BlueCare UnitingCare Queensland

Uniting Aged Care

UCH Uniting Church Homes

Part of the **UnitingCare Australia network**

Blue Care (Qld)

Uniting Aged Care Victoria and Tasmania

Uniting Church Homes (WA)

Submission by three UnitingCare agencies to the Australian Government

Review of the Conditional Adjustment Payment

Additional submission:

Critical issues impacting residential aged care viability

. . . "these UnitingCare agencies care for approximately 6,900 elderly people in residentials representing over 4.0% of funded residential aged care beds."

. . . . "If CAP had not existed, it is estimated that these UnitingCare agencies would incur losses of $36.5 million from the introduction of CAP to the end of the current financial year."

. . . "Without the temporary CAP, losses may have already resulted in UnitingCare agencies withdrawing from the provision of residential aged care services. In the absence of substantive positive funding reform this will occur."

(Extracts from the enclosed submission)

22 October 2008

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Submission enquiries:
Frederick Huckerby
Director of Business Development
Blue Care
T: 07 3720 5301
M: 0407 731 851
E: f.huckerby@bluecare.org.au

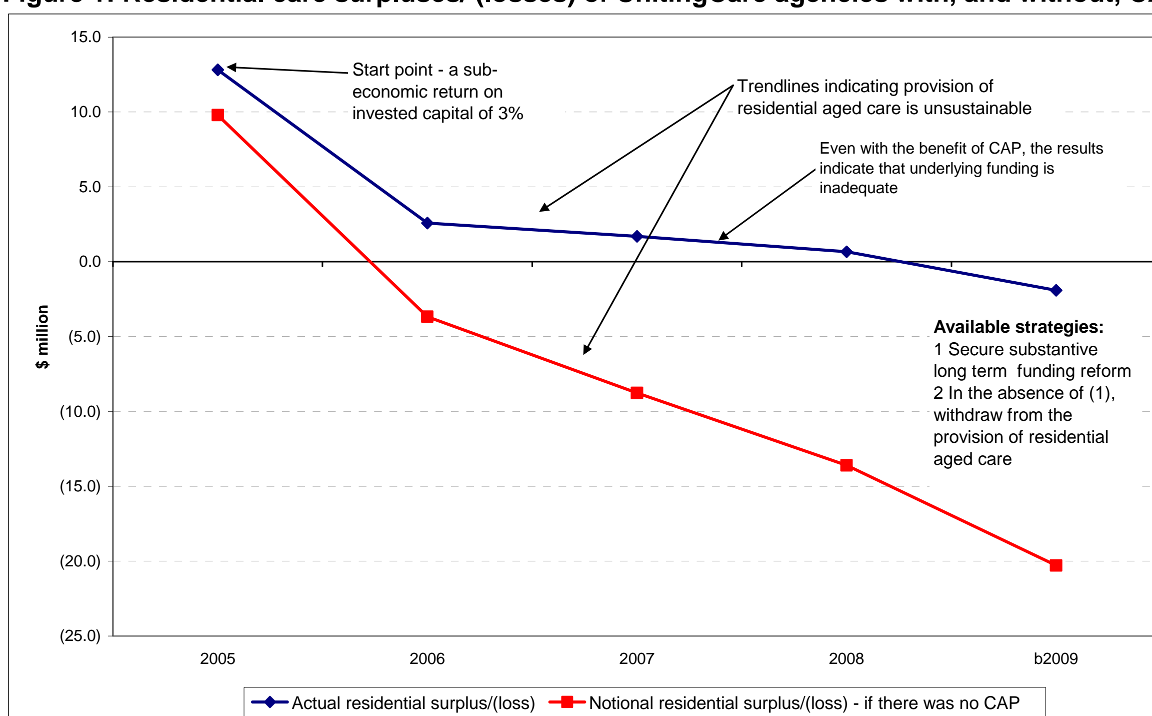
1 Executive summary

In this submission *"UnitingCare" and "UnitingCare agencies" refer to three particular UnitingCare network agencies, Blue Care in Queensland, Uniting Aged Care Victoria and Tasmania and Uniting Church Homes in Western Australia*.

These organisations provide residential aged care and community care services in four states. They provide residential aged care to approximately ***6,900 elderly people representing around 4.0% of funded residential aged care beds***.

This submission responds to the terms of reference. Additionally, it considers issues impacting the survival of providers and makes recommendations for critically needed long term funding reform to address the unsustainable financial position of the UnitingCare agencies and the residential aged care sector. This is exemplified in the chart below:

Figure 1: Residential care surpluses/ (losses) of UnitingCare agencies with, and without, CAP



Source: UnitingCare agencies (financial years and budget year 2009)

The above chart shows the decline in the UnitingCare agencies surpluses prior to the introduction of CAP. It is noted that even at the time of the introduction of CAP, the UnitingCare agencies were earning a sub-economic return. This is in part attributable to charitable provision of care, for example, to low care residents without capacity to pay an accommodation bond and people in rural communities.

The downward trend reflects factors such as increased resident acuity coupled with inability to access bonds from high care residents and input cost increases at a rate greater than income indexation. The trend indicates that the provision of residential aged care is unsustainable. ***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.***

1.1 Submission in response to the CAP terms of reference

Terms of reference (a): The extent to which the medium term financial assistance provided by the CAP has been effective in encouraging efficiency through improved management practices including the effectiveness of the three conditions of achieving CAP

This submission responds in section 5 to the terms of reference which deal with the medium term assistance provided to the industry by the Conditional Adjustment Payment ("CAP").

UnitingCare agencies submit that CAP has been a critical revenue source that has enabled it to continue to achieve a small surplus on residential operations and avoid losses in the four years that it has been implemented. Had CAP not been in place over the past four years, UnitingCare agencies would have incurred substantial losses as shown in the table below:

Table 1: Effect of removing CAP from UnitingCare agencies surpluses (aggregate financial information)

	2004-05#	2005-06#	2006-07	2007-08
CAP (% of care subsidy income)	*1.75%*	*3.50%*	*5.25%*	*7.00%*
	$'000	**$'000**	**$'000**	**$'000**
Actual residential surplus/(loss)	12,809	2,573	1,688	659
CAP	(3,018)	(6,241)	(10,453)	(14,265)
Notional residential surplus/(loss)*	**9,791**	**(3,669)**	**(8,765)**	**(13,606)**

* *The amount the result would have been without CAP*
\# *Excludes Tasmania in financial years 2005 and 2006*

Source: UnitingCare agencies

As is evident from the above table, even with the benefit of CAP, the UnitingCare agencies making this submission have seen surpluses on residential aged care fall from $12.8 million in 2004-05 to near break-even of $0.7 million in 2007-08. ***If CAP had not existed these organisations would have incurred substantial losses in providing residential aged care aggregating $16.25 million over this period.***

UnitingCare agencies submit that the CAP *is* a significant factor in encouraging management efficiency because the funding has provided financial capacity for improvement initiatives.

UnitingCare agencies have vigorously pursued management efficiency in the interests of all stakeholders, particularly for the purpose of being able to maintain capacity to provide services to residents under increasingly difficult financial circumstances.

Since the commencement of CAP on 1 July 2004, UnitingCare agencies have implemented many major efficiency initiatives. These initiatives represent improved management practices in terms in three relevant efficiency sources included in the 2004 Hogan review:

- technical – how we provide residential aged care;
- scale – how we share resources;

- and regulation – how we comply and enhance client care.

The CAP has assisted UnitingCare in meeting the costs of these initiatives.

For UnitingCare, the three conditions imposed by CAP have been unnecessary as each member *has continued* to provide staff information and opportunities regarding workforce training, make audited accounts available each year and be ready to participate in periodic workforce census.

Terms of reference (b): The need for and level of any further medium term financial assistance to encourage efficiency and improved management practices.

As shown in aforementioned table 1, the CAP has been a critical revenue source for UnitingCare. The CAP is now 8.75% of subsidy income for the current financial year ending 30 June 2009. ***UnitingCare agencies residential budget's for the current financial year show a significant decline in surpluses or increasing losses. If CAP had not existed, it is estimated that the UnitingCare agencies would incur losses of $36.5 million from the introduction of CAP to the end of the current financial year.***

Removal of the CAP would have severe implications on UnitingCare's financial viability. Consequences of removal of CAP vary individually for each of the UnitingCare agencies but collectively 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)*; and
- relinquishment of provisional allocations of residential care places and not proceeding with new capital investment *(already happening)*.

It is ***therefore submitted that continuation of CAP and further annual increases are critically needed in the short to medium term to enable survival of many participants whilst a long term plan is developed and implemented for industry viability and to encourage expansion to meet future demand***.

1.2 Additional submission in respect of critical issues affecting industry viability

The review of CAP offers the potential for comprehensive consideration of residential aged care and community care policy with the Government's intention to reform the national health and hospital system.

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

According to a recent survey by chartered accountants, Stewart Brown for financial year 2007, on average, both high care and low facilities incurred losses continuing a downward trend that has been evident for some years, and only 18.2% achieved a break-even or better result[1]. *This situation is a clear signal of both the potential for significant financial failure among providers and a brake to new investment.*

UnitingCare agencies submit that the Terms of Reference for the review of the CAP do not address issues threatening providers' viability and the critical need for long term funding reform.

