REVIEW OF PRICING ARRANGEMENTS
IN RESIDENTIAL AGED CARE

Final Report

WP Hogan
Reviewer

Review of Pricing Arrangements in Residential Aged Care

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5 April, 2004

The Hon Julie Bishop MP
Minister for Ageing
Parliament House
CANBERRA ACT 2600

Dear Minister,

Review of Pricing Arrangements in Residential Aged Care

I am pleased to present the Report of the Review of Pricing Arrangements in Residential Aged Care.

The main focus of the Review has been on the long-term prospects for the industry bearing particularly on sources of funding and pricing arrangements. An extensive array of matters has been taken into consideration including user contributions, relationships between residential care and other aged care programs, structural and regulatory matters, including disincentives, as well as the role of markets.

The document contains recommendations for the short, medium and long term. It is envisaged that those recommendations for the short and medium term would be considered for implementation before 2008. I have also included a number of long term options for consideration.

Yours sincerely,

Warren P Hogan
Reviewer

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PREFACE

The main task of the Review has been to examine the longer term prospects of residential aged care services with particular respect to future arrangements for private and public funding, performance improvement in the industry and longer term financing. Subsidiary concerns were with domiciliary care and related housing needs.

What is of most concern is the impact of the rise in health and aged care spending and of outlays on pensions, and the potential impact these rises will have on taxpayers if there are no policy adjustments. The impact of the rise in aged care spending is at the heart of this Review. A central concern is how intergenerational inequities are to be relieved by the older members of Australia's society taking a relatively higher financial responsibility for their aged care needs while at the same time ensuring that the needy and disadvantaged in society are supported.

The provision of appropriate and quality services for older people is an important objective of public policy. At the same time, with growing demand for aged care, the issue of sustainability is a real concern. The challenge is to balance cost sharing with equity of access while upgrading the quality of care. In a tax-funded system, larger co-payments must be sought from those older people with the means to contribute to their care costs.

Questions directed towards the structural and efficiency themes central to the work of the Review, as embodied in the Terms of Reference, called for analysis of the workings of the aged care industry and the demand for aged care services. Little work on the economic and financial circumstances of the industry had been undertaken in the past. For example, data about accounting and financial matters relevant to the provision of residential aged care services had not been collected systematically. This omission had to be remedied in order to provide a basis for any reasonable understanding of financial and economic conditions experienced by providers and prospects for growth. Similarly there was a need to clarify the nature of the demand for funds to support capital spending necessary to sustain the expansion of the capacity for the provision of aged care.

No less important to the purposes of the Review was an understanding of the ways in which the legislative and administrative frameworks influenced the performance of the industry. These efforts formed the basis for establishing how the industry worked and its relationships with government, federal and state. These assessments in turn were essential to the development of strategic perspectives.

The work of the Review, therefore, quickly emerged as two distinct projects. One was directed to the residential aged care industry and its problems and prospects. The other was about the empirical analysis of the industry with the aim of establishing what

could be determined about the contemporary performances of the numerous providers of residential aged care services. The two main tasks run in parallel and in reality were significant undertakings in their own right.

The challenge was to bring the two projects to completion in a synchronised way. The extension of the work of the Review past the end of 2003 is explained solely by the need to have regard to the results of the accounting and financial analysis as well as other empirical work on efficiency and productivity. Reconciling the claims and proposals from providers and others with the evidence from various empirical studies has been paramount in the work of the Review.

The analyses developed within the Review in conjunction with consultants, has allowed insights into behaviour and performance not previously available. The economic model provides a means of examining the impact of price on the demand for and supply of aged care services, both residential and domiciliary. The workings of this model bring new light to the relationships between government and providers, and the potential contributions by users of services. Underlying the basic model is the expectation of modest gains in productivity which reflects the judgements of providers as to what can be expected of them. Yet work conducted on the efficiency of residential facilities does not support this assessment; much higher gains have been calculated. Moreover, analysis of the relative efficiency of the industry points to a substantial margin between best practice and most performances.

Taking these aspects together, it should be possible to secure gains in ways the industry operates. This means opportunities to bring lower charges to individual users, an extension to the present levels of residential and domiciliary care, and higher real wages. The opportunity to secure these benefits cannot be lost. A more competitive milieu for providing aged care would extract these potential gains.

These items and many others, such as the financial condition survey and workplace modelling, provide information to enlighten many aspects of the work of the Review. The same analyses should be of no less value to providers and governments on the ways the industry, and the individual entities within it, work.

Finally, I would like to express my appreciation to the members of the Expert and Technical Advisory Group and the Industry and Consumer Reference Group for their assistance. Similarly, my sincere thanks to the members of the Taskforce supporting the Review for all their support and assistance given to me during the course of this inquiry. It has been a challenging task and a substantial achievement.

W P Hogan
Reviewer

April 2004

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Reviewer

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TERMS OF REFERENCE

The Government is committed to a flexible and sustainable aged care industry that will provide the level and quality of care required by older Australians now and in the future.

The Review will have regard to:

a) Current government policy and objectives in aged care;

b) The long-term sustainability of the aged care industry;

c) The need to maintain continuous improvement in care outcomes;

d) The need to facilitate equity of access for all Australians; and

e) Other current and recent reviews relevant to aged care.

