of these, 174,669 were residential places, 46,475 community care places and 1,963 transitional care places:

> The resulting national aged care provision ratio as 30 June 2008 was 111.5 operational places per 1,000 people aged 70 years or older.[12]

2.10 The types and levels of care are detailed by the department:

Table 2.1: Types and levels of care

	Residential aged care home: frail older people receive care from full time care staff in purpose-built aged care homes owned by the care provider. These are quire separate from hospitals.	Community care services: older people receiving care in their homes from visiting care providers
High	24 hour nursing Accommodation	Extended Aged Care at Home (EACH) Extended Aged Care at Home – Dementia (EACH–D) package
Low	Accommodation Personal care Support and allied health services	Community Aged Care Package (CACP) Home and Community Care (HACC) (with States and Territories) Assistance with bathing, shopping, cooking, cleaning, etc.

Source: Department of Health and Ageing, *Ageing and Aged Care in Australia*, July 2008, p. 7.

Residential care

2.11 Residential care facilities comprise purpose-built aged care homes owned by a care provider which provide both high (24 hour nursing) and low (personal care, support and allied health services) levels of care.[13]

2.12 Low level care includes the provision of suitable accommodation and related services (including laundry, meals and cleaning) and personal care services (such as assistance with the activities of daily living). High level care includes accommodation and related services, personal care services and nursing care and equipment.[14]

2.13 Under the *Aged Care Act 1997*, the Commonwealth Government subsidises aged care homes to provide residential aged care to the elderly whose care needs are such that they are unable to remain in their own homes. At June 2008, there were

12 Department of Health and Ageing, *Submission 114*, p. 31.

13 Department of Health and Ageing, *Ageing and Aged Care in Australia*, July 2008, p. 7.

14 Department of Health and Ageing, *Report on the Operation of the Aged Care Act 1997*, 2008, p. 16.

2,830 aged care homes in Australia delivering residential care under these arrangements with an occupancy rate of 93.86 per cent over 2007–08. This compares to an occupancy rate of 94.5 per cent over 2006–07 and 95.2 per cent in 2005–06.[15]

2.14 Residential aged care is meeting the care needs of an increasingly dependent group of people. The majority of residents at 30 June 2007 were assessed as high care (70 per cent) compared to 58 per cent of residents in 1998. In addition, 62 per cent of permanent residents who were admitted during 2006–07 were high care. High and low care resident planning and occupancy ratios are discussed in Chapter 8.

2.15 At the same time, the age profile of the resident population continues to increase. Over half (54 per cent) of the 156,549 residents at 30 June 2007 were aged 85 years or older, and over one-quarter (27 per cent) were aged 90 years and over. Overall, only four per cent of residents were less than 65 years of age.[16]

Community care

2.16 Community care is generally delivered in the recipient's own home. Community care assistance is available through the Home and Community Care (HACC) program, Community Aged Care Packages (CACPs), Extended Aged Care at Home (EACH) and Extended Aged Care at Home Dementia (EACH-D).

2.17 The majority of recipients of aged care services in Australia, over 831,500 people in 2007–08, receive low intensity support in the community through the HACC program.[17] The number of HACC clients has increased by 17.6 per cent over the past 5 years from 707,207 to 831,472 in 2007–08.[18]

2.18 CACPs packages of personal care services and assistance are individually-tailored packages of low level care for frail older persons with complex care needs in their own homes. They suit those older persons who would otherwise be assessed as eligible to receive at least a low level of residential care but who prefer to remain living at home with support. CACPs provide frail older people with support to remain at home. In 2007–08, 61,740 people received packages of subsidised community care through the Commonwealth's Community Aged Care Package (CACP) program.

2.19 The CACPs provided under the Aged Care Act's community care arrangements are complemented by EACH and EACH-D packages.[19] EACH

15 Department of Health and Ageing, *Report on the Operation of the Aged Care Act 1997*, 2008, p. 16.

16 Australian Institute of Health and Welfare, *Residential aged care in Australia 2006–07: a statistical overview*, Aged care statistics series 26, p. 1.

17 Department of Health and Ageing, *Submission 114*, p. 7.

18 Department of Health and Ageing, *Submission 114*, p. 19.

19 Department of Health and Ageing, *Report on the Operation of the Aged Care Act 1997*, 2008, p. 18.

packages provide tailored care at home as an alternative to high residential care. EACH-D assist frail older people with high level care needs and dementia or behaviours of concern to remain at home.

2.20 In addition to services funded through the department, the Department of Veterans' Affairs funds the Veterans' Home Care program for eligible veterans and war widows or widowers who have low level care needs. The program provides a wide range of home care services designed to improve their health and well-being and assist people to remain in their homes longer, and to assist their carers.

Funding residential and community aged care

2.21 The Commonwealth Government has primary responsibility for funding and regulating the residential aged care sector and much of the community aged care sector in Australia. The framework under which the sector operates is provided by the *Aged Care Act 1997* and the associated *Aged Care Principles 1997*. The Commonwealth provides approximately three-quarters of the total funds available to residential aged care primarily through residential care subsidies and capital grants to providers.[20] The majority of the funding is provided via the department but specific residential aged care funding is also provided through the Department of Veterans' Affairs for aged veterans. The remaining funding comes from permanent residents in aged care facilities paying accommodation and daily living charges.

2.22 Commonwealth funding for residential and community aged care has risen steadily in response to the growth in the aged population. According to the latest department Report on the Operation of the *Aged Care Act 1997* covering the financial year 2007–08:

> During 2007-08 Australian Government total expenditure for ageing and aged care increased to $8.3 billion, including $6.0 billion for residential aged care subsidies and supplements, $448 million for the community care CACPs and $188 million for the flexible care EACH and EACH-D packages. Australian Government expenditure outside the Act included an increase to $1.006 billion for the joint Australian, state and territory government HACC program.[21]

2.23 Commonwealth expenditure for aged care in 2008–09 will amount to $9.3 billion in total. This compares to earlier years: in 2004–05, $6.7 billion was spent on residential and community aged care whilst approximately $3 billion was spent in 1995–96.[22]

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20 Greg McIntosh and Thomas John, *Aged Care Amendment (Residential Care) Bill 2006 – Bills Digest*, Bills Digest No. 129, 2006–07, p. 4.

21 Department of Health and Ageing, *Report on the Operation of the Aged Care Act 1997*, 2008, p. iv.

22 Greg McIntosh and Thomas John, *Aged Care Amendment (Residential Care) Bill 2006 – Bills Digest*, Bills Digest No. 129, 2006–07, p. 4.

2.24 Funding for 2008–09 will be distributed as follows:

- $6.7 billion for residential aged care subsidies (for permanent and respite care);
- $479 million for Community Aged Care Packages;
- $429 million for flexible care programs including Extended Aged Care at Home (EACH), Extended Aged Care at Home – Dementia (EACH-D), Multipurpose services and Transition Care;
- $1.1 billion for the Home and Community Care (HACC) program with the remaining 40 per cent of HACC funding provided by the states and territories;
- $80.3 million on aged care assessment;
- $55.8 million on the aged care workforce;
- $36.1 million for ageing information and support including the Community Visitors Scheme;
- $29.3 million on culturally appropriate aged care;
- $31.6 million on dementia programs outside of community care;
- $128.2 million on capital assistance; and
- $21.7 million to the Aged Care Accreditation Agency.[23]

2.25 Funding for community care services totalled $2.2 billion in 2008–09, an increase of $260 million over the 2007–08 financial year.[24]

2.26 Residential and community care are funded through subsidy arrangements paid directly to the aged care providers on behalf of the aged care recipients. To receive the subsidy, the care recipient must meet four conditions:

- they must be an approved care recipient determined by the Aged Care Assessment Teams;
- their care must be provided by an approved provider;
- care must be provided in an allocated place; and
- care must be of a specified quality and accredited as such.[25]

Residential aged care

2.27 Subsidised permanent residential aged care was provided to 208,079 aged persons in 2007–08 with an average of 160,000 people receiving care each night.[26]

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23 Department of Health and Ageing, *Submission 114*, pp 11–12.

24 Department of Health and Ageing, *Report on the Operation of the Aged Care Act 1997*, 2008, p. iv.

25 Department of Health and Ageing, *Submission 114*, pp 9–10.

26 Department of Health and Ageing, *Submission 114*, p. 9.

The estimated average annual costs (public and private) for high and low level residential care per recipient were $63,300 and $39,550 respectively (in 2007–08 prices). The department noted:

> On average, care recipient fees account for about 26 per cent of the costs of high-level residential care and about 53 per cent of the cost of low level residential care.[27]

2.28 The Commonwealth provides a care subsidy the level of which is dependent on the resident's care needs according to the Aged Care Funding Instrument (ACFI). The level of care subsidy payable is also subject to an income (but not assets) test.[28] Providers may also receive the Conditional Adjustment Payment (CAP) as a percentage of the ACFI subsidy. CAP was introduced in 2004–05 and is discussed further in chapter 5.

2.29 Accommodation supplements are also paid in respect of some care recipients in residential care to subsidise there accommodation costs. The level of accommodation supplement payable is subject to an assets test.

2.30 The Commonwealth also provides capital grants for providers in rural and remote areas who target special needs groups. Viability supplements are paid to providers of residential (and community care) in some rural and remote areas in recognition of the higher costs of providing care in those regions. The 2008–09 Budget included a measure to make available zero interest loans to assist in expanding the availability of residential aged care beds.

2.31 Users of residential aged care services also contribute to the costs of their care through the fees they pay. In addition to fees, people entering permanent residential aged care may contract, on entry, to make accommodation payments to contribute to the cost of their accommodation. These payments are assets tested, that is only those residents whose assets exceed a prescribed minimum level are required to make the payment. Payments may be in the form of either an accommodation bond or an accommodation charge. An accommodation bond is payable by those who enter residential care at low level care and by those who receive care on an extra service basis. The accommodation bond for low-care residents comprises retention of $9.60 per resident per day (for up to five years) and an interest income on the accommodation bond.[29] An accommodation charge is an additional daily amount which is payable by people who enter permanent residential care at a high level of care; it is payable for up to five years.[30]

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27 Department of Health and Ageing, *Submission 114*, p. 9.

28 Department of Health and Ageing, *Submission 114*, p. 10.

29 UnitingCare Australia, *Submission 76*, p. 20. UnitingCare provided an example where the rate would be $50 per resident per day for a bond of $250,000.

30 Australian Institute of Health and Welfare, *Australia's Welfare 2007*, p. 143.

Home and Community Care program

2.32 Total government expenditure on the Home and Community Care (HACC) program in 2007–08 was $1.652 billion of which $1.007 billion was provided by the Commonwealth. According to the department, total funding for HACC increased from 2006–07 to 2007–08 by $127.9 million.[31]

2.33 HACC clients can be asked to pay fees to contribute towards the costs of services which, according to the department, amount on average to approximately five per cent of the cost of delivering the HACC services.[32]

2.34 The department noted that 97 per cent of HACC clients receive, on average, services worth about $1,200 a year (in 2007–08 prices). Three per cent of HACC clients receive services of more than $16,000 per year and expenditure on them accounts for 30 per cent of all HACC expenditure.[33]

Community Aged Care Package program and Extended Aged Care at Home programs

2.35 According to the department, Commonwealth funding for CACPs and EACH packages is projected to total $729 million in 2008–09.[34] Of the respective packages, the department noted:

> CACPs deliver low-level care at an estimated average annual (total public and private) cost of $15,100 (in 2007–08 prices). EACH and EACH-D packages deliver high-level care at an estimated average annual cost of $43,630 and $49,150 respectively (in 2007–08 prices). On average, care recipient fees account for about 16 per cent of the costs of CACPs and about 5 per cent of the cost of EACH packages.[35]

2.36 Users of CACP and EACH may be required to make a co-payment for certain services. Providers are usually required to reduce or waiver fees in cases of financial hardship.

Expected quality service provision outcomes

2.37 Residential and community aged care is governed by the *Aged Care Act 1997* (the Act) and the User Rights Principles. The legislation is administered by the department and sets out the objectives for the aged care sector:

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31 Department of Health and Ageing, *Submission 114*, p. 17.

32 Department of Health and Ageing, *Submission 114*, p. 8.

33 Department of Health and Ageing, *Submission 114*, p. 8.

34 Department of Health and Ageing, *Submission 114*, p. 9.

35 Department of Health and Ageing, *Submission 114*, p. 9.

- to promote a high quality of care and accommodation for the recipients of aged care services that meets the needs of individuals;
- to protect the health and well-being of recipients of aged care services;
- to ensure that aged care services are targeted towards the people with the greatest needs for those services;
- to facilitate access to aged care services by those who need them, regardless of race, culture, language, gender, economic circumstance or geographic location;
- to provide respite for families, and others, who care for older people;
- to encourage services that are diverse, flexible and responsive to individual needs;
- to help those recipients to enjoy the same rights as all other people in Australia;
- to plan effectively for the delivery of aged care services; and
- to promote ageing in place through the linking of care and support services to the places where older people prefer to live.[36]

2.38 Whilst the *Aged Care Act 1997* (the Act) and its subordinate instruments including the User Rights Principles refer to the concept of 'quality of care', they do not provide a definition. Rather, approved residential and community care providers must comply with a number of standards set out in the *Quality of Care Principles 1997*. These include the Accreditation Standards; Residential Care Standards; Community Care Standards and Flexible Care Standards.

2.39 The Residential Care Standards comprise three principles:

- Residents' physical and mental health will be promoted and achieved at the optimum level in partnership between each resident (or his or her representative) and the health care team.
- Residents retain their personal, civic, legal and consumer rights, and are assisted to achieve active control of their own lives within the residential care service and in the community.
- Residents live in a safe and comfortable environment that ensures the quality of life and welfare of residents, staff and visitors.[37]

2.40 The Community Care Standards comprise seven principles as follows:

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36 Adapted from *Aged Care Act 1997*, Division 2 cited in Standing Committee on Community Affairs, *Aged Care Amendment (2008 Measures No. 2.) Bill 2008 [Provisions]*, November 2008, pp 1–2.

37 *Quality of Care Principles 1997*, Schedule 3, Parts 1–3, pp 21–23.

- Each care recipient and prospective care recipient (or his or her representative) is to have access to information to assist in making an informed choice about available community care services.
- Each care recipient is to receive quality services that meet his or her assessed needs.
- Each care recipient (or his or her representative) is enabled to take part in the development of a package of services that meets the care recipient's needs.
- Each care recipient should be enabled where possible, and encouraged, to exercise his or her preferred level of social independence.
- The dignity and privacy of each care recipient are to be respected, and each care recipient (or his or her representative) will have access to his or her personal information held by the provider.
- Each care recipient (or his or her representative) has access to fair and effective procedures for dealing with complaints and disputes.
- Each care recipient will have access to an advocate of his or her choice.[38]

2.41 The department noted that quality in health care is a multidimensional concept, encompassing a range of issues and areas including:

- access, referring to the capacity of all individuals to receive the same standard of service provision;
- appropriateness, referring to the extent to which the benefits of an intervention outweigh the risks associated with the same intervention;
- technical proficiency (as distinct from technical efficiency), referring to the clinical application of current best practice in skills and knowledge;
- continuity, referring to the extent to which a specific episode of service provision is integrated into an overall care plan;
- safety, referring to risk avoidance and harm minimisation in care delivery;
- acceptability, referring to the degree to which a given service addresses the 'expectations of informed…consumers';
- efficiency, referring to the maximisation of benefits or outputs (e.g. health) for a given level of inputs (e.g. costs); and
- effectiveness, referring to the impact of a particular intervention upon clinical outcome. Importantly, key elements of clinical outcome have been noted to range from survival to the quality of life of the survivor.[39]

38 *Quality of Care Principles 1997*, Schedule 4, Parts 1–7, pp 24–27.

39 Department of Health and Ageing, *The Regulatory Framework for Residential Aged Care in Australia*, November 2005, pp xi–xii.

Chapter 3

The need for reform of the aged care sector

> We do not want a response that bandaids the system financially and ignores the need for reform to deliver better services.
>
> *Mr Harold Milham, Carer.*[1]

3.1 From the inquiry's inception, it became overwhelmingly evident that aged care providers and involved stakeholders across the country recognised a need to reform the aged care sector in Australia. Witnesses commented on the 'bandaid' approach that has been taken to problems within the aged care sector and of the fact that they have been calling for reform for many years. It was argued that the significant problems currently facing the sector and the need to meet future demand must be addressed immediately and in a comprehensive and coherent manner. The Aged Care Association Australia highlighted the need for policy to meet expectations in the area of aged care services:

> 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 basis underpinning the current system is 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.[2]

3.2 Anglicare Australia argued that a 'systemic shake-up of the way in which aged care services are funded, planned, allocated and provided' is required.[3] Similarly, the Aged Care Association highlighted the need for reform of the sector and dialogue:

> …we strongly believe that there is a real need for long-term structural reform and that that dialogue needs to commence very, very shortly between the Australian community, the Australian aged care industry and the Australian government.[4]

3.3 It is clear that growing demand for aged care services and changing expectations of the sector and indeed changing community engagement with the sector pose key challenges to the provision of quality aged care. As one case in point, growing community demand for single bedroom with ensuite residential care accommodation has serious implications for the financial viability of residential aged

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1 Mr H Milham, Alzheimer's Australia, *Committee Hansard*, 13.3.09, p. 71.

2 Aged Care Association Australia, *Submission 92*, p. 3.

3 Anglicare Australia, *Submission 67*, p. 2.

4 Mr R Young, Aged Care Association Australia, *Committee Hansard*, 13.3.09, p. 46.

care providers. According to Grant Thornton Australia, this expectation is 'the major influence on the design of modern residential facilities in Australia' and yet, the returns for operators of such facilities were 'approximately half of those that were achieved by those with older institutional facilities with shared rooms'.[5] However, current Commonwealth Government certification guidelines require an average across facilities of 1.5 residents per room for new buildings permitting two-thirds of residents to be in double rooms and one-third in single rooms.[6]

3.4 Professor Warren Hogan termed the baby boomer generation the 'most diverse demographic grouping to access residential care services in Australia's history'.[7] The committee considers that there is a need for immediate action supported by ongoing sectoral wide dialogue to identify the needs of this generation and their short- and long-term impact on the aged care sector.

3.5 The committee considers therefore, that all stakeholders including all levels of government, residential and community aged care providers, professional bodies, lobby groups, involved individuals, and clients of aged care services and their families need to be engaged in ongoing dialogue. The committee believes that this is best achieved through the establishment of a national aged care forum. Such a forum would be required to meet on a regular basis to discuss key current and future challenges affecting the sector. It should be supported and coordinated, at least in the first instance, by the Department of Health and Ageing (the department). The committee also recommends that such a forum establish a taskforce (or an equivalent body) representing all such stakeholders to action critical issues identified by the national forum.

Recommendation 1

3.6 The committee recommends the establishment of a national aged care forum, reporting directly to the Minister for Health and Ageing and coordinated by the Department of Health and Ageing, to consider, on an on-going basis, current and future challenges to the aged care sector.

Recommendation 2

3.7 The committee recommends that the national aged care forum establish a taskforce (or equivalent body) representative of all involved aged care stakeholders including clients to action and where possible implement determinations of the national forum.

3.8 There are widely held concerns regarding what has been seen as a largely piecemeal approach to aged care funding which has not permitted adequate

5 Mr C Ansell, Grant Thornton Australia Ltd, *Committee Hansard,* 30.1.09, p. 2.

6 Mr A Stuart, First Assistant Secretary, Department of Health and Ageing, *Committee Hansard,* 13.3.09, p. 97.

7 Professor W Hogan cited in Grant Thornton Australia Ltd, *Submission 29*, p. 11.

consideration of the sector as a whole, its future challenges and the changing expectations upon it. Witnesses commented that a systematic review of operations under the *Aged Care Act 1997* is required. Baptistcare, as one case in point, argued:

> The *Aged Care Act 1997* is now entering its twelfth year of operation and with the exception of the Hogan review...in 2004, there has been no systematic review into its operations, nor has there been any evidence based data to suggest that the quality of care has improved since its inception...while this inquiry is welcomed, if for no other reason than the lack of any substantial review of the operation of the Act, it does not address some of the features of the Act's operations that need to be addressed if Australia is to meet its aged care challenges over the next 15 to 25 years.[8]

3.9 The Aged Care Alliance (ACA) highlighted that while the 'interdependence of investment, financing decisions, construction, costs and demand with the subsidy regime is directly relevant to the sector's capacity to continue to meet expected quality standards', policy such as the Aged Care Funding Instrument (ACFI) had been implemented without consideration of the effect on the entire system.[9] The ACA continued:

> The policy weakness remains the separate policy decisions made without consideration of the total capacity and mix of service delivery in the medium term where identifiable demographic trends are identified.[10]

3.10 The committee appreciates such concerns and considers that an all-encompassing review of aged care services in Australia needs to be undertaken. The committee also considers that it is timely, after 12 years of operation and in light of emerging challenges for the sector, that a survey of sectoral operations under the *Aged Care Act 1997* be conducted as a major part of the review.

3.11 Moreover, the committee is acutely aware of the need for future planning in light of growing demand on aged care services, It recommends that such a sectoral review consider future projections to enable planning to address challenges that the industry is expected to face in the future.

Recommendation 3

3.12 The committee recommends that the Department of Health and Ageing, in cooperation with the suggested taskforce and in partnership with all involved stakeholders including clients, undertake an all-encompassing review of the *Aged Care Act 1997* and related regulations. The review should:

8 Baptistcare, *Submission 48*, pp 3–4.

9 The Aged Care Alliance, *Submission 40*, p. 8.

10 The Aged Care Alliance, *Submission 40*, p. 17.

- **equally examine the provision of residential and community aged care services in Australia with consideration of both current and future challenges in the provision of aged care services;**
- **provide future projections to enable both short and longer-term sectoral planning.**

Benchmark of care costs for the provision of quality aged care services

3.13 A recurring theme throughout this inquiry was the need to establish benchmark of care costs in order to understand the relationship between subsidy allocation and indexation.[11] Of this, the Australian Nursing Federation stated:

> The recently released Grant Thornton Report argues that margins in high care are as low as 1.1% and up to 40% of providers are unviable and the recent collective decision by some providers to not tender for beds has brought the viability of the sector into the spotlight. The government contends that the sector is viable. It is difficult to ascertain the truth without a true benchmark of care costs, which is analysed against income.[12]

3.14 Catholic Health Australia held that there is no real relationship between the care subsidies and the cost of care and quality outcomes required.[13] It also maintained that a defined and costed benchmark of care is required:

> This benchmark of care must reflect the real costs of providing a quality aged care service in different regions around Australia, and allow for the flexible delivery of aged care services responsive to the needs of the individual.[14]

3.15 However, concerns were raised that, in addition to the need to reconsider current funding levels, future funding levels required to meet expected demand is also critical. Aged and Community Care Victoria (ACCV) stated for example, that in the area of residential aged care, additional income and funding sources were required in order that the sector can 'provide suitable residential facilities that meet the demands which result from our ageing population'.[15] Mt St Vincent Nursing Home and Therapy Centre expressed the view that aged care has never been funded to enable forward planning to implement improved systems that would otherwise alleviate pressures.[16] This view was supported by ACCV which called on the Federal Government to:

> …undertake, in collaboration with the industry, a review to set in place a defined and properly costed funding benchmark for residential and

11 Grant Thornton Australia Ltd, *Submission 29*, p. 10.

12 Australian Nursing Federation, *Submission 94*, p. 9.

13 Catholic Health Australia, *Submission 75*, p. 6.

14 Catholic Health Australia, *Submission 75*, p. 6.

15 Aged and Community Care Victoria, *Submission 89*, p. 3.

16 Mt St Vincent Nursing Home and Therapy Centre, *Submission 1*, p. 1.

> community care which reflects the real costs of providing quality services. This benchmark should exhibit the real costs of staffing and operating quality care for our elderly, including those who are frail and have complex care needs.[17]

3.16 According to Mr Cam Ansell of Grant Thornton Australia, there is a 'mismatch' between recognition of the need for care and the subsidy levels resulting from the fact that:

> …we have never actually done the amount of research to work out what it does cost to look after a resident, not just in terms of their care and their clinical cost but what does it cost to accommodate them? What are their costs in terms of their support with their personal needs? If we are able to do that, we would be able to build a subsidy system that better reflects actual need…
>
> So if you understand what it costs to deliver the care and the accommodation, you can come up with suitable strategies for your subsidies, you can work out what is appropriate in terms of what the user should pay for and what the taxpayer should pay for, and it also gives you the opportunity to consider how those things change over time so we can then apply an indication that meets that cost.[18]

3.17 The Aged Care Association Australia (ACAA) held that a study of the benchmark costs of care should take place as part of a 'longer review of industry structure and quality deliverables'. Mr Rod Young of the ACAA noted that:

> Until this exercise is undertaken, it will be difficult to know what providers are expected to provide, what the community expects us to provide and what government expects us to deliver. In considering what the index for the industry should be, ACAA is persuaded that it should be done using the index that applies to age pensions, which is made up of either 25 per cent of average male weekly earnings or the CPI, whichever is the greater.[19]

3.18 Mr Young continued:

> What is it actually costing? If we expect the industry to provide this level of service at this level of quality, what should we be paying for that to be achieved? All we have ever done in any of our reviews is look at what the current subsidy is and accept that. When you look at what Hogan did, there were over 700 providers participating in a financial survey. Then what was accepted was: These are our average costs across the various parts of the accounts of those providers and we accept that as being a reasonable assessment. This is the subsidy being paid by government and the income

17 Aged and Community Care Victoria, *Submission 89*, p. 3.

18 Mr C Ansell, Grant Thornton Australia Ltd, *Committee Hansard*, 30.1.09, p. 11.

19 Mr R Young, Aged Care Association Australia, *Committee Hansard*, 13.3.09, p. 47.

> being paid by residents, and we accept that as being a reasonable payment for those care services. We never really analysed it.[20]

3.19 Care Connect suggested that establishing benchmark of care costs for CACP, Extended Care at Home (EACH) and Extended Care at Home Dementia (EACH-D) should consider non-direct care costs such as the initial time spent assessing clients before they are 'activated' on a package of care and case management time.[21]

3.20 Mr Greg Mundy of Aged and Community Services Australia stated that establishing benchmark of care costs is long overdue in Australia:

> The Productivity Commission recommended that in their 1999 report on residential aged groups 10 years ago…I think coming up with a firmer definition of what we expect to be done, what that is likely to cost and relating our subsidies to that would be well supported by many of the stakeholders rather than, as we have been doing, just simply doing what we can get away with in terms of market forces. It would put an end to lots of arguments. It might cause a headache principally for the funders, but I think the other stakeholders would all support getting some data on the table, saying: 'This is what we should be doing. This is a reasonable cost for it. That is where we should start from.'[22]

3.21 The committee acknowledges the need for benchmark of care costs with a view to establishment of an aged care index. In this regard, the committee recalls recommendations of the Productivity Commission and Senate Community Affairs Committee respectively. Recommendation 2 of the Productivity Commission's 1999 inquiry report on *Nursing Home Subsidies* stated:

> The Government should specify its intended outcomes in terms of a standard of care benchmark. The purchase price of care outputs from providers by way of subsidy funding, in combination with funding from residents, should be adequate to meet the cost of providing that benchmark standard of care.[23]

3.22 Recommendation 13 of the Senate Community Affairs Committee's 2005 *Quality and equity in aged care* inquiry report in relation to the Aged Care Standards and Accreditation Agency noted:

> That the Agency, in consultation with the aged care sector and consumers, develop a benchmark of care which ensures that the level and skills mix of staffing at each residential aged care facility is sufficient to deliver the care required considering the needs of residents. The benchmark of care that is

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20 Mr R Young, Aged Care Association Australia, *Committee Hansard*, 13.3.09, p. 51.

21 Care Connect Ltd, *Submission 71*, p. 1.

22 Mr G Mundy, Aged and Community Services Australia, *Committee Hansard*, 20.2.09, p. 8.

23 Productivity Commission, *Nursing Home Subsidies*, Inquiry Report, 1999, p. 86.

> developed needs to be flexible so as to accommodate the changing needs of residents.[24]

3.23 The committee reaffirms the work of the Productivity Commission and Senate Community Affairs Committee in this regard and recommends a national survey of benchmark costs of residential and community aged care. Such a survey will establish benchmark of care costs which can then be applied to funding and operational issues.

Recommendation 4

3.24 The committee recommends that the Department of Health and Ageing in association with the suggested taskforce and in consultation with all aged care stakeholders including clients undertake analysis to establish benchmark of care costs.

Audited General Purpose Financial Reports

3.25 Aged care providers are required to submit Audited General Purpose Financial Reports to maintain the Conditional Adjustment Payment (CAP) funding. Concerns were raised in relation to the relevance of information required in the reports and that the Department of Health and Ageing no longer releases the data contained in the reports. Of the first concern, Mr Cam Ansell of Grant Thornton Australia stated:

> General purpose financial reports... are highly summarised information that apply all Australian accounting standards. Unfortunately, in terms of giving an indication of performance, it is very limited. It only provides a very small assessment of what performance is in residential aged care.[25]

3.26 According to Mr Ansell, initial recommendations that general purpose financial reports 'allow providers to understand how they are performing and for decision makers to be able to understand what aspects of their business were causing them to perform the way they were performing' were not taken up.[26]

3.27 ACAA also noted that the department has not released the data from 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.[27]

3.28 The department responded that the data had not been made available in the last few years 'because we had some concerns about the methodological soundness of it'.[28] Dr David Cullen, Department of Health and Ageing, commented further:

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24 Senate Community Affairs Committee, *Quality and equity in aged care*, June 2005, p. 50.

25 Mr C Ansell, Grant Thornton Australia Ltd, *Committee Hansard*, 30.1.09, p. 5.

26 Mr C Ansell, Grant Thornton Australia Ltd, *Committee Hansard*, 30.1.09, p. 6.

27 Aged Care Association Australia, *Submission 92*, p. 5.

> The CAP reporting requirements developed over time. In the first few years providers were permitted to opt out of certain accounting standards and also not to report at the residential care segment. They reported at the whole entity level rather than at their residential care operations level. We provided that data for the first two years because we had agreed to do so, but we were very unhappy with the accuracy or the ability to draw conclusions from that data because there was noncompliance with accounting standards. We then went through a process of tightening those…
>
> Providers were transitioning towards compliance with the accounting standards. We chose to pause for a few years with releasing the data because we had concerns about whether adequate conclusions could be drawn from it. We are now satisfied that we have all providers reporting according to the accounting standards and reporting on their residential care segment. So this data set is one that we are confident about and on which some analysis has been done.[29]

3.29 The committee acknowledges the concerns expressed by the department in relation to the soundness of the data. In the circumstances of the current claim and counter claim about viability, the committee finds it very difficult to understand the delay in fixing such a vital tool. However, if the department is satisfied that the reports are now in accordance with accounting standards, publication of the data should recommence as soon as practicable.

Recommendation 5

3.30 The committee recommends that the Department of Health and Ageing recommence publication of Audited General Purpose Financial Reports as soon practicable and continue to publish such reports annually as a matter of course.

Recommendation 6

3.31 The committee recommends that the Department of Health and Ageing review the Audited General Purpose Financial Reports with an aim to identifying any necessary reporting changes to ensure that the information available provides a clear and comparative understanding of provider performance.

Nationally consistent aged care data

3.32 During the inquiry, concerns were also raised about the lack of nationally consistent aged care data. Ms Derryn Wilson of the Municipal Association of Victoria stressed the importance of addressing the issue from the perspective of local councils:

> In terms of a national aged-care planning framework, there needs to be a coordinated development and use of supply, demand and utilisation datasets. That fundamental need for data has been there for quite some time,

28 Mr A Stuart, Department of Health and Ageing, *Committee Hansard*, 21.4.09, p.26.

29 Dr D Cullen, Department of Health and Ageing, *Committee Hansard*, 21.4.09, p.26.

> and it is an absolute necessity. There is opportunity to build on the local area data and to incorporate a range of related program areas with agreed processes with the three tiers of government and the involvement of providers and consumers.
>
> The lack of publicly available supply and utilisation data to the local area level from the Commonwealth aged-care programs has long been a source of irritation for councils. That need for data has been around. It really needs to be addressed. We also believe that it is fundamental to good service system planning, and it requires that opportunity to be able to evaluate and consider what is really a quality product.[30]

3.33 Whilst there are a number of bodies who conduct surveys on performance in the aged care sector, much of the research is conducted by private companies which offer their analysis for a fee. Therefore, their data may not be publicly available, and rather, has to be purchased as part of a commercial-in-confidence arrangement between the body in question and the purchaser. The committee is also concerned that different methodological approaches which utilise different indicators and employ different definitions do not lend themselves easily to comparative analysis. Moreover, where such data is not publicly available, public scrutiny and discussion across the sector is all but impossible.

3.34 The committee recommends that a common assessment approach be considered by the sector in cooperation with all levels of government in order that a nationally accepted standard be instituted and published with a view to establishing the financial status of aged care in Australia. Such an approach should be transparent and enable disaggregation of information.

3.35 The committee appreciates that a number of bodies, including the Australian Institute of Health and Welfare, produce important information on the aged care sector and that in many instances, what is required is greater coordination to enable data sharing rather than simply the creation of new data sets. In this regard, Ms Derryn Wilson of the Municipal Association of Victoria noted:

> I think there is certainly existing data that could and should be shared, but I think…that, as we move forward, with an older Australia, there are lots of issues that do need to be built into the data collection, and that includes relationships with other programs. For instance, there is quite a lot of data on HACC utilisation that is shared between the state and LGAs. And you cannot really look at CACPs without looking at who and how many are using the HACC services.[31]

3.36 Similarly, Ms Janet Carty of the Tasmanian Department of Health and Human Services emphasised the need for streamlining reporting across the sector:

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30 Ms D Wilson, Municipal Association of Victoria, *Committee Hansard*, 20.2.09, p. 14.

31 Ms D Wilson, Municipal Association of Victoria, *Committee Hansard*, 20.2.09, p. 18.

> What we are talking about here is – and I think it was what the providers were talking about in the previous section – that there is a huge reporting burden. That is a major amount of work, and we would like to see some of that streamlined. We have done a lot of that work through the community care reform initiatives. We are aware that you can get synergies across the system in planning and in quality reporting. It is of concern that there are major disparities across each different program type, and different requirements under each program type. We would suggest that you could possibly develop a system—or even that a system may have been developed, through submissions—that might be less onerous for providers to report on.[32]

3.37 In light of the evidence before it, the committee recommends the establishment of a national roundtable of key bodies engaged in research, aged care surveys and data gathering which is representative of stakeholders across the sector including all levels of government. The objective of the roundtable would be to discuss and publicise methodology, approach and findings to enable streamlining of data and provide for comparative analysis and ongoing information sharing.

3.38 Comprehensive nationally agreed data sets and application across the sector have the potential to provide a clear picture of the financial health of aged care providers, their efficiency in meeting client needs, to inform ongoing debates in the sector, and the policy decisions emanating from them.

Recommendation 7

3.39 The committee recommends the establishment of a nationally consistent methodological approach to data gathering and research on the financial status of the residential and community aged care sector. Towards this goal, the committee recommends the establishment of a roundtable of key stakeholders engaged in such research and facilitated by the Department of Health and Ageing to discuss and agree upon common indicators and definitions to enable comparative analysis.