Accordingly, in this submission, UnitingCare agencies also outline these issues in section 6 and makes recommendations for critically needed long term funding reform to enable sector providers to survive and provide services to meet the rapidly growing demand for aged care in Australia (section 7). The issues and associated recommendations are summarised below:

Table 2: Summary of issues and recommendations

Issue	Recommendation
Workforce	
Current funding is insufficient to allow for aged care and community care providers to compete with the acute sector and this has a detrimental effect on both the residential aged care sector's capacity to compete for staff, train staff and retain staff.	1. The Australian Government introduce a transparent mechanism and sufficient recurrent funding to achieve and maintain comparable wages and working conditions with the acute health care sector for all staff working in residential and community aged care. 2. The Australian Government examines regulation and current industry practice in terms of staffing mix and fund pilot programs to evaluate less expensive models of residential care. 3. The Australian Government dedicate funding to ensure all staff in aged care and community care have access to education and training that furthers their qualifications and skill levels, together with funded strategies to facilitate attendance barriers such as replacement staffing, reimbursing travel time and costs and provision for clinical placements.
Recurrent funding is inadequate and input costs are increasing faster than operational funding	
Recurrent funding for residential aged care and the current indexation formula are an inadequate basis upon which to provide quality care and do not reflect the real cost of care provision.	4. In September 2008, the Productivity Commission raised 'unbundling' as a means of more accurately price the individual components to better reflect their underlying cost. As raised by the Productivity Commission: ▪ The Australian Government implement a transparent method of estimating input cost increases that is relevant to the aged care and community care sectors and capable of being subjected to external scrutiny and review. ▪ The Australian Government implements periodic indexation based on such a transparent method. 5. The CAP be retained as an interim funding measure and increased by 1.75% each year until the Australian

[1] Survey results released to a UnitingCare agency

Issue	Recommendation
	Government develops and implements the above-mentioned indexation reform and underlying operational funding levels to enable long term industry viability and to encourage expansion to meet future demand.
Even with the benefit of CAP, the UnitingCare agencies making this submission have seen surpluses on residential aged care fall from $12.8 million in 2004-05 to near break-even of $0.7 million in 2007-08.	6. The Australian Government sourced operational funding be independently reviewed to: ▪ enable resetting at a level that will enable efficient providers to derive a commercial return; ▪ allow for explicit funding of cost imposts incurred in providing care in rural and remote areas and disadvantaged economic catchments; and ▪ implements a resource based subsidy system which recognises the true cost of provision of care.
Capital Funding is not sufficient to encourage investment in new capacity	
Salient features of capital funding are: ▪ the prohibition of refundable deposits (bonds) for high care beds; and ▪ the accommodation charge/supplement (rent) of $26.88 per resident per day applying to high care beds and low care beds occupied by financially disadvantaged residents. 'Beds' cost in excess of $200,000 to establish. The maximum accommodation supplement /charge is sufficient to fund investment in an aged care bed to an amount of approximately $120,000. The shortfall in capital funding exceeds $80,000 per bed.	7. As raised by the Productivity Commission in September 2008, refundable deposits (accommodation bonds or capital contributions) be extended to standard high care services. 8. The manifestly inadequate maximum daily accommodation supplement or 'rent' of $26.88 per resident per day for supported residents be increased *for new facilities* to reflect current costs of development. It is envisaged this will require doubling the supplement to $54 per resident per day, for new facilities operationalised after an announcement date (of say, 1 July 2009).
The Productivity Commission reported in 2008 that the ability of providers to differentiate their services in terms of price and quality is highly constrained. For example, 'extra service' places only provide choice in hotel type services and not personal care. The restrictive regime surrounding extra services simply denies residents choice and access to better quality facilities and also denies providers access to capital funding. The eligibility criterion includes an onerous DoHA pre-requisite that a provider is a "very good" provider.	9. The Australian Government widely de-regulate extra service status places to enable greater consumer choice and improved funding to providers. This should include eliminating the onerous, subjective DoHA pre-requisite for extra service status places that a provider is a "very good" provider.
Regulation is stifling efficiency and optimal use of resources	
UnitingCare providers are having difficulty retaining qualified staff in leadership roles in residential care reportedly due to their	10. The Australian Government prioritise regulation reduction as recommended by the Regulation Taskforce.

Issue	Recommendation
interactions with the regulatory agencies being a negative and demoralising experience. Issues include: ▪ Inconsistent evidentiary requirements leading to delays and rework. ▪ Complaint resolution managed through DoHA which is not flexible enough to allow for management of differing severity in complaints.	
The process known as the Aged Care Approvals Round ("ACAR"): ▪ Utilises allocation formulae which do not address need in particular catchments. ▪ Lacks transparency as applicants are poorly informed of the process and reasons for the outcome. ▪ Is excessively costly for providers because of the complexity of information required by DoHA.	11. The Australian Government: ▪ Review allocation formulae to ensure they address need in particular catchments and for service types. ▪ Improve transparency by notifying unsuccessful applicants of the process and reasons for the outcome. ▪ Making application forms shorter and less complex.
ACFI has led to a shift in the distribution of funding. More funding is available for high care at the expense of low care which will ultimately affect approved providers' capital income because refundable deposits (bonds) are prohibited in standard high care services. Monitoring of ACFI claims for existing residents indicates that, but for grand parenting, one UnitingCare provider would lose $13.94 per resident per day on 1,167 residents or 72% of resident conversions to ACFI. This is a cause for concern as to the potential detrimental impact on operating income for new residents.	12. The Australian Government set aside contingency funding to support residential aged care providers in the event that the ACFI substantially erodes provider's income or renders the provision of low level care unviable.

Stephen Muggleton, Executive Director, Blue Care
Robyn Batten, Executive Director, Uniting Aged Care Victoria and Tasmania
Vaughan Harding, Chief Executive Officer, Uniting Church Homes

22 October 2008

2 Introduction

The UnitingCare agencies making this submission provide residential aged care and community care services in four states[2]. They provide residential aged care to approximately 6,900 elderly people representing around 4.0% of funded residential aged care beds. Their respective organisations are long-term church based organisations who operate in metropolitan, regional and rural areas.

Two principal impacts of the Conditional Adjustment Payment ("CAP") are to be examined in the terms of reference of the Review, those are:

- *The extent to which the medium term financial assistance provided the CAP has been effective in encouraging efficiency through improved management practices , including the effectiveness of the three conditions in achieving the objectives of the CAP.*
- *The need for and level of any further medium term financial assistance to encourage providers to become more efficient through improved management practices*.

This Review is an important initiative which offers the potential for comprehensive consideration of residential aged care and community care policy with the context of reform of the national health and hospital system.

In this submission, UnitingCare responds to the above terms of reference which deal with the *medium term assistance* provided to the industry by CAP (section 5).

The medium term funding provided by CAP is one component of the federal government's funding of the residential aged care sector. UnitingCare providers submit that the Terms of Reference for the review of the CAP are narrow and do not address issues threatening providers' viability and the critical need for long term funding reform. Accordingly, this submission:

- outlines these issues in section 6:
  - workforce ageing and shortages;
  - input cost increases which far exceed operational funding indexation;
  - a substantial capital funding shortfall; and
  - regulation that stifles efficiency and optimal use of resources.
- makes recommendations to address these issues and *the critical need for long term funding reform* to enable sector providers to survive and provide services to meet the rapidly growing demand for aged care in Australia (section 7).

[2] This submission is also supported by UnitingCare Wesley Partners' Residential Aged Care Services (South Australia)

3 Brief profile of UnitingCare providers

As noted, in this submission, “UnitingCare” or “UnitingCare providers” comprise:

- Blue Care (Queensland)
- Uniting Aged Care (Victoria and Tasmania)
- Uniting Church Homes (WA)

They are significant providers of residential aged care and community care. Each member is committed to quality holistic care services that address clients’ physical, intellectual, emotional, and spiritual needs.

The philosophy of UnitingCare is non-discriminatory and services are available to all members of the community regardless of socio-economic, ethnic, religious or spiritual background. An overview of each member’s scale of services is shown in the table below:

Table 3: Overview of scale of services (Queensland, Victoria, Tasmania and WA)

	Queensland	Victoria and Tasmania	Western Australia
Staff employed	9,847	2,195	1,219
Volunteers	3,030	742	330
Residential aged care			
No. of hostels	58	9	11
No. of nursing homes	35	15	6
No. of residential aged care beds	4,231	1,827	884
Provisional	471	-	-
Community care			
No. of client home visits p.a.	2,045,923	n/a	788
No. of home nursing centres	77	-	-
No. of respite centres	59	13	-
No. of day therapy centres	12	5	2
No. of Cth Carelink Centres	4	-	-
Community Aged Care Packages	1,451	517	228
Extended Aged Care at Home Packages	258	120	87
No. of National Respite for Carers Programs	22	10	1

Source: UnitingCare, financial year ended 2007

4 Overview of residential and community aged care industry

4.1 Overview

For *background understanding*, an overview of residential aged care, community care and the context of CAP within aged care funding are shown in this section 4.

Residential aged care refers to the provision of accommodation and nursing services to the elderly in dedicated residential facilities (as distinct from retirement living which has no direct government involvement). Residential aged care can be grouped into two broad care categories:

- low care – involving the provision of accommodation and services such as laundry, meals, cleaning, personal care services and low level nursing care; and
- high care – legislation prescribes nursing services as well as the provision of accommodation, related services and equipment to cater for the higher dependency health requirements of high care residents.

Community care refers to the provision of healthcare services to elderly individuals living in the community.

Industry ownership is highly fragmented, consisting of a large number of very small providers and very few large entities and publicly listed entities operating residential and community care services. Ownership is spread between religious and charitable organisations (44%), private providers (27%), community organisations (18%) and state governments (11%) (AIHW: 2008)[3].