The Review, in consultation with service providers, health professionals and consumers, will:

1. Examine the current and alternative funding arrangements for residential aged care and report on:
   - the underlying operating and capital cost pressures of the industry;
   - the level of efficiency, and opportunities for improved productivity, in the industry;
   - the efficiency of the current and alternative funding arrangements and their effectiveness for the industry, residents and their families in providing quality care and accommodation; and
   - the long-term sustainability of the current and alternative funding arrangements.
2. Examine long-term financing options for residential aged care, including:
   - user contributions to the cost of aged care;
   - the interaction of residential aged care with community care and other aged care and health programmes;
   - the role of the Commonwealth and other levels of government, including identification of factors that result in duplication, gaps and ambiguity;
   - the role of extra service provision;
   - structural, regulatory and financial disincentives to investment in residential aged care; and
   - the role of markets, including capital markets, in residential aged care.

3. Make recommendations on:

   - the appropriate future public and private funding arrangements, including appropriate future indexation arrangements for the industry;
   - performance improvement in the industry, including the appropriate use of performance indicators; and
   - long-term financing of the aged care industry.

Additional Referral

Resident Classification Scale Review and Response (March 2003)

R8 The requirement for an ACAT assessment prior to moving a resident from low to high care be removed and a series of administrative rules be developed to ensure appropriate categorisation of residents.

R9 The DoHA investigate and model additional payments for special medical activities. These activities should be typically of short duration, namely IV therapy, major wound management, intensive pain management and tracheostomy. Consideration to additional payment for insulin-dependent (for diabetes) residents should also be given.

R10 The requirement for mandatory RCS re-appraisal every twelve months be removed. This action requires further discussion with the Aged Care Standards Agency to ensure that current accreditation requirements adequately assess ongoing assessment and review practices within facilities.

R11 The requirement for shifting by at least two categories (within a twelve month period) to be recognised for subsidy adjustment to be removed.

R14 Financial penalties as a result of downgrade be modified to recognise a tolerance level determined in conjunction with the industry-wide validation study.

R15 The Government and Aged Care Industry representative groups negotiate an Agreement to share the financial risk of implementing reforms to the current RCS system, estimated at three years.

List of recommendations

Recommendation 1 The planning arrangements

The Government's 2001 commitment to provide 108 places for every 1000 people aged at least 70 should be confirmed as ongoing.

The Review also considers that the planning arrangements should be more flexible so that they can:

a) adjust responsively to the development of new care approaches;

b) encourage innovation in service delivery;

c) take account of current utilisation in high care and low care;

d) take account of the needs of older people with special needs, including those of Indigenous people, older people in rural and remote areas, older people from culturally and linguistically diverse backgrounds, older people with disabilities, older people with dementia, homeless older people and veterans.

There should be a review of the Government's needs-based planning arrangements after 2008.

Recommendation 2 Greater flexibility in allocations

The Government should create a strategic pool of up to 3000 additional places each year for the next four years to meet structural and regional distortions, especially in the transition period up to the end of 2008.

The places should be able to be used flexibly for any form of care—residential or community care or for such allocations as multi-purpose services and allocations to support innovative care models.

The Government should establish a 'Ready List' of providers with plans and approvals to start within three months of allocation of places to secure the rapid implementation of projects so as to diminish the gap between allocation and implementation. Those on the list should be accorded priority for any general offer about bed allocation. Failure to perform as required by status on the Ready List will mean loss of any standing for allocation of places until the specific Ready List project is completed.

Recommendation 3 Increased support for aged care assessment

The additional funding provided in the 2003–04 Budget for the Aged Care Assessment Program should be confirmed as ongoing and indexed each year in line with the base funding for the Program.

The Review would also endorse the Australian Government funding an expanded role for Aged Care Assessment Teams to provide a single assessment service for community and residential care services with a stronger focus on supporting consumers in making informed care choices.

Recommendation 4 ACAT role in reassessment of existing residents

Aged Care Assessment Teams should no longer be required to assess residents whose care needs have increased to a higher Resident Classification Scale category. However, Aged Care Assessment Teams must still be required to undertake an assessment where a resident moves to another facility as a result of increased care needs.

Recommendation 5 Resident Classification Scale

Basic subsidies should be paid at three levels: high care, medium care and low care, replacing the existing Resident Classification Scale (RCS) categories in the following way:

a) Low care to consolidate current RCS levels 5 to 7;

b) Medium care to replace RCS levels 3 and 4; and

c) High care to replace RCS levels 1 and 2.

Recommendation 6 Funding Supplements

The arrangements through which supplements are paid for the provision of oxygen and enteral feeding should be extended to other specific care needs or medical conditions.

These specific care needs could include:

a) short-term medical needs, such as IV therapy, wound management, intensive pain management and tracheostomy;

b) specific care needs, such as for dementia sufferers exhibiting challenging behaviours or for residents requiring palliative care; and

c) care needs of people from diverse or disadvantaged backgrounds such as the homeless elderly and Indigenous Australians.

The rate of payment for any new supplements should reflect the incremental increase in the cost of providing the appropriate treatment and/or level of care.

Recommendation 7 Aged Care Standards and Accreditation Agency

The role of the Aged Care Standards and Accreditation Agency should be directed mainly to the accreditation of services and the dissemination of accreditation results.

The Agency should significantly improve its focus on supporting informed consumer choice and consumer input to monitoring standards by:

a) improving direct communication with consumers, including those with special needs, and by better informing other organisations of the level of quality provided by specific services; and

b) exploring, with consumers and the industry, a star rating system to assist consumers to more readily compare services and to provide incentives for providers to become more competitive in providing quality services.