Deficiencies in information on aged care needs and services

3.40 The Australian Institute of Health and Welfare noted a number of information gaps which limit service planning including:

- the absence of a currently accepted approach to measurement of potential or action demand for formal aged care services;
- the lack of national level information about the care preferences of potential and current aged care program consumers and their carers and families;

32 Ms J Carty, Department of Health and Human Services, *Committee Hansard*, 27.3.09, p. 82.

- the lack of on-going information about the care needs of people who receive CACPs, EACH or EACH-D packages and the amount and type of assistance provided through these programs; and
- the absence of cross-program information which could be used, among other things, to develop more robust estimates about the numbers of people using all aged care services and to build better evidence about utilisation patterns and pathways through the system of aged care services as a whole.[33]

3.41 Witnesses before the committee including Mr Greg Mundy of ACAA emphasised that such information is vital for planning and to establish greater accuracy in regard to the current ratio of high and low care:

> The current ratio does not recognise the actual demand that presents at the door, which is more like 60 per cent high care rather than 50 per cent, so we ought to take account of that. But rather, than just come up with a number, I think it would repay a quick three-month study of more detailed characteristics of older people and their needs so that we have got just a little bit more science behind those numbers.[34]

3.42 Concerns were also raised about the lack of information provided on the Commonwealth planning process. Ms Derryn Wilson from the Municipal Association of Victoria elaborated:

> The Australian Institute of Health and Welfare reports have the data at the state and national level, but data on either the Commonwealth planning process or for utilisation in parts of the other planning processes for community care is not made available at the state level. So there is a big gap there in everybody being on the same page with the same knowledge that helps, then, look at the quantitative situation and allows that qualitative discussion about why are we different from this place. What is different about our community that we are not using as many of this sort of thing? It does make the process much less rich and informed.[35]

3.43 The committee acknowledges such deficiencies in information and the need to address them and suggests that the recommended taskforce (or equivalent body) under the auspices of the national aged care forum consider means of address.

Recommendation 8

3.44 The committee recommends that the Department of Health and Ageing in association with the suggested taskforce (or equivalent body) and in collaboration with the Australian Institute of Health and Welfare review and address deficiencies in information in the aged care sector.

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33 Australian Institute of Health and Welfare, *Submission 113*, p. 4.

34 Mr G Mundy, Aged and Community Services Australia, *Committee Hansard*, 20.2.09, p. 6.

35 Ms D Wilson, Municipal Association of Victoria, *Committee Hansard*, 20.2.09, p. 14.

Chapter 4

Current funding levels and expected quality service provision outcomes

> Older persons should be able to enjoy human rights and fundamental freedoms when residing in any shelter, care or treatment facility, including full respect for their dignity, beliefs, needs and privacy and for the right to make decisions about their care and the quality of their lives.
>
> *Principle 14 of the United Nations Principles for Older Persons*

Introduction

4.1 The overwhelming majority of residential and community aged care providers who participated in the inquiry held that that the current funding levels for both residential and community aged care are inadequate and do not reflect the real costs of providing high quality care.[1] It was argued that this is impacting adversely on the provision of quality care and, indeed, on the viability of providers and thus on the availability of sufficient aged care services in the long term.

4.2 This chapter considers current funding levels and whether they are sufficient to meet the expected quality service provision outcomes. It explores the financial performance of aged care providers, staffing issues and capital funding.

Common concerns of residential and community aged care providers

4.3 Many witnesses stated that the aged care sector was in 'crisis' and that financial losses in the sector would see the closer of beds and the inability of the sector to meet the demand in the future through the provision of new and expanded facilities. Mr Gerard Mansour of Aged and Community Care Victoria stated:

> …there is no doubt whatsoever that our industry is just like a rubber band that is stretched near its limit. Our industry is increasingly concerned about how well we will be able to cater for our ageing population. This concern over recent years has moved to a real fear that we now face an impending crisis.[2]

4.4 Mr Martin Laverty of Catholic Health Australia (CHA), while not supporting that the sector was currently in crisis, however commented that 'if we do not make changes to capital and operational subsidies today and if we do not revise the

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1 See for example, Aged and Community Care Victoria, *Submission 89*; Management Consultation and Technology Services, *Submission 42*; Anglicare Australia, *Submission 67*; Catholic Health Australia, *Submission 75*; Kiama Municipal Council, *Submission 27*; Aged and Community Services Association of NSW and ACT, *Submission 61*; Aged Care Association Australia – SA Inc, *Submission 63*.

2 Mr G Mansour, Aged and Community Care Victoria, *Committee Hansard*, 20.2.09, p. 35.

opportunity for consumer contributions to their care we will in fact have that potential problem in the years ahead of us'.[3]

4.5 The committee heard evidence that not only residential care but also community care was facing difficulties. According to Aged and Community Care Victoria, providers of Community Aged Care Packages are:

> …"stretched" in their capacity to respond adequately to the needs of their clients due to funding levels, inability to access HACC services at subsidised rates and poor integration between programs.[4]

4.6 Mr Greg Mundy of Aged and Community Services Australia commented that 'our aged-care system is close to being broken and we need to find some fixes for some longstanding issues'. Mr Mundy argued that the current funding levels are insufficient and pointed to three principal reasons to support this claim:

> One is that, over the last decade or more, the amount of service that we have been able to provide to each of our residents and each of our community care clients has steadily declined…
>
> Secondly, we have problems in competing for staff with the state operated health system. We cannot match the wages that they pay in that system, so recruitment and retention of staff is always an issue. The third aspect is that we do have great difficulty nowadays putting new high-care residential facilities on the ground. It is very difficult to make those projects come out cash-flow positive.[5]

4.7 Submitters also pointed to recent surveys of the sector, principally the Grant Thornton survey, as further indicators of the poor financial performance of aged care providers.

4.8 Mr Mundy went on to comment that the indexation formula, particularly in relation to wages, used by the Commonwealth is contributing to these difficulties. He commented that: 'It has been not a sudden development but a steady development over a long period of time that the value of the Commonwealth's subsidies for care has not kept pace with the cost of providing that care…So there has been a steadily widening gap between what it costs us to provide services and what the subsidies will cover.'[6]

4.9 Ms Mary Murnane, the Department of Health and Ageing, responded to these comments and noted that while some providers 'find the going very hard indeed for a variety of reasons', those reasons are not because of current funding levels. The funding levels have been substantially increased and the 'gross amounts that are spend on aged care are very great indeed'.[7] Ms Murnane also stated:

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3 Mr M Laverty, Catholic Health Australia, *Committee Hansard*, 123.3.09, p. 2.

4 Aged and Community Care Victoria, *Submission 89*, p. 5.

5 Mr G Mundy, Aged and Community Services Australia, *Committee Hansard*, 20.2.09, p. 2.

6 Mr G Mundy, Aged and Community Services Australia, *Committee Hansard*, 20.2.09, p. 2.

7 Ms M Murnane, Department of Health and Ageing, *Committee Hansard*, 21.3.09, p. 17.

> I would not say that there is a current and present crisis. There are certainly some organisations, some homes, that are in difficulty, and we are dealing with those…
>
> The claims that we are regarding very seriously indeed are the claims about capital need into the future. As Mr Stuart said, we do listen carefully to industry. We have forums where we speak with industry groups, and those forums are not acrimonious; they are respectful where there is a respectful exchange of views. I think I have made clear that as to a crisis, we would say no. There is not a present crisis. Aged care is a key policy of government. We know that the numbers of people seeking support in extreme old age are going to increase and we are of course looking at that. We are particularly examining very proactively the claims that are made about capital needs into the future.[8]

4.10 Ms Murnane concluded:

> We are not complacent, but we are not seeing signs that there is a crisis across the industry and across the provision of aged care now. That does not mean we are complacent, but that would be our reading of the evidence.[9]

4.11 Mr Andrew Stuart of the Department of Health and Ageing also commented:

> The industry continues to deliver care every night to about 175,000 older Australians. Insolvency in this industry is extremely rare. The care continues to be delivered at a quality that is appropriate against the accreditation and certification standards. I do not see a crisis in delivery in care in residential care in Australia.[10]

Financial performance of aged care providers

4.12 A substantial number of aged care service providers raised concerns regarding their financial stability and sustainability. According to The Bethanie Group, recent reports indicate that up to 40 per cent of aged care facilities are not performing at breakeven levels.[11] The Aged and Community Services Association of NSW & ACT cited a 2008 financial performance survey to highlight that 57 per cent of residential aged care services in NSW are currently operating at a deficit.[12]

4.13 Other providers have faced substantial reductions in their surpluses. UnitingCare Australia noted that the Conditional Adjustment Payment (CAP) has been a 'critical revenue source' enabling it to continue to achieve a small surplus on residential operations and avoid losses in the four years that it has been implemented. However, UnitingCare Australia highlighted that even with the CAP, its agencies surpluses on residential aged care have fallen from $12.8 million in 2004–05 to

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8 Ms M Murnane, Department of Health and Ageing, *Committee Hansard*, 21.3.09, p. 10.

9 Ms M Murnane, Department of Health and Ageing, *Committee Hansard*, 21.3.09, p. 17.

10 Mr A Stuart, First Assistant Secretary, Department of Health and Ageing, *Committee Hansard*, 13.3.09, p. 79.

11 The Bethanie Group, *Submission 81*, p. 3.

12 Aged and Community Services Association of NSW &ACT, *Submission 61*, p. 2.

$0.7 million in 2007–08. According to UnitingCare, had the CAP not existed, these organisations would have incurred serious losses in providing residential aged care aggregating $16.25 million over this period:[13]

> The downward trend reflects factors such as increased resident acuity coupled with inability to access bonds from high care residents, input cost increases at a rate greater than income indexation, increasing compliance costs and rising repairs and maintenance costs as building stock deteriorates.[14]

4.14 According to the Grant Thornton Australia survey, the most common explanation for the declining financial performance was that 'staff and general care costs were escalating faster than increases in Government subsidies'.[15] Other witnesses also pointed to consumer demand for single room ensuite facilities.

4.15 Mr Stuart, the Department of Health and Ageing, responded that capital investment in the sector has been strong recently, with building commencements having increased since 2001 and having plateaued in March 2007. Mr Stuart also noted that returns per resident for efficient providers, defined as the top quartile, increased between 2006–07 and 2007–08.[16] The department also commented that net funding growth has been 8 per cent resident.[17]

Surveys of the aged care sector

4.16 Many witnesses pointed to the results of recent surveys as indicating the poor financial performance of the aged care sector. In particular, they pointed to the October 2008 Grant Thornton Australia Aged Care Survey which reported that providers of residential aged care services are 'experiencing low and deteriorating financial returns' at a time when there is unprecedented demand for high care services. The survey reported an average return on investment of approximately 1.1 per cent.

4.17 The survey revealed concerns regarding the viability of both small and large operations, many of whom were incurring unsustainable losses. It found that the average earnings of aged care service providers before interest, taxation, depreciation and amortisation (EBITDA) in 2008 was $2,934 per bed per annum, a decline from $3,211 in 2007.[18] The survey also commented that older, institutional facilities with shared rooms consistently out-performed modern, single-room facilities which are most preferred by consumers. Grant Thornton Australia continued:

> Modern high care facilities with single bedrooms reported the worst results, averaging $2,191 compared to $4,233 per bed achieved in older facilities

13 UnitingCare Australia, *Submission 76*, p. 2.

14 UnitingCare Australia, *Submission 76*, p. 16.

15 Grant Thornton Australia Ltd, *Submission 29*, p. 6.

16 Mr A Stuart, Department of Health and Ageing, *Committee Hansard*, 21.4.09, p. 1.

17 Department of Health and Ageing, *Supplementary submission 114a*, p. 25.

18 Grant Thornton Australia Ltd, *Submission 29*, p. 3.

> with shared rooms. This represents an average return on investment of approximately 1.1% for modern, single bedroom facilities.[19]

4.18 However, Grant Thornton Australia noted the following:

> The survey revealed that earnings achieved in dated, institutional facilities were almost double those achieved in the modern facilities that meet consumer demand for privacy, dignity and comprehensive care.[20]

4.19 The Department of Health and Ageing responded to evidence in relation to the surveys. Citing two surveys (not including Grant Thornton Australia), Dr David Cullen from the department provided evidence that returns were higher in 2007–08:

> Both of the benchmarking studies of the industry, which have been conducted for many years, that is, the Stewart Brown survey and the James Underwood and Bentley's MRI survey, show that the returns of providers in the 2007–08 year were higher than the 2006–07 year.[21]

4.20 Mr Stuart also commented that the general purpose financial reports that the department receives from all aged-care providers show a general improvement in financial performance to 2007–08.[22]

4.21 According to Dr Cullen, the Bentley's survey of 2007–08 established that single-bed operators made up 51 per cent of the top quartile.[23] Moreover, Dr Cullen stated that the Bentley survey demonstrated that 'efficient providers of single-bed facilities and of shared facilities make the same level of return'.[24]

4.22 However, a joint statement of James Underwood & Associates, Stewart Brown Business Solutions and Grant Thornton Australia submitted to the committee emphasised contrary findings:

> Our research confirms that modern, single-room High Care services make very poor or negative returns on average. These returns are far below the returns achieved in older, shared-room High Care services.
>
> In our opinion, modern, single-room High Care services – other than those with extra service approvals – are not viable under current funding and regulatory arrangements.[25]

4.23 Ms Murnane responded to this comment:

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19 Grant Thornton Australia Ltd, *Submission 29*, p. 3.

20 Grant Thornton Australia Ltd, *Aged Care Survey 2008*, Second Report January 2009, p. 3. Document tabled during public hearing, 30 January 2009.

21 Dr D Cullen, Department of Health and Ageing, *Committee Hansard*, 13.3.09, p. 81.

22 Mr A Stuart, Department of Health and Ageing, *Committee Hansard*, 21.4.09, p. 2.

23 Dr D Cullen, Department of Health and Ageing, *Committee Hansard*, 13.3.09, p. 95.

24 Dr D Cullen, Department of Health and Ageing, *Committee Hansard*, 13.3.09, p. 95.

25 Aged Care Association Australia, Additional information received following 13.3.09 public hearing, Joint Statement of Researchers, p.1.

> What we have been saying is that, apart from the Grant Thornton data, when we looked at the Bentleys data and the Stewart Brown data, what we found was an agreement that there is an increase in revenue. They are making a different point.[26]

4.24 Grant Thornton Australia stated that the 'overwhelming majority' of those residential aged care facilities in the top quartile are 'either extra service facilities – so they are able to get bonds in high care – or they are older institutional facilities with multi-bed wards':

> So just looking at the top quartile and accepting that as being the benchmark to which everyone performs takes away from the fact that the majority of those operating in the top quartiles will be delivering a service that is not desired by the consumer.[27]

4.25 Dr Cullen also commented on the Grant Thornton survey and noted that the results are an average across the industry. However, he stated that the other two surveys, whilst also publishing an average result, make the point that it is far more appropriate to look at the result achieved by the top quartile of providers. These providers are doing the best that they can with the revenue which is made available to them, and those returns are far higher and are increasing. Dr Cullen concluded:

> What the top quartile shows you is what an efficient provider can achieve. The entire industry could be efficient if it wished to be. If the entire industry behaved efficiently, like the top quartile does, it would be able to achieve the result, and then the average result across the industry would be the average result achieved by the top quartile.[28]

4.26 Dr Cullen also stated that there are different types of providers in the sector ranging from small businesses for profit with perhaps one or two homes to large not-for-profit organisations. With the small business operator, the owner is the director and the partner is the director of nursing. They pay themselves wages, provide cars and perhaps accommodation out of the business but 'at the end of the day on their tax sheet they show either a very bare profit, a breakeven, or perhaps even a loss'. On the other hand, a not-for-profit aged care home has no need to make a surplus and may provide additional services. Dr Cullen also commented that among the larger players in the industry a number engage in financial transfers between related entities, such that the aged care provider or a number of aged care homes owned by a particular structure will make a loss, but there is another entity elsewhere, perhaps even offshore, that makes substantial profits by providing management services to those entities. Dr Cullen concluded:

> These are anecdotal representations of different parts of this sector and how it is that providers can be at once solvent and not looking like closing down, very stable, continuing to run efficient care, meeting accreditation

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26 Ms M Murnane, Department of Health and Ageing, *Committee Hansard*, 21.4.09, p. 19.

27 Mr C Ansell, Grant Thornton Australia Ltd, *Committee Hansard*, 30.1.09, p. 13.

28 Dr D Cullen, Department of Health and Ageing, *Committee Hansard*, 13.3.09, p. 87.

> requirements and at the same time there is significant data in the industry showing a lot of breakeven-type activity.[29]

4.27 The department provided the committee with a comparison of the three surveys. This is produced in appendix 3.

4.28 Much of the debate concerning research findings in relation to the financial position of residential aged care providers centred around the definition of a 'single-bed facility'. Grant Thornton Australia stated that its working definition was that of a facility with more than 70 per cent single-bed rooms and that:

> As such, modern facilities with predominantly single rooms and "a few doubles" would be included in the definition of "single bed facilities".[30]

Aged Care Approval Round applications and plans for expansion

4.29 Witnesses commented that there is evidence that providers are ceasing to bid for beds under Aged Care Approval Round (ACAR) rounds and are ceasing to invest in the new provision of services either by refurbishing their existing facilities or building new ones. In addition, a number of the new aged care places allocated by the Australian Government are unused or have been returned.[31] It was argued that this indicated the poor state of the sector.

4.30 It was noted for example, that for the first time, there was an under-subscription for residential aged care licenses in the 2007 ACAR in Western Australia and Tasmania.[32] Ms Anne-Marie Archer of the Aged Care Association commented that in 2008 there was a shortfall in bed allocations nationally and only 67 per cent of beds were available were allocated.[33] The Aged Care Association Australia WA and Aged and Community Services WA also stated that there are thousands of beds currently 'offline' for reasons including decommissioning and provisional allocation without construction. According to the organisations this has occurred in Western Australia for two reasons: first, the cost to build is prohibitive; and second, the daily funding is not adequate.[34]

4.31 UnitingCare Australia indicated to the committee that it would not be proceeding with a major development in Melbourne. Although the Victorian Government had provided land to build a 90-bed residential aged care facility to help relieve the pressure on the hospital system, financial analysis revealed that UnitingCare Australia would lose $20 million over 20 years if it went ahead with the facility. UnitingCare Australia noted that that was based on operating at the Stewart

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29 Dr D Cullen, Department of Health and Ageing, *Committee Hansard*, 13.3.09, p. 89.

30 Grant Thornton Australia Ltd, Additional information received following 13.3.09 public hearing, p. 3.

31 Grant Thornton Australia Ltd, *Submission 29*, p. 7.

32 Grant Thornton Australia Ltd, *Submission 29*, p. 7.

33 Ms A Archer, Aged Care Association Australia WA, *Committee Hansard*, 30.1.09, p. 38.

34 Aged Care Association Australia WA and Aged and Community Services WA, *Submission 84*, p. 2.

Brown benchmarks. However, UnitingCare Australia had concluded that 'we cannot pay for that capital when that is how much we would lose over 20 years, so we will not do that.'[35] UnitingCare Australia also commented that no-one in its network with the exception of one small facility applied for residential places in the latest ACAR round because 'we do not believe it is sustainable'.[36]

4.32 Of the consequences, Ms Anne-Marie Archer of the Aged Care Association Australia WA noted:

> This lack in demand for services is going to have an enormous long-term impact on the ability of this state to deliver services in the future, as there are time delays from allocation to actually implementing and developing these services.
>
> Some of the delays in the provision of these services can be partially attributed to the areas around zoning and development applications—in some cases up to years—and this can have a huge impact upon providers' business cases in regard to construction costs et cetera, but the major impediment is the funding that is provided for the development of infrastructure. Currently, the per bed rate allocation of funding, as you learnt before, is $109,000. Unfortunately, in WA, with our construction costs, to date providers are receiving construction quotes of in excess of $200,000, and it is—as the WA Department of Health indicated—three times that amount, if not more, in the regional areas. [37]

4.33 Mr Greg Mundy of Aged and Community Services Australia highlighted the significance of the under-subscription for licences:

> …I think we are now getting to the point where, when aged-care providers are not bidding for free resources from the Commonwealth government that they can put on their balance sheet, at no cost to themselves, then I think that should be a really, really powerful warning sign. We now have four jurisdictions in Australia—Western Australia, Tasmania, the ACT and the Northern Territory—where people are not taking these free gifts from the Commonwealth government to put on their balance sheet. The figures in Queensland and New South Wales are not actually that much better. Those states will also be undersubscribed outside the south-east corner of Queensland and outside Sydney. So I think that is actually a very powerful warning sign to us.[38]

4.34 The department argued that building activity in the sector did not support the argument that the sector was under strain. Dr Cullen commented that the level of building activity in the industry is higher now than at any stage in the decade since aged care construction statistics have been collected and concluded 'that would tend to

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35 Ms R Batten, UnitingCare Australia, *Committee Hansard*, 13.3.09, p. 26.

36 Ms R Batten, UnitingCare Australia, *Committee Hansard*, 13.3.09, p. 27.

37 Ms A-M Archer, Aged Care Association WA, *Committee Hansard*, 30.1.09, p. 38.

38 Mr G Mundy, Aged and Community Services Australia, *Committee Hansard*, 20.2.09, p. 3.

indicated that providers are more willing to make investments in care now, just on the pure statistics, than they have been at any time in the past'.[39]

4.35 The department noted that capital investment (a trailing indictor) has been strong with building commencements having increased since 2001, and then reached a plateau in March 2007 at about $342 million per quarter. Lead indicators also show that growth is strong. Between July 2007 and December 2008 building approvals have averaged around $100 million in approvals per month.[40]

4.36 The department also pointed to planned and completed building activity. The 2007–08 survey of aged care homes undertaken by the department indicated that 18,700 places were being planned for construction or upgrading. It noted that 'while there is a slight decline from the planned places from the 2006–07 survey, it is still three times the number of additional residential places delivered by completed building work in 2007–08 and over two and half times that to be delivered by building work in progress at 30 June 2008'. The department concluded that 'thus the planned work will form a significant pipeline of building activity in coming years'.[41]

4.37 Dr Cullen commented:

> As long as people are willing to enter the industry and build, then you can make a judgment that the return must be sufficient. We have provided a great deal of evidence to you to show that people are entering and building in the industry. You must be able to conclude, from the fact that all of that construction activity has occurred, that the rational beings who undertook that construction activity must have made a judgment that the return was sufficient for them to undertake that activity.[42]

4.38 Mr Stuart went on to state:

> We are listening to the sector. We are watching aged-care place applications. We are interested in all of those indicators but we also have this data that shows increases in funding in recent years, return growing faster than cost, eight per cent growth in funding into this current financial year, and aged-care providers have over the last decade substantially rebuilt the aged-care sector at funding levels lower than they are currently in real turns.[43]

4.39 TriCare commented on the use of Australian Bureau of Statistics (ABS) data concerning increased building activity for residential aged care facilities. TriCare stated:

> Our research confirms that there is no specific measure of government funded residential care facilities and no conclusion which can be reached in

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39 Dr D Cullen, Department of Health and Ageing, *Committee Hansard*, 13.3.09, p. 82.

40 Department of Health and Ageing, *Supplementary submission 114a*, p. 5.

41 Department of Health and Ageing, *Supplementary submission 114a*, p. 17.

42 Dr D Cullen, Department of Health and Ageing, *Committee Hansard*, 21.3.09, p. 22.

43 Mr A Stuart, Department of Health and Ageing, *Committee Hansard*, 21.3.09, p. 22.

relation to government funded residential aged care construction via ABS data.[44]

4.40 TriCare went on to state that is have been informed by the ABS that:

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

4.41 TriCare concluded that the building statistics encompasses retirement village development and construction of which is surging 'given the lack of government restrictions on capital funding mechanisms in that sector'.[45]

4.42 Given the conflicting views on the construction statistics, the committee sought advice from the ABS. The ABS commented that it uses the Functional Classifications of Buildings (FCB) for a range of ABS publications including building activity and construction work done. For these collections the function of the completed building is generally determined at the time the building approval is lodged. The definition of aged care facilities (including nursing homes) states that they are buildings used in the provision or support of aged care facilities, excluding dwellings such as retirement villages.

4.43 The ABS concluded that it was not in a position to make comment on the claims made in the various submissions. Neither the Building Approvals collection nor the Building Activity Survey collect information on the source of the funding on any project. However, the ABS does classify a building by sector of ownership.[46]

Construction costs

4.44 Many submitters commented on the increase in costs for the construction of aged care facilities. The issues identified included the increase in costs in areas where there is competition from other sectors, high costs associated with geographical location particularly remoteness and a shift in consumer expectation towards single room ensuite accommodation. The issues of costs in rural and remote areas is canvassed in Chapter 6. The following addresses the general issue of construction costs.

4.45 In evidence, providers indicated that construction costs per bed ranged up to $180,000. Some costs were higher due mainly to remoteness. According to Grant Thornton Australia, the average anticipated building costs for new facilities was

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44 TriCare, *Submission 123*, p. 11.

45 TriCare, *Submission 123*, p. 11.

46 Australian Bureau of Statistics, *Addition Submission 33a*, pp 1–2.

$176,000 per bed excluding land costs, which is a substantial increase from between $74,000 and $85,000 per bed in 2003. Of the increase, Grant Thornton Australia noted:

> The increase represents both a change in the cost of construction as well as changing expectations of consumers.[47]

4.46 The shift towards single ensuite rooms was highlighted by many witnesses as having a major impact on funding and resources. The Aged Care Association Australia commented:

> 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 additional staffing costs of operating single room services each with separate bathroom and toilet.[48]

4.47 However, the aged care sector saw the shift toward single-room ensuite accommodation from multi-bed wards as a cost burden for the industry. According to Mr Young of Aged Care Association Australia (ACAA):

> In a number of the reports that are before you, particularly the work that Grant Thornton did, they have looked at the difference between single-room, ensuite accommodation and multibed wards often without ensuites. The returns that you get on those different types of accommodation run at about two to one, which is quite significant. The whole industry has or is moving to a single-room, ensuite framework, and that is considerably more expensive to operate. There is nothing in any of the subsidy reform processes that we have looked at for the last nearly 20 years now—other than the lump sum contributions in hostels—to actually reflect that changing cost burden for the industry.[49]

4.48 The department indicated that its survey of aged care facilities had shown a median cost of construction of $150,000 per place. Some 58.6 per cent of projects were completed for less than $155,000 per place, while some 14.8 per cent of projects cost more than $200,000 per place. The department concluded that the latter were constructed as 'extra service aged care homes or to a design specification well in excess of the current aged care building certification standards'. The department also noted that many facilities were built for less than the median cost and these included single room ensuite facilities:

> Many of the aged care homes with construction costs below $150,000 per place were also for design specification in excess of the current aged care

47 Grant Thornton Australia Ltd, *Submission 29*, p. 7.

48 Aged Care Association Australia, *Submission 92*, p. 11.

49 Mr I Young, Aged Care Association Australia, *Committee Hansard*, 13.3.09, p. 51.

> building certification minimum standards, including many developments entirely composed of single room ensuites.[50]

4.49 Mr Stuart commented that the Australian Government does not require single-bed facilities with ensuites. Mr Stuart went on to state:

> The Australian government policy requires for new buildings to achieve certification an average across the facility of 1.5 residents per room. That ratio permits two-thirds of the residents to be in double rooms and one-third to be in single rooms. The certification requirements also allow existing buildings to be renovated to still include some four-bed accommodation, provided it is not a sweeping refurbishment, in which case we expect them to meet the requirements for new buildings. I would submit that the industry has been, perhaps to its credit, substantially exceeding the requirements that are set in the government's certification guidelines.[51]

Potential impact of the global financial crisis

4.50 The department commented that the aged care sector is 'relatively (but certainly not completely) sheltered from the effects of the global financial crisis'. The department pointed to the sector's income stream which is almost completely underwritten by government; resident contributions in residential aged care are further underwritten by the pension system; and by aged care supplements and consumer demand for aged care is not expected to decrease very significantly as a result of the global financial crisis.[52]

4.51 Mr Stuart, Department of Health and Ageing, went on to comment:

> The other aspect is that the department adopts a risk based approach to compliance monitoring. We use a range of information sources, like complaints data, prudential returns and information coming in from other sources—media even—to identify where there may be emerging compliance risks.
>
> We also, in looking at that, try to identify whether there might be emerging financial risks. Similarly, we have been engaging more closely with the financial sector—the major banks—to talk to them about emerging developments in the sector and their attitudes to financing. At any point in time we will have at least a few approved providers about whom we may have concerns of varying degrees. There are currently one or two approved providers whom we are in discussions with on their financial position and we are providing some assistance to via consultancy services and the like to look at their operations with a view to identifying strategies to improve their situation.[53]

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50 Department of Health and Ageing, *Supplementary submission 114a*, p. 18.

51 Mr A Stuart, Department of Health and Ageing, *Committee Hansard*, 13.3.09, p. 97.

52 Department of Health and Ageing, *Supplementary submission 114a*, pp 23–24.

53 Mr A Stuart, Department of Health and Ageing, *Committee Hansard*, 21.4.09, p. 42.

4.52 However, providers stated that they were feeling the impact of the financial crisis. UnitingCare Australia for example, stated that its investment income had fallen.[54] Mr Glenn Bunney of Sundale Garden Village commented that non-operational income had 'virtually disappeared overnight'. There had also been investment write-offs and the disappearance of interest income and, at the same time, the effective interest rates that are being charged by banks have not dropped.[55]

4.53 Mr Andrew Sudholz of Japara Holdings commented that the global financial crisis has seen lending practices change dramatically:

> The banks are not lending as much, they are retreating from the industry or they are suffering from the global financial crisis. Thirty billion dollars of construction property funding is going to come out of our domestic market and be paid back to the global banks over the next 12 months.[56]

Conclusion

4.54 The committee received contradictory evidence in relation to the financial wellbeing of the aged care sector, and therefore the preparedness of the sector to meet growing demand. On one hand, providers argued that the sector is in crisis, or at the very least facing a crisis in the near future. On the other hand, the Department of Health and Ageing argued that there are significant government resources going into the sector and that there is evidence of increasing returns for providers and other indicators of strong financial viability including the level of building approvals.

4.55 The committee notes the arguments put by the department to support its view. However, in relation to the use of building activity as an indicator of the strength of the sector, the committee is of the view that the present building activity is likely driven by past allocations of beds rather than new allocations.

4.56 The committee considers that at the heart of the matter is the question of methodological approach and definitions of key terms. In the previous chapter, the committee has addressed the need for nationally consistent aged care data.

4.57 The committee also recognises that there is a need to establish a clear understanding of the financial status of aged care providers. This in turn requires insight into the funding status and needs of such providers and in this regard, the committee heard evidence of the need to establish a benchmark of care costs.

4.58 The committee also considers that, given the contradictory evidence and the emerging demands on the aged care sector as a result of the ageing of the population, a 'stress test' of the sector be undertaken to test the resilience of the sector. Such a test would measure the financial wellbeing of the sector and help to establish whether the sector is in crisis and whether it is in a position to meet future needs.

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54 Ms L Hatfield Dodds, UnitingCare Australia, *Committee Hansard*, 13.3.09, p. 27.

55 Mr G Bunney, Sundale Garden Village, *Committee Hansard*, 7.4.09, p. 79.

56 Mr A Sudhoz, Japara Holdings Pty Ltd, *Committee Hansard*, 20.2.09, p. 46.

Recommendation 9

4.59 The committee recommends that the Department of Health and Ageing undertake a 'stress test' of the aged care sector in order to measure the sector's financial wellbeing.

Costs associated with accreditation, regulation and compliance measures

4.60 The Aged Care Standards and Accreditation Agency is responsible for accreditation under the *Aged Care Act 1997* and applies four accreditation standards with 11 expected outcomes per standard:

- management systems, staffing and organisational development;
- health and personal care;
- resident lifestyle; and
- physical environment and safe systems.[57]

4.61 A number of both residential and community aged care providers were concerned with the overall increase in cost burdens associated with new regulations and compliance measures within the aged care sector. According to a number of providers, the pressure on them to meet such demands implies the diversion of staff away from meeting care needs of clients to that of administration associated with compliance. Baptist Community Services of NSW & ACT as one case in point, noted:

> The administrative load on staff is estimated to have increased by 50% over the past three years. Data from the Stewart Brown Aged Care Survey 2008 indicates that administration costs in residential aged care are now only just below the costs of feeding residents.[58]

4.62 Of these pressures, the Share & Care Community Service Group noted:

> There is pressure on all HACC providers to meet escalating demand within existing resources…The increase in quality standards, expectations of accountability and transparency, requirements for continuous consumer feedback and the massive increase of staff time to implement, monitor and evaluate all these items is in no way presently reflected in the funding. Whilst Share & Care agree these governance and operational measures are essential, there has been no increase in funding to compensate for the additional hours all these processes necessitate.[59]

4.63 The Aged and Community Services Association of NSW & ACT identified the range of increasing demands on the industry:

> Funding for aged care services is further impacted by government policy increasing demands such as police checks, compulsory reporting, increased validation of residential care funding claims, increased accreditation visits

57 Blue Care Uniting Care Queensland, *Submission 18*, p. 18.

58 Baptist Community Services of NSW & ACT, *Submission 21*, p. 2.

59 Share & Care Community Services Group, *Submission 5*, p. 3.

> and food safety standards and mandatory food safety programs. These costs have to date been absorbed totally by the industry.[60]

4.64 The ACCV noted that there are increasing costs involved in demonstrating that facilities are compliant because of an increase in the number of contact visits and documentation required under the Complaints Investigation Scheme (CIS). ACCV stated that there is a duplication of paperwork:

> Accreditation has raised the bar each time increased resources are required, as well as extra time to respond to this. As regulatory paperwork requirements extend above and beyond the ACFI in documenting care, there is a regular 'double up' in documents, assessments and records.[61]

4.65 The Shire of Kojonup highlighted the difficulties for smaller providers in covering the additional costs of administrative and compliance measures. Detailing the experience of the Springhaven Aged Care Hostel, a 22-bed low care facility, the Shire noted:

> In 2005 surveyors from the Aged Care Standards and Accreditation Agency Ltd advised management that our facility would not meet future accreditation requirements if it did not move from an overnight sleep over (on call) arrangement, to 24 hour stand up shifts. This was despite no change in the number of beds or the average RCS since the previous accreditation process.
>
> In 2007 the agency further advised that they believed there needed to be more staffing to handle administration. Between the new shifts and additional staff, required by the accreditation agency to meet the standards, and the increase in staff costs, the total staffing has increased from $441,000 in June 2005 to $568,000 in June 2008. This represents a 28% increase in costs without any increase in funding.[62]

4.66 The Department of Health and Ageing maintained that measures are being implemented to respond to the burdens associated with new regulations and compliance measures including an 'eBusiness strategy'.[63] However, concerns were raised that there remained little recognition of the time, cost and resource constraints on providers to fulfil such demands. Ms Anne-Marie Archer of the Aged Care Association Australia WA informed the committee:

> One of the biggest complaints we get from staff in the industry is the level of compliance et cetera insofar as it relates to the excessive documentation…The amount of time that they actually spend doing the

60 Aged and Community Services Association of NSW & ACT Inc, *Submission 61*, p. 2.

61 Aged and Community Care Victoria, *Submission 89*, p. 3.

62 Shire of Kojonup, *Submission 70*, p. 1.

63 Department of Health and Ageing, *Report on the Operation of the Aged Care Act 1997: 1 July 2007 to 30 June 2008*, p. 35.