The delivery of services is based upon 170,071 residential places. The allocation of residential places comprises 62% high care and 38% low care. The size of facilities varies between 20 places and 149 residential places with the majority between 21 and 60 beds.

4.2 Regulation

The operation of aged care facilities is regulated by the Australian Government under the Aged Care Act 1997 with accreditation and compliance monitoring carried out by the Aged Care Standards and Accreditation Agency, Office of Quality and Complaints and the Commissioner of Complaints.

The structure of residential care is wholly determined by the Department of Health and Ageing through its annual allocation round of residential care places and community care packages which is based on its regional planning ratios (“ACAR”).

Allocated residential care places (“bed licences”) are issued by the Australian Government as one of either low care, high care, high care extra service or low care extra service.

Residential aged care facilities must meet building certification standards, which seek to ensure minimum levels of physical standards for building. Stringent building certification standards come into effect in 2008.

[3] *Residential aged care in Australia 2006–07, A statistical overview,* June 2008, Australian Institute of Health and Welfare

4.3 CAP in context of total funding

Eligibility of an individual for government funded aged care is determined by Aged Care Assessment Teams (“ACATs”) through assessment of an individual’s medical, physical, social and psychological care needs. The degree of care provided varies significantly, from low level living assistance within the community to intensive nursing/hospital care. Aged care is generally provided under one of three programs:

A *residential aged care provider’s income stream* is comprised of resident contributions and funding through the Department of Health and Ageing (“DoHA”).

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

Table 4: Illustrative provider’s daily income - a high care resident

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

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

Source: UnitingCare agencies

For most high care residents, a provider earns:

- a daily care fee from a resident equivalent to 85% of an aged pension;
- an Aged Care Funding Index (“ACFI”) subsidy (less any resident contribution);
- a daily accommodation supplement (or a ‘rent’) for the provision of the home; and
- the CAP as a percentage of the ACFI subsidy.

In the above illustration, the provider earns total revenue of $198.32 for the provision of 24 hour high level care, hospitality and accommodation. *This income level contrasts with the acute sector where it has been estimated that the cost to care for an elderly person after recovery from the acute admission phase as $967 per day*[4].

A provider’s income is distinguished by whether it is providing high care or low care. A significant difference in the funding of these two levels of care is that a provider is entitled to ask for an accommodation bond from a low care resident (subject to leaving the resident with no less than $34,500 in assets). *Subject to a small retention, accommodation bonds*

[4] Rudd, K, 2007 *Fresh ideas for Transition from Hospital to Aged Care,* media statement, June 30, http;//www.alp.org.au/media

are refundable deposits which entitle the provider to the interest on bond during the period of time a resident is accommodated.

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

Table 5: Illustrative provider's daily income - a low care resident

	Pensioner (assets < $34,500)	**Non-pensioner with assets > $90,410**
Resident payments		
Basic daily fee	32.95	32.95
Income-tested daily fee	0	47.94
Accommodation bond – retention (max)**		9.60
Accommodation bond – interest (say $250,000 x 7.5%)**	0	51.37
DoHA payments		
'ACFI' care subsidy (less income tested fee)	47.94	0.00
CAP (8.75% of the care subsidy)	*4.19*	*4.19*
Accommodation supplement (for >40% supported residents)	26.88	0.00
Total daily income	**$111.96**	**$146.05**

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

Source: UnitingCare agencies

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

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

4.4 Demand for services

The number of Australians aged over 65 is projected to increase dramatically over the next 50 years as the baby boomer generation ages. Specifically, the number of people over 65 is projected to double from 2.7 million in 2004 to 5.4 million by 2028, and may reach approximately 7.3 million by 2051.

Therefore, growth in the aged population has created rapidly increasing demand for aged care services (residential and in-home) and this is expected to continue for at least the next 20 years. Indeed, there is now a shortage of *quality* facilities, particularly in the high care category.

The proportion of residents in high care has rapidly increased to around 70% of all residents in residential care. This trend reflects a dramatic increase in the number of community aged care packages which has served to keep frail aged in their own home and defer their entry to residential aged care.

For more background information, the residential aged care industry is further profiled in *Appendix A*.

4.5 Overview of residential aged care financial performance

The financial performance of residential aged care industry participants is relatively well documented through a review of pricing arrangements conducted by Professor W.P. Hogan, in 2004[5] and industry financial surveys conducted by chartered accounting firms Grant Thornton, Stewart Brown and Co, and Bentleys MRI + James Underwood & Associates.

The residential aged care industry measures financial performance, inter alia, on per bed day and per bed per annum. These denominators enable comparison of one organisation's performance against another. The latter (per bed per annum) enables ready measurement of financial performance against invested capital per bed.

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

Stewart Brown's survey for financial year 2007 covered 10.3% of funded beds. That survey shows that ***on average both high care and low facilities incurred losses continuing a downward trend that has been evident for some years***. Stewart Brown reported average EBITDA[6] per bed per annum of $1,930 (high care) and $4,814 (low care) and that ***only 18.2% (or 18 of 99 high care facilities) achieved a break-even or better result***. Based on a required a pre tax and interest return of, say, 12% on EBITDA, then this level of financial performance would enable an average operator to invest up to $16,083 per bed in high care and $40,116 per bed in low care (net of bonds)[7]. ***Clearly, industry financial performance will not encourage new investment*** with the current cost of establishing new beds costing in excess of $200,000.

Bentleys MRI/James Underwood & Associates survey for 2005-06 found that on average, high care facilities achieved EBITDA of $1,901 per place per annum. On an investment per place of, say, $200,000, this would represent an average return of 0.95% per annum. Low care respondents were better performed with an investment return equivalent to 1.92% on the same basis[8].

Financial information used in the Hogan review is now six years out of date. It is evident from subsequent survey results that financial performance has fallen since then.

Overall the aforementioned survey results indicate that ***even high performing providers are not able to achieve earnings sufficient to induce investment in new beds***. The residential aged care industry financial performance is further profiled in *Appendix B.*

[5] *Review of Pricing Arrangements in Residential Aged Care,* Professor W.P. Hogan, April 2004
[6] EBITDA – earnings before interest, tax depreciation and amortisation
[7] $1,930/12% = $16,083. $4,814/12% = $40,117.
[8] Rider Levett Bucknall estimated the average building cost of a residential aged care bed at $219,611 in January 2008. Source: Aged Care Industry Council, Estimation of Capital Needs for the High Care Residential Aged Care Sector, November 2007, *PricewaterhouseCoopers*

5 Submission in respect of Conditional Adjustment Payment

5.1 Background

The Review of Pricing Arrangements in Residential Care was conducted by Professor W.P. Hogan in 2004 with a broad stakeholder reference group comprising providers, consumers, unions and DoHA.

Professor Hogan recommended a 'conditional incentive supplement'. That incentive was to be linked to gains in efficiency, productivity and workforce training.

The Terms of Reference specify two measures to be examined:

- the extent to which the medium term financial assistance provided by the CAP has been effective in encouraging efficiency through improved management practices including the effectiveness of the three conditions of achieving CAP; and
- the need for and level of any further medium term financial assistance to encourage efficiency and improved management practices.

Residential aged care providers are only eligible to receive the CAP under the following three conditions, that they:

- give staff information and opportunities regarding workforce training;
- make audited accounts available each year to residents, potential residents and their representatives and any person or agency authorised by the Secretary of DoHA; and
- take in a part in periodic workforce census.

The terms of reference imply that management practices are a factor in efficiency and that it is within the scope of management. Professor Hogan's review considered *efficiency* in terms of:

- technical efficiency - a measure of the relative performance of services in converting inputs (labour and capital) into outputs (days of care).
- scale efficiency - a measure of the degree to which a service could improve its productivity by changing its scale of operations to the optimal scale.
- allocative efficiency - is a measure of whether the observed input-mix is optimal (economies of scope within a service's operation eg extension of services to social services).
- dynamic and regulatory efficiency.

Professor Hogan recommended that 'the need for, and value of the (incentive) supplement, should be reviewed . . . continued eligibility of providers for the supplement should be linked to gains in efficiency, productivity and workforce training . . . the concepts of productivity and efficiency should be understood as embracing commitment to workforce training and enterprise bargaining'.

5.2 Response to the Terms of Reference (a)

Term of reference (a): The extent to which the medium term financial assistance provided by the CAP has been effective in encouraging efficiency through improved management practices including the effectiveness of the three conditions of achieving CAP

Improved management practices

It is submitted that *CAP which reached 7% of care subsidy income in 2007-08 has been a critical revenue source that has enabled UnitingCare to continue to achieve a surplus on residential operations and avoid losses in the four years that it has been implemented.*

The effect of removing CAP from the net surpluses of UnitingCare providers collectively over the four years from 2004-05 to 2007-08 is shown in the table below:

Table 6: Effect of removing CAP from UnitingCare agencies' surpluses (aggregate fin. information)

	2004-05#	2005-06#	2006-07	2007-08
CAP (% of care subsidy income)	*1.75%*	*3.50%*	*5.25%*	*7.00%*
	$'000	**$'000**	**$'000**	**$'000**
Actual residential surplus/(loss)	12,809	2,573	1,688	659
CAP	(3,018)	(6,241)	(10,453)	(14,265)
Notional residential surplus/(loss)*	**9,791**	**(3,669)**	**(8,765)**	**(13,606)**

** The amount the result would have been without CAP*
 # Excludes Tasmania in financial years 2005 and 2006

Source: UnitingCare agencies

As is evident from the above table, even with the benefit of CAP, the UnitingCare providers making this submission have seen surpluses on residential aged care fall from $12.8 million in 2004-05 to near break-even of $0.7 million in 2007-08. *If CAP had not existed these providers would have incurred substantial losses aggregating $16.25 million over this period.*

UnitingCare providers submit that the CAP *is* a significant factor in encouraging management efficiency because the funding has provided financial capacity for improvement. Since the commencement of CAP on 1 July 2004, UnitingCare providers have vigorously pursued management efficiency in the interests of all stakeholders, particularly for the purpose of being able to maintain capacity to provide services to residents under an increasingly difficult financial circumstances.