The costs of accreditation should continue to be shared by Government and providers.

a) Providers should bear the total cost of accreditation audits after 2008; and

b) Government funding for the Agency should be increased, based on the robust assessment of the costs of current and projected workload. This funding should be governed by an agreement with the Department of Health and Ageing, which specifies the services required of the Agency and their unit costs.

Recommendation 8 Aged care workforce

The Government should refocus and expand its support for the education and training of aged care nurses and care workers.

The Government should increase the number of registered nurse places at Australian universities by 2700 over the next three years, with 1000 first-year places commencing in the 2005 academic year. These additional places should only be available to universities that offer specialist training for aged care nurses, including preceptor[1] programs for newly graduated nurses and aged care placements for students.

The Government should support aged care providers to assist at least 12 000 enrolled nurses to complete medication management training, 6000 aged care workers to complete a Certificate Level IV qualification and 24 000 aged care workers to complete a Certificate Level III qualification by 2007–08. This training support should only be available to providers who are compliant with the education and staff development accreditation requirements, maintain their training expenditure at a

1 Strictly mentor, but a generally accepted term in nurse education.

minimum of their 2003–04 level and provide in addition at least half of the cost of the additional training supported by this measure.

The Government should work with state and territory governments to expand the number of aged care training places available in the Vocational Education and Training Sector.

Recommendation 9 Guarantee Fund

The Government should establish a guarantee fund:

a) managed by an Authority established for the purpose;

b) funded by an industry levy, the amount of which is determined on actuarial advice; and

c) in the event of a defined 'default event', people with entitlements are able to recover accommodation bond amounts from the Fund.

A default event in relation to an approved provider, happens when:

a) the approved provider becomes bankrupt or insolvent;

b) the approved provider if it is a corporation, is being wound up or ceases to exist and there are insufficient funds to repay the accommodation bond entitlements; or

c) the approved provider is otherwise unable to meet the approved provider's liabilities under the enabling legislation.

As well as management of the Fund, the Fund Authority is to have prudential oversighting authority of approved providers. The powers of the Authority should include but not be limited to:

a) the ability to examine the financial affairs of an approved provider, by means of inspection and analysis of the records, books and accounts;

b) the ability to review, the value of the assets of each approved provider's corporate entity;

c) the ability to appoint an administrator of the corporate entity;

d) the ability to apply to court for the winding up of insolvent approved providers;

e) the ability to require an approved provider to enter into negotiations for the disposal of assets and if that fails, to secure an outcome to avoid where possible a claim on the Fund.

Recommendation 10 Financial assessment on entry

Assessment of residents' or prospective residents' income and assets should be the responsibility of the Australian Government and carried out by Centrelink and not the aged care provider, preferably prior to entry into care.

Recommendation 11 Viability Supplement

The Government should increase the total amount available for the viability supplement for rural and remote services.

The Government should also review the viability supplement's rates and eligibility requirements to ensure that they do not create perverse incentives against consolidation. At the very least the eligibility requirement should be raised to include facilities with 30 beds or fewer.

Recommendation 12 Targeted capital assistance

The Australian Government should maintain a small targeted capital assistance program to assist those services experiencing exceptional circumstances.

Recommendation 13 Conditional Incentive Supplement

The Government should introduce an incentive supplement, payable in addition to all existing subsidies and supplements, with the value of the supplement for each resident to be set at 1.75 per cent on an annual basis. The need for, and value of the supplement, should be reviewed in 2007–08. Continued eligibility of providers for the supplement should be linked to gains in efficiency, productivity and workforce training.

Recommendation 14 Comprehensive data repository

As a complement to Recommendation 13, the existing aged care information infrastructure should be substantially expanded, building on the existing expertise within the Australian Institute of Health and Welfare and should include quality and financial performance data.

Recommendation 15 Corporate information

The names of entities and major shareholders of the companies and associate companies having ownership or part ownership of residential aged care services should be required by the Department of Health and Ageing.

The monitoring and authorisation of transfers should be extended beyond key personnel to personnel of entities owning providers, subject to review after 2008.

In the contribution to efficiency improvements the Department of Health and Ageing implement immediately provisions for electronic funding and information transfers for all accounting, financial and supervisory requirements relating to providers.

Recommendation 16 Concessional, transitional and assisted residents

The Government should consider modifying the concessional resident supplement arrangements by:

a) increasing the maximum rate of the concessional resident supplement to $19.00 a day, indexed annually;

b) abolishing the 40 per cent threshold;

c) introducing a sliding assisted resident supplement for residents with assets between 2.5 times and ten times the pension to ensure that the assisted resident supplement plus the maximum accommodation charge payable by each resident is equal to the maximum rate of the concessional resident supplement; and

d) extending the concessional resident arrangements to all transitional residents remaining in the system.

Recommendation 17 Adjusted subsidy reduction

The Government should abolish the adjusted subsidy reduction so that all providers receive the same level of subsidy.

Recommendation 18 Pensioner supplement

Eligible pensioners should be able to gain the benefit of the rent assistance payment and the pensioner supplement should be abolished.

The maximum basic daily care fee for all residents should be set at 85 per cent of the value of the maximum rate of the basic single pension plus the full value of the maximum rate of rent assistance.

This is a medium term proposal the full implications of which require the most careful scrutiny. All distributional impacts across classes of pensioners and other residents should be investigated.