> documentation is time taken away from care, and that amount of documentation is increasing.[64]

4.67 Ms Lin Hatfield Dodds of UnitingCare Australia highlighted the tension between the compliance burden and meeting care needs:

> The tragedy is the burden of administration and compliance on our care staff. All of us want better quality of life outcomes for the people we are providing services to. That is the motivator for a very punitive compliance burden we carry. It means that our care staff are diverted from care. There is a very perverse outcome in terms of real quality of life outcomes for Australians.[65]

4.68 Whilst providers recognised the need for regulatory and compliance regimes, concerns focused on the rigidity of the system. Mr Martin Laverty of Catholic Health Australia argued in this regard:

> We think there should be a greater opportunity for incentives for good performance balanced with the requirement for strong accreditation standards. But we have swung too far in favour of heavy compliance rather than looking at innovation and incentives for good provision of quality care.[66]

4.69 Mr Rod Young of the ACAA expressed a similar view:

> In respect of compliance and overregulation, we believe that the accreditation agency has shifted from its educative and support function. As an industry we have been highly supportive of the whole accreditation process to achieve and maintain quality in the industry, but we feel that the balance between compliance, regulation and quality improvement in the industry has shifted too far to the compliance framework.[67]

4.70 Ms Hatfield Dodds of UnitingCare Australia shared the same concern:

> The need for regulatory controls is not disputed. We are absolutely committed to a transparent system that ensures that all citizens get the care they need and that all taxpayers can see where their money is going, but our current system of regulation is expensive and cumbersome and has perverse outcomes in terms of quality of life and priorities for staff time and effort. We believe the purpose of a regulatory system should be to support the policy intent of legislation, protect citizens and ensure accountability. We need clear guidelines both as providers and consumers for identification and management of risks and clear indicators of quality of life. We need a respectful and cooperative working relationship between the department and providers built on recognition of the negative impacts of regulatory and

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64 Ms A-M Archer, Aged Care Association Australia WA, *Committee Hansard*, 30.1.09, p. 39.

65 Ms L Hatfield Dodds, UnitingCare Australia, *Committee Hansard*, 13.3.09, p. 36.

66 Mr M Laverty, Catholic Health Australia, *Committee Hansard*, 13.3.09, p. 2.

67 Mr R Young, Aged Care Association Australia, *Committee Hansard*, 13.3.09, p. 47.

> accreditation and complaint systems that are built on negative determinants.[68]

4.71 Similarly, Mr Bryan Dorman of the ACAA also highlighted:

> My objective in my organisation is to have 24-seven continuous improvement. But we still have this punitive process where you are either wrong or you are right. There is no value adding. There is no educational component to it all. We are ready for a next-generation compliance process. The next generation is where the staff engage with getting better at what they are doing and the system works in favour of that, not just whether you are good or bad. There are a lot of other industries that work it very effectively. There is no reason why it would not work in our space.[69]

4.72 Such views are consistent with those of the Productivity Commission. In its 2008 report on aged care services, the Productivity Commission noted that:

> Over coming decades, pressures on the demand-side of the aged care market are expected to accentuate a number of weaknesses in the current policy framework, including:…inefficiencies arising from excessive government regulation…[70]

4.73 Dr Lynn Arnold of Anglicare Aged Care Association South Australia affirmed that in addition to the difficulties involved in regulation itself, the federal and state regulatory burdens conflict:

> We are not asking for a deregulated approach, we are simply asking for a re-examination of the array of regulations, if you like, micro-regulatory reform, that will prevent regulations conflicting with each other and actually result in the outcome that they ostensibly seek not being able to be achieved. We do have examples of that between state and federal regulations that make the working environment not able to provide for the aspirations of residents because of conflict between the two.[71]

4.74 Ms Derryn Wilson of the Municipal Association of Victoria identified initiatives in place between councils to address the challenges of meeting the administrative requirements:

> In some regions the bigger councils supported the smaller councils by sharing their paperwork and working together. In a few instances the state also paid for a support worker consultant to go and work alongside a small group and help them get their processes in place, and they also provided some general education and training in the area.[72]

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68 Ms L Hatfield Dodds, UnitingCare Australia, Committee Hansard, 13.3.09, p. 26.

69 Mr B Dorman, Aged Care Association Australia, *Committee Hansard*, 13.3.09, p. 58.

70 Productivity Commission, *Trends in Aged Care Services: some implications*, Research Paper, September 2008, p. xx.

71 Dr L Arnold, Anglicare Aged Care Association South Australia, *Committee Hansard*, 13.3.09, p. 63.

72 Ms D Wilson, Municipal Association of Victoria, *Committee Hansard*, 20.2.09, p. 17.

4.75 Mr Stuart of the Department of Health and Ageing commented that the aim of the ACFI was in part to reduce paperwork:

> ...the government, in introducing the ACFI, had several objectives, one of which was a radical reduction in paperwork and nurse time. We are getting a lot of feedback to the effect that that is certainly being experienced.[73]

Conclusion

4.76 The committee considers that compliance measures are essential in the aged care sector. The committee acknowledges that the concerns of aged care providers in relation to accreditation are not grounded in a belief that the outcomes for residents in aged care facilities should be watered-down.

4.77 The committee appreciates that meeting regulatory obligations including accreditation standards is creating tension for providers who must balance the administration requirements with meeting care needs of clients. The compliance regime is a particular impost on smaller providers. For these reasons, the committee recommends that a review of costs and resources (borne by providers) required to meet such measures is undertaken. In addition, the committee considers that there is a need to identify and implement more cost effective measures of meeting compliance measures and to put in place support for smaller providers in relation to the compliance regime. It believes that the recommended advisory taskforce in association with the Department of Health and Ageing could undertake such a review.

Recommendation 10

4.78 The committee recommends that the Department of Health and Ageing, in association with the suggested taskforce, undertake a review:

- **to identify the costs and resources required to meet new regulation, accreditation and compliance measures with a view to rationalising the administrative processes as required; and**
- **to identify more cost effective means of meeting the requirements of the compliance framework.**

Recommendation 11

4.79 The committee recommends that the Department of Health and Ageing implement measures, including additional funding, to assist smaller providers to meet the requirements of the compliance framework.

Reduction in the provision and quality of services

4.80 Of particular concern to providers was the issue of the provision and quality of services within the aged care sector. Many witnesses commented that the quality and quantity of services has diminished and that this was further evidence of the crisis within the sector.

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73 Mr A Stuart, Department of Health and Ageing, *Committee Hansard*, 21.4.09, p. 35.

4.81 Witnesses argued that present funding arrangement, including the indexation formula, are impacting adversely on provider viability and service provision. For example, Bromilow Home Support Services stated that there has been a reduction in services hours provided to clients and commented that 'it is impossible for service providers to maintain consistency in the service levels provided to clients form one year to the next when subsidy levels continue to fall in real terms'.[74] Aged and Community Services Australia (ACSA) commented that the hours of service per client has declined in both residential and community care, reducing the quality of life of clients and increasing the risk of more intensive and expensive interventions being required. According to the ACSA, the impact is most acute in high care residential care as ageing in place tends to mask the same phenomenon in low care.[75]

4.82 Aged and Community Services SA & NT commented that not only were there less after hours service provision and a loss of real hours of direct care, but also a loss of diversity, loss of matching and 'cherry picking' of waiting lists.[76] Anglicare noted that the rationing services impacts particularly on older people with limited means and limited alternative supports.[77]

4.83 The Australian Medical Association took the view that older Australians in residential aged care facilities 'do not have access to medical care equal to the standard enjoyed by the rest of the population' and that the Australian Government, as the funder of aged care, should 'provide specific funding to approved aged care providers to enable them to secure appropriate medical care and supervision on an ongoing basis for their residents'.[78]

4.84 The Committee's attention was drawn to innovative models of health service provision within aged care facilities to secure more holistic tracking of the health status of residents and their subsequent treatment.[79] Such models may benefit in the medium term from demonstration funding to explore their efficacy.

4.85 Mr Stephen Teulan of UnitingCare Australia commented:

> Given what is happening with the lack of indexation of subsidies, if we look at residential care but particularly community care, which has not had the benefit of the conditional adjustment payment, the additions to the subsidy in recent years, what is impacting there is that providers are just providing fewer services under the same packages to the community than they were previously because when salaries are going up at four to five per cent and the subsidy increase is two per cent there is no choice. The people who lose

74 Bromilow Home Support Services, *Submission 49,* p. 5; see also Boandik Lodge Incorporated, *Submission 80,* pp 1–2.

75 Aged and Community Services Australia, *Submission 72*, p. 2.

76 Aged and Community Services SA & NT, *Submission 90,* p. 8 and p. 2.

77 Anglicare, *Submission 67,* p. 3.

78 Australian Medical Association, *Submission 14*, p. 1.

79 See for example, HealthCube, *Submission 122,* p. 5.

> out in the community are those who receive the services. They just receive less.[80]

4.86 Other witnesses also supported the view that the service purchasing capacity of a Community Aged Care Package (CACP) had diminished.[81] The ACSA maintained since 1995 funding has resulted in packages less able to meet assessed needs.[82] Perth Home Care Services held the same view, detailing the decline in the service purchasing capacity of CACP program:

> Our own experience is that since...2000 a CACP package was able to provide an average of seven hours per week with the capacity to increase to 10 hours per week for short periods of increased need. In 2008 this has reduced to five hours per week with limited capacity to increase hours to seven per week for increased need.[83]

4.87 Aged and Community Care Victoria (ACCV) held that the 'failure of funding levels to match identified care needs now fundamentally threatens the capacity of the industry to continue to provide its high standard of care'.[84]

4.88 A similar sentiment was also expressed by AMANA Living, which stated that the disparity between the amount of funding provided by Commonwealth, and the actual cost of aged care services (in this case residential care), will have negative long term consequences if the problem is not addressed:

> While the Commonwealth funds residential aged care to the tune of $114 per day (Minister Elliot's own data), an acute care bed costs $1,000 per day. The future lack of adequate residential care provision will impact very seriously on the already overstretched acute health system with serious ramifications for older people and for the overall cost of providing care.[85]

Workforce issues

4.89 One of the key issues of concern amongst aged care providers in relation to their financial position and thus ability to provide quality services is that of the recruitment and retention of staff. The difficulties in retaining aged care staff in a context in which the sector is unable to match let alone compete with the wages and conditions offered by other sectors was highlighted in evidence.[86] It was recognised, moreover, that the growing complexity and diversity of care needs require specialised

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80 Mr S Teulan, UnitingCare Australia, *Committee Hansard,* 13.3.09, p. 29.

81 Care Connect, *Submission 71*, p. 2.

82 Aged and Community Services Australia, *Submission 72*, p. 2.

83 Perth Home Care Services Inc, *Submission 32*, p. 1.

84 Aged and Community Care Victoria, *Submission 89*, p. 4.

85 AMANA Living, *Submission 3*, p. 1.

86 See for example, Mr D Kelly, Liquor, Hospitality and Miscellaneous Union, *Committee Hansard,* 30.1.09, pp 29–30; Mr J Toohey, Aged Care Alliance, *Committee Hansard,* 7.4.09, p. 23.

nurses and other qualified professionals which further impacts on expenditure and the nature of care provided.

Recruitment and retention of profession nursing and aged care staff

4.90 A substantial number of submitters raised concerns regarding the challenges of recruiting and retaining professional nursing staff in residential aged care facilities. Citing statistics from the Australian Institute of Health and Welfare, the Australian Nursing Federation (ANF) stated:

> At the same time as there are growing numbers of residents and their dependency is also increasing the numbers of registered and enrolled nurses employed in aged care has fallen from 38,633 in 1995 to 34,021 in 2005 a decline of 4,602. Over the same time the number of residential aged care places has increased from 134,810 in 1995 to 161,765 an increase of 26,955.[87]

4.91 The Aged Care Standards and Accreditation Agency (ACSAA) reported in August on staffing issues within aged care facilities found to be non-compliant:

> Among those homes found to be non-compliant in 1.6 Human resource management, it was found that a significant proportion did not maintain appropriate numbers and types of staff, with many of them not being able to ensure that staff skills and qualifications were the right fit for the work required and to reflect their residents' needs.[88]

4.92 The ACSAA went on to state that:

> …in homes where workloads are unrealistic, or where staff are unqualified, poorly trained or poorly deployed, then process malfunctions will occur across a wide range of expected outcomes.[89]

4.93 The ANF highlighted in its submission that the work of 'registered and enrolled nurses is progressively being substituted by unlicensed carers, which now represent the bulk of the workforce providing aged care services'.[90] Yet, recent evidence suggests a correlation between skills mix and patient outcomes. Citing a 2007 Australian study which reinforced findings of a number of international studies, the ANF noted that

> …[a] skill mix with a higher proportion of registered nurses produced statistically significant decreased rates of negative patient outcomes such as decubitus ulcers; gastrointestinal bleeding; sepsis; shock; physiologic/metabolic derangement; pulmonary failure; and failure to rescue.
>
> The study found one extra registered nurse per day would reduce the incidence of decubitus ulcers by 20 per 1000 patients, of pneumonia by 16

87 Australian Nursing Federation, *Submission 94*, p. 2.

88 Aged Care Standards and Accreditation Agency, *The Standard*, August 2008, p. 2.

89 Aged Care Standards and Accreditation Agency, *The Standard*, August 2008, p. 3.

90 Australian Nursing Federation, *Submission 94*, p. 4.

per 1000 patients, and of sepsis by 8 per 1000 patients. Patients are also less likely to fall and suffer injury as registered nursing home hours increase.[91]

4.94 A number of providers held that the ACFI had 'skewed' funding towards high residential care at the expense of low care funding which was creating dependence on specialist nursing services. In Western Australia, as one case in point, 72 per cent of all new admissions were of persons into high residential care requiring a high concentration of nurses.[92]

4.95 According to other evidence, problems in recruiting and retaining professional nursing staff also extended to care workers. The Australian General Practice Network (AGPN) highlighted that there was a workforce shortage affecting all care providers including personal care workers, general practitioners and allied health professionals as well as nurses.[93]

4.96 The Liquor, Hospitality and Miscellaneous Union (LHMU), whose members comprise approximately 75 per cent of the aged care workforce, stated that there was an annual turnover of direct care workers of 25 per cent.[94] Citing a 2008 National Institute of Labour Studies report, the LHMU noted that the high turnover rate was related not only to low remuneration but also work conditions. According to the report, 26 per cent of personal carers felt that they were able to spend sufficient time with residents whilst 36 per cent did not fell under pressure to work harder and 43 per cent found their job more stressful than they imagined.[95]

Conclusion

4.97 The committee acknowledges the concerns of providers in relation to the recruitment of professional nursing and other aged care staff and recognises that the issue must be addressed if the sector is to meet growing demand on its services in both the immediate and longer term. For this reason, the committee holds the view that the issue of staffing requirements must be considered in the recommended overarching review of the aged care sector. This will enable immediate and longer term projections in terms of staffing requirements and complement work currently undertaken to address aged care workforce challenges.

Recommendation 12

4.98 The committee recommends that the issue of professional nursing and other aged care staffing requirements be considered in the overarching review of the aged care sector.

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91 Australian Nursing Federation, *Submission 94*, p. 4.

92 See for example, Aged Care Association Australia WA and Aged and Community Services WA, *Submission 84*, p. 1.

93 Australian General Practice Network, *Submission 68*, p. 8.

94 Liquor, Hospitality and Miscellaneous Union, *Submission 112*, p. 2.

95 Liquor, Hospitality and Miscellaneous Union, *Submission 112*, pp 2–3.

Wages

4.99 A considerable number of submissions highlighted the problems with nurses' wages which, according to some evidence, are at least 10 per cent below that of equivalent staff in the acute care sector with some submitters commenting that the difference was up to 20 per cent.[96] According to Murchison Community Care, this disparity remains despite wage increases of 4 per cent a year for the past 6 years.[97] Aged and Community Service Australia stated that wage levels for aged care staff continue to lag behind those paid by other employers in the same labour market, further exacerbating the difficulties experienced in recruiting and retaining skilled staff.[98]

4.100 Mr Dave Kelly, Secretary of the Liquor, Hospitality and Miscellaneous Union, made the following comments in relation to wages:

> I have got a rate down there at the bottom for zookeepers. The LHMU also has the privilege of negotiating on behalf of staff at the Perth Zoo. A zookeeper under the EBA that we have negotiated with the state government gets $27, almost $28, an hour. I do not provide that just for a bit of humour: it is serious. This is what we pay people to care for animals at the Perth Zoo. What we pay staff to care for the elderly is significantly less. You would have to ask yourself, 'What does that say about the value that we attribute not only to the staff but to the elderly?'[99]

4.101 In a 2008 report on aged care services, the Productivity Commission commented on wages in the sector and noted:

> It is not uncommon for nurses employed in aged care to be paid at least 10 per cent less than their peers in the acute care sector for performing similar or equivalent work. For nurses in most settings, there has been a general trend, over the last 10 years, to adopt enterprise bargaining agreements and move away from award wage structures…the median real wage gap between aged care nurses on enterprise based agreements and those working in public hospitals has been maintained since 2005. As a result of the comparatively low wages in aged care, registered and enrolled nurses continue to be attracted to other parts of the health and community care sectors.[100]

4.102 The Valley View Aged Care Facility also raised the issue of disparity between nursing staff salaries in the private and public sectors:

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96 Murchison Community Care Inc, *Submission 36*; Management Consultant and Technology Services, *Submission 42*; Tongala and District Memorial Aged Care Service Inc, *Submission 83*; Baptcare, *Submission 59*; Valley View Aged Care Facility, *Submission 60*; Hotel Group of Companies, *Submission 79*.; Brotherhood of St Lawrence, *Submission 12*, p. 2.

97 Murchison Community Care Inc, *Submission 36*, p. 2.

98 Aged and Community Service Australia, *Submission 72*, p. 2.

99 Mr D Kelly, Liquor, Hospitality and Miscellaneous Union, *Committee Hansard*, 30.1.09, p. 30.

100 Productivity Commission, *Trends in Aged Care Services: some implications*, Research Paper, September 2008, p. 144.

> Salary sacrificing in public and not for profit sectors leaves the private sector at a severe disadvantage. The private sector is expected to provide the same standard of care as the not for profit and public sectors without being about to provide wage parity for the top quality nursing staff due to lack of finances.[101]

4.103 Wages account for a large proportion, 70 to 80 per cent, of total costs for aged care providers. According to the Darlingford Upper Goulburn Nursing Home, 87 per cent of its non-negotiable expenditure comprises staffing costs.[102] Similarly, Havilah Hostel stated that wages contribute up to 80 per cent of operating costs.[103] The House Group of Companies commented that the high turn over of nursing staff required the use of nursing agency staff and led to the expenditure of more than $750,000 on agency casual staff in 2007 which 'had a serious effect not only on the stability of our organisation and quality of care, but also on our profitability'.[104]

4.104 Providers argued that funding was insufficient for the wage gap to be closed. Mr Martin Laverty of Catholic Health Australia commented that changes need to be made to either the fringe benefits tax concessions or the care subsidies aged care providers received in order to provide parity with the acute sector.[105] UnitingCare Australia highlighted that the National Aged Care Alliance estimated in 2006 that $250 million per annum was required to achieve and maintain comparable wages and working conditions with the acute health sector.[106]

4.105 Mr Rod Young of the Aged Care Association pointed to the Productivity Commissions 2007 report and noted that the report 'accepted an industry estimate that the cost of putting aged care in a position to pay wages similar to those in the acute hospital sector would be a one-off payment of $450 million and an annual additional payment of $100 million to maintain parity between the two systems'.[107]

4.106 However, the ANF argued that there is capacity in the sector to improve wages. The ANF noted for example, that in 2005 the NSW Industrial Relations Commission awarded a significant pay increase (23 per cent) to nursing staff in aged care which bought wages close to parity with the public sector. While providers argued an incapacity to pay, the Commission stated that 'we consider that nothing the employers have put regarding their capacity to pay would prevent an increase in wages for nurses in the aged care industry that achieves fair and reasonable pay rates that properly reflect the work value of nurses'. The ANF concluded that 'to our

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101 Valley View Aged Care Facility, *Submission 60*, p. 1.

102 Darlingford Upper Goulburn Nursing Home, *Submission 19*, p. 1.

103 Havilah Hostel, *Submission 86*, p. 1.

104 House Group of Companies, *Submission 79*, p. 2.

105 Mr M Laverty, Catholic Health Australia, *Committee Hansard*, 13.3.09, p. 11.

106 UnitingCare Australia, Submission 76, pp 17–18.

107 Mr R Young, Aged Care Association Australia, *Committee Hansard*, 13.3.09, p. 47.

knowledge the pay increases did not result in a comprehensive collapse of the sector in NSW causing nursing homes to close as was the dire prediction of the provider'. [108]

4.107 The ANF went on to comment that the wages gap has developed between aged care nurses and nurses in other sectors is a consequence of enterprise bargaining agreement outcomes:

> While the content of federal safety net awards covering nursing staff in both the acute and aged care sectors remains broadly comparable, enterprise bargaining outcomes have let to significant differences in remuneration levels. The difference is primarily due to the inability to secure comparable enterprise bargaining outcomes to those in the acute sectors.[109]

4.108 The ANF also noted that Commonwealth funding initiatives implemented since 2002 to enhance the capacity of aged care employers to offer competitive salaries were not tied to wages and that 'much of the money was used for other purposes'. According to the ANF:

> The parlous state of bargaining in the sector has led to an inability of employers to fully complete in the labour market and they have struggled to recruit and retain nurses and other health professionals.[110]

4.109 The Productivity Commission noted that despite Commonwealth initiatives wage differences between the aged care and acute sectors have not narrowed. The Commission concluded that there were two main reasons for this: first, the extra funding is broadly similar to funding increases in the acute care sector; and second, there is no requirement on aged care providers to direct the extra funding towards paying higher wages to their workers.[111]

4.110 The ANF stated of a possible solution:

> It is recommended that a nursing occupational award covers all health sectors including aged care. Bargaining mechanisms need to be strengthened and stringent accountability requirements be placed on the providers to show that funding is expended on care in such a manner that provides for commensurate wages and conditions.[112]

4.111 In response to such concerns and suggestions, Dr Cullen of the Department of Health and Ageing argued of the salaries paid by the top quartile of aged care providers:

> I know of some of the providers. I know their enterprise bargaining agreements and I know that they are generous compared with the award and at a benchmark of what is done elsewhere. I do not want to be misquoted.

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108 Australian Nursing Federation, *Submission 94*, p. 6.

109 Australian Nursing Federation, *Submission 94*, p. 6.

110 Australian Nursing Federation, *Submission 94*, p. 6.

111 Productivity Commission, *Trends in Aged Care Services: some implications*, Research Paper, September 2008, p. 146.

112 Australian Nursing Federation, *Submission 94*, p. 6.

> There is no evidence that I am aware of, and I do not believe any evidence has been given to the committee, that the top quartile achieved that by cutting costs.[113]

Conclusion

4.112 The committee acknowledges that the Department of Health and Ageing has undertaken a number of initiatives to attract professional staff. The committee also recognises that the issue of attracting and retaining adequate aged care staff (including that of professional nursing staff) is complex and that there is no single solution. It therefore calls on the suggested advisory taskforce in consultation across the sector to identify the key challenges in relation to staffing and to identify a range of methods of address, particularly in rural and remote areas.

Recommendation 13

4.113 The committee recommends that the Department of Health and Ageing, in association with the suggested taskforce, review aged care staffing challenges and identify methods of address, with particular focus on staffing requirements in rural and remote areas.

Capital funding of residential aged care facilities

4.114 A number of aged care providers highlighted the lack of capital funding available to ensure that the sector is able to provide the services required in the future. Whilst accommodation bonds and charges provide aged care facilities with a capital stream to upgrade and maintain buildings, some providers may not attract sufficient residents who pay accommodation payments. For this reason, the costs of capital works are covered by an ongoing program of targeting capital assistance for such providers.

4.115 According to the department, in 2007–08, $45 million in capital assistance was allocated under the Capital Grants for Residential Aged Care program to assist providers of residential care to improve and upgrade 30 aged care homes, of which 80 per cent of the funding was provided to services in rural and remote areas:

> Of this, $12.5 million was allocated as Residential Care Grants, to support fire and safety related improvements and other works required for accreditation and certification, as well as the construction of new accommodation. The remaining $32.5 million was provided through the Regional and Rural Building Fund to assist rural and regional aged care homes to upgrade the quality of their buildings or to expand, thereby increasing access to aged care places for rural communities.[114]

4.116 In addition, the 2008–09 Budget included a measure to provide $300 million in zero real interest loans to assist in expanding the availability of residential aged care beds. Such loans are available to build or expand aged care facilities in non-metropolitan regions where there is a shortage of beds for permanent and respite care.

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113 Dr Cullen, Department of Health and Ageing, *Committee Hansard*, 13.3.09, p. 88.

114 Department of Health and Ageing, *Submission 114*, p. 25.

According to the department, the loans will provide up to an addition 2,500 aged care beds in areas of need. Loan recipients will pay interest at a rate equal to the Consumer Price Index.[115] Zero Real Interest Loans are administered through two rounds with $150 million worth of loans distributed in the first round in April 2008 allocating 1,348 aged care beds and 107 community care places in areas of high need.[116]

4.117 For providers not entitled to capital grants or zero real interest loans, capital funding is derived from the accommodation charge, currently a maximum of $26.88 per resident per day or where residents enter low care only, the retention and interest derived from a refundable accommodation bond.[117] Many residential high care providers maintain that as they have to pay more for their capital than the bond system in low care, they have lower rates of return. In addition to this, their staff costs are higher because high care demands a greater number of nurses and other care staff than low care.[118]

4.118 A number of providers maintained that funding levels were inadequate and as a consequence, construction of new high care facilities and redevelopment of existing high care facilities was non-viable.[119] According to Aged and Community Services Australia, current payments for capital purposes do not cover the costs of expanding residential care facilities, particularly high care, and to meet contemporary standards.[120] Similarly, Japara Holdings stated:

> Firstly, new aged care facilities (high care) are not being built because the cost of building new high care facilities far exceeds the end value, based on current government funding arrangements.
>
> Secondly the cost of upgrading older style existing high care facilities to best practice standards and 2008 compliance is significant, however as no additional revenue is obtained to provide a return on this capital expenditure, Approved Providers cannot under take these essential upgrades.[121]

4.119 The Western Australian Government recognised the establishment of a viable capital funding stream for infrastructure as the primary difficulty regarding aged care funding:

> Since the introduction of the Aged Care Act 1997, the residential age care sector has been troubled by the inability to establish a viable capital funding

115 Department of Health and Ageing, *Submission 114*, p. 26.

116 Department of Health and Ageing, *Submission 114*, p. 26.

117 Aged Care Association Australia – SA Inc, *Submission 63*, p. 2.

118 Mr Mundy, Aged and Community Services Australia, *Committee Hansard*, 20.2.09, p. 9.

119 Aged and Community Services Australia, *Submission 72*; Japara Holdings Pty Ltd, *Submission 74*; Aged Care Association Australia – SA Inc, *Submission 63*.

120 Aged and Community Services Australia, *Submission 72*, p. 3.

121 Japara Holdings Pty Ltd, *Submission 74*, p. 1.

> stream to finance the construction of new facilities or upgrade and maintain existing facilities in order to operate.
>
> Concomitant to this problem is the absence of a planning and/or monetary mechanism to quickly operationalise beds leading up to three-year time lapses between allocation and operationalisation.[122]

4.120 Villa Maria, Murchison Community Care Inc and Capcare maintained that they utilise their capital funding to contribute to operational costs, leaving the respective provides to source additional funding for the development and maintenance of the building and its infrastructure.[123] According to Villa Maria, this requirement typically resulted in the facility going into a 'deficit position'.[124]

4.121 The position of many providers in relation to capital funding is contextualised by the Aged and Community Services Association of NSW & ACT:

> The current capital and operational funding levels do not adequately take into account current economic variables such as building maintenance, wages, petrol etc. The inability to charge bonds in ordinary high care (nursing home) and the capping of the accommodation charge significantly impacts on capital funding streams. Currently a bond with the interest and retention amount far exceeds the worth of a daily accommodation charge. Many approved providers have recently put expansion plans on hold as the capital costs of providing new places as well as the ongoing maintenance of buildings and amenities are exceeding current funding.[125]

4.122 A Grant Thornton Australia 2008 survey of 700 nursing homes and hostels throughout the country recognised increasing costs of construction and low returns as the principal impediments to the re-development of aged care facilities whilst noting that much of Australia's building stock remains dated:

> Providers of residential aged care services are experiencing low and deteriorating financial returns at a time of unprecedented demand for high care services. This is particularly the case for the modern, single room facilities most preferred by consumers. Older, institutional facilities with shared rooms consistently outperformed new services. These results reveal a lack of incentive to renovate old facilities, or to build new ones, representing a threat to the viability of the residential aged care sector.[126]

4.123 Of the consequences, the survey noted:

> The regulatory and pricing framework now threatens the viability of the aged care sector by suppressing incentives to invest in modern aged care

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122 Western Australian Government, *Submission 111*, p. 1.

123 Villa Maria, *Submission 38*; Murchison Community Care Inc, *Submission 36*, Capecare, *Submission 13*.

124 Villa Maria, *Submission 38*, p. 1.

125 Aged and Community Services Association of NSW & ACT, *Submission 61*, p. 2.

126 Grant Thornton Australia Ltd, *Submission 29*, p. 6.

> infrastructure. This decline in investment severely limits choice for consumers of aged care services.[127]

4.124 Mr Stephen Teulan, UnitingCare Australia, informed the committee that the organisation's return on investment is currently under 2 per cent and that as a consequence there is little incentive to recreating services or rebuilding services in the future and 'what will happen in the absence of anything else is that people will not apply for new places; they will not build and the services available to Australian community will diminish'.[128]

4.125 Mr Rod Young of the ACAA emphasised the need for urgency in addressing capital funding needs:

> But there is no doubt, given the current trends in the industry, that repairing the capital capability for residential high care is certainly an absolutely urgent priority. If you look across the industry and talk to providers, the number of them who are completing construction work that is in train but who have clearly indicated they will not continue to invest any more until there is restitution to some sort of financial viability is alarming. In my opinion, we will see an almost total halt in the industry over the next two years if that is not repaired. So you would have to say that is fairly urgent; nonetheless, the operating income for the industry, given the current level of returns, is of almost equal importance. However, I think capital needs to be addressed as the first priority.[129]

4.126 According to the ACAA, during the 2007–08 financial year, $1.45 billion was spent by the industry on building works.[130] At the same time, a 2007 analysis by PricewaterhouseCoopers cited in a number of submissions to this inquiry established that on conservative assumptions regarding capital costs, the capital raising capacity of the industry is likely to be under-funded by as much as $5.7 billion in capital over the next 12 years.[131] Yet the Grant Thornton Australia survey established that 44 per cent of Australia's aged care facilities are more than 20 years old.[132] However, according to the body:

> Many operators have deferred or abandoned plans for the redevelopment of their aged care services because of the level of investment required and low returns generated from facilities that meet preferences.[133]

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127 Grant Thornton Australia Ltd, *Submission 29*, p. 3.

128 Mr S Teulan, UnitingCare Australia, *Committee Hansard*, 13.3.09, pp 29– 30.

129 Mr R Young, Aged Care Association Australia, *Committee Hansard*, 13.3.09, p. 49.

130 Aged Care Association Australia, *Submission 92*, p. 13.

131 Aged and Community Services Australia, *Submission 72*, p. 3.

132 Grant Thornton Australia Ltd, *Submission 29*, p. 8.

133 Grant Thornton Australia Ltd, *Submission 29*, p. 7.

Conclusion

4.127 The committee received evidence and submissions from aged care providers and stakeholders from all parts of Australia which put a similar view: that the aged care sector is facing difficulties with the level of funding that it receives. That level is viewed as being inadequate to provide the services required, to meet increased costs such as wages and to implement the expansion needed to meet future demand. The Department of Health and Ageing's evidence did not accord with the provider's view of the sector. The committee considers that given the importance of the issues raised, that it is time for an all encompassing review, as recommended by the committee, to be undertaken.

Chapter 5

The current indexation formula

Introduction

5.1 This chapter considers the factors impacting on financial viability of the aged care sector including increasing costs such as wages, construction costs, changing consumer expectations and the adequacy of the current indexation formula and specifically Commonwealth Own Purpose Outlays and the Conditional Adjustment Payment (CAP) to address those costs.

Indexation formula

5.2 In aged care, the basic subsidy rates are adjusted annually in line with movements in the Commonwealth Own Purpose Outlays (COPO). COPO indexation arrangements came into effect in relation to residential aged care funding from 1 July 1996. COPO is weighted 75 per cent for wage costs and 25 per cent for other costs and 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.[1]

5.3 As part of the Commonwealth's initial response to the Hogan Review, from the 2004-05 financial year, a Conditional Adjustment Payment (CAP) for residential aged care was provided. CAP aims to provide 'medium term financial assistance to residential care providers to assist them to become more efficient, and more able to continue to provide high quality care to residents, by improving corporate governance and financial management practices'.[2]

5.4 The amount of CAP payable in respect of resident is calculated as a percentage of the basic subsidy amount payable in respect of a resident. In 2004–05, CAP was 1.75 per cent and then rose annually by 1.75 per cent increments. CAP was initially introduced for four years and subsequently extended for a further four years with no further annual increases so that the CAP is currently set at 8.75 per cent. According to the Australian Government, this increase will result in $2 billion in total CAP payments to the residential aged sector over the next four years to 2011–12.[3]

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1 Aged Care Association Australian, *Submission 92,* Attachment B, p. 14.

2 Australian Government, *Report on the Operation of the Aged Care Act 1997*, 1 July 2007 to 30 June 2008, p. 39.

3 Australian Government, *Report on the Operation of the Aged Care Act 1997*, 1 July 2007 to 30 June 2008, p. 40.

5.5 In the 2008–09 Budget, it was announced that a review of the CAP arrangements would be undertaken to examine the CAP's effectiveness in encouraging efficiency through improved management practices and the future need for, and level of, this type of assistance. According to Australian Government, the findings of the review will be submitted for consideration in the preparation for the 2009–10 Budget.

Adequacy of the current indexation formula

5.6 Concerns were raised by a number of witnesses regarding the current indexation formula as its adequacy in compensating providers for the provision of services impacts directly on their financial viability and their ability to provide high quality services. The Aged Care Alliance submitted to the committee, providers are constrained by static revenue flows based on subsidies and periodic adjustments by mechanisms such as COPO. Providers have limited influence over cost increases and no capacity to adjust the price of their services.[4]

5.7 Mr Martin Laverty of Catholic Health Australia commented:

> We would observe that there is not a mechanism by which the market is able to inform the setting of prices, the provision of service and the types of services that are provided, and nor is there an adequate mechanism to determine what is an adequate Commonwealth subsidy to provide services for those that do not have the capacity to meet the cost of the care themselves.[5]

5.8 The significance of indexation for providers was highlighted by Mr Gerard Mansour of Aged and Community Care Victoria:

> There is a whole range of cost drivers that impact on the industry. So it is not surprising, given that we do not control pricing, that the industry relies very heavily on indexation. It is like a slow death. If indexation is gradually declining over time at any one point of change, then the impact is marginal but the compounding impact of not meeting rising costs is most significant. As I characterised it earlier, I hear very regularly about how stretched and pushed the industry is and I have described it in a number of places as being like the taut rubber band.[6]

5.9 It was argued by many providers that the current formula does not adequately recognise the costs of the delivery of aged care services.[7] Aged and Community Services Australia (ACSA) stated, for example, that the indexation formula had

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4 Aged Care Alliance, *Submission 40*, p. 11.