This term of reference implies that management practices are a factor in efficiency. Three relevant efficiency sources were included in the Hogan review:

- technical – how we provide residential aged care;
- scale – how we share resources;
- and regulation – how we comply and enhance client care.

UnitingCare agencies have considered improved management practices in terms of these three relevant efficiency sources. Some examples implemented by the submitting UnitingCare agencies are listed below:

Technical efficiency:

- implementation of service manager development programmes
- implementation of EBAs focused on rewarding measured aged care specific competencies
- development of a range of productivity tools
- deployment of specialists to support residential aged care service managers.

Scale efficiency:

- sharing of residential management between close facilities
- extension of existing facilities to increase bed yield
- centralised procurement.

Regulatory compliance efficiency:

- implementation of a comprehensive risk management system
- tools for reporting and monitoring client care
- tools for supporting applications for accreditation.

As is evident from the above, UnitingCare providers have developed and/or implemented a range of far reaching management initiatives to improve efficiency. The CAP has *assisted* UnitingCare in meeting the costs of these initiatives.

The effectiveness of the three conditions

For UnitingCare, the three conditions imposed by CAP have been unnecessary as each member *has* continued each of the following practices in place before the introduction of CAP:

- providing staff information and opportunities regarding workforce training
- making audited accounts available each year to residents, potential residents and their representatives and any person or agency authorised by the Secretary of DoHA
- being ready to participate in periodic workforce census.

5.3 Response to Terms of Reference (b)

Term of reference (b): The need for and level of any further medium term financial assistance to encourage efficiency and improved management practices.

It was earlier submitted that CAP has been a critical revenue source for UnitingCare. The financial effect of 7% CAP is shown earlier.

The CAP is now 8.75% of subsidy income for the current financial year ending 30 June 2009. ***Each of the UnitingCare organisation's residential budget's for the current financial show either a significant decline in surpluses or increasing losses***.

The effect of notionally removing CAP from the net surpluses of UnitingCare providers collectively over the four years from 2004-05 plus the budget for 2008-09 is shown below:

Table 7: Effect of removing CAP from UnitingCare agencies actual and *budgeted* results

	2004-05#	**2005-06#**	**2006-07**	**2007-08**	***Budget 2008-09***
CAP (% of care subsidy income)	*1.75%*	*3.50%*	*5.25%*	*7.00%*	*8.75%*
	$'000	**$'000**	**$'000**	**$'000**	***$'000***
Actual residential surplus/(loss)	12,809	2,573	1,688	659	(1,907)
CAP	(3,018)	(6,241)	(10,453)	(14,265)	(18,383)
Notional residential surplus/(loss)*	**9,791**	**(3,669)**	**(8,765)**	**(13,606)**	**(20,290)**

** The amount the result would have been without CAP*
 # Excludes Tasmania in financial years 2005 and 2006

Source: UnitingCare agencies

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. The results in also 2008 benefited from a one-off funding supplement of $3.50 per high care resident per day for 9 months.

As is evident from the above table, even with the benefit of CAP, the UnitingCare providers making this submission expect to incur, for the first time, a substantial loss of $1.9 million on residential aged care in 2008-09. *If CAP had not existed, it is estimated that the UnitingCare providers would incur losses of $36.5 million from the introduction of CAP to the end of the current financial year.*

The removal of the CAP without other substantial, positive funding reform *would have severe implications on each of UnitingCare providers' financial viability*. Consequences of removal of CAP vary across each of the individual UnitingCare organisation but collectively may include:

- withdrawal from the provision of residential aged care (closure of existing facilities)
- deferral/abandonment of new investment *(this is 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)*.

Whilst an industry policy perspective may be that withdrawal of some industry participants (or de-fragmentation) is desirable for developing industry efficiency, it is submitted that the UnitingCare providers making this submission already exploit scale and technical innovation and yet are experiencing difficult and deteriorating financial circumstances.

It is therefore submitted that continuation of CAP and further annual increases are critically needed in the short to medium term to enable survival of many participants whilst a long term plan is developed and implemented for industry viability and to encourage expansion to meet future demand.

6 Additional submission: Issues adversely impacting the residential aged care industry

6.1 Introduction

The medium term funding provided by CAP is one component of the Australian Government's funding of the residential aged care sector. It is submitted that the sector faces adverse issues including:

- workforce
- input cost increases which far exceed operational funding indexation
- a substantial capital funding shortfall
- regulation that stifles efficiency and optimal use of resources.

This section and section 7 go beyond the scope of our submission in respect of CAP and outline a number of these issues and possible solutions for long term funding and regulatory reform to enable sector providers to survive and provide services to meet the rapidly growing demand for aged care in Australia.

6.2 Workforce

Issues

Aged care nurses and other health professionals in the sector are paid less than peers in the acute sector as a consequence of wage increases in the public health system as hospitals desperately attempt to attract and retain staff.

Further, acute/hospital sector staff are advantaged in respect of wages, conditions, career structures and training.

Current funding is insufficient for residential aged care and community care to allow for the significant staff development necessary to respond to the growing demands of our ageing population.

Implications

These disparities significantly disadvantage aged care providers when competing for, and retaining staff.

High staff turnover is both detrimental to client care and a significant impediment to efficiency in aged care sector with management resources.

Remedies

UnitingCare considers that the following remedies for residential aged care and community care are required:

- A transparent mechanism, accompanied by sufficient recurrent funding, to achieve and maintain comparable wages and working conditions with the acute health care sector for all staff working in residential and community aged care. Preliminary

costing undertaken by the National Aged Care Alliance (NACA) in 2006 estimated funds required for this adjustment at approximately $250 million per annum.

- A review to examine regulation and current industry practice in terms of staffing mix and who should be responsible for various activities. Some rationalisation may be possible. A way forward may be the funding of pilot programs to evaluate less expensive models of residential care.
- Dedicated funding to ensure all staff in aged and community care have access to education and training that furthers their qualifications and skill levels, together with funded strategies to facilitate attendance barriers such as replacement staffing, reimbursing travel time and costs and provision for clinical placements.
- Reduction of paperwork to provide care staff with increased caring time and greater staff satisfaction.

6.3 Input costs are increasing faster than operational funding

Background

The Commonwealth Own Purpose Outlays ("COPO") indexation arrangements came into effect with respect to residential aged care funding from 1 July 1996.[9]

UnitingCare understands that the pricing arrangements are set in the short-term on the basis of Treasury parameters established for budget commitments which are in-confidence and not for public release, being future projections.

Issues

UnitingCare is incurring input cost increases which are rising at a much faster rate than funding indexation, particularly wages.

In recent years, increases in subsidy income have been 2% on 1 July of each year. During that same period, UnitingCare providers have incurred increases in the major cost input, staff wages, at rates of greater than 4% under enterprise bargaining agreements. An example of these is shown in the table below:

Table 8: Example of wage input cost increases

	Nurses	AWU/MISO	Admin/ Clerical	Allied Health (Community)	Allied Health (Professionals)
Aug 2005					4.00%
Sep 2005				4.00%	
Oct 2005	3.25%				
Jan 2006			2.75%		
Jul 2006	4.75%	4.05%	3.00%		
Aug 2006					2.00%
Oct 2006				4.00%	
Jan 2007			3.00%		
Feb 2007					2.00%
Jul 2007	4.50%	4.10%	3.00%		
Sep 2007				4.00%	4.00%

Source: A UnitingCare agency

[9] http://www.health.gov.au/internet/wcms/publishing.nsf/content/health-investinginagedcare-report-07-7-3.htm (W P Hogan, Reviewer April 2004)

Additionally, UnitingCare agencies are being forced by staff shortages to turn to agency staff. The effect of greater reliance on agency staff has had the effect of exacerbating the shortfall between cost increases and funding increments from indexation.

Looking forward, competition from the acute health sector for scarce staff may be expected to add to the shortfall.

In addition to wage costs, many other inputs such as food, fuel, real estate costs have been subject to cost increases which exceed the COPO indexation.

Neither the Resident Classification Scale (RCS) care subsidy system nor its successor, ACFI have been developed through the determination of the true costs of delivering care and accommodation to residents.

The cumulative effect of a care subsidy not founded on the true costs of care and inadequate indexation is the collapse in UnitingCare's net surplus as disclosed in section 5.3 of this report. UnitingCare's experience is consistent with the decline in industry financial performance of the industry as reported by Stewart Brown and referred to earlier in section 4.5 of this document.

Remedies

UnitingCare agencies consider that the following remedies are required:

- implementation of a transparent method of estimating input cost increases that is relevant to the aged care and community care and capable of being subjected to external scrutiny and review
- implementation of periodic indexation based on the above-mentioned method
- implementation of resource based subsidy system which recognises the true cost of provision of care.

6.4 Capital Funding is not sufficient to encourage investment in new capacity

6.4.1 Background

Capital investment in residential aged care may come from owner's equity or debt. Not-for-profits may source equity from bequests.

For-profit providers have an obligation to provide a commercial return to equity providers. Both for-profit and not-for-profit providers have an obligation to service debt providers.