Recommendation 19 Accommodation payments

Accommodation payments for non-concessional permanent residents entering care should be as follows:

a) Options for making capital contributions should be consistent between low care and high care, not least to remove disincentives to ageing in place;

b) The notion of a 'bond' that is both a form of corporate debt (a no interest loan) and a source of fees through retention payments is confusing and should cease. Corporate debt and fees (no matter how derived) should be clearly separated;

c) Subject to retaining at least the statutory level of assets, new residents to have the option of paying:

   i) a fully refundable lump sum bond (not subject to retention amounts) to be held for the period of the resident's stay; or

   ii) a daily rental charge, applicable for the duration of the resident's stay;

The accommodation bond should be payable on entry to the service and should be repayable within a reasonable period of the resident's departure from the service, with interest being payable from the date of the resident's departure from the facility to ensure that the bond is repaid in a timely manner.

Existing residents should continue to be covered by the current accommodation payment arrangements including the five year limit on charges and retentions from bonds.

Recommendation 20 Research into neuro-degenerative diseases

Attention should be given to research into neuro-degenerative diseases, with funding provided for:

a) comprehensive prevalence studies; and

b) further data matching studies to enable a better understanding of neuro-degenerative disease pathways and the services accessed along pathways.

The National Health and Medical Research Council should continue to give priority to research into the prevention of dementia and dementia related illnesses and to encourage multi-disciplinary research into the care of people with such illnesses.

Option 1 Vouchers

In the longer term, consideration should be given to placing the choice of provider in the hands of the prospective resident or the resident's family, that is a system whereby the prospective resident is granted an authority to spend aged care monies on care and accommodation should be considered.

Selection of location and exercise of right of choice under this system for those people with dementia or who have no support available from relatives or other carers would require intervention by ACAT members and geriatricians or state guardianship bodies as appropriate. A preference would be for geriatricians independent of the hospital system with no connection to any residential aged care facility. The ACAT teams would be called upon to maintain monitoring of the condition of these residents on a case management basis.

Option 2 Contracting Agency

In the longer term, the Government may wish to consider the establishment of a contracting agency to act on behalf of the Government to negotiate prices and conditions for residents in facilities operated by board and management of provider entities. The contract would reflect a set of specified residents classified by some revised version of the Resident Classification Scale with a margin allowing for the inevitable swings in residents' condition as specified by an adapted Resident Classification Scale schedule. However, the contracting agency need not confine its efforts to these features alone but should include provisions about pricing and maximum and minimum values for accommodation bonds for those entities seeking accommodation bonds.

Option 3 Means testing

In the longer term, the aged care means testing arrangements should be brought into line with those that obtain for the age pension.

Moreover, in determining an individual's income and assets the same gifting and deeming rules as obtain for the age pension should apply.

Option 4 Asset transfer period

In the longer term, the Government to review arrangements to extend the period in which asset transfers by individuals to other persons and entities not under their control are deemed to be a part of that person's wealth at the time when a valuation for aged care purposes is required.

Option 5 Revised assets test arrangements

In the longer term, consideration be given to exempt the proceeds of sale of the family home from a tax imposition or inclusion in an asset valuation assessment by:

a) allowing the funds from any sale to be deposited with a government agency;

b) paying the CPI increase on a quarterly basis as a return or income on the value of the deposit;

c) allowing some part of the deposit to buy a suitably designed residence incorporating aged care features;

d) exempting the value of the deposit and any subsequent purchase of appropriate aged care housing from taxation or assessed valuations for residential aged care participation until the resident no longer requires care; and

e) applying these provisions equally to aged care support offered in domiciliary situations.

Option 6 Place allocation auction

In the longer term the Government should consider an auction system for place allocations.

ABBREVIATIONS

ABARE	Australian Bureau of Agricultural and Resource Economics
ABS	Australian Bureau of Statistics
ACAP	Aged Care Assessment Program
ACAS	Aged Care Assessment Service (Victoria)
ACAT	Aged Care Assessment Team
ACDC	Aged Care Dynamic Cohort Model
ACH	Aged Care Housing Group
ACHA	Assistance with Care and Housing for the Aged
ACPAC	Aged Care Planning Advisory Committee
ACPR	Aged Care Planning Region
ACSA	Aged and Community Services Australia
ADL	Activities of Daily Living
AIHW	Australian Institute of Health and Welfare
AIPC	Australian Institute of Primary Care
AIRC	Australian Industrial Relations Commission
AMA	Australian Medical Association
ANC	Australian Nursing Council
ANF	Australian Nursing Federation
ANHECA	Australian Nursing Homes and Extended Care Association
ANTS	A New Tax System
APRA	Australian Prudential Regulation Authority
ASIC	Australian Securities and Investments Commission
ATA	Acute Transition Alliance
AWE	Average weekly earnings
AWOTE	Average weekly ordinary time earnings
BCA	Building Code of Australia
BPSD	Behavioural and psychological symptoms of dementia
CACP	Community Aged Care Package
CALD	Culturally and linguistically diverse
CAM	Care Aggregated Module
CAPM	Capital Asset Pricing Model
CBD	Central business district
CJD	Creutzfeldt-Jakob Disease
COCARE	Churches of Christ Care
COPO	Commonwealth Own Purpose Outlays
CPI	Consumer Price Index
CRS	Complaints Resolution Scheme
CSHA	Commonwealth State Housing Agreement
CSTDA	Commonwealth State/Territory Disability Agreement
CSWO	Community Social Welfare Organisation
DFLE	Disability-free life expectancy
DoHA	Department of Health and Ageing
EACH	Extended Aged Care at Home
EBA	Enterprise Bargaining Agreement
EBITDA	Earnings before interest, tax, depreciation and amortisation
EFT	Effective full-time
EN	Enrolled nurse
EPC	Enhanced Primary Care
FBT	Fringe Benefits Tax
GDP	Gross domestic product
GP	General practitioner
HACC	Home and Community Care
HR&SS	Home Rehabilitation and Support Scheme
IGR	Intergenerational Report