5 Mr M Laverty, Catholic Health Australia, *Committee Hansard*, 13.3.09, p. 2.

6 Mr G Mansour, Aged and Community Care Victoria, *Committee Hansard*, 20.3.09, p. 37.

7 See for example, Villa Maria, *Submission 38*, p. 2; Echuca Benevolent Society Inc, *Submission 53*, p. 3.

resulted in a 'steadily widening gap between the costs of providing a service and the subsidies provided by the Australian Government'.[8]

5.10 A major concern with the current indexation formula was that it does not adequately take into account the cost drivers for aged care providers, in particular wage increases. Some submitters commented that wages account for 70 to 80 per cent of their total costs. It was noted that annual wage increases are generally between three and four per cent per annum. Aged and Community Services SA & NT stated that the current indexation arrangement was 'inadequate' because it 'does not actually reflect the health and aged care labour market conditions'.[9] The Australian Physiotherapy Association noted that indexation had not maintained parity with salary increases in the health sector where competitive salaries are necessary to ensure that sufficient numbers of appropriately trained and qualified staff are employed in aged care to maintain quality of service.[10]

5.11 Other costs such as groceries have increased about five per cent while utilities have increased about 10 per cent per annum.[11] Tasmanian providers, for example, indicated that they expected their electricity costs to increase significantly (25 to 30 per cent) from July 2009 as they move into the retail contestible electricity market. Aged & Community Services Tasmania noted that 'considering energy costs are in the top five expenditure items for residential care facilities this has significant implications for our sector in Tasmania'.[12]

5.12 Witnesses argued that present formula was impacting adversely on provider viability and service provision. According to ACSA the indexation system and system of user charging for the costs of accommodation in particularly high care, has led to increasing numbers of residential aged care services operating at a loss with all suffering declining returns.[13] Capecare, for example, provided details of the impact of the current indexation system's failure to recognise the actual costs of aged care:

> The operating result has gone from a surplus of $7.03 per bed per day in 2005/06 to a budgeted deficit of $11.37 in 2008/09. Wages and related costs (leave provision, training, workers compensation, and superannuation) make up 75% of all operating costs. Wages and related costs have increased by 23% during these 4 years. Operating income had increased by 10% during the same period.[14]

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8 Aged and Community Services Australia, *Submission 72*, p. 4.

9 Aged and Community Services SA & NT, *Submission 90*, p. 8 and p. 2; see also UnitingCare Australia, *Submission 76*, p. 18.

10 Australia Physiotherapy Association, *Submission 23*, p. 3.

11 See for example, *Submission 21*, Baptist Community Services NSW & ACT, p. 3; *Submission 35*, Yackandandah Bush Nursing Hospital, p. 2.

12 Aged & Community Services Tasmania, *Submission 73*, p. 3.

13 Aged and Community Services Australia, *Submission 72*, p. 3.

14 Capecare, *Submission 13*, p. 3.

5.13 Villa Maria, a non-for-profit operator of residential and community-based care, commented:

> Continued pressure for wage related increases are outstripping fee increases, creating a growing area of concern about long-term financial viability. Essentially, the indexation applied to subsidies is not maintaining relativity to wages increases. [15]

5.14 The Brotherhood of St Laurence (BSL) also submitted that the inadequacy of the current indexation is demonstrated by the BSL's current Enterprise Bargaining Agreement which allowed for an annual salary increase of 4 per cent for staff and the current annual increase of most supplies in excess of 4 per cent. The CPI increase for the year to September 2008 was 5 per cent and the annual COPO increase was around 2.3 per cent. This left a gap of around 1.7 per cent which for the BSL meant a funding shortfall, in terms of indexation only, of nearly $98,500 for the 2008-09 financial year. The BSL stated that these figures take into account the CAP.[16]

5.15 Submitters argued that the impact of the shortfall in subsidies has led to service providers seeking savings in operation costs. Anglicare noted that the rationing of services impacts particularly on older people with limited means and limited alternative supports.[17]

5.16 Submitters also argued that the current indexation formula for community based services has not kept pace with costs, particularly travel costs for home-based services. For example, Bromilow Home Support Services stated that there has been a reduction in services hours provided to clients and commented that 'it is impossible for service providers to maintain consistency in the service levels provided to clients from one year to the next when subsidy levels continue to fall in real terms'.[18] Care Connect commented that the annual packaged care subsidy increase, as determined by the COPO index has fallen behind the annual rate of increase in unit costs of providing care and operating services. As a result, the amount of care that can be purchased per package has been severely eroded over the last ten years.[19]

5.17 NCOSS similarly commented that the existing indexation method is inappropriate for community care, as it does not reflect the real staffing and other costs of running services. NCOSS also noted that the indexation for Community Aged Care Packages and HACC are calculated in a slightly different way for each program resulting in different levels of compensation for similar cost increases.[20] Aged Care

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15 Villa Maria, *Submission 38*, p. 2.

16 Brotherhood of St Laurence, *Submission 12*, p. 2.

17 Anglicare, *Submission 67*, p. 3.

18 Bromilow Home Support Services, *Submission 49*, p. 5; see also Boandik Lodge Incorporated, *Submission 80*, pp 1–2.

19 Care Connect, *Submission 71*, p. 2.

20 NCOSS, *Submission 52*, p. 3.

Queensland also noted that services such as Day Therapy Centres have lower levels of COPO indexation applied, with that result that Day Therapy Centres received 2 per cent indexation and other community care programs received 2.2 per cent.[21]

5.18 Evidence was also provided to the committee concerning the long-term impact of the current indexation formula on the sector. According to the House Group of Companies, the real value of COPO has eroded 23.5 per cent over the past eight years, which means according to the group, 'a continued deterioration of our sector's viability in the long run'.[22]

5.19 Mr Peter Wright of Anglicare Aged Care South Australia commented:

> I would like to reiterate that we have experienced our costs rising faster than CAP and COPO combined. In effect, we are going backwards, because our costs are exceeding the reimbursement or the indexation method that is employed. You probably have the paper by the Aged Care Industry Council, which gave a very good summary of the shortcomings of the COPO and the CAP. It is very poignant to point out, without going through the detail of that paper, that COPO/CAP increases are actually less than the safety net adjustments and also the average weekly overtime earnings adjustments. We are well behind some key benchmarks.[23]

5.20 The Aged and Community Services Association of NSW and ACT held that whilst the CAP was not introduced for community aged care, COPO does not adequately recognise increases in wages with the result that purchasing capacity of a Community Aged Care Package (CACP) has diminished considerably since 1994:

> Between 1995/96 and 2005/06 the value of the package had increased by 27%, yet the overall increase in the ordinary time earnings of full time working adults has been 64%, more than double the increase in CACP subsidy.[24]

5.21 Alzheimer's Australia cites the Aged Care Industry Council submission to the CAP Review to demonstrate that the indexation of CACPs, EACH and HACC has been at a level below the increase in labour costs:

> …from 1996–7 to 2003–04, the Commonwealth's "COPO" indexation formula meant that the CACP subsidy increased by 21.6%. During that same period, ordinarily time earnings for full time adults increased by 47.3%.
>
> Indexation of community care subsidies needs to be based on the labour component. The Conditional Adjustment Payment should be paid immediately to community care services. Continuation of CPI indexation

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21 Aged Care Queensland, *Submission 62*, p. 6.

22 House Group of Companies, *Submission 79*, p. 2.

23 Mr P Wright, Anglicare Aged Care SA, *Committee Hansard*, 13.3.09, p. 69.

24 Aged and Community Services Association of NSW and ACT, *Submission 61*, p. 3.

> simply means fewer services being provided as increase in wage costs eat into service provision hours.[25]

5.22 According to NCOSS, the growth of the HACC program has been compromised by inadequate indexation. Citing the Aged and Community Services Association of NSW and ACT, NCOSS maintained that the indexation method does not reflect the true costs:

> …estimating that, between 1999–2000 and 2001–02, the HACC Program in NSW had been underfunded by between $17.6m and $28.5m. Indexation for the same period to HACC services in NSW was estimated at 6.36% according to the COPO method; other indices suggest a figure closer to 14% for increases in costs for this period.[26]

5.23 The Department of Health and Ageing (the department) responded to these comments and noted that the Government has provided substantial increases in funding for residential aged care. The expenditure in 2008–09 is estimated to be $6.7 billion which represents an increase of some 10.8 per cent over the expenditure of $6.0 billion in 2007–08. In 2008–09, Government funding for each day a resident spends in residential care will be about 8 per cent more than it was in 2007–08 for a resident of the same level of frailty. This growth reflects the increases in funding accompanying the implementation of the new Aged Care Funding Instrument (ACFI) and funding changes to accommodation charges and supplements introduced on 20 March 2008.

5.24 The Government made changes to enable increases in accommodation payments – both government subsidies and user contributions – particularly in high care. Overall these changes will deliver increased revenue to the residential care sector of more than $750 million over four years, including more than $480 million in increased government subsidies. In 2008–09, the changes will result in an increase from the Commonwealth of more than $267 million in residential care funding. Once fully phased in the changes will deliver more than $350 million per year in increased revenue, mostly in respect of high care residents, to support investment in high care facilities.

5.25 The growth in Government funding to the residential aged care sector reflects indexation and the Conditional Adjustment Payment, population growth, increases in frailty and changes in policy. Net funding growth has been 8 per cent per resident. The contribution of various factors to this total growth for 2008–09 is as follows:

- indexation contributed 28 per cent;
- CAP contributed 18 per cent;
- frailty growth contributed 17 per cent; and

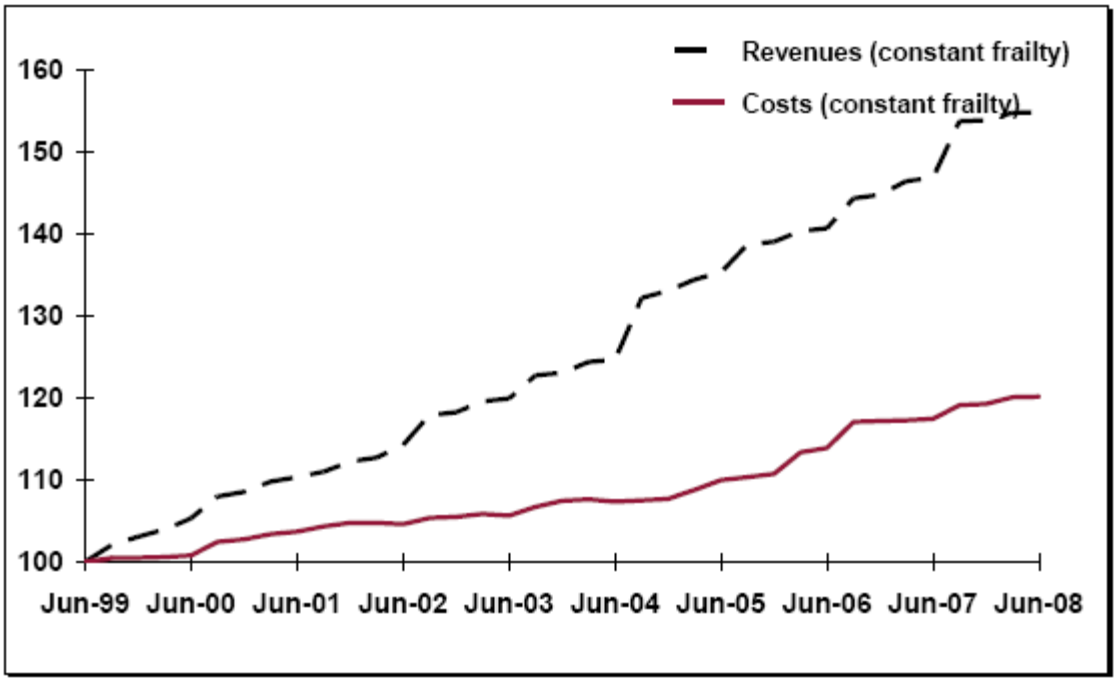
25 Alzheimer's Australia, *Submission 87*, p. 5.

26 Council of Social Services of New South Wales, *Submission 52*, p. 3.

- new policy contributed 37 per cent.[27]

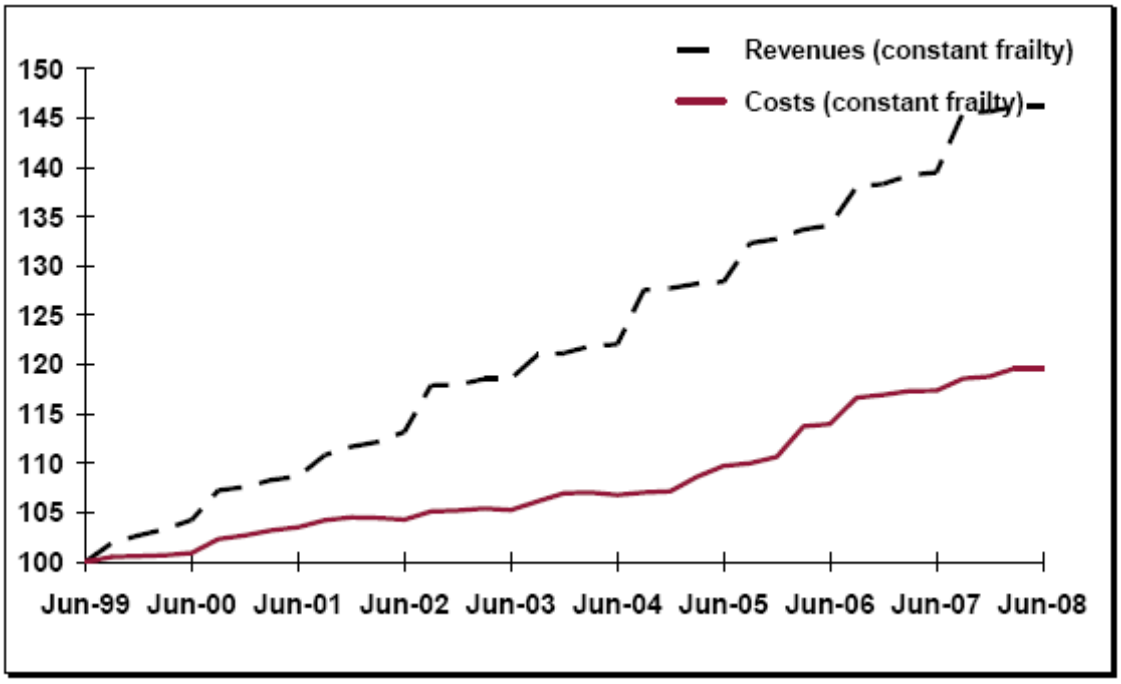
5.26 The department also noted that developed cost and revenue indices for both high- and low-care providers to look at the comparison of cost to revenue for both low- and high-care homes. Mr Stuart commented that the revenue has been increasing faster than cost since 1998–99. The department provided the following comparison of the growth of revenue indices with the growth in cost indices. The data is presented on an index basis with revenue and cost for 1998–00 set to 100.

Graph 5.1: Unit cost and revenue growth (constant frailty) – low care



27 Department of Health and Ageing, *Supplementary submission 114a*, p. 26.

Graph 5.2: Unit cost and revenue growth (constant frailty) – high care



Source: Department of Health and Ageing, *Supplementary Submission 114a*, p.26-27.

5.27 Mr Andrew Stuart from the Department of Health and Ageing commented on the difference in the department analysis and that of the sector:

> I think I should explain that the main difference between what the department has been doing in this area and what the industry has been doing is that the industry has been comparing revenue to prices, in particular labour prices, on a per-unit basis, and the department has taken account of productivity improvement in looking at the relationship between revenue and cost.[28]

5.28 Dr David Cullen, from the department also made these comments:

> What we do know and what we have given in evidence here is that, for the last 10 years—and we have only gone back 10 years in our data—revenue has grown faster than cost. So, if that is the case, if revenue has grown faster than cost and if, as we have given you evidence, the average payment per resident this year is eight per cent greater than the average payment per resident of the same level of frailty last year, that would seem to indicate that the problem is not on the revenue side.[29]

28 Mr A Stuart, Department of Health and Ageing, *Committee Hansard*, 21.4.09, p. 3.

29 Dr D Cullen, Department of Health and Ageing, *Committee Hansard*, 21.4.09, p. 12.

And further:

> The fundamental difference between the department's analysis and the industry's analysis is that the industry looks at what would be called the unit costs of inputs and says, 'How much does a unit of import go up?' We look at the unit cost of outputs. We say, 'How much does it cost to produce a day of care?' When you are producing a day of care, or in any industry, each year you make productivity improvements. It becomes cheaper to produce care one year on the next because of productivity improvements. We take that into account; they do not.[30]

Use of COPO and CAP

5.29 According to witnesses the reason for the inadequacy of indexation in the aged care sector is the use of COPO and its failure to recognise actual costs in the industry. These problems have been longstanding and the compounding impact over the last decade has resulted in increasing negative impacts on the sector. Mr Greg Mundy of Aged and Community Services Australia stated:

> In terms of…the indexation formula, that is one of two main contributors to that scenario. It has been not a sudden development but a steady development over a long period of time that the value of the Commonwealth's subsidies for care has not kept pace with the cost of providing that care. The main reason for that is that the way the government measures wage cost increases is based on what we used to call the safety net adjustment, now the Fair Pay Commission adjustment. Health staff are in relatively short supply, especially but not only nurses, and they have done better than that adjustment over a long period of time. So there has been a steadily widening gap between what it costs us to provide services and what the subsidies will cover.[31]

5.30 Many submitters voiced the same concern as Mr Mundy about the recognition of wage increases. Submitters noted that over the past 10 years the subsidy increase have averaged approximately two per cent per annum which is far below annual increase in wages and other cost inputs.[32] In addition, it was noted that 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.[33] The result of this, according to Care Connect, in a method of indexation 'insufficient to maintain pace with real increases in the costs of running businesses and providing care'.[34]

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30 Dr D Cullen, Department of Health and Ageing, *Committee Hansard*, 21.4.09, p. 13.

31 Mr G Mundy, Aged and Community Services Australia, *Committee Hansard*, 20.3.09, p. 2.

32 Aged Care Association – SA Inc, *Submission 63*, p. 4.

33 Aged and Community Services Association of NSW and ACT Inc, *Submission 61*, p. 3.

34 Care Connect, *Submission 71*, p. 2.

5.31 The concerns about the recognition of wage movements are longstanding. In its 2008 report, the Productivity Commission made the following comments on COPO:

> A longstanding concern of the aged care industry has been that the indexation of basic subsidy rates is not based on movements in industry-specific costs. Rather, subsidies are indexed using the Commonwealth Own Purpose Outlays (COPO) index, which is weighted 75 per cent for wage costs and 25 per cent for non-wage costs. The COPO is premised on the view that virtually all wage increases are productivity based. Hence, it only makes provision for safety net increases in wages and for economy-wide movements in non-wage costs. Thus, if productivity gains within the aged care sector do not keep pace with other sectors, the subsidy, as indexed, will be increasingly inadequate.[35]

Comparison of aged care indexation with other indices

5.32 Submitters provided the committee with comparisons of the current indexation compared with other indices. Aged and Community Care Australia provided the following comparison of combined COPO/CAP subsidy to SNA – Minimum Wage and AWOTE.

Table 5.1: Comparison of COPO, CAP, SNA and AWOTE

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

Source: Aged and Community Care Australia, *Submission 92*, p. 16.

5.33 Blue Care provided the following analysis of HACC indexation.[36]

35 Productivity Commission, *Trends in Aged Care Services: some implications*, Research Paper, September 2008, p. 99.

36 Blue Care, *Submission 18*, p. 26.

Table 5.2: Comparison of HACC indexation with other cost indices and Blue Care's input cost increases

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

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

Source: Blue Care and Australian Bureau of Statistics

5.34 Witnesses also noted that the Department of Veterans' Affairs is understood to have abandoned the COPO index for its Veterans' Home Care program.[37] The BSL commented:

> It is clear that the current COPO indexation is inappropriate for the Aged Care industry. The Veterans' Home Care program does not use the COPO index and private health insurance premiums have had much higher increases authorised by successive Ministers for Health, which have actually fuelled wage growth.[38]

The Conditional Adjustment Payment

5.35 The committee was provided with evidence on the importance of CAP to the aged care sector. It was noted by Catholic Health Australia that CAP was a significant factor in maintaining subsidy levels close to the CPI:

> Most notably, increases in both High care subsidy rates (average 3.5% per annum) and Low care rates (average of 3.7% per annum) only kept pace

37 Aged and Community Services Association of NSW and ACT Inc, *Submission 61*; Aged and Community Services Australia, *Submission 72*.

38 Brotherhood of St Laurence, *Submission 12*, p. 2.

> with CPI growth and, indeed, slightly exceeded it when topped up by the CAP payment set at 1.75%.[39]

5.36 Witnesses noted that the CAP was intended as a temporary measure but for many providers CAP was required to maintain their viability. The Aged Care Alliance noted that 'the effects of external costs, the inadequacy of COPO and workforce issues have created high dependence on its [CAP's] continuation'.[40] UnitingCare Australia, which provides residential aged care to approximately 6,900 elderly people representing approximately four per cent of funded residential aged care beds, noted that without the temporary CAP:

> …losses may have already resulted in UnitingCare withdrawing from the provision of residential aged care services. In the absence of substantive positive funding reform this will occur.[41]

5.37 Indeed, UnitingCare Australia maintained that had the CAP not existed, its agencies would have lost $36.5 million from the time of the introduction of the CAP to the end of the 2008–09 financial year. Consequences of removing the CAP for UnitingCare Australia agencies may include:

- withdrawal from the provision of residential aged care (closure of existing facilities);
- deferral/abandonment of new investment (*already happening*);
- refurbishment of run-down facilities rather than replacement (*already happening*);
- relinquishment of provisional allocations of residential care places and not proceeding with new capital investment (already happening).[42]

5.38 Concerns were raised in a number of submissions that the CAP is now effectively frozen for the next four years with no annual 1.75 per cent increase. According to Management Consultant and Technology Services and Baptcare, without the annual increase adjustment, the aged care industry cannot further stretch COPO funding increases, which are already less than costs, and have been eroded 23.5 per cent over the past eight years.[43] They maintain that this freeze will result in a drop of funding of $750 per resident per annum. The Aged Care Association Australia – SA commented that 'at best, CAP has prevented further erosion in the real value of subsidies, but has gone no way to offsetting the significant erosion which accumulated during the years before the introduction of CAP'.[44]

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39 Catholic Health Australia, *Submission 75*, p. 9.

40 The Aged Care Alliance, *Submission 40*, p. 11.

41 UnitingCare Australia, *Submission 76*, Attachment, p. 1.

42 UnitingCare Australia, *Submission 76*, Attachment, p. 3.

43 Management Consultant and Technology Services, *Submission 42*; Baptcare, *Submission 59*.

44 Aged Care Association Australia – SA, *Submission 63*, p. 4

5.39 Aged Care Association Australia WA and Aged and Community Services WA also noted that the reporting requirements for the CAP were considerable whilst the industry had not been provided with any certainty that the payments will continue in coming years.[45]

5.40 Alzheimer's Australia maintained that the 'biggest anomaly' of the indexation system was in relation to community aged care:

> Community care has a very high proportion of its costs as labour costs, but the indexation of CACPS, EACH and HACC ahs been at a level well become the increase in labour costs. The additional funding that flowed to residential care as a result of the Conditional Adjustment payment (CAP) did not flow to community care, despite its higher labour costs.[46]

5.41 COTA Over 50s also noted that the CAP has not been applied to the community care program despite the cost pressures which it maintains are similar to that in residential care.[47] The Aged and Community Services Association of NSW and ACT held a similar view, stating that the CAP should be extended to community care programs from 2009.[48]

Calls for an improved indexation formula

5.42 Witnesses argued that there was a need for a new indexation formula which adequately addresses the sector's needs. The BSL for example, commented that:

> A new long term indexation formula needs to be introduced which accurately captures all the cost drivers such as wage increase, consumer items, building costs and energy and water prices.[49]

5.43 Mr Stephen Teulan, UnitingCare Australia, commented:

> Unless indexation of subsidies improves in terms of the way that it is calculated or in the meantime if the conditional adjustment payment does not continue there is going to be a huge hole in the budgets of every residential aged care provider in Australia.[50]

5.44 The committee received a number of suggestions as to how the indexation formula could be improved. CHA recommended the introduction of a new benchmark weighted at 75 per cent for wage growth and 25 per cent for non-wage growth, using

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45 Aged Care Association Australia WA and Aged and Community Services WA, *Submission 84*, p. 2.

46 Alzheimer's Australia, *Submission 87*, p. 5.

47 COTA Over 50s, *Submission 93*, p. 2.

48 Aged and Community Services Association of NSW and ACT Inc, *Submission 61*, p. 4.

49 Brotherhood of St Laurence, *Submission 12*, p. 2.

50 Mr S Teulan, UnitingCare Australia, *Committee Hansard*, 13.3.09, p. 29.

the Labour Price Index (Health and Community Services) for the wage element and the CPI for general prices.[51]

5.45 Blue Care submitted that future indexation formulae should:

- reflect aged care providers' input cost increases as measured by industry specific indices; and
- recognise regional input costs disparities such as staff costs imposts present in mining areas.[52]

5.46 An industry specific indices, or an 'Aged Care index', was also supported by other submitters.[53] According to Baptcare, a long term 'aged care index' which properly recognises all cost drivers, wage growth, consumer items, building costs and increased energy and water prices is required.[54] Similarly, the Aged and Community Services Association of NSW and ACT held that a specific residential aged and community care index should be developed and applied annually in order that movements in the average cost of care are covered each year. According to the association:

> This could be administered by an independent body, analogous to the Fair Pay Commission, to ensure transparency and to avoid conflicts of interest.[55]

5.47 Submitters also supported the extension of CAP to community care services.[56]

Conclusion

5.48 Witnesses raised grave concerns about the adequacy of the indexation formula used by the Commonwealth for both residential and community aged care, particularly in relation to addressing wage increases. The committee considers, on the balance of the evidence before it, that the current indexation formula may no longer be appropriate for the aged care sector. The committee therefore considers that the formula needs to be reviewed and modified if required. The suggested review of the benchmark of care costs, as detailed in Chapter 3, should inform this review.

Recommendation 14

5.49 The committee recommends that the taskforce undertake a review of the indexation formula used for the aged care sector in order to identify its adequacy in relation to costs faced by the sector and to identify modifications to the formula if required.

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51 Catholic Health Australia, *Submission 75*, p. 9.

52 Blue Care, *Submission 18*, p. 24.

53 See for example, Melaleuca Home for the Aged, *Submission 39*, p. 2.

54 Baptcare, *Submission 59*, p. 1.

55 Aged and Community Services Association of NSW & ACT, *Submission 61*, p. 4.

56 Baptist Community Services NSW & ACT, *Submission 21*, p. 3.

5.50 The committee further recommends that consideration be given to an independent mechanism to continually assess the indexation formula.

5.51 The committee also acknowledges that a review of CAP is presently being undertaken. The committee strongly urges the Commonwealth to consider the continuation of CAP whilst the recommended all-encompassing review is being undertaken.

Chapter 6

Addressing special social and demographic needs

> It was once said that the moral test of government is how that government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; and those who are in the shadows of life, the sick, the needy and the handicapped.
>
> *Hubert H. Humphrey 1911–1978*

Introduction

6.1 This chapter considers the regional variations in the costs of service delivery and the construction of aged care facilities. It also considers socio-economic variations of aged care recipients which impact on the cost and availability of services provided with specific focus on persons of non-English-speaking backgrounds, Indigenous Australians, Veterans and the socio-economically disadvantaged including homeless persons.

Residential and community aged care in rural and remote areas

6.2 People living in rural and remote areas have poorer health than those in major cities and this is reflected in their higher levels of mortality, disease and health risk factors.[1] Rural people have lower access to health care compared with their metropolitan counterparts because of reasons including distance, time factors, costs and transport availability.

6.3 The ageing rural population experience problems with accessing appropriate aged care services: rural and remote aged care providers face significantly higher operating and capital costs compared to their urban counterparts as a consequence of distance and travel requirements; workforce shortages limit the services available; and the dispersed population impacts on the viability of services.

Cost of aged care services in rural and remote areas

6.4 Witnesses pointed to the differences in the provision of services between urban and rural and remote areas and argued that the funding regime did not adequately take into account these differences. Catholic Health Australia (CHA) noted:

> There is no equity between metropolitan and rural and remote Australia in the current capital and operational funding regimes. Failure to correct this

1 Australian Institute of Health and Welfare, *Australia's Health 2008*, p. 83.

> imbalance in the funding arrangements will lead to the demise of many rural services.[2]

6.5 Citing a 2003 unpublished independent report on the financial viability of residential services in rural and remote NSW, CHA argued that generally residential aged care services in remote areas are functioning with both operating and net losses due to a range of extra costs including:

- the small population on which to draw their client base results in a resident mix with a higher proportion of lower dependency residents and hence lesser funding;
- unfavourable occupancy levels sometimes influenced by other residential aged and community care services within the same client catchment areas;
- lower than average Accommodation Bond levels and in some case no capacity to charge a bond or charge due to the family home being unsaleable;
- having to maintain staffing levels that are not necessary when the resident profile changes;
- higher staff recruitment, retention and training costs; and
- higher costs for insurances, medicines, incontinence aids, laundry, food and maintenance.[3]

6.6 Other submitters also commented on the difference between clients in urban and rural and remote areas. Witnesses noted that accommodation bonds in rural areas are considerably lower than in metropolitan areas.[4] Of the situation, Aged and Community Care Victoria (ACCV) stated that 'rural communities will normally have lower income generation capacity at all levels, including more limited resources and sources of bond income for capital raising'.[5]

6.7 HN McLean Memorial Retirement Village in Inverell noted that there is a significantly higher percentage of concessional residents in rural and remote areas. This limits the number of accommodation bond opportunities available to rural provides.[6] The number of concessional residents is particularly high in the Northern Territory, with the Northern Territory Government commenting that the proportion of new residents classified as concessional, assisted or supported residents in 2008–09 was 64 per cent in the Northern Territory compared to 33.4 per cent nationally.[7] Mr Greg Mundy, Aged and Community Services Australia, also commented that in

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2 Catholic Health Australia, *Submission 75*, p. 10.

3 Catholic Health Australia, *Submission 75*, p. 10.

4 Eliza Purton Limited, *Submission 11*, p. 2 and p. 5.

5 Aged and Community Care Victoria, *Submission 89*, p. 7.

6 HN McLean Memorial Retirement Village, *Submission 9*, p. 6.

7 Northern Territory Department of Health and Families, *Submission 25*, p. 1.

rural and remote parts of Australia there is a need for low care that stems from the dispersed population'.[8]

6.8 Mr Gerard Mansour of Aged and Community Care also commented on the size of facilities in small rural communities and noted that many had only 20 or 30 beds 'because that is simply all the community needs'. However, the average viability point is 60 to 70 beds. In addition, there is a move from low to high care and there is a loss of bonding.[9]

6.9 Witnesses also pointed to the higher costs for fresh food, fuel and electricity and construction in rural and remote areas.[10] The high level of construction costs in rural and remote are was canvassed extensively in evidence. Ms Gail Milner of the Western Australian Department of Health, commented that the cost of providing a service in the Kimberley and the Pilbara is more than 50 per cent higher than the metropolitan area in wages, consumables, and transport with construction costs are up to three times higher in the Kimberley.[11] Aged Care Queensland commented that there were widely varying costs for the construction of new beds across Queensland with the average around $200,000 but some in excess of $300,000 in isolated areas.[12] While Aged Care Association and Aged and Community Care Western Australia indicated that in some remote areas costs were in the order of $600,000 per room.[13]

6.10 Aged Care Association and Aged and Community Care WA also commented on the impact of resources boom in Western Australia on the availability of services in remote areas:

> This building crisis has resulted in greater pressure on the community care sector and given the physical distances that need to be covered the current funding does not adequately support these services.
>
> As a result there are many frail elderly who require residential care but there are no places and they exist in a rotation between the hospital and their home.
>
> Unfortunately due to the lack of resources, appropriate infrastructure and the capacity to deliver services in some areas; long-standing members of regional and remote towns and communities are forced to move away from their friends, family and home to receive much needed care services. [14]

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8 Mr G Mundy, Aged and Community Services Australia, *Committee Hansard*, 20.2.09, p. 6.

9 Mr G Mansour, Aged and Community Care Victoria, *Committee Hansard*, 20.2.09, p. 40.

10 See BlueCare Unitingcare Queensland, *Submission 18*, p. 29; Darlington Upper Goulburn Nursing Home, *Submission 19*, p. 1.

11 Ms G Milner, WA Department of Health, *Committee Hansard*, 30.01.09, pp 25–26.

12 Aged Care Queensland, *Submission 62*, p. 6.

13 Aged Care Association and Aged and Community Care Western Australia, *Submission 84*, p. 5.

14 Aged Care Association and Aged and Community Care Western Australia, *Submission 84*, p. 6.

6.11 The Council of Social Services of New South Wales argued that there is limited availability of CACPs and EACH in rural areas:

> Often in rural areas there are not high enough numbers in a local area to meet the ratios to get much service, even though there can be significant numbers of older people.[15]

6.12 Rural providers supplied the committee with examples of their worsening financial situation. Capecare in Busselton WA stated that is operation has gone from a surplus of $7.03 per bed per day in 2005–06 to a budged deficit of $11.37 in 2008–09. The turn around in the operating position was due to increases in wages and related costs. Capecare reported that it was subsidising its residential care operations by using capital funding income streams which would normally be earmarked for upgrading and replacing buildings and income streams from other sources.[16]

6.13 Mr Cam Ansell, Grant Thornton Australia, noted that the returns generated in non-urban area are about 30 per cent less than those operating in metro areas.[17]

Government assistance to rural and remote aged care services

6.14 The Department of Health and Ageing (the department) noted that to assist with the extra costs of delivering services in rural and remote areas, additional funding is available through the viability supplement, capital grants and zero interest loans. The viability supplement for residential aged care is designed to assist regional and remote service providers which meet specific criteria. Eligible services are generally those with fewer than 45 places and in less accessible locations. In 2007–08, about $15 million was provided under the viability supplement to 467 residential services.[18]

6.15 The viability supplement for community care programs amounted to around $3.7 million in 2007–08, provided in recognition of the higher costs and recruitment challenges faced by such services. The viability supplement for community care programs is structured such that the more remote the location of the client the higher the supplement. In 2007–08, the average viability supplement per person per day paid to services located in very remote areas was over $8 for CACP and EACH programs, this compares to $3 in non-remote areas.[19]

6.16 The department also noted that capital grants are available for residential aged care to providers who do not have a sufficient capital stream to upgrade and maintain buildings. This often occurs in rural and remote areas where providers do not have many residents able to pay an accommodation bond. The department stated that in

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15 Council of Social Services of New South Wales, *Submission 52*, p. 7.

16 Capecare, *Submission 13*, p. 2.

17 Mr C Ansell, Grant Thornton Australia Ltd, *Committee Hansard*, 30.01.09, p. 4.

18 Department of Health and Ageing, *Submission 114*, p. 22 and p. 24.

19 Department of Health and Ageing, *Submission 114*, p. 24.

2007–08, almost 80 per cent of the $45 million of capital assistance allocated was provided to rural and remote areas. Of this $12.5 million was allocated as Residential Care Grants with the remaining $32.5 million provided through the Regional and Rural Building Fund to assist with the upgrading of buildings or to allow providers to expand.[20]

6.17 Zero real interest loans are available for the development of infrastructure in rural and remote areas.

6.18 The Australian Government, in conjunction with those states and territories that need such services, operate Multi-purpose Services. They operate under the *Aged Care Act 1997* and deliver a mix of aged care, health and community services in rural and remote communities, many of which cannot sustain separate services. The department noted that some health, aged and community care services may not be viable in a small community if provided separately. By bringing the services together, economies of scale are achieved to support the services. Each Multi-purpose Service is financed by a flexible funding pool to which the Australian Government and state and territory governments contribute. This is reviewed regularly. A Multi-purpose Service can use the money to provide a mix of services, including aged care, best suited to its community's needs.