In the case of not-for-profit operators, the underlying aged care operations need to have a sufficiently robust return on capital employed to provide a margin over the cost of debt, to ensure capacity to service principal and so that variability in earnings will still enable debt servicing.

Once invested in residential aged care facilities, a provider is able to access the following income streams to service equity and debt:

High care:

- A maximum accommodation supplement or charges ‘rent’ which is currently regulated at a maximum of $26.88 per resident per day for residents admitted after 20 March 2008.

Low care:

- A maximum accommodation supplement for ‘supported’ or ‘concessional’ residents which is currently regulated at a maximum of $26.88 per resident per day for residents admitted after 20 March 2008.
- Accommodation bond comprising:
  - retention of $9.60 per resident per day (for up to 5 years)
  - interest income on the accommodation bond (say, $50 per resident per day for a bond of $250,000).

The cost of establishing a new residential aged care bed is reportedly in excess of $200,000 per bed (excluding land):

- “Costs of building a new bed have jumped to $200,000 in some places” Aged Care Association, Chief Executive Rod Young, Perth 2007
- Rider Levett Bucknall (quantity surveyors) - $219,611[10].

UnitingCare’s quantity surveyor based estimates for the construction cost of new building in 2008 exceed $200,000 per bed, excluding land and plant and equipment fit-out.

A salient feature of the capital funding is the maximum accommodation charge/supplement (rent) of $26.88 per resident per day applying to high care beds and low care beds occupied by financially disadvantaged residents. New facilities are frequently being built to the standard of four star hotel accommodation. The amount of the supplement/charge contrasts unfavourably from a provider’s perspective with daily room rates for such hotel accommodation. How many hotel rooms are available for $26.99 per day?

Where providers can access accommodation bonds for low care beds, the market generally enables them to access a sufficient bond to meet capital requirements[11].

6.4.2 Capital funding shortfall – the accommodation supplement is manifestly inadequate

As stated by the Productivity Commission in September 2008, the current pricing arrangements covering accommodation payments give rise to inefficient cross-subsidies between low and high residential care and distort investment decision-making.

UnitingCare providers submit that there is capital shortfall as a consequence of the inadequacy of the amount of the maximum accommodation supplement /charge of $26.88 and the regulatory prohibition of bonds for high care beds.

[10] Estimate specifically commissioned for Report for Aged Care Industry Council - Estimation of Capital Needs for the High Care Residential Aged Care Sector, PricewaterhouseCoopers November 2007
[11] This is not always the case in lower socio-economic areas and rural and remote areas.

UnitingCare providers submit that the accommodation supplement /charge *is sufficient to fund investment in an aged care bed of approximately $120,000 and that there is shortfall in capital funding in the order of $80,000 per bed.*

This is demonstrated in the following financial analysis:

Assumptions

Key assumptions for a commercial landlord investor are as set out in the table below:

Table 9: Assumptions for a commercial landlord investor in a residential aged care bed

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

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

The above assumptions have been applied to develop projected cash flows available to provide a net income stream to a hypothetical property investor.

Projected cash flow

A projected cash flow has been developed using the above assumptions to provide an internal property investment rate of return of 9%[12].

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

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

Table 10: Projected cash flow per bed (extract)

Year	**0**	**1**	**2**	**3**	**4**	**5~**	**~30**
Rent		9,321	9,321	9,955	10,590	11,228	20,816
Capital replacements							
Depreciation tax shield		1,163	1,163	1,163	1,163	1,163	1,163
Purchase land/ sell land	(20,000)						64,868
Building cost	*(116,310)*						0
Net cash flow $	**(136,310)**	**10,484**	**10,484**	**11,118**	**11,753**	**12,391**	**86,847**

[12] In the present interest rate environment this may be inadequate. It is assumed that this is an adequate long term IRR with a stable tenant and the rental stream available from a Government supplement and resident charges.

As indicated by the above table, ***an investment in a bed of $116,310 would provide an adequate return to a commercial property investor***[13].

This calculation accords with information in the public domain as to the amount the previous government intended to fund. "The Government based its figures on the assumption $105,000 per place was sufficient to cover construction costs. Belcher believes that even before land is factored in $140,000 is closer to the mark[14]". Applying the amount of $140,000 quoted by Belcher and land content of $20,000, then the amount available for construction is net $120,000 which closely approximates UnitingCare's calculation of $116,310.

Shortfall in funding

If $200,000 per bed is a benchmark construction cost, then the shortfall in capital funding is $83,690 per bed. If the cost of land and plant fit-out is considered then the shortfall is likely to exceed this amount.

On this basis, if the UnitingCare agencies were to proceed with replacement of standard high care beds with a 120 bed standard high care facility under the current funding arrangements this would result in wealth transfer away from the agency (or any provider for that matter) to the community of $10 million.

Not for profit estimate

UnitingCare agencies, as not-for-profit providers, do not necessarily need to achieve a commercial rate of return. If the abovementioned assumptions are relaxed to provide an IRR of 7.5% and the depreciation tax break is excluded, then an investment in construction of $126,149 provides this rate of return.

6.4.3 The accommodation supplement/charge is insufficient to service borrowings

UnitingCare agencies submit that accommodation supplement/charge insufficient to service bank borrowings.

Consideration has been given to a provider's position assuming a bed costing $200,000 to establish is 50% debt funded at a 9% per annum interest rate over 25 years. A debt amortisation schedule is shown below:

Table 11: Debt amortisation schedule – (single bed)

Year	Principal $	Interest $	Repayment $	Balance $
1	100,000	9,000	(10,181)	98,819
2	98,819	8,894	(10,181)	97,532
3	97,532	8,778	(10,181)	96,130
~	~	~	~	~
24	17,909	1,612	(10,181)	9,340
25	9,340	841	(10,181)	**0**

Source: UnitingCare agency

[13] UnitingCare would be pleased to provide the financial modelling behind these calculations to interested government agencies.
[14] Industry journal, 2007. Wayne Belcher, CEO Churches of Christ Care (Bethanie Group), WA.

As is indicated by the above table:

- Cash generation per resident to meet the principal debt obligation is in excess of $10,000 per resident per annum
- Interest expense is in the range of $8,000 to $9,000 per resident in the early years.

Debt providers usually include a range of financial performance covenants. A common covenant is interest cover measured by the ratio of earnings before interest and tax ('EBIT')/interest expense. Interest cover ratio covenants are often in the range of 2.0 to 3.0. This range of cover ratios would require a provider to derive EBIT per resident of $16,000 to $27,000 in the early years of the loan.

Stewart Brown's survey for financial year 2007 survey reported average EBITDA per bed per annum of $1,930 (high care) and $4,814 (low care). *This level of earnings is clearly inadequate to meet interest obligations of $8,000 to $9,000 per resident per annum, particularly for high care.*

This analysis is supported by the public comment of an aged care banking specialist as a panellist at a recent industry seminar to the effect that a proposal for standard high care beds is unbankable[15]. Additionally, other commercials bankers have indicated to a UnitingCare agency in discussion that 'customers just cannot make standard high care proposals work even with $300,000 bonds on the low care component'[16].

6.4.4 Accommodation bonds are not allowed for standard high care beds

In respect of standard services, bonds can currently be levied only for places in low-care facilities.

Accommodation bonds are generally financed by the sale of residents' homes, and are returned to their estate upon death, minus a small retention. ***An accommodation bond is effective means of user pays from the existing equity of a resident. They place little or no financial burden on residents and beneficiaries of resident's estate receive a return of virtually the entire capital sum***.

The absence of accommodation bonds or equivalent funding has caused UnitingCare to abandon proposed new building projects.

Under highly restrictive eligibility criteria, providers may be able to offer extra services in high care and access a resident bond. However, the eligibility criteria include an onerous DoHA pre-requisite that a provider is a "very good" provider. This policy has denied a UnitingCare organisation access to extra service status beds even though that provider significantly outperforms the average provider in accreditation and compliance. This particular policy denies resident choice and access to better quality facilities and denies providers access to capital funding.

The Productivity Commission reported in September 2008, that the ability of providers to differentiate their services in terms of price and quality is highly constrained. For example, while 'extra service' places provide a degree of additional choice in residential care.

[15] Aged Care Critical Issues Forum, Grant Thornton Conference Centre, 16 April 2008, Brisbane
[16] Discussion between a UnitingCare agency and aged care sector banking specialists in 2007

However, this is limited to hotel type services (accommodation, food and other amenities) and does not extend to personal care. The ability of older people to exercise choice of community care services is constrained by the current program and funding mix.

6.5 Regulation is stifling efficiency and optimal use of resources

6.5.1 Burden of compliance

Background

Residential aged care is a highly regulated industry, with a range of accreditation, inspection and compliance regimes. The need for regulatory controls is not disputed – older Australians who are vulnerable and dependent on others for shelter, care and control of their finances are entitled to the highest levels of security and dignity. However, there are questions as to whether the existing regulation is effective, especially as development of regulation can be seen as reactive and overlapping.

There are a number state, territory and commonwealth agencies active in monitoring and regulating the care industry.

The Regulation Taskforce (2006, p. 33) concluded that some changes to the regulation of residential care since the Aged Care Act 1997 were ineffective, that the burden of regulation on the industry was excessive, and that duplication appeared unnecessarily costly for both providers and government.

Issues

Accreditation by the Aged Care Standards and Accreditation Agency (ACSAA) can take up to one month to prepare per facility. The process is complicated where facilities share a single site (eg mixed high and low care residential care) where multiple accreditations are required.