LPI	Labour Price Index
MPS	Multipurpose Service
MTAWE	Male total average weekly earnings
NACAP	National Aged Care Advisory Program
NATSEM	National Centre for Social and Economic Modelling
NHMRC	National Health and Medical Research Council
OECD	Organization for Economic Cooperation and Development
OH&S	Occupational health and safety
PBI	Public Benevolent Institution
PHIAC	Private Health Insurance Administration Council
PICAC	Partners in Culturally Appropriate Care Project
RACS	Residential Aged Care Service
RCS	Resident Classification Scale
RN	Registered nurse
SAAP	Supported Accommodation Assistance Program
SAM	Standard Aggregated Module
SNA	Safety Net Adjustment
VAHEC	Victorian Association of Health & Extended Care
WACC	Weighted average cost of capital
WCI	Wage Cost Index
YLD	Years of life lost due to disability

1. ESTABLISHMENT OF THE REVIEW

In the 2002–03 Budget, the Australian Government committed $7.2 million for a comprehensive review of the pricing arrangements in residential aged care. The Terms of Reference[1] focus on the future needs of the sector and provide broad scope to examine future funding needs and options for the aged care sector, specifically long-term financing options, taking into account such matters as the improved care outcomes now required under accreditation, underlying cost pressures in the provision of care, including movements in nurses' and other wages, and increases in workers' compensation and other insurance premiums.

The Minister for Ageing appointed an Industry and Consumer Reference Group (ICRG),[2] comprising a diverse group of providers, consumer representatives and aged care workforce representatives, and an Expert and Technical Advisory Group (ETAG)[3] to provide advice to the Review.

An extensive public consultation phase was undertaken. Advertisements were placed calling for submissions to the Review and a wide-ranging formal and informal consultations program was undertaken. In addition to the public consultation process, the Review undertook a number of less formal consultations and visits to facilities and individuals with expertise in areas of aged care.

At the same time as the consultations were being undertaken, a number of comprehensive financial and other consultancies were commissioned.

1.1 The context of the Review

Aged care services play a central role in the delivery of health care services in Australia. On any given night about one in every 100 Australians receive care in a residential care service or through a community care package. In addition, about four in every 100 Australians receive aged care services at home or in the community every year, primarily through the Home and Community Care (HACC) program. The services also form a significant part of the Australian economy. In 2002–03, they contributed about one per cent of Australia's Gross Domestic Product (GDP). They accounted for more than one per cent of all building activity in Australia and about five per cent of non-dwelling building activity. Almost two in every 100 Australian workers are employed in aged care activities.

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1 See page xv
2 Appendix B.
3 Appendix B.

As in many other countries, the aged care sector is more highly constrained by regulation than many other industries. The Australian Government (the Government), and to a lesser extent state and territory governments, heavily regulate quantity, quality, location and price. These regulatory arrangements stem, at least in part, from fears about the vulnerability of residents to exploitation and unsafe practices. Nevertheless, these constraints affect a wide range of economic outcomes. First, they diminish the extent of competition between providers and, in particular, make it more difficult for prospective providers to enter the market. Second, they restrict consumer choice and reduce the consumer's ability to bargain over entry conditions. Third, they curtail innovation in service design and delivery. Finally, they adversely restrict enterprise mix and investment in the sector.

The generosity of successive governments in funding aged care is not sustainable in the long term. Over the next 40 years, the total cost of supplying aged care services, assuming the continuation of current policy, will more than double in real terms. Most of this growth will be concentrated in the middle two decades. Over the next 10 years, the cost of supplying aged care services will grow by 11 per cent in real terms, compared to 28 per cent in each of the following two decades.

Projections must be treated cautiously because much can change in the span of four decades. What is certain, however, is that health and aged care spending, and outlays on pensions, will rise steeply in the future. The Treasury's *Intergenerational Report 2002–2003* (the IGR) estimated that if policies are not adjusted, the current generation would impose a higher tax burden on the next generation of about five per cent of GDP by 2041–42. Subsequent to the IGR, the Australian Bureau of Statistics revised upwards its population estimates raising the likely commitments arising from current policy arrangements over the next few decades.

Given these pressures, the Government's establishment of the Review of the Pricing Arrangements in Residential Aged Care in the 2001–02 Budget was timely. Price is central to allocation of resources, both for the services provided to residents and for the cost of funds to sustain expansion of productive capacity. The central questions are whether, and how, future older Australians can take greater financial responsibility for their aged care needs in order to relieve intergenerational inequities. All this must be achieved in circumstances where the disadvantaged in society are provided with appropriate support.

Clarification of the issues associated with regulation is essential. Some features have a direct impact on the efficiency and competitiveness of residential aged care services (RACS). Others bear upon the quality of the care and accommodation provided. These are designed to inform and protect the residents and reassure their families about the standard of care expected of providers.

A shift in the pattern of regulatory requirements in the aged care setting should serve two purposes: moderate economic regulation for efficiency and productivity gains; and

reinforce those regulations bearing upon quality and empowerment to enhance the position of residents and their families.