6.19 Around 86 per cent of all aged care places provided by Multi-purpose Services are for residential care Multi-purpose Services located in outer regional areas, such as Broken Hill, provided just over half of all places for this program.[21]

6.20 Whilst it was recognised that the rural and remote viability supplement was provided in recognition of the difficulties faced in relation to high cost burdens, providers maintained that the supplement was 'inadequate' to meet the additional costs faced in such areas. Anglicare Australia maintained that despite the additional funding, many rural and remote providers struggle:

> The cost of providing services in such locations in unsustainable, even with supplements, for many providers. In addition, both residential and community care providers face difficulties in attracting and keeping good staff.[22]

6.21 Aged Care Association and Aged and Community Care WA commented that the existing viability supplement is a 'one size fits all' approach based on remoteness rather than on need. The association stated that it would be more advantageous to have a viability supplement that is based on actual costs.[23] The Northern Territory

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20 Department of Health and Ageing, *Submission 114*, p. 25.

21 Department of Health and Ageing, *Submission 114*, p. 27.

22 Anglicare Australia, *Submission 67*, p. 4.

23 Aged Care Association and Aged and Community Care Western Australia, *Submission 84*, pp 6.

Government also commented that 'these supplements are considered by the aged care sector as too low and it is uniformly applied across Australia irrespective of local cost of living or how remote is a remote locality'.[24]

6.22 Aged and Community Services Australia commented that the current viability supplements measure remoteness to assess eligibility but, like the aged care program as a whole, makes no realistic empirical assessment of actual costs.[25] Aged and Community Services SA & NT held that ensuring quality service provisions in rural and remote communities as well as to those with special needs required support beyond the rural viability supplement which is 'measured by remoteness':

> The current funding does not cover the cost of components such as culturally appropriate training, interpreter services, recruitment, complex needs and culturally sensitive relationship building. Nor does it acknowledge that there are other issues directly related to the organisation delivering services or the economic capacity of the community in which the organisation is based which will have an impact on the quality of service delivery.[26]

6.23 The Aged Care Association Australia maintained that the viability supplement was a 'poor distributor of additional subsidy to reflect cost variables in rural and remote locations'.[27] The association was of the view that a revised system of service cost and capital cost should be developed which reflects the significant variations in rural and remote areas.

6.24 In addition, Aged and Community Services Association of NSW & ACT commented that in some instances where providers have merged to maintain viability, they have been penalised through loss of the supplement, yet have managed to remain operational.[28]

6.25 Witnesses proposed a number of ways to assist providers with the additional costs of providing services in rural and remote areas. The Shire of Kojonup submitted that the viability subsidy is the appropriate mechanism for addressing regional variation but that it 'needs a higher weighting towards the size of the facility as this is the key driver of viability'. The subsidy also needs to be fully indexed to account for cost escalation.[29]

6.26 Share & Care Community Services Group recommended that the Government consider an additional 'Rural Payment' for organisations outside metropolitan

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24 Northern Territory Department of Health and Families, *Submission 25*, p. 2.

25 Aged and Community Services Australia, *Submission 61*, p. 5.

26 Aged and Community Services SA & NT, *Submission 90*, p.1.

27 Aged Care Association Australia, *Submission 92*, p. 21.

28 Aged and Community Services Association of NSW & ACT, *Submission 61*, p. 4.

29 Shire of Kojonup, *Submission 70*, p. 3.

regions.[30] While Eliza Purton considered that a tiered structure of funding that better recognised and supported regional issues (such as smaller bonds and higher costs) was required.[31]

6.27 Aged and Community Services Australia recommended that:

> …we should adjust the value of those rural and remote supplements to reflect some robust index of what the actual costs are, rather than setting it as a fixed amount and then indexing it by CPI every year. Even if it was right on day 1, it would not be right two years down the track.[32]

6.28 Mr Greg Mundy, Aged and Community Services Australia concluded:

> In terms of the viability of rural and remote aged-care provision, I think here is no escaping the fact that, if you want to guarantee access to services in all parts of Australia, there are some places where it will cost more to do that for a whole range of quite obvious reasons. We just need to bite that bullet and acknowledge that that is the case. We currently measure the eligibility for those rural supplements. We support the concept of supplements with huge precision using ARIA measurements—the precise number of kilometres from health facilities and so on. However, we do not measure the amount of money that you need to bridge the gap with any sort of precision at all. So we test eligibility within an inch of its life, but we do not actually have any robust, tested, researched estimate of what it actually costs to provide aged-care services anywhere in Australia or, therefore, the extra costs of doing it in rural communities.[33]
>
> One is that ensuring access to aged-care services in rural and remote parts of Australia is going to cost more, so we need to bite that bullet. It is partly about the value of the subsidies and whether the rural and remote additional subsidies actually do cover those costs.[34]

Workforce issues in rural and remote areas

6.29 A key concern raised by a number of submitters was of the difficulties in attracting and retaining qualified staff in regional and rural areas.[35] Rural communities already face substantial challenges in relation to workforce recruitment and retention. Providers noted that it was extremely difficult to attract and retain staff, particularly in areas where there was competition from mining companies. In addition, the cost of housing was seen as a major impediment to attracting staff with Ms Evans of St

30 Share & Care Community Services Group, *Submission* 5, p. 5.

31 Eliza Purton Limited, *Submission 11*, p. 5.

32 Aged and Community Services Australia, *Committee Hansard*, 20.2.09, p. 10.

33 Mr G Mundy, Aged and Community Services Australia, *Committee Hansard*, 20.2.09, p. 2.

34 Mr G Mundy, Aged and Community Services Australia, *Committee Hansard*, 20.2.09, p. 10.

35 See for example, Villa Maria, *Submission 38*.

Bartholomew's House stating that most of the remote areas do not have the infrastructure for housing of care workers.[36]

6.30 Training was also raised as a concern with providers stating that training was either not available or not convenient given the time required to travel to and from training courses. As most training courses are provided in metropolitan areas, providers find it difficult to release staff and pay additional costs such as fuel and overtime.[37] Ms Merril Hecker of the Share & Care Community Services Group commented on the difficulties of providing training in rural and remote areas and the need for a coordinated approach:

> We access the training where we can, but we are limited as to how many numbers can attend. We cannot allow all our staff to attend a training session if it is an all-day session, say in medication. Advocare I think only do a couple of hours. You can allow your staff to go to that. If it is only for a couple of hours, that is good, but your medication session may take six hours…
>
> In the rural area in particular, you work on those that are around you and invite them in. That way you can do a couple of sessions over a month or whatever, so that everybody gets trained. Half your staff will be there for the six hours at one session while the other staff are out covering your clients, and then at a later session you reverse it. We have done that in the last 12 months, working with a couple of other providers, and I find that that works really well.[38]

Impact of distance

6.31 Many submissions raised the issue of the impact of distance on the provision of aged care services particularly community care and on the availability and cost of training aged care workers.

6.32 Share & Care Community Services Group informed the committee of the disadvantage that they face:

> Our biggest concern at present are the travel costs involved in servicing consumers. In rural areas it is not uncommon to travel 20 kilometres to service clients. The additional miles in rural areas and the costs associated need recognition and additional funding applied.[39]

6.33 According to the Aged and Community Services Association of NSW & ACT, the capacity of care services to meet the needs of older persons is impacted by the travel distances required and that:

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36 Ms L Evans, St Bartholomew's House, *Committee Hansard*, 30.1.09, p. 75.

37 Share & Care Community Services, *Submission 5*, p. 5.

38 Ms M Hecker, Share & Care Community Services, *Committee Hansard*, 30.1.09, pp 74–75.

39 Share & Care Community Services, *Submission 5*, p. 5.

> Transportation costs in conjunction with a lack of competition for market resources also contribute to higher costs. Availability of appropriate workers and the increased costs of education and training as a result of limited community infrastructure and the need to replace employees for longer due to travel requirements further impacts on the cost of service delivery.[40]

6.34 Similarly, the Productivity Commission noted in its 2008 report:

> In rural and remote areas, the costs of education and training are higher due to a lack of local infrastructure and the need to replace workers for longer when they travel for training.[41]

Meals on wheels

6.35 Australian Meals on Wheels, a service which enables aged persons to live at home in the community for longer, receives up to 30 per cent of its funding from the HACC program whilst the sale of meals accounts for most of its other income. However, according to the body, services around the country are struggling with costs, volunteer support and regulatory compliance and changing demand:

> Meals on Wheels is a 'needs based' service. Meals numbers are growing only modestly however total client numbers are increased to a greater rate as more clients go on meals for less than 5 days per week with the opportunity to attend day care and other services (also important for their well being). However, it means that the unit cost per meal increases as total costs rise and meals numbers remain constant even though client numbers are in fact increasing.[42]

6.36 Australian Meals on Wheels maintains that if prices rise (to meet costs) to a level where clients cut their spending and have to reduce the number of meals they need to sustain their nutrition requirements, 'their health will be compromised and the likelihood of requiring higher and more expensive hospital care is inevitable' and:[43]

> A day in the public hospital system costs $1,117; a day in residential aged care costs $100; Meals on Wheels receives less than $2 per day.
>
> The message we advocate is simple – an increase in funding at the Meals on Wheels 'beginning' part of the health and wellness continuum can save a lot of public money at the residential aged care and hospital 'end'.[44]

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40 Aged and Community Services Association of NSW & ACT, *Submission 61*, p. 4.

41 Productivity Commission, *Trends in Aged Care Services: some implications*, Research Paper, September 2008, p. 151.

42 Australian Meals on Wheels, *Submission 7*, p. 1.

43 Australian Meals on Wheels, *Submission 7*, p. 1.

44 Australian Meals on Wheels, *Submission 7*, p. 2.

6.37 Ms Carol Jones-Lummis of Share & Care Community Services Group commented on the changes facing Meals on Wheels and the volunteers who support it:

> Meals on Wheels is probably, as you say, the service that uses the most volunteers. About eight years ago the local town had the Meals on Wheels service and was run completely by volunteers. They no longer could cope with the accountability and reporting requirements and all the rest of it. They were predominantly aged. In fact, I think one of the youngest was in her sixties or something and there was an elderly lady of about 80. They asked Share and Care to take it on. The biggest issue, of course, is that volunteers like to come in, they want to do their volunteering hour or two hours, and they want to go home.
>
> Unfortunately, because of the litigious society we live in, as an organisation I am now required to have working with children checks—because we also do younger and disabled, if required—and police clearances. We need to make sure that they are put through that system. Then they have training. We are required by our insurer to make sure they do training, so they are then required to come in and do all this training. We have looked at probably a 90 per cent drop in the last eight years. That is huge. At the moment, we are starting to see a few more come in, but not enough. Meals on Wheels was built on the fact that it would be managed by volunteers. Unfortunately, that is no longer the case among many of the organisations that supply it.[45]

6.38 The Share & Community Services Group also maintained that funding provided to Meals on Wheels should be increased.[46]

Conclusion

6.39 The committee considers that the demands placed on providers of aged care services in rural and remote Australia are unique. While the Department of Health and Ageing provided evidence of the extent of the Commonwealth's assistance through the viability supplement and other programs, the committee believes that there remain difficulties in the delivery of aged care services in non-urban areas and that there is evidence of poor long term viability of providers. The committee considers that this is a matter that should be addressed by the recommended sectoral review.

Recommendation 15

6.40 The committee recommends that the all-encompassing review specifically consider the provision of aged care services in rural and remote areas and the effectiveness of the current viability supplement to support service provision.

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45 Ms C Jones-Lummis, Share & Care Community Services, *Committee Hansard*, 30.1.09, p. 68.

46 Share & Care Community Services Group, *Submission 5*, p. 5.

Norfolk Island

6.41 The committee received two submissions addressing the particular circumstances of aged care in Norfolk Island.[47] The following issues were highlighted:

- funding levels for Norfolk are insufficient to meet the expected quality services provision outcomes;
- there is not funding or infrastructure currently available to provide in home services;
- veterans living on Norfolk Island are unable to access home care services currently available to veterans residing in Australia;
- the hospital provides the only aged care facilities but there are limited beds available and no secure area for clients with dementia or psychiatric disorders; and
- medication is more expensive on Norfolk Island.

6.42 Mr D Hogan noted that in July 2008 discussions had taken place on a proposal to develop homecare services. However, this proposal has not progressed.[48]

Recommendation 16

6.43 The committee recommends that the Commonwealth and Norfolk Island Government initiate discussions in relation to a proposal to develop homecare services on Norfolk Island.

Persons of non-English speaking and culturally diverse backgrounds

6.44 According to the ACCV, a 2006 report from Nous Group noted that by 2011, in Victoria 30.8 per cent of all older people will be from culturally and linguistically diverse backgrounds, which is a rise from 23.1 per cent in 1996.[49]

6.45 The issue of discrimination in aged care against the aged of non-English speaking backgrounds and those from culturally and linguistically diverse backgrounds was raised with the claim that such persons are financially disadvantaged and not in a position to pay either accommodation bonds or accommodation charges. This leaves them vulnerable to discrimination: 'If given a choice of which resident to admit, the provider will choose a resident who can pay. This leaves older Australians from Non-English Speaking Backgrounds at the end of many waiting lists'.[50]

47 Mr D Hogan, *Submission 95*; Mr A Tavener, *Submission 98*.

48 Mr D Hogan, *Submission 95*, p.3.

49 Aged and Community Care Victoria, *Submission 89*, p. 10.

50 Management Consultants and Technology Services, *Submission* 42, p. 1.

6.46 Ms Derryn Wilson of the Municipal Association of Victoria also commented that among some members of the ethnic community, where success in Australia is very marked by home ownership and giving it to your children, there is a reluctance to go into care if a bond has to be paid.[51]

Conclusion

6.47 The committee considers that the needs and expectations of clients from non-English speaking backgrounds are an important consideration in the provision of aged care services. They should be taken into account by the review of the aged care sector.

Recommendation 17

6.48 The committee recommends that the all-encompassing review specifically consider and address the expectations and needs of persons from non-English speaking backgrounds.

Socially and financially disadvantaged persons

6.49 Concerns were also raised about the availability of aged care services to persons who are socially and financially disadvantaged. Homeless persons, older persons living in caravan parks and boarding houses and those who are socially marginalised were identified amongst this group. Mr Bryan Lipmann of Wintringham noted, however, that it not just the homeless on the street, but also those in rented accommodation who are at risk and this can only worsen:

> …a huge number of people who are just pensioners struggling in rented accommodation who are one incident away from becoming homeless. This is the group that is significantly at risk. If I have learnt anything from all these years of working in this, it is that a percentage of those people at risk do become homeless—and it can only get worse with the booming ageing population plus the financial meltdown.[52]

6.50 Wintringham outlined the problems of accessing adequate aged care services for this group of people who often have no resources other than their pension, no family support, and are sometimes reluctant to accept services:

- destitute and marginalised people have few resources to assist them to purchase the provision of aged care services, for example, it is very difficult to supply a Community Aged Care Package to a client of 'no fixed address';
- many disadvantaged people do not have the ability or anyone to support them through the complex health system to receive appropriate referrals;
- aged care providers may be required to take on the entire 'burden of care' for people without families or friends, with insufficient funding to meet the costs

51 Ms D Wilson, Municipal Association of Victoria, *Committee Hansard*, 20.2.09, p. 19.

52 Mr B Lipmann, Wintringham, *Committee Hansard*, 20.2.09, p. 54.

of providing this level of care providers of services to the elderly homeless face higher operating costs;

- providers of services for disadvantaged persons are unable to charge fees or access accommodation bonds so that services are limited and funding for new facilities is restricted;
- maximum residential ACFI funding of $29.71 a day is provided for residents the highest level behavioural care needs however, this makes access to specialist opinions extremely difficult given that as an example, a neuropsychiatric report can cost between $650 and $2,000.[53]

6.51 Wintringham also noted that the model of care required of its residents is different from that usually provided in aged care facilities. For example, care for traditional ageing dementias such as Alzheimer's disease requires a rigid lifestyle. However, for the client group cared for by Wintringham 'you need to keep them alive, aware and changing, and they can learn—they have not lost the ability to learn. They can still participate.' While the model of care is available, Wintringham commented that the problem is how to fund the service to ensure that this particular client group remains as healthy and active as possible.[54]

6.52 Ms Sally Kingdon-Barbosa of St Bartholomew's House commented that homeless people with complex needs find it difficult to be placed in mainstream high-care facilities.[55] In addition to these problems, the Grant Thornton Australia survey of 700 aged care facilities established that the deteriorating financial position of not-for-profit providers had necessitated more 'commercial' policies in relation to resident aged care admission often at the 'cost to the financially and socially disadvantaged people in these programs'.[56]

6.53 While acknowledging the bipartisan support for the plight of the elderly homeless, Mr Lipmann of Wintringham commented that the Aged Care Act does not allow the minister or senior bureaucrats in Canberra sufficient flexibility. Mr Lipmann stated:

> For a very many number of years, I have been travelling to Canberra, pleading the need to create a special needs category for the elderly homeless. There are a few special needs categories, which you may or may not be aware of, such as veterans and rural and remote. We argued that if we could create homelessness as a special needs category it would then allow all ministers, future ministers and all bureaucrats during the planning

53 Wintringham, *Submission 43,* pp 1–4.

54 Mrs H Small, Wintringham, *Committee Hansard,* 20.2.09, p. 55.

55 Mrs S Kingdon-Barbosa, *Committee Hansard,* 30.1.09, p. 66.

56 Grant Thornton Australia Ltd, *Submission 29,* p. 6.

> process, through the ACAT et cetera, to seek to address the special needs of the elderly homeless.[57]

6.54 St Bartholomew's House also recommended that recognition be given to those facilities which are currently providing quality aged care to the homeless, with strategies in place to assist them to be classified as extra service facilities, or similar, which recognise and adequately fund the intensive and specialised support in the provision of that care.[58]

6.55 Mr Lipmann went on to conclude that if funding is not adequate then the alternatives are unsatisfactory:

> That is the significant problem with aged care. If you have someone whose needs cannot possibly be met through the Aged Care Act, you either institutionalise them and lock them into a padded cell, which is inhuman, or our staff can look after him—they are skilled enough to look after this guy. We were able to get money from the state under a disability issue to care for him, and he is still going, but it is an extraordinarily difficult process. It seemed to us that the Commonwealth should address the needs of those extremely difficult clients.[59]

6.56 The ACCV noted that affordable rentable housing for the elderly is required of a diversity of styles in different locations in order to ensure that people feel at home and remain connected to their established communities.[60] The ACCV maintained that the issue of homelessness should be incorporated into the planning and service responses of all mainstream health and welfare services and supported by a public communication strategy.[61]

6.57 Catholic Health Australia argued for an expansion of the capital grants programs for the development of residential services that target lower socio-economic communities:

> These communities, most often found in rural and regional areas, often have a higher proportion of concessional residents – as well as lower property value. Consequently residents who do pay bonds, pay a low bond rate.[62]

6.58 Similarly, views were raised that more needs to be done to assist those with a disability or complex medical need or illness.[63]

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57 Mr B Lipmann, Wintringham, *Committee Hansard*, 20.2.09, p. 54.

58 Ms S Kingdon-Barbosa, *Committee Hansard*, 30.1.09, p. 66.

59 Mr B Lipmann, Wintringham, *Committee Hansard*, 20.2.09, p. 55.

60 Aged and Community Care Victoria, *Submission 89*, p. 10.

61 Aged and Community Care Victoria, *Submission 89*, p. 14.

62 Catholic Health Australia, *Submission 75*, pp 10–11.

63 Aged and Community Care Victoria, *Submission 89*, p. 11.

6.59 The committee appreciates the specific challenges to homeless elderly persons and recommends that the department review the implications of the incorporation of 'elderly homeless' as a special category under the *Aged Care Act 1997.*

Recommendation 18

6.60 The committee recommends that the Department of Health and Ageing conduct a review into the implications of 'elderly homeless' incorporated as a special needs category under the *Aged Care Act 1997*.

Recommendation 19

6.61 The committee recommends that the suggested all-encompassing aged care review specifically consider and address the expectations and needs of the homeless and other socio-economically disadvantaged persons.

Indigenous Australians

6.62 A number of submissions including that of the ACCV acknowledged that the needs of Indigenous communities are different from those of the non-indigenous community and that a lack of resources in rural and remote communities can have greater consequences.[64] The Northern Territory Government noted that frail elderly Indigenous people often choose for cultural and spiritual reasons to remain in their communities and as a consequence, receive less support then they would if they were living in a regional centre.[65] Ms Maureen Sellick, Advocare, commented on the difficulties of those with high care needs:

> I think that is also particularly the case for Aboriginal people in rural and remote areas. For example, in the Kimberley I believe there are very few high-care places for people generally. You might have an older Aboriginal man, for example, who needs high care. There are no places in the Kimberley, and he has to then live in a place in Subiaco. It just does not work out for him at all, so he is not able to survive. You might have, again, someone in the Kimberley—say Kununurra—who can only get a place in Derby, for example, well and truly away from his supports.[66]

6.63 In addition, due to many socio-economic and lifestyle issues, Indigenous people in general require aged services well before they reach 70 years. [67]

6.64 The Council of Social Services of New South Wales (NCOSS) noted that Indigenous communities tend to make 'less use of residential aged care and consequently require higher levels of community care support'. NCOSS further noted that Indigenous persons with disabilities do not utilise many community care services:

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64 Aged and Community Care Victoria, *Submission 89*, p. 10.

65 Northern Territory Government, *Submission 25*, p. 2.

66 Ms M Sellick, Advocare, *Committee Hansard*, 30.1.09, p. 58.

67 Dubbo City Council, *Submission 2*, p. 2.

> NCOSS notes the employment of culturally appropriate staff and volunteers can ensure that services are appropriate and are utilised by Aboriginal people. But emphasis must also be placed on improving the responsiveness of generalist services to Aboriginal communities.[68]

6.65 Commenting on the current usage rate of community services by Indigenous Australians, NCOSS noted:

> Because Aboriginal people have lower life expectancy than other people in the population, their timely access to aged care services can be delayed and the appropriateness of those services can be diminished without attention to individual needs and cultural responsiveness. Additionally, the number of older people in Aboriginal and Torres Strait Islander communities is increasing. Consequently, the usage rate of many community support services by Aboriginal people is unacceptable and disproportionately low.[69]

6.66 NCOSS recommended that in light of the lower life expectancy of Indigenous Australians, the access age for aged care and community care support services should be lowered to 45 years in line with the HACC program.[70] Dubbo City Council considered that a separate disability factor recognising the Aboriginal population of a Local Government Area should be a component of any aged care service/facility allocation needed in NSW due, in part, to the Indigenous people need to access aged care services before the aged of 70 years.[71]

6.67 The Department of Health and Ageing noted that the National Aboriginal and Torres Strait Islander Flexible Aged Care Program assists older Indigenous Australians access appropriate care as close as possible to their communities, which are mainly in rural and remote locations. The Program provides a mix of residential and community places, however the mix has a higher proportion of community places (38 per cent compared with 14 per cent). Over half of all places in this program are provided in remote areas.

6.68 There are 30 services funded under the Program providing aged care services to approximately 600 older Aboriginal and Torres Strait Islander people. In 2006–07, an additional 150 places and funding of $15.1 million over 4 years was provided for Program.

6.69 In 2006–07, the Remote and Indigenous Support Services Program was established with funding of $42.6 million over five years. This program is targeted to aged care services provided by Aboriginal and Torres Strait Islander owned or operated organisations anywhere in Australia and by services located in remote and very remote locations providing community, flexible and/or residential care.

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68 Council of Social Services of New South Wales, *Submission 52*, p. 5.

69 Council of Social Services of New South Wales, *Submission 52*, p. 5.

70 Council of Social Services of New South Wales, *Submission 52*, p. 6.

71 Dubbo City Council, *Submission 2*, p. 2.

Additional assistance provided under this program includes peer and professional support services, emergency support services and capital funding.[72]

6.70 The committee recognises that more can be done to address the specific expectations and needs of Indigenous Australians in relation to the provision of appropriate aged care. Indeed, it appreciates that aged care services must be client-focused in order to accommodation the diverse range of requirements including that amongst Australia's Indigenous communities. For this reason, it encourages the suggested overarching review of the sector to specifically consider aged care services for Indigenous Australians.

Recommendation 20

6.71 The committee recommends that the suggested all-encompassing aged care review specifically consider and address the expectations and needs of elderly Indigenous Australians and their communities.

Recommendation 21

6.72 The committee recommends that the Department of Health and Ageing consider further initiatives to attract culturally-appropriate staff in consultation with involved stakeholders including Indigenous clients.

Veterans

6.73 The National Ex-Service Round Table on Aged Care (NERTAC) noted that whilst the accreditation process requires aged care providers to provide information in relation to its address of the special needs of Indigenous Persons and culturally and linguistically diverse groups, there was no such requirement in relation to veterans. Of the current situation, NERTAC stated:

> Feedback from our visiting welfare officer system is that many facilities do not identify veterans and war widows or the wider ex-services community…If the aged care provider does not identify veterans then how can they respond to these needs? A suggestion has been that the accreditation process could be enhanced to require providers to detail the focus which they put on services for veterans special needs group.[73]

6.74 The committee heard that veterans in aged care often had special needs relative to the general community. According to t Mr Ross Smith, representing the National Ex-Service Round Table on Aged Care, the rate of alcohol and non-medical drug abuse is higher in the veteran community as a result of post-traumatic stress disorder and other military exposures.

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72 Department of Health and Ageing, *Submission* 114, p. 29.

73 NERTAC, *Submission 8*, p. 2.

6.75 Mr Smith also drew the committee's attention to the special emotional needs of veterans in aged care as a result of their military service:

> If someone has been through life as a farmer and has been through droughts and that sort of thing, they are happy to talk about them, whereas the ex-services community generally is not. Some of the conditions we now know as post-traumatic stress disorder are often hidden. They are well publicised in the case of Vietnam veterans, but we know that they will come out in later life. They will come out in the World War II veterans, who are typically 80-plus years of age. Some of that, we believe, is accentuated by conditions such as dementia and depression and often mixed up in those two things. They are causal factors, anyway. It is fairly difficult to unscramble all those things, but as people age the incidence of dementia will cause those things to come out and may trigger an event of post-traumatic stress disorder which has not been diagnosed in the last 50 or 60 years.[74]

6.76 Mr Smith stated that there is a need to better diagnose these mental conditions as part of the admission process, and that this was also a general issue for the community and not restricted to aged care alone.

6.77 The committee notes that veterans are specified under the Allocation Principles as a special needs group. It appreciates the particular circumstances faced by veterans and respective challenges that may be faced by their carers. This is further evidence of a need for a client focused approach in the aged care sector.

74 Mr R J Smith, NERTAC, *Committee Hansard*, 7.4.09, p. 52

Chapter 7

The question of inequity in user payments

> Older persons should remain integrated in society, participate actively in the formulation and implementation of policies that directly affect their well-being and share their knowledge and skills with younger generations.
>
> *Principle 7 of the United Nations Principles for Older Persons*

Introduction

7.1 This chapter considers user payments between different groups of aged care clients with focus on payments within residential and community aged care respectively as well as in comparison with each other.

7.2 The chapter also explores the views of some providers that greater flexibility is required in the aged care system to accommodate clients with the capacity to pay for services. It also highlights views of providers that greater flexibility in regard to payment and care options is required and explores options including accommodation bonds for residential care and the decoupling of residential accommodation and care. The chapter also considers a concurrent view of many providers that a shift is required in the service and care relationship in aged care from that between government and provider to that of provider and client. In this regard, emphasis was placed on the need for a client-based approach which enables flexibility to respond to the changing needs of such clients and which emphasises continuity of care at the expense of aged care classifications.

Concerns of residential and community aged care providers

7.3 A substantial number of residential and community aged care providers held the view that there are inequalities in user payments in the aged care sector. Anglicare Australia argued that there is an inequality in user payments 'across the whole spectrum of aged care services, from HACC through to high level residential care' and that instead:

> … aged care services should be looked at as a continuum of care (with individuals being able to move flexibly both between levels of services, and in and out of the system, as their needs change). A consistent platform for means tested fee setting, and for the payment of subsidies, should be set across the system. Those with high levels of wealth and income who are able to pay should fully meet the costs of their services and care, while

> those with limited or no capacity to pay should have the cost of their care subsidised at a fair and reasonable level.[1]

7.4 The Aged Care Association Australia (ACAA) held that there is 'considerable inequality' in how a person is treated in the aged care sector depending on where they enter the system, whether community, low care residential or high care residential'.[2] However, of greatest concern to the ACAA and many other residential aged care providers was the fact that unlike low care residents, high care residents are not required to pay accommodation bonds.[3] This issue is addressed later in the chapter.

7.5 In relation to community aged care, Alzheimer's Australia argued that:

> Varying user payments do create difficulties in community care, leading to consumers being uncertain as to how much they are going to have to pay for different services.[4]

Aged Care Funding Instrument

7.6 The Australian Government subsidies the provision of residential aged care to those approved to receive it. Each resident is provided a payment of a basic subsidy plus any supplements that the resident is entitled to.[5] On 20 March 2008, the Aged Care Funding Instrument (ACFI) was introduced as a new system to assess the amount of the basic subsidy. Under the ACFI, all existing permanent residents who entered residential care before 20 March 2008 retain their basic subsidy at the level determined under the former Resident Classification Scale (RCS) but were gradually be assessed under the new ACFI with full replacement of the RCS complete by April 2009. Of the status of existing permanent residents, the Australian Government noted:

> These pre-20 March residents will only move to the new ACFI basic subsidy if the rate determined under the ACFI exceeds their grand-parented rate under the former scale by more than $15 for the regular annual assessment or $30 for an ad hoc 'major change.' The level of basic subsidy for respite residents will continue to be at set rates determined by the ACAT's assessment of the resident as high or low care.[6]

7.7 Whereas the RCS comprised appraisals of aged care residents which were rated on a classification scale of one to eight with associated funding of a 'daily basic subsidy' tied to each classification, the system underpinning the ACFI centres on 12

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1 Anglicare Australia, *Submission 67*, p. 4.

2 Aged Care Association Australia, *Submission 92*, p. 23.

3 Aged Care Association Australia, *Submission 92*, p. 23.

4 Alzheimer's Australia, *Submission 87*, p. 6.

5 Australian Government, *Report on the Operation of the Aged Care Act 1997: 1 July 2006 to 30 June 2008*, p. 36.

6 Australian Government, *Report on the Operation of the Aged Care Act 1997: 1 July 2006 to 30 June 2008*, p. 36.

questions that apply to aged care residents, each with four ratings from A to D.[7] According to the Aged Care Industry Council, the ACFI was intended to cater for the 'increasingly high needs of high care residents'.[8]

7.8 Mr Andrew Stuart, First Assistant Secretary of the Department of Health and Ageing (the department) stated in this regard:

> ACFI provides funding on the basis of care level. Taken together the planning arrangements and the funding arrangements try to secure access for a variety of people and then fund appropriately according to their care need.[9]

7.9 Aged and Community Care Victoria (ACCV) held the view that as an assessment tool, the ACFI has the potential over time to:

> …streamline the method of assessing resident care needs when compared to the former RCS system. The strong caution is that the potential for streamlining systems is being compromised due to the continuation of other burdensome compliance obligations, including those under the aged care accreditation system.[10]

7.10 However, the ACCV noted that as a funding tool, there were concerns across the industry about the ACFI in terms of the levels of funding allocated. The ACCV argued that whilst the ACFI was intended to cause a shift in funding from lower to high care, the lack of additional funding and subsequent redistribution of current funding from the current pool will 'inevitably cause gaps and issues'.[11]

7.11 In evidence before the committee, Mr Gerard Mansour of the ACCV continued:

> The ACFI, in effect, only distributed funding from low-care residents to high-care ones. This is the consequence of changing any funding model without allocating significant additional resources. We now have a growing and increasing number of residents with increasingly high care needs. The consequence is clear: an increasing number of Victorians will be denied access to a residential home care place because providers receive zero or minimal funding, despite the fact that they will have ACAT assessment.[12]

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7 Australian Government, *Report on the Operation of the Aged Care Act 1997: 1 July 2006 to 30 June 2008*, p. 39.

8 Aged Care Industry Council, *Review of Conditional Adjustment Payments*, October 2008, p. 3, http://www.health.gov.au/internet/main/publishing.nsf/Content/72F6764DCAD97E9FCA2574E100077804/$File/Submission64.pdf (accessed 15 December 2008).

9 Mr A Stuart, Department of Health and Ageing, *Committee Hansard*, 21.4.09, p. 4.

10 Aged and Community Care Victoria, *Submission 89*, p. 3.

11 Aged and Community Care Victoria, *Submission 89*, p. 4.

12 Mr G Mansour, Aged and Community Care Victoria, *Committee Hansard*, 20.2.09, pp 35–36.

7.12 According to the Royal College of Nursing, Australia (RCNA), the ACFI focus on high care has re-shaped aged care services ensuring that:

> …an access issue is developing for low-care where people with social isolation or anxiety states are not funded in a sustainable way ($0–$6 per day) and are therefore not able to be admitted. As well, the effect of shifting resources from low to high care with no additional funding has overall consequences for staffing, building, equipment and risk management.[13]

7.13 Dr David Cullen, Department of Health and Ageing commented on ACFI assessment for low level care:

> Low-care rates vary from $0 up to…$6 or so. The vast majority of people who enter for low care are at the higher end of that spectrum. It is certainly true that there are some residents who are now assessed under the ACFI and who receive an assessment for $0 or $6, but there were also some residents assessed under the RCS who received $0. There were also some residents who were assessed under the previous hostel care instrument who received $0.
>
> It is certainly true that, as a matter of policy, successive governments have sought to encourage community care so that residents who require very low levels of care have received over years—and this goes way back before 1997—lower and lower levels of subsidy so as to encourage them to remain in the community. At the same time, community care was uplifted so that there would be something there for them. But the vast majority of residents who enter at low care are funded towards the upper end of that spectrum of funding.[14]

7.14 UnitingCare Australia maintained that the ACFI has not been developed through the determination of the real costs of delivering care and accommodation to residents.[15] According to the RCNA, the $15 funding hurdle is arbitrary and prevents funding from being matched to resident care needs.[16] The ACCV argued that the $15 funding barrier should be abolished before existing residents can access the new ACFI funding. According to the ACCV, this barrier is a 'clear attempt to artificially 'limit" funding to match care needs.[17] Grant Thornton Australia also maintained that the subsidy allocations under ACFI (and the previous RCS) are largely arbitrary because research into the cost of delivering care and accommodation has not been conducted.[18]

7.15 The RCNA maintained that the low entry authorised by the Aged Care Assessment Teams (ACAT) if often inconsistent with the ACFI assessment and that

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13 Royal College of Nursing, *Australia*, *Submission 101*, p. 2.