There is anecdotal evidence from within the UnitingCare that member organisations are having difficulty retaining qualified staff in leadership roles in residential care, due to their reported interactions with the regulatory systems, such as accreditation and validation, being a negative and demoralising experience.

The extra pressure of spot checks from the agency and the complaints unit is reported to put increased pressure and stress on workers already managing high workloads and expectations and severely reduces job satisfaction.

There are a range of agencies that may undertake unannounced visits including ACSAA, the Office of Quality and Complaints and the Commissioner of Complaints. Inspections are not coordinated and each visit requires significant staff time. For example, unannounced visits by ACSAA require at least two staff to be detached from duties for inspections. There appears to be little flexibility in the practice of scheduling reviews, meaning that senior staff will be required at short notice. There have been reports by care staff of inconsistent evidence requirements, leading to delays and rework.

Complaint resolution managed through DoHA represents a significant workload. UnitingCare managers have expressed concern that the system is not flexible enough to allow for management of differing severity in complaints.

Mandatory reporting demands time of service managers and care staff. The scope and extent of this needs consideration.

Building certification has led to the virtual elimination of new shared rooms. Provision of care and maintenance is more costly in single rooms. Some residents prefer sharing.

Remedies

UnitingCare agencies consider that the Federal Government should prioritise regulation reduction as recommended by the Regulation Taskforce.

6.5.2 Allocation of residential aged care places

Background

The aged care planning, allocation and approvals processes have been in place for over twenty years with the dual purpose of controlling Commonwealth outlays as well as ensuring places are allocated in geographic areas where the 70 and over aged cohort reside.

A fundamental aim of the allocation process when it was established was regional equity. The argument has been that without the allocation of places according to regional planning areas, access would depend on the locational preferences of provider investors.

In 1986, the aged care planning ratio was set at maintaining the then existing national ratio of 100 residential beds per 1,000 persons aged 70 and over (60 low care beds and 40 low care beds).

Over the years, this formula has changed a number of times with community aged care packages being included in the 1990s. The current formula which was introduced in 2007 is 113 places per 1,000 people aged 70 and over comprising 44 high, 44 low and 25 community packages.

Each year the Department of Health and Ageing advertises a number of places based on the above formula and calls for expressions of interest (applications) from interested people. This process is known as the Aged Care Approvals Round ("ACAR") and involves an assessment of the expressions of interest and the allocation of places to successful applicants.

Issues

UnitingCare agencies consider the ACAR process:

- utilises allocation formulae which do not address need in particular catchments and for service types
- lacks transparency as applicants are poorly informed of the process and reasons for the outcome
- is excessively costly for providers because of the complexity information required by DoHA.

Remedies

UnitingCare agencies consider that the Australian Government should:

- review allocation formulae to ensure they address need in particular catchments and for service types
- improve transparency by notifying unsuccessful applicants of the process and reasons for the outcome
- make application forms shorter and less complex.

6.5.3 ACFI

Background

The ACFI ("Aged Care Funding Instrument") introduced on 20 March 2008 and replaced the Resident Classification Scheme ("RCS").

ACFI is a substantial change to the way aged care is funded and the way in which care is assessed. ACFI operates with a number of domains of health and behaviour that are assessed to gain an overall 'score' for each individual.

Issues

The introduction of ACFI has led to a shift in the distribution of funding. More funding is available for high care at the expense of low care which will ultimately affect approved providers' capital income because refundable deposits (bonds are prohibited in standard high care services).

There is a real risk that the elderly in genuine need of low level residential care will not find access to a home because of the truncation of low level funding under ACFI.

ACFI uses a medical approach to assessing care needs. This approach is very different from the legislative requirement of assessing and delivering care in a person-centred / individualised way.

Monitoring of ACFI claims for existing residents since 20 March 2008 has indicated that, but for grand parenting, a UnitingCare provider would lose $13.94 per resident per day on 1,167 residents or 72% of resident conversions. This result probably understates the impact because of increased acuity. This is a cause for concern as to the potential detrimental impact on income for new residents.

Remedies

The Australian Government should honour the guarantee of funding for residents on the RCS saved rate and assess residents who are under the RCS saved rate against the ACFI appraisal (last appraisal submitted) to assess whether the ACFI appraisal is correct.

The Australian Government should set aside contingency funding to support residential aged care providers in the event that the ACFI substantially erodes provider's subsidy income or renders the provision of low level care unviable.

7 Additional submissions: Recommendations

In respect of the issues outlined in section 6 and to enable residential aged care providers to survive and meet demand for residential aged care, the submitting UnitingCare agencies recommend that:

Workforce:

1. The Australian Government introduce a transparent mechanism and sufficient dedicated funding, to achieve and maintain comparable wages and working conditions with the acute health care sector for all staff working in residential and community aged care.
2. The Australian Government examines regulation and current industry practice in terms of staffing mix and implements funding pilot programs to evaluate less expensive models of residential care.
3. The Australian Government dedicate funding to ensure all staff in aged care have access to education and training that furthers their qualifications and skill levels, together with funded strategies to facilitate attendance to barriers such as replacement staffing, reimbursing travel time and costs and provision for clinical placements.

Input cost increases far exceed operating funding indexation:

4. In September 2008, the Productivity Commission raised 'unbundling' as a means of more accurately pricing the individual components to better reflect their underlying cost. As raised by the Productivity Commission:
    - The Australian Government implement a transparent method of estimating input cost increases that is relevant to the aged and community care industry and capable of being subjected to external scrutiny and review.
    - The Australian Government implement periodic indexation based on such a transparent method.
5. The CAP be retained as an interim funding measure and increased by 1.75% each year until the Australian Government develops and implements the above-mentioned indexation reform and underlying operational funding levels to enable long term industry viability and to encourage expansion to meet future demand.
6. The Australian Government sourced operational funding be independently reviewed to:
    - enable resetting at a level that will enable efficient providers to derive a commercial return
    - allow for explicit funding of cost imposts incurred in providing care in rural and remote areas and disadvantaged economic catchments
    - implement a resource based subsidy system which recognises the true cost of provision of care.

Capital funding shortfall:

7. As raised by the Productivity Commission in September 2008, refundable deposits (accommodation bonds or capital contributions) be extended to standard high care services.
8. The manifestly inadequate daily accommodation supplement or 'rent' of $26.88 per resident per day for supported residents is increased for new facilities to reflect current costs of development. It is envisaged this will require doubling the supplement to $54 per resident per day, for new facilities operationalised after an announcement date (of say, 1 July 2009).
9. Extra services are widely de-regulated to enable greater consumer choice and improved funding to providers. This should include eliminating the onerous and subjective DoHA pre-requisite that a provider is a "very good" provider[17].

Regulation stifles efficiency and optimal use of resources:

10. The Australian Government prioritise regulation reduction as recommended by the Regulation Taskforce.
11. The Australian Government review allocation formulae to ensure they address need in particular catchments and for service types:
    - improve transparency by notifying unsuccessful applicants of the process and reasons for the outcome
    - making application forms shorter and less complex.
12. The Australian Government set aside contingency funding to support residential aged care providers in the event that the ACFI substantially erodes provider's subsidy income or renders the provision of low level care unviable.

[17] This policy has denied a UnitingCare agency access to extra service status beds even though that provider outperforms the average in accreditation and compliance.

Appendices

Appendix A: Brief industry profile

Overview

The two basic types of aged care in Australia are residential aged care and community care.

Residential aged care refers to the provision of accommodation and nursing services to the elderly in dedicated residential/hospital facilities (as distinct from retirement living which has no direct government involvement). Residential aged care can be grouped into two broad care categories:

- low care – involving the provision of accommodation and services such as laundry, meals, cleaning, personal care services and low level nursing care; and
- high care – legislation prescribes nursing services as well as the provision of accommodation, related services and equipment to cater for the higher dependency health requirements of high care residents.

Community care refers to the provision of healthcare services to elderly individuals living in the community.

Industry ownership is highly fragmented, consisting of a large number of very small providers and very few large entities and publicly listed entities operating residential and community care services. Ownership is spread between religious and charitable organisations (44%), private providers (27%), community organisations (18%) and state governments (11%) (AIHW: 2008)[18].

The delivery of services is based upon 170,071 residential places The allocation of residential places comprises 62% high care and 38% low care. The size of facilities varies between 20 places and 149 residential places with the majority between 21 and 60 beds.

In the community care segment of the sector, there are approximately 38,000 Community Aged Care Packages ("CACPs") and 4,500 Extended Aged Care at Home ("EACH") packages. The Home and Community Care ("HACC") program which is jointly funded by the federal government, states and territories with over another 777,000 persons receiving assistance.

While the predominant age of residents is greater than 85 years, there are 6,412 residents below the age of 65 years. Service delivery in residential facilities and in the community is centered on individuals who have different needs with consequent complexity in care requirements and the delivery of care.

[18] *Residential aged care in Australia 2006–07, A statistical overview,* June 2008, Australian Institute of Health and Welfare

Regulation

Allocation of places ("ACAR")

The operation of aged care facilities is regulated by the Commonwealth Government under the Aged Care Act 1997 with accreditation and compliance monitoring carried out by the Aged Care Standards and Accreditation Agency.

The structure of residential care is wholly determined by the Department of Health and Ageing through its annual allocation round of residential care places and community care packages which is based on its regional planning ratios. The transparency and efficiency is currently the subject of review by external consultants and the Probity Report is to be presented to the Department and the Minister for Ageing.

The Australian government aims to have 113 residential places and community care packages per 1,000 people aged 70 years and over by 2007. The target comprises 88 residential care places (44 low care and 44 high care) and 25 community care places.