1.2 The Review process

Submissions and consultations

The Review was established with the intention that it:

> *…provide an opportunity for all interested individuals and organisations to contribute to shaping the future arrangements for the funding and financing of residential aged care designed for a modern and growing Australian economy in an increasingly competitive world.*[4]

Throughout the course of the year, the Review progressively released a number of contextual and background papers for the information of stakeholders. These papers included:

- *Call for Submissions*[5], containing the terms of reference and establishment of ETAG and ICRG;
- *The Context of the Review*[6], which outlined the current composition of the aged care sector, including profiles of aged care recipients and industry providers, the role and aims of government, factors affecting demand and the findings of other recent reviews relevant to residential aged care;
- *The Commonwealth Legislative Framework*[7], which explained the legislative basis for the provision of residential aged care by the Commonwealth and the interrelationships between the various aspects of the Commonwealth's legislative schema;
- *Long Term Aged Care—International Perspectives*[8], which describes the experiences of other countries in their provision of aged care. It comprised six concise studies of how long term care for the aged is provided in the United Kingdom (focusing on England), Germany, Denmark, Singapore, New Zealand and Japan;

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4 Portfolio Budget Statements 2002–03: Health and Ageing Portfolio.

5 Review of Pricing Arrangements in Residential Aged Care, *Call for Submissions*, Commonwealth of Australia, 2003.

6 Review of Pricing Arrangements in Residential Aged Care, *Background Paper No 1: The Context of the Review*, Commonwealth of Australia, 2003.

7 Review of Pricing Arrangements in Residential Aged Care, *Background Paper No 2: The Commonwealth Legislative Framework*, Commonwealth of Australia, 2003

8 Review of Pricing Arrangements in Residential Aged Care, *Background Paper No 3: Long Term Aged Care—International Perspectives*, Commonwealth of Australia, 2003

- *Historical Perspectives*[9], concerned with the historical development of the Australian Government's involvement in funding, planning and regulating support for older people. The paper clarifies the policy legacies inherent in the current arrangements for supporting frail older people.

The Review called for submissions in January 2003, receiving 349 submissions, including a number of confidential submissions. The main reasons for confidentiality were to ensure the privacy of residents and or their families or to protect financial or commercially sensitive information. A list of submissions is at Appendix C.

The following table shows the total number of submissions, broken down by state and confidential status.

Table 1–1: Submissions by state

State/Territory	Public	Confidential	Total
New South Wales	86	18	104
Victoria	98	8	106
South Australia	21	5	26
Western Australia	34	10	44
Tasmania	9	3	12
Queensland	21	14	35
Northern Territory	1	0	1
Australian Capital Territory	11	4	15
State not specified	3	0	3
Anonymous submissions	0	3	3
TOTAL	**284**	**65**	**349**

Profile of submitters

Submissions were received from governments and government agencies, aged care providers, care recipients and their families, staff, industry associations and unions, and special interest groups. The following table gives a breakdown of submissions by type of submitter.

9 Review of Pricing Arrangements in Residential Aged Care, *Background Paper No. 4: Historical Perspectives: the evolution of the Australian Government's involvement in supporting the needs of older people*, Commonwealth of Australia, 2003.

Table 1–2: Sources of submissions

Origin	
Federal government agency	1
State government department or provider	16
Local government department or provider	6
Religious provider	67
Community provider	40
Other non-profit provider	46
Private provider	55
Individual—staff	16
Individual resident/family	43
Professional association	15
Industry association	18
Other	26
Total	**349**

The submissions formed the basis of the consultations process, although consultations were not confined to those people or organisations who had made submissions. In recognition of the need to gain as wide an understanding as possible, the Review had discussions with industry, aged care experts, health care experts and financial institutions as well as with those on the basis of a submission. A full list of consultations and visits to facilities is at Appendix D.

1.2.2 The financial data submissions and analysis

Early on in the Review, it was determined that very little information was held on the financial performance and efficiency of aged care providers. The Review decided to undertake a financial data survey of providers in order to:

- determine some baseline data for further analysis;
- develop an economic model of the aged care industry (Access Economics);
- undertake an efficiency analysis of the sector (Centre for Efficiency and Productivity Analysis—CEPA).

The financial data analysis is discussed in detail in Chapter 3 and additional data is contained in Appendix A.

Financial data collection and storage

The financial data consultancy was established to provide the Reviewer and Taskforce with accurate and up-to-date financial information about the income, costs, capacity, operating expenses and staffing of aged care homes. The initial consultancy to receive, store, conduct top line analysis on and de-identify financial data provided to the Review was undertaken by KPMG. This data processing stage was part of a broader research agenda to explore cost pressures and the impact of pricing arrangements on the operation of the residential aged care system. A particular requirement for the initial data gathering stage was to ensure the confidentiality of financial data provided to the Review.

KPMG was required to:

- directly receive the data component of submissions to the Review;
- securely store the submissions;
- match and merge the submitted data with data provided by the Taskforce;
- remove factors that identify the merged data;
- present the merged, de-identified data to the Aged Care Price Review Taskforce in an agreed electronic form;
- seek further information and/or clarification of the submitted data from its source when requested by the Taskforce;
- provide top line analysis of the data by quartile of earnings, running expenses, relative labour costs, capital and profitability against Departmental data on regionality and sector; and
- destroy all submitted data on 12 December 2003.

All aged care approved providers were contacted, first by a letter from the Reviewer to introduce the Review to providers and to encourage them to respond to the request for financial information to assist the inquiry. The providers were then contacted by KPMG to participate in the survey.