14 Dr D Cullen, Department of Health and Ageing, *Committee Hansard*, 21.4.09, p.33.

15 UnitingCare Australia, *Submission 76*, p. 19.

16 Royal College of Nursing, *Australia*, *Submission 101*, p. 2.

17 Aged and Community Care Victoria, *Submission 89*, p. 5.

18 Grant Thornton Australia Ltd, *Submission 29*, p. 8.

there is some confusion related to the ACAT determined high care/low care category split which has yet to be resolved:

> As a result, bonds levied for low care have to increase. These bonds currently average around $250,000 preventing many from accessing low care when they need it.[19]

7.16 This position was supported by Catholic Health Australia who argued that the ACAT were 'deliberately assessing some people as High care so as they will not have to pay a Bond':

> In one case an ACAT assessed a resident as High care but when assessed under the ACFI, attracted Nil funding for Activities of Daily Living (ADL), Nil funding for the Behaviour Supplement (BEH) and Nil funding for Complex Health Care (CHC).[20]

7.17 The ACCV also voiced concern that the ACFI will result in those with higher care needs being targeted, further accentuating inequalities.[21]

7.18 Catholic Health Australia noted that under the ACFI, of the 64 funding levels, only 12 are low care and of them, 50 per cent generate less care subsidies than was the case under the RCS system. As a consequence, providers are, according to Catholic Health Australia, finding fewer incoming residents assessed as low care with a 'number attracting too little funding to be admitted'.[22]

7.19 Management Consultant and Technology Services and ACCV argued that inequalities in user payments exist with ACAT-assessed residents on RCS categories 6, 7 and 8 unable to obtain subsidies under the ACFI.[23] According to the former, minimum ACFI payment for all clients to assist with bed, board, food, cleaning and laundry costs would bridge the gap between funding and actual costs.[24]

7.20 Grant Thornton Australia noted that under the ACFI, the funding level is now so low for potential residents that 'it is not feasible to admit them unless they can afford to pay a substantial accommodation bond'.[25] The risk therefore is that such people may not have access to community care services to remain at home or live in conditions where the provision of community care services is not possible. Moreover, Grant Thornton Australia argued that whilst the ACFI is expected to provide a greater weighting towards high care needs:

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19 Royal College of Nursing, *Australia*, *Submission 101*, pp 2–3.

20 Catholic Health Australia, *Submission 75*, p. 8.

21 Aged and Community Care Victoria, *Submission 89*, p. 9.

22 Catholic Health Australia, *Submission 75*, p. 8.

23 Management Consultant and Technology Services, *Submission 42*; Aged and Community Care Victoria, *Submission 89*.

24 Management Consultant and Technology Services, *Submission 42*, p. 1.

25 Grant Thornton Australia Ltd, *Submission 29*, p. 8.

> …the overall impact of this initiative is only a redistribution of resources under the same basic framework and the net change in subsidy flow will be negligible after grand parenting provisions expire.[26]

7.21 ECH Inc, Resthaven Inc and Eldercare Inc maintained that the ACFI weighting towards high care residents will cause a reduction in admissions of people assessed as requiring low care and that whilst people requiring low care will not be accepted into residential care, there will be a concomitant reduction in bond revenue.[27]

7.22 The Aged Care Association Australia WA and Aged and Community Services WA maintained that the ACFI had focused funding on high residential care services adversely impacting funding provisions for low care which in turn will have a negative impact on community care services. Of the consequences, the organisations noted:

> The current funding for low care services is becoming a deterrent for future admissions and this will have a very serious impact on the capacity of community care services to continue to deliver care for the growing demand within our wider community.[28]

7.23 Aged and Community Services SA & NT noted that the increasing trend whereby clients were moved straight into high care from the community implicated the revenue raising ability of providers from low care accommodation bonds which implicated the viability of low residential care.[29]

7.24 According to UnitingCare Australia a transparent method of estimating input cost increases which are relevant to the aged and community care sector and capable of being subjected to external review and analysis is required.[30]

Grandparenting

7.25 As part of the transition to the ACFI from the RCS, the RCS 'saved rate' for existing residents will continue to be grandparented until either the person's care needs increase to the extent that an ACFI rate becomes payable or the resident departs care. Therefore, subsidies will continue to be paid at the existing rate (plus indexation) for a resident on an 'RCS-saved rate' until either their care needs increase to the extent that

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26 Grant Thornton Australia Ltd, *Submission 29*, p. 8.

27 ECH Inc, Resthaven Inc and Eldercare Inc, *Submission 85*, p. 9.

28 Aged Care Association Australia WA and Aged & Community Services WA, *Submission 84*, p. 1.

29 Aged and Community Services SA & NT, *Submission 90*, pp 6–7.

30 UnitingCare Australia, *Submission 76*, p. 19.

an ACFI rate becomes payable or the resident is discharged from the aged care home.[31]

7.26 The role of grandparenting in relation to the ACFI was explained by Mr Stuart of the department:

> … it is true that the amount of funding for the most frail residents in aged care is going from $128 to $171 over a period of four years. A part of the reason for that is that, in introducing the ACFI, the government was grandparenting existing residents who are in aged care on the RCS if the provider would be better off as a result of that grandparenting. That grandparenting comes at a very considerable cost because what you are saying on the introduction of ACFI is, 'We will only allow providers to win; we won't allow them to lose.' The impact of that is a considerable net cost to government. As a partially offsetting cost reduction, the government has chosen to phase up the maximum fee for the most frail residents.[32]

7.27 The ACCV voiced concern regarding the financial viability of the aged care industry once the grandparenting impact had worn off and stated that:

> Aged care providers currently receive vitally important short term financial protection from the negative effects of the funding redistribution due to the ACFI grandparenting provisions. This means that residents who would otherwise move to 'lower' ACFI funding rates under the new system will be replaced by new entrants.[33]

7.28 Similarly, UnitingCare Australia noted that without grandparenting, one of its providers would lose $13.94 per resident per day in relation to 1,167 residents or 72 per cent of resident conversions to ACFI.[34]

7.29 The ACFI introduces 64 funding points (compared to the eight funding points under the RCS) which are designed to enable greater flexibility in matching funding to resident care needs. However, the concern of a number of submitters including ACCV is that whilst the ACFI is intended to encourage a shift in funding from those with lower care needs to those with higher care needs, the funding system has been introduced with 'minimal additional funding'. The ACCV argues that the real effect of this 'has been for current funding to be redistributed from the existing pool' which will result in gaps and issues.[35]

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31 Department of Health and Ageing, *Aged Care Funding Index Frequently Asked Questions*, 30 October 2008, p. 31, http://www.health.gov.au/internet/main/publishing.nsf/Content/C78B2B9CA7EECF5FCA2573F600053D1E/$File/FAQs1008.pdf (accessed 15 December 2008).

32 Mr A Stuart, Department of Health and Ageing, *Committee Hansard*, 21.4.09, p. 34.

33 Aged and Community Care Victoria, *Submission 89*, p. 4.

34 UnitingCare Australia, *Submission 76*, p. 6.

35 Aged and Community Care Victoria, *Submission 89*, p. 4.

7.30 Wintringham voiced concern in relation to what it regards as a lack of interconnection between funding and aged care assessment undertaken by the Aged Care Assessment Service (ACAS):

> There is no direct, apparent link, however, between the criteria the ACAS teams use for their assessment, ACFI assessments and the siloed funding linked to each assessment and made available to provide appropriate care. We have repeatedly found that a client's care needs are far more complex and so – far higher and more expensive to provide than their assessed funding level.[36]

7.31 A number of residential aged care providers shared the view that the $10, $20 and $30 cap on the maximum ACFI subsidy for high care residents should be scrapped immediately.[37] The Echuca Benevolent Society stated that the cap should be replaced with 'suitable payment for the care being carried out, that is required for each resident in our facilities'.[38]

7.32 Mr Stuart, Department of Health and Ageing, responded:

> The ACFI is an instrument that is designed to give an overall return to an aged-care home. We do not expect to pay through the ACFI for a particular staff member to stand by a particular bed. Because there is an increased flow of funding to the sector because of the grandparenting cost to government, the government has chosen to put a cap on the growing increase in care funding as well. I am simply explaining government policy to you.[39]

7.33 Despite such concerns regarding the ACFI, Catholic Health Australia reaffirmed that the instrument was still in its infancy. Mr Martin Laverty continued:

> In defence of the ACFI, the ACFI has not been in place for 12 months at the moment. I think when the ACFI is reviewed, which is scheduled to occur by the end of this year I understand, it is appropriate that there is a specific focus on the applicability of the ACFI to address these particular behaviours and we are certainly going to be looking at the review of the ACFI to ensure that it is meeting the specific needs of those who have previously been homeless.[40]

Conclusion

7.34 The committee recognises the ACFI as an instrument that seeks to simplify the system and its administrative burden. Whilst it recognises that there are a range of

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36 Wintringham, *Submission 43*, p. 2.

37 See for example, Baptcare, *Submission 59*; Tongala and District Memorial Aged Care Service Inc, *Submission 83*; Aged and Community Care Victoria, *Submission 89*.

38 Echuca Benevolent Society, *Submission 53*, p. 3.

39 Mr A Stuart, Department of Health and Ageing, *Committee Hansard*, 21.3.09, p. 35.

40 Mr M Laverty, Catholic Health Australia, *Committee Hansard*, 13.3.09, p. 12.

views on the ACFI, the committee appreciates that the system requires adequate time to operate before meaningful analysis of its effectiveness can be undertaken. However, the committee recognises that a thorough review of the ACFI is both timely and vital to establish its impact on the sector. For these reasons, the committee encourages the Department of Health and Ageing to consider and address the concerns of aged care providers in the forthcoming ACFI review.

Aged Care Assessment Teams

7.35 The Aged Care Assessment Teams (ACAT) are responsible for assessing and approving older persons for Australian government subsidised aged care including residential aged care, Community Aged Care Packages (CACPs), Extended Aged Care at Home (EACH), and dementia-specific Extended Aged Care at Home-Dementia (EACH-D). The Australian government provides funding to the states and territories to operate and manage the ACAT whilst the states and territories also provide funding to the ACAT.

7.36 A number of residential aged care providers raised concerns regarding the complexities involved when a client moves from low to high care including the circumstances where an ACAT re-assessment was required and of the funding gap that results from delays in re-assessment.[41] Mr Ken Baker of Baptistcare elaborated:

> That process is currently complicated, because to go from low care to high care you have to be re-ACATed, and that becomes a real hurdle for us to get through, especially if someone comes in under the current system where they might come in as a low care and we do our initial assessment and find that they are high care. Our funding stream is completely interrupted by the dependence on the ACAT teams to come back and to reassess that person, which they are not always that prompt in doing because, as far as they are concerned, they have done an assessment.[42]

7.37 A gap in funding provision can result as Ms Anne-Marie Archer of the Aged Care Association Australia Western Australia explains:

> With regard to the provision of the aged-care assessment teams, an assessment is made for entry into aged care. Invariably, it is made at the time in a situation that is outside the residential care environment. When someone comes into a care environment, they are assessed then by the provider. The assessment of the care needs in that care environment could be different from those of the ACAT or their care needs may have increased in that time. They do not get funded for the care that they receive in a particular environment up until such time as the ACAT comes back and does a reassessment—for example, if they have gone from low care to high care.

41 See for example, Mrs Small, Wintringham, *Committee Hansard*, 20.2.09, p. 56 and Wintringham, *Submission 43*, p. 2.

42 Mr K Baker, Baptistcare, *Committee Hansard*, 30.1.09, p. 95.

> There is an enormous differentiation in the amount of money it costs to care for someone in different levels of care. That amount of money is lost in the system up until such time as the ACAT comes out and provides yet another assessment. There is no ability to recoup that, regardless of the fact that they have been providing that care, and that is why one of the positions of the association is to ensure that potentially in the future the ACAT service is to really assess eligibility for care as opposed to simply determining high and low care.[43]

7.38 Anglicare stated before the committee that the delay in ACAT re-assessment had cost them about $100,000. Dr Lynn Arnold of Anglicare Aged Care South Australia explains:

> To the extent that we still have low care and high care, the changes have resulted in our being significantly financially impacted by delays not being retrospectively funded. What that means is that when somebody moves from low care to high care in that assessment, which can take as little as two weeks, it is not a problem when it does, but when it takes two months or more it is a problem. There being no retrospectivity has cost us something like 1,800 days of funding in the last six months, at a cost of about $100,000. That represents quite a significant cost impact for us.[44]

7.39 Mr Wayne Belcher of The Bethanie Group suggested an alternative:

> The assessment issues under ACFI: it seems appropriate to me that ACAT, rather than saying, 'You are high care or low care,' should rather say, 'We have assessed you as being appropriate for residential care, as being appropriate for community care, or either, and we can encourage you by pointing you to appropriate providers who may be able to meet your needs,' and let the existing regulatory framework between providers and clients pick up the necessary service provision.[45]

7.40 Ms Anne-Marie Archer of the Aged Care Association Australia WA also suggested an alternative solution to the committee:

> It would be far more advantageous for the industry if there could be just a simple gatekeeping process as opposed to a stipulation and having to come back out. This is extra resources for the state, but it is a huge impost on providers financially if there is a shift in that person's care needs and they cannot get a staff member out, because they invariably have an understaffing issue themselves.[46]

7.41 Recommendation 10 of a 2007 National Review of the ACATs (the review) addressed the issue of re-assessment:

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43 Ms A-M Archer, Aged Care Association Australia WA, *Committee Hansard*, 30.1.09, p. 40.

44 Dr L Arnold, Anglicare Aged Care South Australia, *Committee Hansard*, 13.3.09, p. 63.

45 Mr W Belcher, The Bethanie Group Inc, *Committee Hansard*, 30.1.09, p. 110.

46 Ms A-M Archer, Aged Care Association Australia WA, *Committee Hansard*, 30.1.09, p. 40.

> That the Australian Government considers revising the legislative requirements for re-assessment of those residents:
>
> - moving from low to high care within an aged care complex where the low and high care facilities have separate provider numbers
> - who enter an aged care facility with a low care approval but require high care.[47]

7.42 The consolidated response to the review by Australian, state and territory governments released in February 2008 stated:

> The Department notes this recommendation. In regard to legislative changes this is a matter for the Australian Government to consider in the context of other aged care reforms currently underway.[48]

7.43 Implementation of such a recommendation would address providers concerns raised before the committee. The committee therefore urges the Australian Government to implement the 2007 recommendation with a view to reform of the requirement for reassessment under the two conditions outlined by the national assessment.

Recommendation 22

7.44 The committee recommends that the Australian Government implement the recommendation of the 2007 National Review of Aged Care Assessment Teams and review the legislative requirement for re-assessment of those residents:

- **moving from low to high care within an aged care complex where the low and high care facilities have separate provider numbers;**
- **entering an aged care facility with a low care approval but who require high care.**

7.45 Concerns were also raised during the course of the inquiry about the time it took for the ACAT to conduct assessments. In this regard, Mr Ian Yates of COTA Over 50s Ltd stated:

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47 Communio Pty Ltd, *National Review of Aged Care Assessment Teams*, Final Report, Prepared for the Department of Health and Ageing, November 2007, Recommendation 10, p. 15, http://www.health.gov.au/internet/main/publishing.nsf/Content/135F747EC126FC60CA2574090003E506/$File/National%20ACAT%20Review%20Final%20Report%20Nov%202007.pdf (accessed 3 April 2009).

48 Department of Health and Ageing, *Response to Recommendations of the National Review of ACATs*, 27 February 2008, p. 7, http://www.health.gov.au/internet/main/publishing.nsf/Content/135F747EC126FC60CA2574090003E506/$File/Response%20to%20Nat%20ACAT%20Review%20Final%20270208.pdf (accessed 3 April 2009).

7.46 We would also emphasise that, in terms of inequity and according to the official data, both anecdotally and my understanding of it, access to assessment around the country varies in terms of time and quality. I am sure that departmental staff could talk to you about pursuing that issue between the Commonwealth and the states. For the sake of proposing a benchmark, we have said in here that, if something has arisen and you have a need, you ought to be able to get an ACAT assessment within five working days. Getting the support early that that assessment provides you with is quite critical, because people can escalate in terms of their needs if they are not addressed quickly. In some places you can get ACAT assessments very quickly and in other places waiting lists of weeks and months are not uncommon. I do not think the government of the Australian Commonwealth should accept that. We, as consumer advocates, find that unacceptable.[49]

7.47 Such concerns were also voiced by the 2007 review which noted:

> The key findings that relate to the efficiency of ACATs are:
>
> • ACATs demonstrate varying levels of efficiency. Some teams are overwhelmed with demand and are unable to effectively improve processes to improve efficiency. Others are meeting high demand.
>
> • Many teams are contributing considerable team time to the development and review of processes, forms, templates, education programs etc. There is little evidence of systematic sharing of resultant improvements. This also appears the case with work being sponsored at the jurisdictional level – advances made in one state or territory are not obviously being shared or extended across others.
>
> • The external operating environment that ACATs work in can make their role inefficient. They have to be cognizant of an increasing number of programs, eligibility criteria and service providers.[50]

7.48 In review recommended that Aged Care Assessment Program (ACAP) officials explore and implement strategies to 'increase the efficiency of the ACATs, especially those with long waiting times for assessments' and that a national breakthrough collaborative or extensive use of clinical practice improvement model should be considered in this regard. This recommendation was taken up to the extent that the government committed ACAP officials to explore methods to achieve efficiency improvement.[51]

7.49 In response to concerns relating to both the delays experienced in securing ACAT assessments and concerns regarding re-assessment requirements, Mr Andrew

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49 Mr I Yates, COTA Over 50s Ltd, *Committee Hansard*, 13.3.09, p. 42.

50 Communio Pty Ltd, *National Review of Aged Care Assessment Teams*, Final Report, Prepared for the Department of Health and Ageing, November 2007, p. 12.

51 Department of Health and Ageing, *Response to Recommendations of the National Review of ACATs*, 27 February 2008, p. 4.

Stuart, First Assistant Secretary of the Department of Health and Ageing (the department) stated:

> There are two things being done. One is that the government has already passed legislation late last calendar year to make unnecessary a number of previous kinds of ACAT approvals, a number of which actually go to some of the improved flexibility that people have been asking for at the committee hearing, including today. If you are approved for a high care package at home then you do not have to be separately re-approved and reassessed for a low care package at home, for example, and to reduce the number of times that a person has to go before an aged care assessment team to have it confirmed that they are still eligible for residential care when time passes.
>
> We are very significantly reducing the number of aged care assessment teams assessments that are required and are now moving towards negotiating with the states and territories about a new aged care assessment team agreement, which will take effect from 1 July, which will seek to turn that reduced workload into much quicker turnaround on some of the assessments that have been lagging. We are going to be wanting to put in place particular standards and milestones to be met.[52]

7.50 The committee is concerned about this apparent information gap between the experiences of providers and the reforms introduced by the department. The question remains as to whether this disjuncture reflects a reality which, despite such reforms, has changed little for providers. The committee urges the department to launch an information campaign on the ACAT directed at both providers and clients in order that evident deficiencies in information are addressed.

Recommendation 23

7.51 In light of disparities in information regarding the Aged Care Assessment Team (ACAT) assessments and re-assessments between the Department of Health and Ageing and involved providers, the committee recommends that the department launch an information campaign on recent reforms to the ACAT.

7.52 Other providers emphasised that greater national consistency was required in terms of the assessment process to enable greater efficiency. Catholic Health Australia's Mr Martin Laverty stated in this regard:

> If there were a genuinely national system you would have a consistency as to how assessments were being made. I have to acknowledge that because we are assessing an individual’s characteristic, obviously there is an opportunity for differing subjective opinions as to the capabilities of a person, but when you have one aged care provider saying to us, ‘We know

52 Mr A Stuart, Department of Health and Ageing, *Committee Hansard*, 13.3.09, p. 85.

> that different members of ACAT teams are producing different results', that does not suggest a genuinely national approach.[53]

7.53 In relation to the issue of national consistency, the 2007 review stated that:

> The review team identified variations in interpretation of the true intent of the ACAP. The Guidelines are interpreted in many different ways, often determined by individual values and experiences of staff, based on their work in other parts of the health/aged care continuum.
>
> The vast majority of data collected about ACATs is throughput based, with a focus on timeliness and volume. This supports the notion that ACATs are about volume – as the axiom suggests people only manage what they measure. The program needs to be able to articulate what a quality service is and to develop performance measures accordingly. These can then be used to measure team performance, allow for team benchmarking and can be incorporated into funding agreements and accreditation programs.[54]

7.54 The review's recommendation highlighted the need for nationally consistent performance indicators:

> That ACAP Officials seek expert advice to develop a set of validated, specific assessment tools and develop criteria for their use in the ACAT context. This work should build on current models and work undertaken by the Department and other work sponsored by the Australian Health Ministers Advisory Council (AHMAC). The criteria and indicators employed should be consistent with those used in HACC and other community care programs, as appropriate.[55]

7.55 The consolidated response to the review by the Australian, state and territory governments agreed with the recommendation and affirmed that:

> Standardised assessment clinical tools are strongly supported and should lead to greater consistency of ACAT assessments and recommendations. The adoption of a set of standardised assessment tools for ACATs will also improve equitable access to services and overall be an important building block in achieving a stronger relationship between the outcome of assessments and the appropriate level of care.[56]

7.56 The committee acknowledges that standardisation in relation to the ACAT is a 'work in progress' and strongly supports efforts in this regard.

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53 Mr G Laverty, Catholic Health Australia, *Committee Hansard*, 13.3.09, p. 4.

54 Communio Pty Ltd, *National Review of Aged Care Assessment Teams*, Final Report, Prepared for the Department of Health and Ageing, November 2007, p. 157.

55 Communio Pty Ltd, *National Review of Aged Care Assessment Teams*, Final Report, Prepared for the Department of Health and Ageing, November 2007, Recommendation 11, p. 15.

56 Department of Health and Ageing, *Response to Recommendations of the National Review of ACATs*, 27 February 2007, p. 7.

7.57 A number of aged care providers before the committee highlighted that, as a means of ensuring greater national consistency, more was needed to be done for the ACAT to operate as a single nationally consistent program. According to Catholic Health Australia, ideally ACAT would then serve as a genuine single national entry process into aged care. Of the idea, Catholic Health Australia's Mr Martin Laverty stated:

> Quite specifically we think that the ACATs, the aged care assessments teams that the Commonwealth government funds but the states and territories operate, should in fact be a single, nationally consistent program. It does not necessarily have to be operated by the Commonwealth but it should certainly have a greater control by the Commonwealth. We have also said that the entry point should be more visible to the community, just as Centrelink is a visible entry point for those seeking the support of the welfare system. At the moment we do not have a clear understanding as consumers as to how to take advice on how to enter and seek guidance through the aged care system. It is usually a family member who is guiding or making decisions on behalf of someone entering aged care. If that person has not experienced the aged care system before it is the case that they do not really know where to start and they do not know who to trust as they seek their advice. We think the Commonwealth can address that by establishing a single entry point for aged care around Australia.[57]

7.58 Part of the role of ACATs is to assist older people and their carers to establish what sort of care meets their needs when they are no longer able to manage at home without assistance. According to the department, ACATs also provide information on 'suitable care options and can help arrange access or referral to appropriate residential or community care'.[58]

Conclusion

7.59 The committee appreciates that the role of the ACATs should be that of a single national entry point for clients and their families and encourages the department to consider suggestions of this nature with view to simplify the system to the fullest extent possible for aged care clients nationwide. In addition to this, the committee recommends that a parallel education campaign be conducted to inform both new and potential aged care clients of the aged care services available to them and of their rights and entitlements in relation to such services.

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57 Mr M Laverty, Catholic Health Australia, *Committee Hansard*, 13.3.09, p. 3.

58 Department of Health and Ageing, *How Aged Care Assessment Teams (ACATS) Can Help You*, Information Sheet No.1, January 2008, (http://www.health.gov.au/internet/main/publishing.nsf/Content/43EEB445E116CA3ACA256F1900100461/$File/Aged%20Care%20Information%20Sheet%20-%20January%202008.pdf, (accessed 9 April 2009).

Recommendation 24

7.60 The committee recommends that the Department of Health and Ageing review methods directed to affirming the ACAT as a single nationally consistent program which genuinely serves as a single entry point to aged care services. The review should entail dialogue with aged care clients and providers as well as liaison with state and territory health departments.

Recommendation 25

7.61 The committee recommends that the Department of Health and Ageing conduct a national education campaign directed at new and potential aged care clients to raise awareness of the aged care services available to them including the role of ACAT and of their rights and entitlements in relation to such services.

Accommodation bonds for high residential aged care

7.62 A number of submissions held that there is an inequity with regard to the payment of accommodation bonds with many arguing that such bonds should be payable for residential high care and not just low care (hostels) and high care with extra service status.[59] Indeed, Aged and Community Services SA & NT held that low care residents paying an accommodation bond are cross-subsidising high care residents paying an accommodation charge or concessional residents covered by the government.[60]

7.63 A similar view was expressed by Aged and Community Services Australia:

> Increasingly since 1997, low care residents paying an accommodation bond have been cross subsidising high care residents paying an accommodation charge and concessional residents paid for by Government. This is becoming increasingly the case since more new residents are entering as high care and the average value of bonds has increased with the value of residential property in many parts of Australia.
>
> This inequity is compounded by the fact that high care, accommodation charge paying residents are treated differently to bond paying low care residents if they sell their home. For high care entrants any lump sum they hold, and use to pay their accommodation charge, is included for pension assessment purposes whereas the lump sum bond payment made by a low care resident is exempt.[61]

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59 See for example, The Association of Independent Retirees Ltd, *Submission 65*; UnitingCare Australia, *Submission 76*; Echuna Benevolent Society Inc, *Submission 53*; St Mary's Villa, *Submission 2*; Yackandandah Bush Nursing Home, *Submission 35*; Ms Hazel Bridgett, *Submission 100*; Aged Care Association Australia – SA Inc, *Submission 63*; House Group of Companies, *Submission 79;* Aged Care Association Australia WA and Aged and Community Services WA, *Submission 84*; Baptiscare, *Submission 48*.

60 Aged and Community Services SA & NT, *Submission 90*, p. 9.

61 Aged and Community Services Australia, *Submission 72*, p. 6.

7.64 According to Aged and Community Services Australia, the industry's view that the ACFI will result in a re-targeting of residential aged care to clients with higher care needs are being confirmed by early indications and that such a situation will 'further accentuate the inequalities' between low care and high care clients.[62]

7.65 As accommodation bonds are refundable deposits, they entitle the provider to the interest on the bond during the period in which a resident is accommodated. Under the current arrangements, only clients in residential low care and not clients in residential high care can pay accommodation bonds as Grant Thornton Australia explained:

> Unlike low care services, current legislation prevents high care residents from contributing accommodation bonds upon admission to high care facilities. As a result, most new high care facilities must be financed through external borrowings and the financing costs have a major impact on the viability of providers that operate on such tight margins.[63]

7.66 In 2007, Professor Hogan noted the impact of this policy:

> Rejecting of their use in ordinary high care reflects a failure to understand their critical funding role. It denies the role for simple 'user-pays' policies to meet the needs for care of an ageing population in coming decades …[64]

7.67 The Echuca Benevolent Society held that no bonds in high care is unjust because it gives rise to cross-subsidisation between low and high residential care creating with it two tiers of residents.[65] The Productivity Commission expressed the same view in its September 2008 research paper:

> The current pricing arrangements covering accommodation payments give rise to inefficient cross-subsidies between low and high residential care and distort investment decision-making. The problems posed by these anomalies could be addressed in a number of ways. One previously proposed option would be to require all residents who can afford to make a capital contribution to pay either a lump sum bond, or a daily or periodic rental charge (at a level equivalent to the bond).[66]

7.68 The Tongala and District Memorial Aged Care Service Inc expressed the opinion that moving way from the no bonds in high care policy would provide some immediate relief and reduce complexity in the system, provide greater fairness with all

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62 Aged and Community Services Australia, *Submission 72*, p. 6.

63 Grant Thornton Australia Ltd, *Submission 29*, p. 7.

64 Professor Warren Hogan, *The Organisation of Residential Aged Care for an Ageing Population*, The Centre for Independent Studies Policy Monograph 76, 2007, p. 1, http://www.cis.org.au/policy_monographs/pm76.pdf (accessed 8 January 2009).

65 Echuca Benevolent Society Inc, *Submission 53*, p.3.

66 Productivity Commission, *Trends in Aged Care Services: some implications*, September 2008, p. xxi.

eligible residents paying the same type of accommodation payment and remove the existing two tiers of residents.[67] Of the policy, Baptist Community Services of NSW and ACT stated:

> If the 'no bonds in high care' stance of various Australian Governments over the years is maintained, it is critical that the current accommodation charge for high care be reviewed. Data from the Stewart Brown Aged Care Report 2008 shows that providers are supplementing the day-to-day operational costs with income from capital. The result of this is high care facilities operating at a net trading loss per day of $7 and low care also showing a net trading loss per day of $4.[68]

7.69 A number of witnesses argued that accommodation bonds are vital in meeting the costs of capital funding which is not currently adequate under funding arrangement. Indeed, in his 1997 report, Professor Warren Hogan noted that, for this reason, accommodation bonds have provided an important source of funding for the expansion of aged care facilities:

> Accommodation bonds have been the sole means of bringing flexibility to an otherwise rigid pricing and funding system arising out of central planning. Bonds have allowed access to funds for meeting the servicing costs of capital funding not otherwise effectively provided through government subsidies and payments, or approved charges on residents. Access to accommodation bonds in low care and extra-service high care has also helped support provision of facilities in high care, especially in those facilities where a mix of care between low and high is offered.[69]

7.70 The Western Australian Government highlighted that the unavailability of accommodation bonds to high care providers has hindered new construction and the upgrade of existing facilities in Western Australia. In addition:

> This situation has been further exacerbated by the 2008 Aged Care Act Accreditation requirements where all providers irrespective of the level of care, are required to undertake substantial capital investment to meet new privacy standards.[70]

7.71 ACCV held the same view, arguing that the ongoing reduction as the proportion of residents entering low care has ensured that the level of accommodation bond will continue to increase, which in turn, providing further fuel to the argument that low care residents effectively cross-subsidise the facility capital realising costs across the industry.[71] Similarly, Japara Holdings stated that accommodation bonds

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67 Tongala and District Memorial Aged Care Service Inc, *Submission 83*, p. 4.

68 Baptist Community Services of NSW and ACT, *Submission 21*, p. 3.

69 Professor Warren Hogan, *The Organisation of Residential Aged Care for an Ageing Population*, The Centre for Independent Studies Policy Monograph 76, 2007, p. 3,

70 Western Australian Government, *Submission 111*, p. 2.

71 Aged and Community Care Victoria, *Submission 89*, p. 7

should be introduced into high care enabling provides to receive the capital required to build new facilities and complete renovations on older-style facilities to bring them up to best practice standard.[72] Catholic Health Australia further noted:

> The regulations surrounding accommodation bonds have had the effect of reducing available capital investment within the sector….The current disparity between who is charged an accommodation bond and who is not creates perverse incentives.[73]

7.72 The ACAA highlighted the consequences for high care residents of their ineligibility to pay an accommodation bond:

> …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.[74]

7.73 In instances where self-funded retiree couples have non-home assets and one 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. If the person is entering low care, they will be required to pay a bond. However, if the couple's non-home assets are held in superannuation, part of their funds will have to be released to pay the bond. According to the ACAA, this can 'on occasions leave the person not requiring care in a seriously depleted financial state'.[75]

7.74 In the case of high care residents, any lump sum held by them which they may use to pay their accommodation charge is included for pension assessment purposes whereas accommodation bonds in low care are exempt.[76] Professor Hogan noted in 2007 that bonds for high care was attractive to management compared to charges because:

> …of their contribution to the capital needs of the aged care entity; whereas accommodation charges simply meet the costs of servicing the capital

72 Japara Holdings Pty Ltd, *Submission 74*, p. 4.

73 Catholic Health Australia, *Submission 75*, p. 8.

74 Aged Care Association Australia, *Submission 92*, p. 23.

75 Aged Care Association Australia, *Submission 92*, p. 23.

76 Aged and Community Services SA & NT, *Submission 90*, p. 9.

> which still must be raised and, most importantly with debt, repaid. Accommodation bonds offer a self-replenishing means of funding.[77]

7.75 Mr Cam Ansell from Grant Thornton Australia noted that whilst the introduction of bonds would by itself 'create some impetus and the opportunity for stimulating the sector into developing':

> It would also create a much greater interest in the for-profits outside of the existing group. As a short-term solution, I certainly think that that would have a very positive effect. It does not take aside the fact that there are many other aspects of the industry that are heavily overregulated. While that might be a good short-term fix, I think there is a strong argument to go back and look at the broader system to see what we can do to encourage investment and sustainability in the longer term.[78]

7.76 Whilst a substantial proportion of residential aged care providers supported accommodation bonds for residential high care, others expressed caution with the option. Aged and Community Services Australia, was one case in point as Mr Greg Mundy explained:

> What we have argued for in our submission is to take a step back and say, 'The concept we should think about here is rent'—that anyone who occupies any space, whether it is an office, a hospital or their home, has to pay something that covers the replacement value of the accommodation that they are in. That is the underlying concept. If you are living in a high-cost city like Perth or Sydney then the rent is going to be higher than in a low-cost place such as Dubbo or Wagga or somewhere like that. It would much more sensible to link those two things in the same property market so that you allow people to realise the value of assets that have appreciated in that place and pay a price that matches the value of those assets.
>
> Once we have established that concept that people should pay a fair rent for their accommodation—and the government should pay for those that cannot afford it—how they pay is a second-order question. If people want to pay it upfront in a lump sum, we should discount what they pay, because that is a value to us. If we allow people to pay from their estate, we would need a reasonably tight contract around that, but we should charge more because the interest cost applies to us.
>
> But if everyone paid on an equal basis for what they are getting, with protection for the majority of our clients who are going to be income poor, then I think we could offer people choices in terms of how they pay. Bonds might well suit lots of people. The pension system treats bonds very kindly and, unless the government was going to change that, most older people would be better off capitalising their rent and paying it once. But, as for the

77 Professor Warren Hogan, *The Organisation of Residential Aged Care for an Ageing Population*, The Centre for Independent Studies Policy Monograph 76, 2007, p. 1.

78 Mr C Ansell, Grant Thornton Australia Ltd, *Committee Hansard*, 30.1.09, p. 9.

> concept that people should pay the replacement costs of the accommodation they are in, I find it hard to find convincing arguments against that.
>
> One of the old, traditional objections to the bond system is that, for people going into high care, where the average length of the stay might be six or seven months, you are adding one more stress factor in what is already a very difficult period in their lives. Let people pay a monthly rental while they see how things pan out. And long-stay high-care residents—essentially those with dementia—could go down the capitalisation route. They are going to have to sell the house anyway. It would be convenient for people. For those who genuinely are in a form of palliative care, we would charge on a fortnightly or monthly basis like any other form of accommodation. So bonds could be part of the solution, but I think there is room to open up that concept a little bit and make sure that it is fair and equitable.[79]

7.77 Moreover, it was noted that the introduction of bonds in high care would not necessarily impact on providers who focus on meeting the needs the financially vulnerable. The Brotherhood of St Laurence is one such provider which operates a concessional rate at approximately 85 to 90 per cent for residential care. Of the issue of bonds for high care, Mr Alan Gruner of the brotherhood noted:

> As I mentioned, we only have about 10 per cent of our residents actually pay bonds anyway, so it is not an area we particularly target. My own personal opinion is that there is a need within the industry for something to happen in aged care, in terms of funding, because the growing need is in the provision of high care. But without adequate revenue, it is becoming more and more difficult to provide those sorts of services. So whether it is through a bond or another means I think there needs to be an allocation of funding within the high-care area to assist service providers to provide their services, particularly building costs, as well as service provision.[80]

7.78 The Australian Nursing Federation, which does not support bonds in high care, recognised the need for an alternative to bonds which have traditionally funded capital costs particularly in light of the fact that 70 per cent of aged care residents are entering high care.[81]

7.79 Mr Stuart of the Department of Health and Ageing raised three issues for consideration in relation to bonds for high care. First, people going through a rapid health related transition would, have at the same time, to make immediate decisions about their financial affairs. Mr Stuart noted two other matters:

> My second comment is in relation to equity. The discussion we have just been having applies equally to bond charging, because bonds are an uncapped financial contribution. In low care, particular residents are worth more to the provider than others because an uncapped bond can be charged

79 Mr G Mundy, Aged and Community Services Australia, *Committee Hansard*, 20.2.09, pp 3–4.

80 Mr A Gruner, Brotherhood of St Laurence, *Committee Hansard*, 20.2.09, p. 21.

81 Australian Nursing Federation, *Submission 94*, p. 9.

> for some and not for others. Currently, in high care, that is not the case. In high care, we have people whose needs are more urgent and less discretionary than those in low care. So you would have to think very hard about what increased regulation you would need to put in place to ensure access for people with low assets into high care if you were going to allow an uncapped bond to be charged.
>
> The third area is in relation to prudential requirements. The bond is by its nature essentially an unsecured loan from the resident to the aged-care provider. The aged-care provider is not a financial institution. The government has managed this risk—and you would appreciate the kind of risk we are talking about, particularly since we have been experiencing a global financial crisis—by making the industry as a whole responsible if a particular provider defaults on the bond amounts…
>
> What I am raising is the issue that the size of bond holdings would then potentially be more than double and there would be a large number of providers who would never have held bonds before. Under those circumstances, the department would be thinking very hard about prudential arrangements…[82]

Conclusion

7.80 The committee appreciates that accommodation bonds for high care are widely supported by residential aged care providers. It also notes that many providers believe that the high / low care separation is artificial and based on a classification of the ACFI with no relation to the support needs of the resident population.[83] The committee believes that the full ramifications of the implementation of bonds in high care are yet to be analysed and should be included in the recommended holistic review of flexible funding options for the sector.