Allocated residential care places ("bed licences") are issued by the Federal Government as one of either low care, high care, high care extra service or low care extra service. Since the introduction of the "ageing in place" policy as part of 1997 industry reforms, residential aged care facilities have been able to offer both low care and high care beds at the same facility, enabling providers to offer a continuum of care in a familiar environment and reducing disruption to the resident.

Residential aged care facilities must meet building certification standards, which seek to ensure minimum levels of physical standards for building. Stringent building certification standards come into effect in 2008. This may result in a degree of industry rationalisation as some of the lower end operators struggle to meet the increased regulatory standards.

Funding

Eligibility of an individual for government funded aged care is determined by Aged Care Assessment Teams ("ACATs") through assessment of an individual's medical, physical, social and psychological care needs. The degree of care provided varies significantly, from low level living assistance within the community to intensive nursing/hospital care. Aged care is generally provided under one of three programs:

- Residential Aged Care – the provision of government subsidised residential aged care for those assessed as having low or high care needs and who wish to enter residential care.
- CACPs – the provision of community care and assistance, such as assistance with personal care and meals, domestic assistance and transport, to individuals who are assessed as having low level residential care needs but wish to remain in the community; and
- EACH packages can be provided to individuals eligible for a high level of residential care but who wish to, and are able to, continue to live in the community.

A *residential aged care provider's income stream* is comprised of resident contributions and funding through the Department of Health and Ageing ("DoHA").

For most high care residents, a provider earns:

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

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

Under *highly restrictive eligibility criteria*, providers may be also able to offer extra services, in either low care or high care that involves a much higher standard of accommodation, food and other services. The extra service component of residential care is not covered by government subsidy. Extra service places may comprise up to 15% of total allocated places.

Demand for services

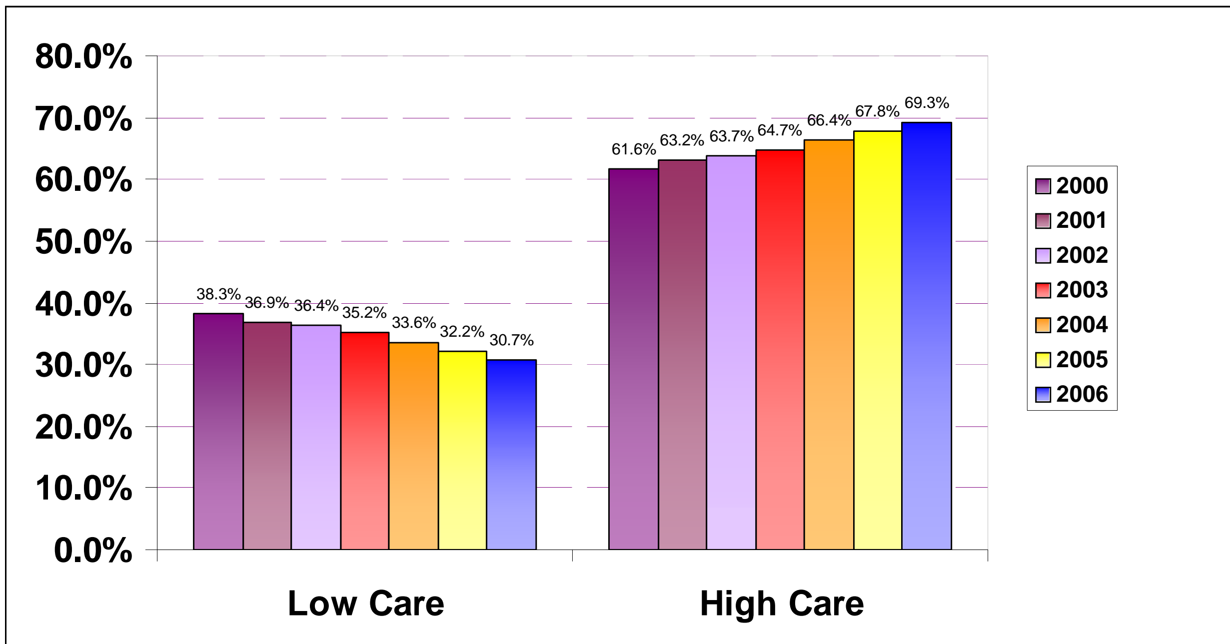
The number of Australians aged over 65 is projected to increase dramatically over the next 50 years as the baby boomer generation ages. Specifically, the number of people over 65 is projected to double from 2.7 million in 2004 to 5.4 million by 2028, and may reach approximately 7.3 million by 2051. Sustained low levels of fertility (albeit improving currently) and increasing life expectancy at birth are expected to result in a sustained shift to a more senior-weighted age structure of the population.

Therefore, growth in the aged population has created rapidly increasing demand for aged care services (residential and in-home) and this is expected to continue for at least the next 20 years. Indeed, there is now a shortage of quality facilities, particularly in the high care category.

Demand for residential aged care tends to be localised as most residents do not want to move far from family homes and other family and social infrastructure. However, while local demographics play a role in broad terms, demand is expected to increase across all regions of Australia.

The proportion of residents in high care has rapidly increased to around 70% of all residents in residential care as shown in the chart below:

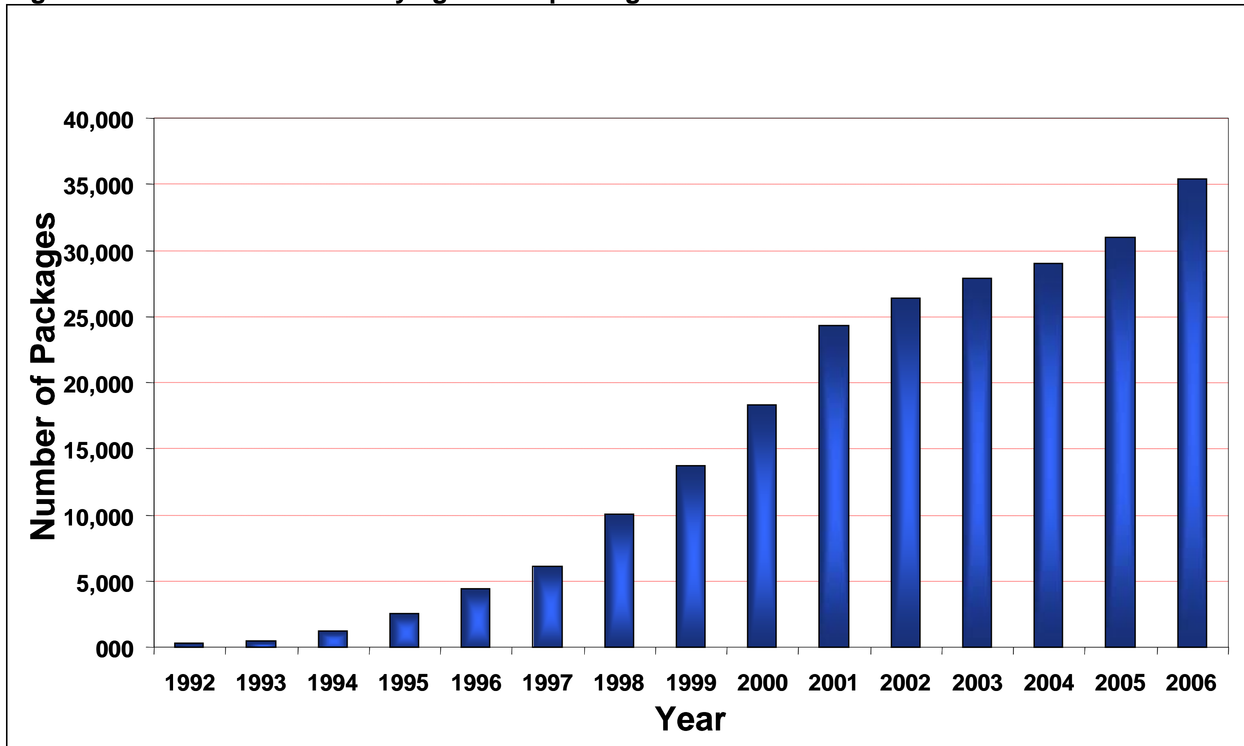
Figure 2: Proportion of residents in low care and high care: 2000 to 2006



Source: Grant Thornton

This trend reflects a dramatic increase in the number of community aged care packages which has served to keep frail aged in their own home and defer their entry to residential aged care as shown below:

Figure 3: Number of community aged care packages 1992 to 2006



Source: Australian Institute of Health and Welfare, Older Australia at a glance: 4th edition, p126

This increased provision of community care has led to increased acuity levels in residential aged care.

Appendix B: Brief profile of residential aged care financial performance

Introduction

The financial performance of residential aged care industry participants is relatively well documented through a review of pricing arrangements conducted by Professor W.P. Hogan, in 2004[19] and industry financial surveys conducted by chartered accounting firms. The analysis in this section of this submission is based on the following sources (in order of recency):

- Aged Care Financials Performance Benchmarks Year Ended 30 June 2007, Stewart Brown and Co ('Stewart Brown');
- Grant Thornton, October 2008 and February 2008;
- National Residential Aged Care Survey Bentleys MRI + James Underwood & Associates 2006; and
- Review of Pricing Arrangements in Residential Aged Care, Professor W.P. Hogan.

Analysis of financial performance

The residential aged care industry measures financial performance, inter alia, on per bed day and per bed per annum. The common denominators of bed day and bed per annum enable comparison of one organisation's performance against another. The latter (per bed per annum) enables ready measurement of financial performance against invested capital per bed.