The financial data survey provided a mechanism for residential aged care providers and other parties to include sensitive financial data on their operations as a part of their contribution to the Review.

An economic model of the industry

The Review commissioned Access Economics to model the Australian aged care system with particular emphasis on Australian Government financing of the sector. It was anticipated that the model would inform the Review and later the Department of Health and Ageing (the Department) of possible developments in the aged care system under different assumptions.

The resulting model, the Aged Care Dynamic Cohort Model (ACDCM), aimed to:

- encompass the broad features of the current aged care system;
- allow for analysis of a range of alternative policies and health/disability trends;
- provide projections into the future;
- avoid preconceptions to the extent possible, allowing value judgements to lie with the model user more than the model builder.

The model and the implications for aged care are discussed in Chapter 4.

Efficiency analysis of the aged care industry

The Review commissioned the University of Queensland's Centre for Economic and Productivity Analysis (CEPA) to analyse the level of efficiency in the residential aged care industry in Australia and opportunities for improved productivity. The report outlined the potential for productivity and efficiency improvement in the industry, and provided estimates of the additional costs of some structural inefficiencies (e.g. smaller sizes in rural areas) that are brought about by policy commitments (e.g. universal access).

CEPA conducted an analysis of the KPMG survey data, of UnitingCare data, comprising information on 89 facilities and of the last seven annual surveys conducted Bentley MRI and James Underwood and Associates.

Other consultancy projects

A number of additional consultancy and research projects was undertaken on behalf of the Review. A list of the papers produced is contained in Appendix E.

Apart from the analyses discussed above, further studies were commissioned to examine residents' records with respect to their entry assessments to aged care facilities, workplace themes, the income and wealth of the older members of Australian society and regulatory compliance requirements for the industry.

These studies were necessary because there has been little prior work undertaken on these topics. They were essential precursors to the tasks listed in the Terms of Reference on development and efficiency in the industry.

The analyses developed within the Review in conjunction with consultants, have allowed insights into behaviour and performance not previously available. The economic model provides a means of examining the impact of price on the demand for and supply of aged care facilities, both residential and domiciliary[10].

[10] Domiciliary care means care provided to clients in their own homes.

2. THE AGED CARE FRAMEWORK

2.1 Introduction

The provision of aged care is a complex set of arrangements, involving all tiers of government, with care being provided by a range of public, charitable, private and community providers. The care that is provided varies significantly, subject to the degree of dependency of the recipient, the support available to that person from family and friends and the services available to them.

Australian Government funding for aged and community care has increased from $3 billion in 1995–96 to $5.6 billion in 2002–03 and is expected to be approximately $6 billion in 2003–04.[1] This funding is additional to any health care funded services, such as Medicare or services received under the Pharmaceutical Benefits Scheme.

Aged care is structured around either residential aged care or caring for the aged while they remain in the general community. While the Review is primarily committed to a consideration of residential aged care, it necessarily involves consideration of community care, given the degree of interaction between the two forms of care.

The ageing of the population and the increased longevity of aged persons are significant factors for policy development in the delivery of aged care services. The anticipated increases in the target population and consequential increases in expenditure required to meet the residential and other aged care needs of the population provide challenges for government and providers.

2.1.1 The policy and regulatory framework

The role of the Australian Government

The Australian Government funds and regulates the provision of aged care. The history of Australian Government involvement is set out in the background paper Historical Perspectives. The current role of the Australian Government in aged care is set out in detail in the following documents:

- Annual Report on the operation of the *Aged Care Act 1997* (latest edition is 1 July 2002–30 June 2003);
- Aged Care in Australia (published annually by DoHA);

[1] Department of Health and Ageing (DoHA), *Report on the Operation of the* Aged Care Act 1997 *1 July 2002 to 30 June 2003*, Commonwealth of Australia, 2003, p. 21.

- Pricing Review Background Papers, including:
  - *Call for Submissions;*
  - *The Context of the Review;*
  - *The Legislative Framework;*
  - *Historical Perspectives.*

The discussion which follows is based on material contained in the documents listed above, as well as departmental guidelines and manuals.

Policy framework

The Australian Government has the following broad objectives for the delivery of aged care, namely quality, equity, efficiency and sustainability.[2] These principles have underpinned the Review's examination of Australia's aged care regulatory and financing arrangements.

Quality of care

Aged care's regulatory and financing arrangements must recognise fundamental basic standards, and assign specific responsibilities for assuring quality of care. This aspect includes maximising the opportunities for residents to achieve an optimal quality of life, maintain their self-esteem, address their physiological and social needs, and achieve security and independence. It also includes encouraging flexibility, so that services are able to adapt to individual needs and choices and acknowledge diversity, and innovation, so that services can develop, incorporate and optimise the use of technology.

Equity of access

The arrangements must facilitate and encourage equity, including ensuring accessibility, so that special needs or geographic location need not deny access. Equity also includes affordability—fair and equitable means testing and payment mechanisms to secure or maintain economic security and ensure that ability to pay does not deny access. However, the ability of some to purchase a higher standard or another form of care should not be denied. Equity also requires objectivity, so that access is based upon an objective and regularly updated determination of care needs.

[2] Review of Pricing Arrangements in Residential Aged Care, Background Paper No. 1: The Context of the Review, Commonwealth of Australia, 2003, p. 35.