Decoupling of residential aged care and accommodation costs

7.81 In light of ongoing concerns in relation to the adequacy of aged care funding as well as the disparities between high and low residential care funding, decoupling costs of residential care from accommodation costs was suggested. Mr Geoff Taylor of the Aged Care Association Australia WA stated of his organisation's support for such an initiative:

> The problem we have with paying wages and the care side of it is purely to do with the poor indexation of our funding system and, if it were indexed properly, the care side of it would cover the wages…The families should have the choice of the accommodation, based on what they can afford and what is provided, and the government should subsidise properly for the

82 Mr A Stuart, Department of Health and Ageing, *Committee Hansard*, 21.4.09, pp 29–30.

83 See for example, Catholic Health Australia, *Submission 75*, p. 7.

> concessional residents who have no assets, who cannot afford to pay anything.[84]

7.82 Mrs Susan Parr of Aged and Community Services Tasmania (ACST) held a similar view:

> It is the belief of our members that a separation needs to occur between care and accommodation. A range of options for accommodation could well be developed, and care is the area where we should be striving for excellence. Accommodation should be linked, we believe, to market forces. That would free up enough of the sector for it to be able to operate as a business while care services remain as highly regulated as they need to be and funded accordingly.[85]

7.83 Whilst in support of such an initiative, Mr Greg Burgess of the Freemasons' Homes of Southern Tasmania highlighted the need for a safety net:

> ACST suggested—and our organisation has in its submission—that the separation of care and accommodation should be considered. The deregulation or the market forces would then look at the accommodation issues. Certainly there would need to be a safety net built into any process to cater for supported residents, as there is now with rental assistance, for example, for low-income pensioners with rental payments. Allowing market forces to determine and for the industry to provide options as to the quality and size of accommodation may well be a very reasonable option to be pursued across all areas of resident classification—high and low. But I stress there would need to be a safety net for supported residents.[86]

7.84 Mr Ian Yates of COTA Over 50s argued along similar lines:

> You should have a classification instrument for care, and paying for accommodation should be a separate issue. You should work out what your user contributions are and then users and their families should be able to pay them flexibly in a way that suits them—and what will suit one may not suit another.[87]

7.85 Mr Andrew Stuart, First Assistant Secretary of the Department of Health and Ageing also raised concerns of a context emerging whereby:

> …aged-care housing costs were completely open slather and to be borne by the resident because that would lead to the exclusion of less well-off people from care. Because residential care housing and residential care in the end come as a package people have to gain access to both the housing and the care to get residential care. So if housing costs became open slather

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84 Mr G Taylor, Aged Care Association Australia WA, *Committee Hansard*, 30.1.09, p. 47.

85 Mrs S Parr, Aged and Community Services Tasmania, *Committee Hansard*, 27.3.09, p. 5.

86 Mr G Burgess, Freemasons' Homes of Southern Tasmania Inc, *Committee Hansard*, 27.3.09, p. 28.

87 Mr Ian Yates, COTA Over 50s Ltd, *Committee Hansard*, 13.3.09, p. 43.

> depending on what people could afford, then you would really have to worry about access.[88]

7.86 Mr Stuart noted, moreover, that if the industry were allowed to 'charge open slather on housing costs', it opened up the question of how the government should respond for concessional residents who currently make up approximately 50 per cent of the current population:

> Does it pay open slather for them too? I do not think so. I do not think that would be efficient for the taxpayer. There would have to be some thought about ramping up the regulatory requirements on access if you were to uncap accommodation costs.[89]

7.87 At the same time, a number of witnesses held the view that decoupling or unbundling residential aged care services had considerable potential. As one case in point, Grant Thornton Australia stated:

> Whilst the principles would need to be developed with reference to the government's broader health and welfare policy framework, the unbundling of residential aged care services would provide the foundation for a system that enhances consumer choice and facilitates sustainability for both providers of care and the Australian taxpayer.[90]

7.88 In its 2008 research paper, the Productivity Commission noted that clients of community care receive subsidised personal and health care, they generally have to meet their own accommodation costs and living expenses from private means or from income support payments. However, at the same time residential care clients may receive a subsidy for accommodation and everyday living expenses as well as subsidised personal and health care. Of this, the Productivity Commission noted:

> These inequities arise because the public financing principles generally applying in the health system have been applied to all components of residential care, even though some components are more akin to services that are typically provided through the welfare system.[91]

7.89 According to the Productivity Commission, unbundling care and accommodation may address this discrepancy:

> 'Unbundling' the service components that make up aged care provides a way of ensuring that appropriate and consistent public financing principles are applied to each of these components across different types of care. It is also a way of ensuring consistency between aged care services and

88 Mr A Stuart, Department of Health and Ageing, *Committee Hansard*, 21.4.09, p. 27.

89 Mr A Stuart, Department of Health and Ageing, *Committee Hansard*, 21.4.09, pp 27– 28.

90 Grant Thornton Australia Ltd, Answer to question on notice, 30.1.2009 (received 6.3.09).

91 Productivity Commission, *Trends in Aged Care Services: some implications*, Research paper, September 2008, pp 70-71.

> equivalent services provided through the broader health and welfare systems.[92]

7.90 The Productivity Commission listed a number of challenges involved in unbundling the costs of aged care services. At the same time, however, it held the opinion that arguments in favour of unbundling in order to 'achieve equity across different types of care, better targeting of the public subsidy, are fundamentally sound and warrant detailed analysis.'[93]

7.91 Whilst raising caution in relation to concessional residents, Mr Andrew Stuart of the Department of Health and Ageing also recognised the validity of decoupling:

> On the plus side: it recognises that people have housing costs in their own homes, so why shouldn't they have housing costs when they are in residential care? That seems like a reasonable statement to me.[94]

7.92 However, Dr David Cullen, Assistant Secretary of the Department of Health and Ageing held the view that as of March 2008 the government had 'essentially split care and accommodation funding':

> In residential care now the accommodation is paid for by the resident, essentially through their basic daily fee and through their accommodation payment. Where they cannot afford to pay for it, it is paid by the government through the accommodation supplement. That takes care of the accommodation side. On the care side there are the care subsidies and the resident makes a contribution through their income tested fee. So there already is a clear split between payments for accommodation and care.
>
> One of the key structural features of the 2008 changes was that we did ensure that all residents from an accommodation point of view in high care were worth exactly the same amount to the provider. The government pays all of the accommodation supplement for the poorest residents; the richest residents pay all of the accommodation charge themselves; and in between those the government's payment is reduced at the same rate as the resident's payment is increased so that everyone is worth exactly the same. That mechanism means that you have no access equity issue. Providers have no reason to choose one client over another, so you can have a relatively loose regulatory burden as far as access is concerned.[95]

7.93 The committee recognises that the government has taken steps towards what is effectively the decoupling or unbundling of residential care and accommodation. However, it also recognises that additional measures can be taken which would enable

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92 Productivity Commission, *Trends in Aged Care Services: some implications*, Research paper, September 2008, p. 71.

93 Productivity Commission, *Trends in Aged Care Services: some implications*, Research paper, September 2008, p. 74.

94 Mr A Stuart, Department of Health and Ageing, *Committee Hansard*, 21.4.09, p. 27.

95 Dr D Cullen, Department of Health and Ageing, *Committee Hansard*, 21.4.09, p. 28.

greater flexibility for both residential care clients and providers. However, it considers that further analysis is required to establish the ramifications of such measures on aged care funding and service provision. For this reason, the committee recommends that the Department of Health and Ageing conduct a review into decoupling of residential care and accommodation.

Recommendation 26

7.94 The committee recommends that the Department of Health and Ageing analyse decoupling of residential care and accommodation. Such a review should consider and assess the views, concerns and recommendations of involved stakeholders including the Productivity Commission.

Community aged care

7.95 Concerns regarding residential aged care funding regarding the distinction between high and low care in terms of funding are also felt in relation to funding across community aged care. Indeed, a substantial number of witnesses maintained that inequalities exist between the elderly receiving Home and Community Care (HACC) services and those on Community Aged Care Packages (CACP) and Extended Aged Care at Home (EACH) packages.

7.96 COTA Over 50s held the view that inequalities in user payments existed between fees for Community Aged Care Packages and comparable sets of services delivered through the HACC program.[96]

7.97 The ACCV highlighted the repercussions of different payments between HACC and CACP:

> HACC clients pay less for an equivalent range and amount of services than those on the other packages. Lower fees for HACC services have seen some clients refused CACP, because it costs more.[97]

7.98 The Tasmanian Government Department of Health and Human Services also held such concerns. Ms Janet Carty of the department elaborated:

> It is not only the disconnect between HACC and packages; it is the disconnect also within the packages, because there are gaps and overlaps – so we agree with all of that. We are working with the Australian government to try to improve that. There are also different funding regimes, different reporting regimes and different quality regimes.[98]

7.99 Alzheimer's Australia held the same position but from a different viewpoint:

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96 COTA Over 50s, *Submission 93*, p. 3.

97 Aged and Community Care Victoria, *Submission 89*, p. 10.

98 Ms J Carty, Department of Health and Human Services, *Committee Hansard*, 27.3.09, p. 87.

> Because of the difficulties associated with means testing most providers charge only the minimum amount for CACPs and EACH.
>
> In regard to HACC, there exists a national fees policy which, among other things, ensures that a person will not miss out on a HACC service because of inability to pay, and sets limits on the total level of fees for people receiving multiple services, but the policy allows each State and Territory to set its own fees. This has led to considerable variation across States.[99]

7.100 Aged and Community Services SA & NT detailed the allocation differences and consequences:

> The allocation differentials between HACC (a few thousand dollars up to $75,000 +) and CACP ($12,000), EACH ($42,000) and Each D ($46,000) result in difficulties for providers trying to care for clients' changing needs. It is not uncommon for a provider who may have a CACP client to not be able to offer an EACH package because they have none available. Individuals have by necessity had to seek another provider.[100]

7.101 One of the primary concerns raised in relation to HACC was articulated by Care Connect:

> HACC clients are able to access far more hours of service on a low fee as opposed to a lower number of hours per week they can access on a Commonwealth package of care; as such we see a trend of clients seeking to remain on HACC to high care levels and not transition onto a packaged care program.[101]

7.102 According to the National Ex-Service Round Table on Aged Care (NERTAC), the 'failure of the HACC Program to implement a consistent fees policy has created inequity and introduction of co-payments in other programs has created difficulties for consumers and providers'.[102] Similarly, Catholic Health Australia maintained that:

> HACC service user fee arrangements vary between jurisdictions and when compared with the regulated variable fee arrangements under Commonwealth funded community care packages, act to discourage consumers from moving from HACC to the packages despite their increased support needs.[103]

7.103 COTA Over 50s and Alzheimer's Australia held the view that the current gap between CACPs and the various EACH packages is too great.[104] As Alzheimer's

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99 Alzheimer's Australia, *Submission 87,* p. 6.

100 Aged and Community Services SA & NT, *Submission 90,* p. 2.

101 Care Connect, *Submission 71,* p. 3.

102 NERTAC, *Submission 8,* p. 7.

103 Catholic Health Australia, *Submission 75,* p. 11.

104 COTA Over 50s, *Submission 93*; Alzheimer's Australia, *Submission 87*.

Australia noted, the CACP subsidy is currently $34.75 per person a day whilst the EACH subsidy is $116.16 per person per day, and the EACH-D subsidy $128.11 per person per day.[105] In addition, COTA Over 50s held that the differential in some contexts between fees for CACPs and comparable services provided through the HACC program created inequalities.[106]

7.104 According to Catholic Health Australia, part of the problem rests with the fact that no benchmark of care costs have been undertaken in relation to community aged care. The body highlighted that CACPs, EACH packages and EACH-D packages have 'only one funding level each regardless of the hours of care each individual package recipient requires'. For this reason, according to Catholic Health Australia, the service provider is required to 'pool the total package income received and fund the varying hours of care accordingly'.[107]

7.105 The Aged and Community Services Association of NSW and ACT held that funding is unable to meet assessed needs:

> In community care the set rate for care provision of CACP, EACH and EACH-D clients only provides 3 levels of subsidy. This results in declines in the level of services offered to clients as package funding is unable to meet assessed needs. A New Strategy for Community Care – The Way Forward includes the review of fees in community care however this process needs to be driven forward quickly if older Australians are to be able to receive appropriate quality care.[108]

7.106 The Council of Social Services of New South Wales maintained that CACPs provide a 'very low amount of service' as a result of the levels to which they are funded compared to EACH:

> What is CACPs' role, given it can no longer provide a hostel level of care service at the existing levels of funding, as originally intended. Many CACPs try to top up their support using HACC services, even though it's not allowed, as the amount of hours isn't sufficient for many clients to support them appropriately. The difference between support levels of CACP and EACH is significant with no package support level in between.[109]

7.107 Ms Derryn Wilson of the Municipal Association of Victoria argued that rigidity within community care was a central concern:

> I think the rigidity is more between the home and community care services and the CACPs and EACH packages. It is about the community care. I

105 Alzheimer's Australia, *Submission 87*, p. 8.

106 COTA Over 50s, *Submission 93*, p. 3.

107 Catholic Health Australia, *Submission 75*, p. 8.

108 Aged and Community Services Association of NSW and ACT Inc, *Submission 61*, p. 3.

109 Council of Social Services of New South Wales, *Submission 52*, p. 6.

> think what everybody finds is that people's needs change over time, and they can go up and down. You have a system that says, 'If you are around this level of care, you get your services from that, and if you are at this level of care, or you need some additional things that are not available here, you have to tip over into that. There are different providers in the two systems, so people have to swap into another set of arrangements with different fees and different personnel. But often a lot of their core needs remain the same. They will still need help with housework. They might still need help with showering. They might still need a bit of home maintenance. Particularly for people who have already been getting those services in HACC, it is quite a jump to have to go into a care package, primarily sometimes to get case management because case management is not available in HACC. So I think what we are saying about the rigidity is it is this problem of silo programs and not allowing people to have a range of needs met over time and up and down through the one provider, the one system of local care.[110]

7.108 The ACCV argued that there funding distinctions between CACP and EACH implicated the ability of providers to cater for individual client needs:

> From a client or user perspective, the enormous gap in funding between the current CACP and EACH packages means providers are simply unable to cater for individual client needs as they become more frail. Unlike the new ACFI system which has 64 funding points, there are only three points in relation to commonwealth funding community aged care packages: CACP, EACH and EACH Dementia. To compound and limit the flexibility of providers to match care to client needs, individual elderly clients must receive a further ACAS assessment before they can move from the CACP level to the EACH level.
>
> The consequence is clear. Those receiving CACP packages will have substantial increases in their level of frailty or complex care needs and yet be ineligible for additional funding support until they are assessed by the ACAS as needing an EACH package. This substantially limits the capacity for providers to meet care needs.[111]

7.109 A number of providers took the view that community care packages should be streamlined into a single system. Alzheimer's Australia argued that all HACC funding for aged people should be managed by the Commonwealth to enable an 'integrated approach to packaged care across CACPs, EACH and HACC'.[112] ECH Inc, Resthaven Inc and Elder Care Inc held the same view and argued for a 'single, seamless system of home and community aged care'.[113] Baptist Community Services of NSW and ACT maintained that it was difficult for people to move easily between CACPs and EACH

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110 Ms D Wilson, Municipal Association of Victoria, *Committee Hansard*, 20.2.09, p. 15.

111 Aged and Community Care Victoria, *Submission 89*, p. 5.

112 Alzheimer's Australia, *Submission 87*, p. 3.

113 ECH Inc, Resthaven Inc and Elder Care Inc, *Submission 85*, p. 4.

because of availability issues and that such arrangements needed to be streamlined if the system 'is to be able to support people efficiently and effectively'.[114]

7.110 Similarly, Anglicare Australia held that barriers between community-based aged care services as well as the barriers between community and residential care should be eliminated to enable people to move 'flexibly between modes of care as their needs change.' It held that:

> For many people, the pathways to community-based and residential aged care services are complex and daunting. This is amplified by many people entering the system as a result of a crisis event. Now is an opportune time to work together to make the service system more streamlined, easier to navigate and more efficient.[115]

Conclusion

7.111 The committee appreciates the concerns of community aged care providers in relation to funding and its implications on the provision of quality services to Australia's elderly population. For this reason, the committee reaffirms its recommendation to establish benchmark of care costs for aged care. Notwithstanding the establishment of benchmark of care costs, the committee acknowledges that the funding and services for community aged care need to be expanded in light of the demand for such services which is only set to increase.

Recommendation 27

7.112 The committee recommends that the Australian Government expand community aged care funding and services to meet growing demand and expected quality service provision outcomes.

7.113 The committee also acknowledges the views of many providers in relation to dissolving the demarcations between and within community and residential aged care and streamlining services for the purposes of continuity of care and to emphasise care needs over service categories. However, the committee takes the view that such an initiative can only be considered during the course of an overarching review of the aged care sector as a whole.

Client-based aged care system

7.114 A number of aged care providers expressed the view that the aged care system is extremely complex, rigid and inflexible and argued that the funding inequalities within the system were in part, a consequence of an aged care model which is neither client-centred nor client-focused. Suggestions to ensure greater flexibility particularly in relation to funding arrangements focused on the need for a client-based system presupposing a shift from a relationship which is government/provider focused to that

114 Baptist Community Services of NSW and ACT, *Submission 21*, p. 6.

115 Anglicare Australia, *Submission 67*, p. 2.

with a client/provider focus. Mr Cam Ansell of Grant Thornton Australia stated in this regard:

> I think an ideal situation is that, rather than this being a constant negotiation or relationship between the government and the provider, in the future it is necessary for the relationship to be one between the aged-care provider and the resident in the discussions about how they provide financial support in terms of their accommodation; whether it be in the form of an up-front payment—call it accommodation bond if you will—or they may prefer not to do that. They may prefer to hold on to the money or the assets and pay an ongoing fee or rental, like we do in most other areas of our society. I would like to see perhaps a little bit of a view of: what does the consumer want? What are their preferences?[116]

7.115 Mr Ian Yates from COTA Over 50s argued for an entire focus shift:

> We believe that the whole system needs to move to a more consumer directed care model, with much greater involvement of consumers and their carers. All of that is based around a paradigm of our needing to see older people as not having a 'best by' date. We need to see them as being able to make contributions and being supported, with their strengths built upon, encouraged and challenged. That is how we ought to recast the system that we have at the moment.[117]

7.116 Ms Robyn Batten from UnitingCare Australia expressed the view that what is required is planning based on assessed need rather than available supply.[118] Ms Batten continued:

> Effective consumer directed care will not be achieved by just cashing out service funding. It requires consumer involvement in overall system and service design and it is really important at the design phase. Access to independent advice about care options, life planning support and the opportunity to choose when and how to access informal and professional services, sometimes concurrently, and training and technical support to service providers will be required to ensure individual budgets are implemented in a way that provides a high level of satisfaction to consumers.[119]

7.117 Wintringham also stated its concern of the current model:

> Aged care funding is provided in distinct silos. Funds are limited to specific amounts dependent on care recipients meeting certain, established funding criteria.[120]

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116 Mr C Ansell, Grant Thornton Australia Ltd, *Committee Hansard*, 30.1.09, p. 9.

117 Mr I Yates, COTA Over 50s Ltd, *Committee Hansard*, 13.3.09, p. 40.

118 Ms R Batten, UnitingCare Australia, *Committee Hansard*, 13.3.09, p. 25.

119 Ms R Batten, UnitingCare Australia, *Committee Hansard*, 13.3.09, p. 25.

120 Wintringham, *Submission 43*, p. 2.

7.118 The need for system flexibility to enable continuity of care was also highlighted by witnesses before the committee. One such example is that of situations where clients seek to move from one facility to another and a new operator is required to either accept an existing accommodation bond or refuse admittance. The ACAA highlighted concerns in this regard:

> 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.[121]

7.119 Similar concerns were raised from other providers about community care including Mr Nick Mersaides of Catholic Health Australia who stated:

> The fact is that on the community care side it has evolved as a type of service well behind residential care. Residential came first. As other witnesses have put to you, the current arrangements around community care are quite restrictive and rigid in terms of being able to, as your care needs increase, transition to a higher level of subsidy in the same way as you would in residential care. We need to have the same calibration of subsidy levels in the community care sector as we have in residential. Indeed if you want to have a real choice there has to be a signatory between the level of subsidies available on the care side; putting aside accommodation which does not apply, there needs to be some symmetry and consistency of policy in those levels of subsidies between residential and community.[122]

7.120 Mr Ian Yates from COTA Over 50s held the view that HACC needed to be more client focused:

> With HACC, in some cases, you are providing what is essentially community-development infrastructure and services, but we would like to see it being much more client focused than it is at the moment. We think the principal distortion for HACC is that it gets used to create packages because the packages or care system in the community is insufficient. The really big thing that our consultation has told us for over a decade is that consumers want more and more robust community care and community care with much more flexibility in it. They want it to be available at the time they need it and so that it meets their needs. There are too many people in, firstly, the healthcare system and, secondly, residential care because they cannot get access to community care.[123]

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121 Aged Care Association Australia, *Submission 92*, p. 23.

122 Mr N Mersaides, Catholic Health Australia, *Committee Hansard*, 13.3.09, p. 6.

123 Mr Yates, COTA Over 50s Ltd, *Committee Hansard*, 13.3.09, p. 44.

7.121 The committee appreciates the concerns of providers in relation to the aged care system and recognises that the emerging future challenges for the sector require considerable planning in close association with both current and future aged care clients themselves. For this reason, it suggests that its recommended all-encompassing review of the aged care sector take a client-based approach in order that its findings are client focused. Current practices and future challenges should be considered through the lens of aged care clients.

Recommendation 28

7.122 The committee recommends that the all-encompassing review of the residential and community aged care sector take a client-based approach in order to ensure that its findings are client focused.

7.123 As part of calls for greater client-based care, the need for more flexibility to enable a user-pays system for clients who have the ability to finance their care services was raised during the course of the inquiry. This debate centred around a lack of flexibility on the part of the system which ensures that choices of services are limited as are the payment options available to clients as Mr Stephen Teulan of UnitingCare Australia explained:

> Because of their various personal financial situations, some people would prefer to pay up front for a refundable amount. Some would prefer to say, 'I don't want to pay at all now. I would like it charged to my estate.' There is everything in between in terms of daily charges, annuity purchases and everything else. At the moment you cannot do those sorts of things, because the system is completely and utterly inflexible. Both consumers lose out because ultimately they will have lack of choice and they will have fewer services and providers lose out because they cannot provide the services into the future. There will not be the capital to do that. We say the government should pay the actual cost for those people who cannot afford to pay themselves. Those people who can afford to pay should have choice based on various types of services. It should be means tested so they should never be in financial hardship, but there should also be flexibility in the payment arrangements so they can work out their own circumstances. We would be happy with that.[124]

7.124 The Productivity Commission highlighted that one of the key challenges to the sector is the growing and increasingly diverse range of elderly Australians who are expected to demand higher quality aged care services and greater choice in the services they are offered:

> The nature and composition of aged care in the future is being inexorably shaped by two emerging trends: the growing diversity of the aged population and their expectations of greater choice in the availability of

124 Mr S Teulan, UnitingCare Australia, *Committee Hansard*, 13.3.09, p. 33.

> services; and a growing capacity for some older people to self-fund a greater part of their retirement needs (including for aged care).[125]

7.125 A number of providers maintained that given the increasing demand and expectations on care services, greater flexibility is required to enable those who have the means to pay to do so. Catholic Health Australia was one such proponent of this view as Mr Martin Laverty explained:

> …we note the need for a change in the approach to care fees. Our position is that those who have the ability to contribute to their own care should. Those who do not have that ability must be protected by a rigorous safety net, and that is the role of the Commonwealth government to ensure that the concessions that are available for consumers without financial means are legitimately equal to the cost of the provision of their care; at the moment we suggest there is a substantial gap between the actual concession provided by the Commonwealth and the actual cost of delivering care.[126]

7.126 Mr Cam Ansell of Grant Thornton Australia expressed the view that the role of government needs to be that of ensuring access to aged care for those who cannot afford it rather than 'limiting the options available for people who can'.[127]

7.127 A number of witnesses identified decoupling residential aged care and accommodation as the means of ensuring greater flexibility to enable clients a choice and ability to finance their own care services where able.[128] Baptistcare is one such provider as Mr Robert Bunney explained:

> As we have said, you need to separate the accommodation element from the other elements, and then people can have a choice. Yes, there will be people who cannot afford the most basic level of accommodation and that is where government comes in and says, 'All right. We will fund this level,' and the government might decide it will fund shared bathroom facilities.[129]

7.128 Whilst the committee recognises that there have been initiatives undertaken by the Australian, state and territory governments to rebalance public and private financing of aged care services, it believes that there may be scope for greater flexibility in this regard. However, it notes that this issue is entwined with that of the decoupling of residential aged care and accommodation debate and is grounded on common consensus that greater flexibility on the part of the aged care funding system is required. For this reason, the committee encourages its suggested holistic review of the aged care sector to encompass options including decoupling of care and

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125 Productivity Commission, *Trends in Aged Care Services: some implications*, Research paper, September 2008, p. 104.

126 Mr M Laverty, Catholic Health Australia, *Committee Hansard*, 13.3.09, p. 3.

127 Mr C Ansell, Grant Thornton Australia Ltd, *Committee Hansard*, 30.1.09, p. 8.

128 See the above section on decoupling residential aged care and accommodation.

129 Mr R Bunney, Baptiscare, *Committee Hansard*, 30.1.09, p. 104.

accommodation, greater flexibility to enable payment and service options for clients, and a system designed to meet aged care client needs.

Recommendation 29

7.129 The committee recommends that the all-encompassing review of the aged care sector consider options to enable greater flexibility in relation to payments and services directed at providing a client-centred aged care system for Australia.

Chapter 8

Planning ratio, allocations and funding of community care and high- and low-care

> He who would pass his declining years with honor and comfort, should, when young, consider that he may one day become old, and remember when he is old, that he has once been young.
>
> *Joseph Addison 1672 – 1719*

Introduction

8.1 This chapter considers whether the current planning ratio between community, high- and low-care places is appropriate. It also addresses the impact of current and future residential places allocation and funding on the number and provision of community care places.

Current planning ratio

8.2 The current planning ratio of 113 places per 1000 people aged 70 years and over is allocated as follows:

- 44 high care places per 1000 people aged 70 years and over;
- 44 low care places per 1000 people aged 70 years and over;
- 25 (21 CACP and 4 EACH) community care places per 1000 people aged 70 years and over.[1]

8.3 The process of allocating new places begins with an estimation of the number of new places needed to meet increases in the target population. Aged Care Planning Advisory Committees in each state and territory then consider how new places should be distributed between regions and special needs groups and advise the Secretary of the Department of Health and Ageing (the department) on the most appropriate allocation and distribution by different types of subsidy and proportions of care. Under the 2008–09 Aged Care Approvals Round (ACAR), 10 447 aged care places were allocated of which 73 per cent were residential places.[2]

8.4 The *Aged Care Act 1997* specifies the objectives of the planning process:

a) to provide and open and clear planning process; and

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

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1 Aged Care Association Australia, *Submission 92*, p. 25.

2 Department of Health and Ageing, *Submission 114*, p. 34.

c) to allocate places in a way that best meets the identified needs of the community.[3]

8.5 Persons with special needs are defined by the *Aged Care Act 1997* 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 of a kind (if any) specified in the Allocation Principles.[4]

8.6 Of the planning system, the Department of Health and Ageing commented that:

> The planning framework ensures that the growth in the number of aged care places matches growth in the aged population. It also ensure balance in the provision of services between metropolitan, regional, rural and remote areas.[5]

Issues with the current planning system

8.7 Providers raised a range of concerns in relation to the current planning system. Amongst them, the Aged Care Association Australia (ACAA) stated that 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.[6]

8.8 A major concern highlighted by a number of providers was that the current planning system did not recognise the growth in residents in high care. ACCA, for example, noted:

> 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.[7]

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3 Section 12-2 of the *Aged Care Act 1997*.

4 Section 11-2 of the *Aged Care Act 1997*.

5 Department of Health and Ageing, *Submission 114*, p. 33.

6 Aged Care Association Australia, *Submission 92*, p. 25.

7 Aged Care Association Australia, *Submission 92*, p. 27.

8.9 The Australian Institute of Health and Welfare (AIHW) held that it was timely to review the planning ratio, noting that whilst there has been a steady rise in the number of permanent residents classified as high care including 70 per cent in 2007, only 49 per cent of places were designated as high care in 2007.[8] At the same time, the AIHW cited the 2008 Report on Government Services which highlighted that by 30 June 2007, 37 per cent of low care places were occupied by residents with high care needs whilst 67 per cent of all operational places were taken up by high care residents.[9]

8.10 Similarly, the Aged Care Association Australia – SA Inc held that the current planning ratio is not appropriate as the residential aged care population comprises 70 per cent high care residents. According to the association, there exists a 'vast disconnect' between the actual residential care population and the planning ratio between residential high and low care.[10] Moreover, the association argued that as the proportion of high care residents is bound to increase over time, the current ratio will become increasingly inappropriate.

8.11 Mr Alan Gruner of The Brotherhood of St Laurance also commented:

> The ratio, in terms of residential care, is fifty-fifty between high care and low care. In our opinion, there should be a higher ratio of high care—at least a 70 to 30 ratio—given the needs of people coming into residential care and particularly the higher health care they need.[11]

8.12 Mr Gruner went on to state that the future with residential care 'is very much towards the high end, not just because of the ACFI but because of the needs of people as they age'. He noted that many clients requiring low care use community care packages, where they can access those packages and 'that seems more appropriate'.[12]

8.13 However, Mr Andrew Stuart, First Assistant Secretary of the Department of Health and Ageing responded to such concerns:

> Half of all residents entering care for the first time enter at low care, but about 70 per cent of all residents in care at any point in time are in high care. We think those two pieces of information are actually quite separate considerations. The first one is about access and wanting to make sure that people at both low-care and high-care levels can access aged care appropriately. The second is about ageing in place. Once people are in care

8 Australian Institute of Health and Welfare, *Submission 113*, p. 2 and p. 3.

9 Australian Institute of Health and Welfare, *Submission 113*, p. 3.

10 Aged Care Association Australia – SA Inc, *Submission 63*, p. 5; see also Anglicare Australia, *Submission 67*, p. 4.

11 Mr A Gruner, Brotherhood of St Laurence, *Committee Hansard*, 20.2.09, p. 21.

12 Mr A Gruner, Brotherhood of St Laurence, *Committee Hansard*, 20.2.09, p. 21.

> they are able to stay in their current place and age in place within the service.[13]

8.14 Problems with occupancy rates due to the planning system were also raised in relation to the consideration of state-wide rather than local demographic information. The House Group of Companies as one case in point noted that their facilities have experienced vacancy rates of up to 94 per cent due to 'flawed planning ratios which allowed more than six new services to commence operation within a short distance from the Gleneagles, in north-eastern Adelaide'. According to the group, in some areas there are serious shortfalls in place, whilst in others, there has been an over-supply.[14]

8.15 Aged and Community Services Australia (ACSA) held the same view:

> Currently little account is taken of services not directly funded by the Australian Government, allocations are made on the basis of quite large planning regions which sometimes mask the needs of specific communities and it would be appropriate to test the effect of introducing a weighting for the number of very old people (85+) in an area.[15]

8.16 Mr Greg Mansour of Aged and Community Care Victoria also commented that the planning region model of planning leads to misallocations:

> So what happens is the beds are allocated within a planning region. The planning region boundary does not necessarily reflect the community boundary, and you could have nearby towns where the boundary runs between those towns…
>
> Yes, I hear that feedback and I also hear it probably even stronger in relation to community aged-care packages. It is not uncommon for some of our members in certain geographic areas to have vacancies on one side of the boundary and waiting lists on the other. So whilst the regional boundaries are probably—and I can understand why they are important from a planning point of view, but if they are inflexible and they do not operate seamlessly, it will create a problem for communities and I get that feedback.[16]

8.17 Mr Mansour went on to argue that the planning system needs to allow consumer choice so that the appropriate packages can be offered. However, Mr Mansour contended that although this is critically important, there are a range of barriers. For example, if a particular community had a high level of interest in community care there is not a simple straightforward process to allow for the swapping of low-care beds to community aged-care packages. Mr Mansour concluded

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13 Mr A Stuart, Department of Health and Ageing, *Committee Hansard*, 21.4.09, pp 3–4.

14 House Group of Companies, *Submission 79*, p. 3.

15 Aged and Community Services Australia, *Submission 72*, p. 7.

16 Mr G Mansour, Aged and Community Care Victoria, *Committee Hansard* 20.2.09, p. 40.

that 'there is a whole lot of systems that we have put in place, I guess, as checks and balances that inhibit flexibility'.[17]

8.18 The relationship between planning ratios and occupancy rates and their impact on the viability of aged care providers was highlighted by a number of witnesses including the Royal College *of* Nursing, *Australia* which stated:

> Planning for distribution of approved residential and community aged care places requires more strategic targeting with greater attention given to maintaining a comprehensive service able to meet different levels of resident needs. The low level of funding provided for occupied beds means that aged care organisations rely heavily on high occupancy rates to be sustainable.[18]

8.19 The ACAA estimated that the average occupancy in the industry has significantly declined. Utilising June 2007 occupancy levels, the ACAA maintained that the average occupancy has fallen to 93 per cent as at 30 June 2008.[19] Indeed, the Report on the Operation of the *Aged Care Act 1997* for 2008 stated of the occupancy rate in residential care:

> At 30 June 2008 there were 2,830 aged care homes delivering residential care under these arrangements, with an occupancy rate of 93.86 per cent over 2007-08. This compares to 94.5 per cent in 2006-07 and 95.2 per cent in 2005-06.[20]

8.20 The ACAA argued that this declining occupancy rate has led to a context in which there are 12 000 vacant places across the aged care system.[21]

8.21 Catholic Health Australia also noted that the planning and allocation process fails to adequately reflect likely demand for places, particularly residential care places and stated of the Aged Care Planning Advisory Committees (ACPAC):

> The ACPAC have only ABS Census data for the population 70 plus and between Census rounds the ABS and DoHA estimates by region and LGA. The data doesn't always reflect actual population shifts, particularly in geographic areas of high growth in older demographics. The methodology adopted for determining ratios must be made transparent and should include assumptions about socio economic status, access to services, ethnicity and expected utilisation rates of services.[22]

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17 Mr G Mansour, Aged and Community Care Victoria, *Committee Hansard* 20.2.09, p. 41.