Grant Thornton – October 2008

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

Stewart Brown

Stewart Brown's survey for the year ended *30 June 2007* covered 253 residential aged facilities and 10.3% of funded beds. Stewart Brown reported financial results, on average, as shown in the table below:

[19] *Review of Pricing Arrangements in Residential Aged Care,* Professor W.P. Hogan, April 2004

Table 12: Average survey financial results year ended 30 June 2007

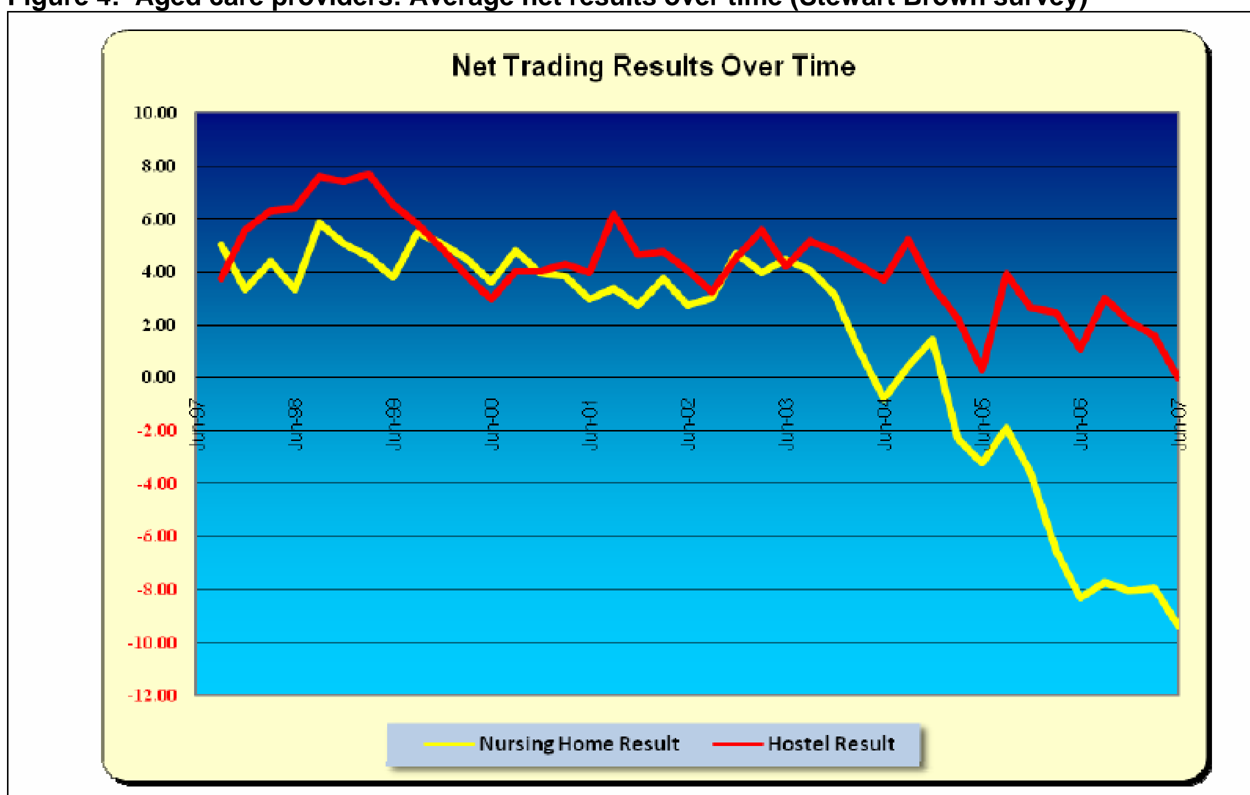
	Nursing Homes		Hostels	
	2006 Bed Day	2007 Bed Day	2006 Bed Day	2007 Bed Day
	$	$	$	$
Income	148.61	154.50	93.89	103.61
Care costs	(102.66)	(106.75)	(47.19)	(54.28)
Other operating costs	(54.28)	(57.14)	(45.64)	(49.39)
Net operating (loss)/profit	**(8.33)**	**(9.39)**	**1.06**	**(0.06)**
Net operating result (annualised $ per annum)	**(3,040)**	**(3,427)**	**387**	**(22)**
EBITDA* ($ per annum)		**1,930**		**4,814**

* Earnings before interest, tax and depreciation

Source: Stewart Brown – year ended 30 June 2007 (annualised calculation, UnitingCare agency)

As is evident from the above table, on average, surveyed operators of both nursing homes (high care) and hostels (low care) incurred losses in financial year 2007. These results continue a downward trend evident for a number of years as shown in the chart below:

Figure 4: Aged care providers: Average net results over time (Stewart Brown survey)



Source: Stewart Brown year ended 30 June 2007

Stewart Brown reported that only 18.2% (or 18 of 99 high care facilities) achieved a break-even or better result.

EBITDA is the acronym for 'earnings before interest, taxes, depreciation and amortisation'. It is calculated by taking operating income and adding back to it interest, depreciation and amortisation expenses. This measure is used to analyse operating profitability before non-

operating expenses (like interest and other non-core expenses) and non-cash charges (depreciation and amortisation). EBITDA is a measure of the cash flow return to a provider (before servicing debt and tax obligations).

Stewart Brown also reported that top 10% high care and low care EBITDA results as shown below with the earlier mentioned averages:

Table 13: EBITDA – average and top 10% - year ended 30 June 2007

	High Care		Low Care	
	Top 10% 2007	**Ave 2007**	**Top 10% 2007**	**Ave 2007**
	$	**$**	**$**	**$**
EBITDA	6,548	1,930	10,640	4,814

Source: Stewart Brown – year ended 30 June 2007 (annualised calculation, UnitingCare agency)

If investors required a pre tax and interest return of 12% on EBITDA, then 'top 10' operators would only be receiving an adequate return on investments per bed of up to $54,566 in high care and $88,666 in low care (net of bonds)[20].

Grant Thornton – February 2008

Grant Thornton have prepared a financial analysis based on data obtained from financial information submitted to DoHA as a requirement of the CAP. Key reported findings included:

- 40% of all providers reported a loss in residential aged care;
- net profit per bed fell by 30% from 2005 to 2006;
- the annual average net profit per bed was around $1,700, a return of less than 2.5%;
- both 'for-profit' and 'no-for-profit' providers experienced declining returns; and
- non-urban providers reported much lower earnings than urban providers.

Grant Thornton also noted that factors which impact financial performance include:

- facility size;
- building configuration and condition;
- location;
- extent of accommodation bonds;
- marketing and reputation;
- resident mix; and
- staff mix.

[20] $6,548 divide by 12% = $54,566. $10,640 divide by 12% = $88,666

These factors also accord with UnitingCare agencies' experience. For example, many older facilities were built with the objective of creating a home-like environment for residents and the configuration does not support efficient staffing. Further, the mining boom and rural staff shortages have brought about a need to 'fly-in and fly-out' nursing staff in inland locations.

Bentleys MRI + James Underwood & Associates

Bentleys MRI and James Underwood & Associates performed a residential aged care aged care financial survey in respect of financial year. 2005-06. This survey had a participation rate of 354 services. The for-profit sector survey 11.6% of participants or 41 services nationally. Key findings include:

High care (112 respondent facilities):

- the average high care return before capital costs was $6.08 per resident per day or $2,220 per annum per place. '"On (an investment cost of) $140,000 per place to commence, this represents an "EBITDA return of 1.6%;
- the average high care return was positively influenced by the presence of some extra service facilities in the survey. Excluding extra services facilities the remaining high care facilities averaged a surplus of $5.21 per resident per day (or $1,901 per resident per annum);
- after interest costs and depreciation, high care facilities on average incurred a loss of $0.06 per resident per day (a near break-even result on average);
- the average private sector return before other costs in 2005/06 was $29.44 per resident per day – an "EBITDA" return of 7.7% on a capital outlay of $140,000 per place. By comparison, the average voluntary/government return was $0.94 per resident per day. Similarly, after inclusion of other costs, the returns varied from $24.64 per resident per day for the private sector to a loss of $(5.49) per resident per day in the voluntary/government sector;
- the results of the survey and predecessors indicate that single rooms increases operating costs very substantially, not just capital costs. As both High Care subsidies and High Care fees for general High Care services; and
- are capped by the Australian Government, this results in a reduction in profitability.

Low care (167 respondent facilities):

- the national average return before other costs figure for low care services increased $10.52 per resident per day. For a service with a capital cost of $140,000 per place, the $10.52 per resident per day (or $3,840 per resident per annum) represents an EBITDA return of just 2.7%;
- the surplus after other costs fell from $5.89 per resident per day in the prior year to $4.19 per resident per day;

Merged (low and high care) services (76 respondent facilities):

- The return before other costs for the voluntary/government merged services fell by $2.50 per resident per annum from 2004/05 levels; and
- on average, services operated at a loss of $1.06 per resident per day.

Hogan

The Hogan review sought financial information related to financial year 2001-02 and received responses from 31% of residential aged care facilities. Key findings included:

- the overall average EBITDA for services across Australia was $2,001 per bed year;
- overall, providers in the 61 to 90 resident size bracket reported the highest average EBITDA at $3862 per bed year which is 93 per cent higher than the average EBITDA result for all services of $2,001; and
- by resident mix, 83% mixed care services reported positive EBITDA. This was followed by mainly low care services at 75%. In comparison, providers with a mainly high care resident mix reported the lowest percentage of services with positive EBITDA figures at 64%.