18 Royal College *of* Nursing, *Australia, Submission 101*, p. 3.

19 Aged Care Association Australia, *Submission 92*, p. 26.

20 Department of Health and Ageing, *Report on the Operation of the Aged Care Act 1997*, 2008, p. 16.

21 Aged Care Association Australia, *Submission 92*, p. 27.

22 Catholic Health Australia, *Submission 75*, p. 11.

8.22 Anglicare Australia also recognised that if planning ratios were set with greater consideration of more localised social and demographic information, clients in turn would have more information to make informed decisions:

> This would need to be accompanied by providing better information to interested parties (existing and potential providers of both residential and community care services; people who may be eligible for assistance) on which to base their decisions on investments and care options. It would also provide a platform to put more control and decision making power in the hands of consumers rather than those of government and providers.[23]

8.23 Baptistcare amongst other providers highlighted the realities of family relationships which impact on planning ratios. Of the current system, Baptistcare stated:

> It considers the numbers of aged people in a region and based on those figures attempts to identify future need. It ignores changes that have occurred in family relationships over recent decades and does not recognize that people entering residential aged care are likely going to prefer residing at a facility close to where their children live, rather than close to where they previously lived.[24]

8.24 Mr Harold Milham of Alzheimer's Australia noted that the reform proposals of the National Health and Hospitals Reform Commission to relate the planning ratio with people rather than places was a means of breaking the relationship between accommodation and care[25] and providing greater choice for clients:

> The approach to reform proposed by the National Health and Hospitals Reform Commission has many elements that are in our submission to your committee. We support the reform developed by the commission for increasing choice in aged care by relating the planning ratio to people rather than places, thus breaking the link between accommodation and care, and providing choice for consumers for a mix of accommodation and care options; basing the ratio on 85-plus, rather than 70-plus, to better reflect the population group cared for; developing a national aged care program to provide for the more effective integration of aged care services; and, finally, the adoption of consumer directed models of care.[26]

8.25 The ACSA argued that the appropriate planning should take into account three points:

- The needs of older people for care and housing extend beyond those provided under the Australian Government's aged care program.

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23 Anglicare Australia, *Submission 67*, p. 5.

24 Baptistcare, *Submission 48*, p. 31.

25 Chapter 7 discusses the separation of residential care and accommodation funding.

26 Mr H Milham, Alzheimer's Australia, *Committee Hansard*, 13.3.09, p. 71.

- These needs need to be met in a specific local area rather than 'in general', or 'statewide'.
- The use of care services tends to increase markedly with age.[27]

8.26 The Municipal Association of Victoria highlighted the need for consideration of client characteristics and evidence of demand based on national datasets in the establishing of planning ratios. Ms Kaye Owen explained:

> In terms of a national aged-care planning framework, there needs to be a coordinated development and use of supply, demand and utilisation datasets. That fundamental need for data has been there for quite some time, and it is an absolute necessity. There is opportunity to build on the local area data and to incorporate a range of related program areas with agreed processes with the three tiers of government and the involvement of providers and consumers.[28]

8.27 Discussion on occupancy rates and differences between and within regions exemplified what some providers viewed as an uneven distribution of places. This reality has, according to Management Consultants and Technology Services led to a situation in which there are 'serious shortfalls in places, and in other areas of oversupply' in Victoria.[29] The body concluded:

> It would be of assistance to providers and assist them with proper planning for places in appropriate allocations if they know where these locations are. It would be helpful for all data at local LGA level to be disclosed.
>
> The current planning ratio should be an indicative model only. For providers who wish to expand services to meet the true needs of their community, there should be flexible model.[30]

8.28 The need for flexibility to meet local demand was also highlighted by ECH Inc, Resthaven Inc and Eldercare Inc who stated that the current planning ratio of 113 places per 1000 persons over 70 years of age should be retained but that flexibility should also be introduced to the Aged Care Approvals Round to enable variations in the residential and community care allocation ratio across regions thereby enabling address of varying demand.[31]

8.29 On the other hand, Baptistcare argued for a market approach to planning ratios:

> The Governments targeted ratio of low-care, high-care and community care places is excessively regulatory. There should be a market approach, which

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27 Aged and Community Services Australia, *Submission 72*, p. 7.

28 Ms K Owen, Municipal Association of Victoria, *Committee Hansard*, 20.2.09, p. 14.

29 Management Consultants and Technology Services, *Submission 42*, p. 2.

30 Management Consultants and Technology Services, *Submission 42*, p. 2.

31 ECH Inc, Resthaven Inc and Eldercare Inc, *Submission 85*, p. 7.

> will come to equilibrium between the three types of places through the laws of supply and demand.[32]

8.30 Other concerns raised during the course of the inquiry centred on the lack of information surrounding the establishment of current planning ratios. According to the Western Australian Government, the calculation of the planning ratios have never been explained:

> The planning ratios are based on historically based planning ratios that have evolved over time without a clear basis for their calculation provided to the sector.
>
> There has always been doubt associated with the calculation of the planning ratios set in 1986 for low and high residential care for the target population.
>
> A transparent explanation has never been provided by the Australian Government leading to concerns that the planning ratios have led to an inherent systemic shortfall in allocated places in general over time.[33]

8.31 The planning ratios have not been comprehensively reviewed since they were first introduced in 1985. The department itself noted that whilst changes had been made to the ratios since their establishment, there have been 'significant demographic changes and changing patterns of use in aged care services'.[34] In terms of the changes, in 2004, in response to the Hogan Review, the Commonwealth increased the operational provision ratio from 100 to 108 places for every 1000 people aged at least seventy, to be achieved in 2007. Further review in 2007 resulted in this ratio increasing to 113 places (88 residential and 25 community care) for every 1000 people aged 70 years or older by December 2011. The balance of places within the provision ratio was also adjusted to increase the number of community care places from 20 to 25 places for every 1000 people aged at least seventy; four of these are for high level community care in the form of EACH or EACH-D packages. Adjustments were also made within the residential care target ratio of 88 places per 1000 people aged 70 years or over to increase the provision of high care from 40 to 44 places.[35]

8.32 According to the 2008 Report on the Operation of the *Aged Care Act 1997*, the department is currently planning to initiate a review of the aged care provision ratio.[36]

8.33 At the same time, however, Mr Andrew Stuart, First Assistant Secretary of the department highlighted that:

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32 Baptistcare, *Submission 48*, p. 31.

33 Western Australian Government, *Submission 111*, pp 4–5.

34 Department of Health and Ageing, *Submission 114*, p. 30

35 Department of Health and Ageing, *Supplementary Submission 114a*, p. 36.

36 Department of Health and Ageing, *Report on the Operation of the Aged Care Act 1997*, 2008, p. 8.

> There are very considerable strengths in the current planning arrangements. We tend to take those for granted in Australia, but I think they are very important to mention. First of all, the planning formula keeps growth in care in line with growth in the ageing population and, secondly, the planning formula directs new aged-care places to the areas of greatest need. Aged care is really one of the very few areas in public policy where growth in expenditure actually goes up in line with growth in the population. It is also one of the few areas of public policy where growth in rural provision actually matches the proportion of the population that lives in those areas. If you are thinking about policy in the area of planning and allocation, you would not want to lose those strengths that we currently have.[37]

8.34 The department also commented on arguments that a planning arrangement based on 80 years of age rather than 70 years of age should be introduced to more closely reflect the average age of residents. In response to such suggestions, the department noted that:

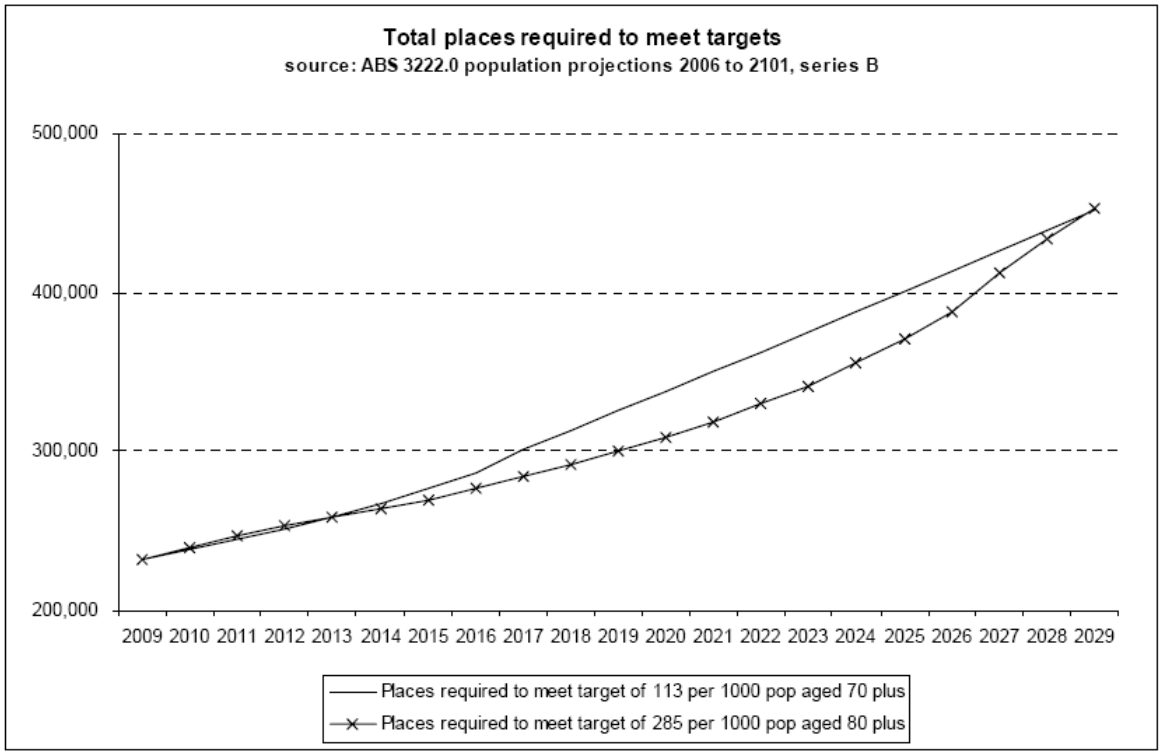
- a very good forward predictor of future demand is the population aged over seventy. Despite impressions to the contrary, older people are not highly mobile and they want to access care where they have been living; and
- to move from a ratio based on seventy years of age to one based on eighty years would soon (from 2013) produce a reduction in the release of new places, and a concomitant saving in government expenditure, because growth in this population will be less rapid than the total growth in those aged over seventy. From the year 2021 there would then be a rapid surge in the number of places required. This surge may challenge the industry's capacity to meet it since it would produce a release of aged care places which is higher than any release to date. The ratio based on those aged over seventy produces a steadier growth path.[38]

8.35 The department provided the following graph to illustrate the latter point.

37 Mr A Stuart, Department of Health and Ageing, *Committee Hansard*, 21.4.09, p. 3.

38 Department of Health and Ageing, *Supplementary Submission 114a*, p. 37.

Figure 8.1: Total places required to meet targets



8.36 The department also responded to comments concerning whether there is an ongoing need for a distinction between low care and high care as there is increasing utilisation of low care places by high care residents. The department pointed to the distinction between accessing aged care services and ageing in place.

8.37 In relation to access, the current aged care planning ratio for low and high care are used for planning purposes and seek to ensure that places are available for residents who need either high or low care on admission. Currently, admissions are distributed evenly between high and low care (49.97 per cent entered as low care in 2007–08). According to the department, to remove the ratio distinction between low and high care could result in reduced access for low care residents.[39]

8.38 In relation to ageing in place, this policy is designed to enable clients to remain in the same environment as their care needs increase where facilities are able to offer the accommodation and care they require. Once a client has entered care they are now generally able to remain in the same residential care service as his or her care needs increase. As a result of ageing in place, the number of care recipients who are actually receiving high level residential care is significantly higher than 50 per cent. Indeed, as at 30 June 2008, some 69 per cent of residents in aged care homes were receiving high level care.[40]

39 Department of Health and Ageing, *Supplementary Submission 114a*, p. 38.

40 Department of Health and Ageing, *Supplementary Submission 114a*, p. 38.

8.39 The department went on to state that ageing in place is supported by the current funding system with the ACFI a better and more objective measure of a residents' care needs. With the introduction of the ACFI, the government has allowed care needs to be reassessed at any time, so that significant increases in frailty can be funded immediately. This further supports the policy objective of ageing in place.

8.40 The department concluded:

> In summary, policy over the last decade has consistently emphasised relative growth in care at home, access to both residential low care and high care, and the capacity for enduring care once a resident is in the residential care setting.[41]

Conclusion

8.41 The committee recognises the new and emerging challenges facing the industry in meeting growing demand and increasingly diverse client needs and expectations. For this reason, the committee believes that it is timely for a transparent and comprehensive review of the planning ratios. Such a review would provide an opportunity to consider demographic and social information not currently utilised and to deliberate on the impact of growing demands on the sector.

8.42 Such a review should consider the continuum of care as a long term solution for the aged care sector and look beyond the distinctions between high and low care. For this reason, the committee recommends that the suggested taskforce review long-term options for the provision of aged care in Australia including continuity of care.

Recommendation 30

8.43 The committee recommends that the suggested taskforce undertake a review of the current planning ratio for community, high- and low-care places. Drawing on all available demographic and social information, the review is an opportunity to assess the planning ratio in light of growing and diverse demand on aged care services.

Recommendation 31

8.44 The committee recommends that the suggested taskforce review continuity of care as a potential long term solution for the aged care sector.

8.45 It should also be noted that witnesses drew a parallel between an effective planning ratio and capital funding. According to the ACAA, the level of investment in capital works ($1.45 billion in 2007–08) is not sustainable if the Government continues to allocate places at the current rate and does not assist with the cost of maintaining vacant places.[42] Similarly, Aged and Community Services Association of

41 Department of Health and Ageing, *Supplementary submission 114a*, p. 38.

42 Aged Care Association Australia, *Submission 92*, p. 27.

NSW and ACT held that planning ratios will not be effective until capital funding concerns are addressed:

> With expected increase in demand for higher levels of care in the community the allocation of Extended Aged Care at Home (EACH) or EACH Dementia (EACHD) would need to be increased. However changes in planning ratios will not be effective if the underlying recurrent and capital funding inadequacies are not addressed at the same time.[43]

8.46 Chapter 4 of this report considers the issue of capital funding in greater depth.

Impact of current and future residential place allocations and funding on community care places

8.47 With the growth in the number of older people living in their home for longer periods of time, demand has risen for services in the community. The Commonwealth provides these services through Home and Community Care (HACC) programs, Community Aged Care Packages (CACP) and Extended Aged Care at Home (EACH) Packages.

8.48 The department noted that in response to the increasing demand for community care programs as an alternative to low or high level residential care, the Commonwealth has been rapidly increasing the number of available community care package places. CACP places increased 43.6 per cent over five years from 2003–04, while EACH high care packages have increased nearly five-fold since they were introduced in 2003–04.[44]

8.49 In evidence, some providers argued that the growth in community aged care packages was leading to excess vacancies in residential aged care. Aged and Community Services Association of NSW and ACT stated:

> The consumer choice is towards community care, rather than residential care and the current planning ratios may result in too many beds for an aged population resulting in reduced occupancy rates and subsequent viability issues.[45]

8.50 Emphasising growing client expectations to remain at home for as long as feasible, Anglicare Australia argued for a change in the ratio between high and low care:

> Most people want, and have the means, to remain in their own homes as long as possible, with an accompanying high demand for community based care. This obviously reduces the demand for low level residential care. This trend is likely to continue. This demands a recalibration of the planning ratio to better reflect older people's preferences and usage. The split

43 Aged and Community Services Association of NSW and ACT, *Submission 61*, p. 6.

44 Department of Health and Ageing, *Supplementary Submission 114a*, p. 39.

45 Aged and Community Services Association of NSW and ACT, *Submission 61*, p.5.

> between new high and low level care residential places should be immediately shifted to 70:30, with future ratios being determined by actual and projected take up of places.
>
> This strongly suggests that the balance between residential and community care needs re-examination, as does the provision of low and high level care in the community (CACP and EACH) and the ease with which people are able to transition from lower to higher levels of care in the community. The current number of places available (for example, the Victorian ratio is 19.4 CACP places per 1000 population aged 70 years and over and 2.4 EACH places), funding levels, as well as eligibility criteria for, CACP and EACH preclude an easy transition, leaving many people no option but to enter residential care before they are ready. There is a need for a continuum of care model to be introduced, with greater flexibility to meet increasing levels of care need and/or different care needs, and with planning ratios more accurately reflecting likely demand for higher levels of care.
>
> It is time to re-examine the level at which the number of overall places is capped and whether ratios between residential and community care need to be retained or could be abandoned, giving more flexibility in the market.[46]

8.51 However, the Royal College *of* Nursing, *Australia* cautioned the unintended consequences of emphasising community care:

> Where feasible and safe, planning is placing greater emphasis on providing community care services due to a preference of many older people to remain at home for as long as possible. However, the unintended consequences have seen a reduction in access to residential care and a greater burden on families and carers who provide aged care with little training; no supervision; meagre resources and at times having to forgo paid employment to do so. Moreover, as people are remaining at home longer, their overall condition can deteriorate to such an extent that when they access aged care they require high care having not received the benefits of good nutrition, informed care and essential treatment and skilled nursing staff.[47]

8.52 The department responded to concerns about excess vacancies in residential care resulting from a growth in community care. It noted that it had not been able to produce analysis which supports or denies this view, despite attempts.[48] The department went on to state:

> Intuitively, *at some level*, providing older people with greater choice in care modality (in their own home or in an aged care home) will lead to some reduction in interest in residential aged care. However,
>
> a) choice in care setting is an explicit goal of policy; and

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46 Anglicare Australia, *Submission 67*, p. 5.

47 Royal College *of* Nursing, *Australia, Submission 101*, p. 3.

48 Mr A Stuart, Department of Health and Ageing, *Committee Hansard*, 21.4.09, p. 4.

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

The Department considers that the overriding dynamic in explaining vacancy levels in aged care currently is not one of competition between care types, but of rapid growth in care places leading to temporary vacancies.[49]

8.53 The department went on to give an example of an area where a new facility may be opened even though there are vacancies in existing facilities. The department stated that the vacancy level 'will be a temporary effect relating to growth' and concluded:

> In situations like these, not all providers welcome the expansion of aged care places but this expansion is essential to meet the overriding public policy objective of meeting the growing demand of the ageing population, which is expected to double in the next twenty years…
>
> It is the Government's intention to facilitate choice and to continue to emphasise growth in care at home. Sufficient vacancies in both community and residential care ensure people can get a place in the care of their choice without undue delay; with providers competing amongst each other to attract customers on the basis of quality of care and amenity.[50]

Conclusion

8.54 In light of the fact that the committee has recommended an overarching review of the aged care sector and indeed supports a comprehensive review of the planning ratios, it considers analysis of place allocations and funding as integral to both such reviews.

Senator Helen Polley

Chair

49 Department of Health and Ageing, *Supplementary submission 114a*, p. 40.

50 Department of Health and Ageing, *Supplementary submission 114a*, pp 40–41.

APPENDIX 1

List of submissions, tabled documents and other additional information authorised for publication by the Committee

Submissions

1	Mt St Vincent Nursing Home and Therapy Centre
2	St Mary's Villa
3	AMANA Living
4	Dubbo City Council
5	Share & Care Community Services Group Inc.
6	Confidential
7	Australian Meals on Wheels
8	National Ex-Service Round Table On Aged Care
9	HN McLean Memorial retirement Village Inverell Ltd
10	Summerhill Community Care Service
11	Eliza Purton Limited
12	Brotherhood of St Laurence Residential Aged Care and Major Projects
13	CapeCare
14	Australian Medical Association
15	Howe, Ms Anna
16	Advocates For Seniors In Care
17	General Practice Victoria
18	Blue Care - Uniting Care Queensland
19	Darlingford Upper Goulburn Nursing Home
20	Municipal Association Of Victoria
21	Baptist Community Services NSW & ACT

22 The Juliana Village

23 Australian Physiotherapy Association

24 Victorian Healthcare Association

25 Northern Territory Department of Health and Families

26 Parkinson's Australia

27 Kiama Municipal Council

28 Confidential

29 Grant Thornton Australia Ltd

30 St. Bartholomew's House

31 Elder Rights Advocacy

32 Perth Home Care Services Inc

33 Australian Bureau of Statistics

34 Ray M Begg Homes

35 Yackandandah Bush Nursing Hospital

36 Murchison Community Care Inc

37 Uniting Church Homes

38 Villa Maria

39 Melaleuca Home for the Aged Inc

40 The Aged Care Alliance

41 Hellenic Community Aged Care

42 Management Consultant and Technology Services

43 Wintringham

44 Huon Elder Care

45 Edith Bendall Lodge

46 Advocare Inc

47 Tandara Lodge Community Care Inc

48 Baptistcare

49 Bromilow Home Support Services

50 Dorothy Impey Home

51 The Mary Ogilvy Homes Society

52 Council of Social Services of New South Wales

53 Echuca Benevolent Society Inc

54 Freemasons Homes of Southern Tasmania

55 Lower Burdekin Home for the Aged Society

56 Presbyterian Care Tasmania

57 May Shaw Health Centre Inc

58 Sundale Garden Village, Nambour

59 Baptcare

60 Aged Valley View Care Facility

61 Aged & Community Services Association of NSW & ACT

62 Aged Care Queensland Incorporated

63 Aged Care Association Australia -SA Inc

64 Meecroft Care Inc

65 Association of Independent Retirees (A.I.R) Limited

66 St Ann's Homes

67 Anglicare Australia

68 Australian General Practice Network

69 Mayflower Community & Care

70 Shire of Kojonup

71 Care Connect

72 Aged and Community Services Australia

73 Aged and Community Services Tasmania

74 Japara Holdings Pty Ltd

75 Catholic Health Australia

76 Uniting Care Australia

77 Queensland Nurses Union

78 Euroa Health Inc

79 House Group

80 Boandik Lodge Incorporated

81 The Bethanie Group Inc

82 Sisters of St. Joseph Aged Care Services (QLD)

83 Tongala and District Memorial Aged Care Service Inc

84 Aged Care Association Australia WA & Aged and Community Services WA

85 ECH Inc, Resthaven Inc & Elder Care Inc

86 Havilah Hostel

87 Alzheimer's Australia

88 Palliative Care Australia

89 Aged and Community Care Victoria

90 Aged and Community Services SA & NT

91 Confidential

92 Aged Care Association Australia

93 COTA Over 50s Ltd

94 Australian Nursing Federation

95 Hogan Mr Dale

96 Fiebig Mr Jeff

97 Dwyer Ms Christina

98 Tavener Mr Allan

99 Vassiliou Mr George

100 Bridgett Ms Hazel

101 Royal College of Nursing, Australia

102 Shire of Boddington

103 Presbyterian Aged Care

104 National Seniors Australia

105 Anglicare Aged Care SA

106 National Carers Coalition

107 Queensland Government

108 South Australian Government

109 Lutheran Community Care

110 City of West Torrens

111 Western Australian Government

112 Liquor Hospitality and Miscellaneous Union

113 Australian Institute of Health and Welfare

114 Department of Health and Ageing

115 Fowlie, Mr A

116 Public Advocates

117 Department of Ageing, Disability and Home Care NSW

118 Dobinson, Mr J

119 Mordialloc Community Nursing Home Inc

120 Department of Health and Human Services TAS

121 Confidential

122 HealthCube

123 TriCare LTD

124 Family Based Care

125 KGA Consulting

Additional Information

Advocare
Supplementary Information

- Answer to Question on Notice taken at 30.1.09

Aged Care Association Australia
Document Tabled at hearing, 20.2.09

- 'The aged care annuity, What is it and how it works'

Supplementary Information

- Addition information received following 13.3.09 public hearing

Aged Care Association WA and Aged and community Service WA
Supplementary Information

- *Answer to Question on Notice taken at 30.1.09*

Aged Care Queensland Inc
Documents Tabled at hearing, 7.4.09

- Opening Statement

Aged & Community Care Victoria
Supplementary Information
- Answer to Question on Notice taken at 20.2.09

Aged & Community Services Australia
Supplementary Information
- Answer to Question on Notice taken at 20.2.09

Aged & Community Services Tasmania
Supplementary Information
- Answers to Question on Notice taken at 27.3.09

Alzheimer's Australia
Document Tabled at hearing 20.2.09
- 'Notes for Senate Finance and Public Administration Committee Inquiry into Residential and Community Aged Care in Australia'

Supplementary Information
- Answer to Question on Notice taken at 13.3.09

Anglicare Aged Care South Australia
Supplementary Information
- Answer to Question on Notice taken at 20.2.09

Baptistcare
Supplementary Information
- Answer to Question on Notice taken at 30.1.09

Blue Care Uniting Care Queensland
Documents Tabled at hearing, 7.4.09
- Opening Statement by Stephen Muggleton, Executive Director Blue Care

Care Connect
Supplementary Information
- Answer to Question on Notice taken at 20.2.09

Department of Health and Ageing
Documents Tabled at hearing, 21.4.09
- Building Costs & Building Indices

Supplementary Information
- Answer to Question on Notice taken at 30.1.09

Department of Health and Human Services Tasmania
Document Tabled at hearing 27.3.09

- Tasmanian Government

Supplementary Information

- Answer to Question on Notice taken at 27.3.09

Freemasons' Homes of Southern Tasmania
Supplementary Information

- Answer to Questions on Notice taken at 27.3.09

Grant Thornton
Document Tabled at hearing, 30.1.09

- 'Aged Care Survey 2008, Second Report January 2009'

Supplementary Information

- Additional information, received following 13.3.09 public hearing
- Answer to Question on Notice taken at 30.1.09

Japara Holding Pty Ltd
Supplementary Information

- Answer to Question on Notice taken at 20.2.09

Municipal Association of Victoria

Supplementary Information

- Answer to Question on Notice taken at 20.2.09

Office of the Public Advocate Queensland
Documents Tabled at hearing, 7.4.09

- Statement

Supplementary Information

- Answers to Question on Notice taken at 7.409

Perth Home Care Service:
Supplementary Information

- Answers to Question on Notice taken at 30.1.09
- Answers to Question on Notice taken at 30.1.09

Presbyterian Care Tasmania
Document tabled at hearing, 27.3.09

- Key Points

Supplementary Information

- Additional information received following 27.3.09 public hearing
- Answer to Question on Notice taken at 27.3.09

Queensland Nurses' Union
Documents Tabled at hearing, 7.4.09

- Attachments to the Queensland Nurses' Union of Employees Submission

Supplementary information

- Additional information received following 7.4.09 public hearing

The Aged Care Alliance
Documents Tabled at hearing, 7.4.09

- Opening Statement by Professor W.P. Hogan
- Proportion of aged care homes undertaking building work

The Bethanie Group Inc
Tabled Document at hearing, 30.1.09

- Letter from the Department of Health and Ageing

The Liquor, Hospitality and Miscellaneous Union
Tabled Document at hearing, 30.1.09

- 'Your Aged Care Union'

The Mary Ogilvy Homes Society
Supplementary Information

- Additional information received following 27.3.09 public hearing

Victorian Health Care Association
Tabled Document at hearing, 20.2.09

- 'Victorian Public Sector Residential Aged Care Services'

Western Australian Government
Supplementary Information

- Answer to Question on Notice taken at 30.1.09

Wintringham
Document tabled at hearing, 20.2.09

- 'Key points from Opening Statement'

Supplementary Information

- Answer to Question on Notice taken at 20.2.09

APPENDIX 2

Witnesses who appeared before the Committee at public hearings

Perth, Friday 30 January 2009

Grant Thornton Australia
Mr Cam Ansell, National Aged Care Director
Western Australian Government
Ms Gail Milner, Acting Operations Director, Innovation and Health System Reform
Mr Rob Willday, Acting Director, Aged Care Policy, Innovation and Health System Reform
Liquor, Hospitality and Miscellaneous Union
Mr Dave Kelly, Secretary, WA Branch
Ms Kelly Shay, Assistant Secretary
Ms Amber-Jade Sanderson, Political Organiser
Aged Care Association Australia WA & Aged and Community Services WA
Ms Anne-Marie Archer, ACAAWA CEO
Mr Geoff Taylor, ACAAWA Federal Director
Mr Glenn Muskett, ACSWA Chairman
Advocare Inc
Mr Greg Mahney, CEO
Ms Maureen Sellick, Manager Policy and Support
Share & Care Community Services Group
Ms Carol Jones-Lummis, CEO
Ms Merrill Hecker, Program Manager
St Bartholomew's House
Ms Lynne Evans, CEO
Ms Sally Kingdon-Barbosa, Manager Aged Care Programs
Perth Home Care Services
Mr Leighton Jay, Board Chairman
Ms Marita Walker, CEO
Shire of Kojonup
Mr Stephen Gash, CEO
Baptistcare
Dr Lucy Morris, Chief Executive Officer
Mr Harold Preston, Chief Financial Officer
Mr Ken Baker, Executive Manager, Aged Services
Mr Robert Bunney, Executive Manager Strategic Development
Mr Leith Counsel, Project Accountant
Uniting Church Homes
Mr Vaughan Harding, Chief Executive
The Bethanie Group Inc
Mr Wayne Belcher, Chief Executive

Melbourne, Friday 20 March 2009

Aged and Community Services Australia
Mr Greg Mundy, Chief Executive Officer
Australian Nursing Federation
Ms Ged Kearney, Federal Secretary
Municipal Association of Victoria
Ms Kaye Owen, Director Research and Policy
Ms Derryn Wilson, Senior Policy Adviser
Brotherhood of St Laurence
Mr Alan Gruner, Senior Manager, Residential Aged Care & Major Projects
Ms Christine Morka, Acting General Manager, Aged & Community Care
Victorian Healthcare Association
Mr Trevor Carr, Chief Executive Officer
Japara Holdings Pty Ltd
Mr Andrew Sudholz, Chief Executive Officer
Wintringham
Mr Bryan Lipmann, Chief Executive Officer
Ms Helen Small, General Manager of Operations
Aged and Community Care Victoria
Mr Gerard Mansour, Chief Executive Office
Mr Paul Zanatta, Manager, Community Care & Small Rural Health
Villa Maria
Ms Valerie Lyons, Chief Executive Officer
Mr Graeme Wickenden – General Manager Business Services
Care Connect
Mr Nicholas Woodlock, Chief Executive Officer
Ms Marisa Galiazzo General Manager, Client Services, Commonwealth Portfolio
Mayflower Group
Ms Frances Mirabelli, Chief Executive Officer

Canberra, Friday 13 March 2009

Catholic Health Australia
Mr Martin Laverty, Chief Executive Officer
Mr Nick Mersiades, Policy Consultant
Australian Medical Association
Mr Francis Sullivan, Secretary General
Dr Peter Ford, Chair, AMA Committee for Healthy Ageing
Australian General Practice Network
Dr Annette Carruthers, Chair, Aged Care Taskforce
Ms Liesel Wett, Deputy Chief Executive Officer
UnitingCare Australia
Ms Lin Hatfield Dodds, National Director
Ms Robyn Batten, Chair, Uniting Care Aged Care Network
Mr Stephen Teulan, Director, Coporate Finace and Stategy
COTA Over 50s Ltd
Mr Ian Yates AM, Chief Executive, COTA Seniors Voice
Aged Care Association Australia
Mr Bryan Dorman, President
Mr Francis Cook, Vice President

Mr Rod Young, Chief Executive Officer
Anglicare Aged Care South Australia
Dr Lynn Arnold AO, Chief Executive
Mr Peter Wright, Executive Manager Aged Care
Alzheimer's Australia
Mr Glenn Rees, National Executive Director
Ms Michelle McGrath, Executive Director, ACT
Mrs Kaye Pritchard, Carer
Mr Harold Milham, Carer

Launceston, Friday 27 March 2009

Aged and Community Services Tasmania
Ms Susan Parr, President
Mr Darren Mathewson, Chief Executive Officer
Meercroft Care Inc
Mr Garth Murphy, Vice-Chairperson of Board
Ms Wendy Shearer, Chief Executive Officer
Mr Paul Stevenson, Financial Manager
Mt St Vincent Nursing Home and Therapy Centre
Mr Tony Muir, Board Chairman
Mr Peter deWeys, Finance Manager
Freemasons' Homes of Southern Tasmania Inc
Mr Greg Burgess, Chief Executive Officer
Eliza Purton Ltd
Mr Malcolm Johnstone, Chief Executive Officer
Mr John Hughes, Chairman of the Board
Ms Cathrin Boerma, Regional Manager, Care Services
Tandara Lodge Community Care Inc
Mr Paul Crantock, Chief Executive Officer
Huon Eldercare
Mr Barry Lange, Chief Executive Officer/Director of Nursing
Mr Colin Patmore, Business Manager
The Mary Ogilvy Homes Society
Ms Jo Hardy, Chief Executive Officer
May Shaw Health Centre Inc
Mr Craig Johnston, Board Chairman
Mr Michael Hannon, Business Manager
Ms Judy Moore, Nurse Manager
Presbyterian Care Tasmania
Hon Dr Frank Madill, Chairman, Board of Directors
Mr Robin Philps, Chief Executive Officer
St Ann's Homes
Ms Susan Parr, Chief Executive Officer
Mr Rod Hunt, General Manager of Operations

Brisbane, Tuesday 7 April 2009

Blue Care Uniting Care Queensland
Mr Steven Muggleton, Executive Director
Mr Fred Huckerby, Director of Business Development
Mr Peter Hoare, Manager, Financial Strategy

The Aged Care Alliance
Professor Warren Hogan, Adjunct Professor, School of Finance & Economics, University of Technology – Sydney
Mr Jim Toohey, Chief Executive Officer, TriCare
Mr Steven Muggleton, Executive Director, Blue Care
Ms Jillian Jeffery, Manager Strategic Development, TriCare
National Seniors Australia
Mr Paul Versteege, Senior Policy Adviser
Office of the Public Advocate - Queensland
Ms Michelle Howard, Public Advocate
Ms Julie McStay, Legal Officer
National Ex-Service Round Table on Aged Care
Mr Ross Smith, Chief Executive Officer
Aged Care Queensland Incorporated
Mr Barry Ashcroft, Deputy Chief Executive Officer
Ms Pam Bridges, Manager for Residential Services
Mr Michael Isaac, General Manager, Eden in Glasshouse Country
Queensland Nurses' Union
Mr Steven Ross, Industrial Officer
Ms Anne Garrahy, Professional Officer
Dr Liz Todhunter, Research & Policy Officer
Sundale Garden Village, Nambour
Mr Glenn Bunney, Chief Executive Officer

Canberra, Tuesday 21 April 2009

Department of Health and Ageing
Mr Andrew Stuart, First Assistant Secretary, Ageing and Aged Care Division
Mr Iain Scott, Acting First Assistant Secretary, Policy and Evaluation Branch
Dr David Cullen, Assistant Secretary, Policy and Evaluation Branch

Appendix 3

Summary of finding of the three surveys of residential aged care

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

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

Source: Department of Health and Ageing, *Supplementary Submission 114a*, p.22.