Efficiency

Aged care's regulatory and financing arrangements must promote and reward efficiency. This includes integration and coordination. The arrangements must also address service gaps, allowing a smooth transition between types of care and ensuring that funding methodologies are, where possible, consistent across sectors. They should also be simple, transparent and accountable for residents, providers or purchasers.

Sustainability

Finally, the arrangements must be sustainable, through a balanced approach that utilises both public and private financial support so that residential care is affordable for individuals and society (that is, taxpayers), in both the short and long term. The Australian Government attempts to ensure that any growth in the provision of services to the aged population is reflective of the growth in the aged population itself. It also tries to ensure balance in the provision of services throughout Australia, as well as between those needing differing levels of care.

Structural reform of the industry

In 1997 the Australian Government implemented a package of structural reforms which made some fundamental changes to the aged care system. These changes included:

- the unification of nursing home and hostel funding;
- reduction of the reliance on Australian Government capital funding;
- greater reliance on resident contributions; and
- greater emphasis on quality control and standards with the implementation of a new standards and accreditation system.

The legislative framework

The primary regulatory instrument is the *Aged Care Act 1997* and the accompanying Aged Care Principles 1997, disallowable instruments under the Act. The Act and Principles came into force on 1 August 1997. The legislation governs all aspects of the provision of residential care, including planning of services, approval of service providers and recipients of care, payment of subsidies and responsibilities of service providers.

The Act and Principles provide for the detailed arrangements for the delivery of aged care, including:

- who goes into subsidised care and on what basis;
- who can provide subsidised care at what level and how many subsidised places they may provide;

- the number and location of subsidised places;
- the fees which can be charged and the subsidies received by providers;
- quality outcomes, including accreditation and certification standards;
- any entry contributions by residents (accommodation bonds) and the conditions governing those contributions; and
- residents' rights.

This specification is ample witness to the broad range of controls over the workings of the aged care industry.

2.1.2 State and local regulatory arrangements

Consideration must also be given to the extent to which states and territories regulate the delivery of services to the aged, both in residential and community care. While aged care is largely an Australian Government responsibility, there is also some capacity in the states and territories to regulate the industry. However, as part of their commitments under National Competition Policy, all governments undertook to review legislation that restricted competition, with the option of only retaining restrictions on competition if those restrictions were found to be in the public interest.

Most states have now undertaken such a review. Only Victoria has specifically 'vacated the field' of regulation of nursing home facilities that are already regulated at the Australian Government level, with Queensland and South Australia expressly exempting federally funded aged care facilities from the operation of their legislation. The ACT has never regulated aged care and it therefore continues to be a solely Australian Government responsibility in that Territory. The Northern Territory, NSW, WA and Tasmania continue to regulate aged care facilities to a greater or lesser extent. However, it should be noted that the WA and Tasmanian regulation is minimal and effectively leaves regulation to the Australian Government.

Following a review of its legislation, the Northern Territory passed legislation requiring all residential aged care facilities to be licensed, imposed conditions on individual licences and required premises to be inspected on an annual basis. New South Wales has undertaken a review of the legislation regulating nursing homes and hostels. The final report is currently with the NSW Minister for Health.

Residential facilities are also required to comply with state regulation of matters such as state and local government planning and building regulations, fire safety of buildings, food preparation and storage, drug administration and consumer protection.[3]

[3] P Hanks, *Regulation of Residential Aged Care: Review of legislation: Commonwealth, State and Territory Legislation*, 2003

2.2 Forms of funded care

Australian Government funding covers subsidised access to residential care, community care and some support for aged care infrastructure requirements.

2.2.1 Residential care

Residential care is provided to those people who are no longer able to maintain themselves or be maintained by others in their own homes. Care is provided on a high care or low care basis and there is provision for care recipients to opt for 'Extra Service' care, which provides hotel like services and a higher standard of accommodation for additional fees paid by the resident, but regulated under the Act.

The two main types of residential aged care are high care (formerly nursing home) and low care (formerly hostel). Residents are classified according to the Resident Classification Scale (RCS), with residents classified as RCS 1–4 being high care and residents classified as RCS 5–8 comprising the low care category. Place allocations are on the basis of low care or high care, although the Ageing in Place policy means that some low care places are temporarily used to deliver high care.

Low care and high care

Low level care includes the provision of suitable accommodation and related services, such as laundry, meals and cleaning, and personal care services, such as assistance with bathing, dressing and toileting. High level care includes accommodation and related services, personal care services and nursing care and equipment.

Extra Service places

Up to 15 per cent of the number of allocated places in each state or territory can be allocated as extra service places. Extra Service can be provided in both high and low care facilities. Extra Service places may be all of a facility's places or only some of them. Extra service care involves the provision of a significantly higher standard of accommodation, food and services than in standard residential services.

As at 30 June 2003, there were 6427 places approved for Extra Service in 148 homes. This number equals 3.8 per cent of residential places.

Residential respite care

Residential respite is short term care in aged care homes made available to frail older people for reasons such as relieving carers, the unavailability of a carer, illness or holidays. A care recipient is entitled to 63 days respite care within a financial year, with the possibility of extensions of 21 days at a time if the Aged Care Assessment Team (ACAT) considers this to be necessary.

Admissions to residential respite have increased by 32 per cent over the last six years, or from 36 119 in 1996–97 to 47 716 in 2002–03. The number of resident days occupied in residential respite care in 2002–03 was estimated at slightly more than 985 000.[4]

Recipients of residential respite care pay a daily care fee. The maximum fee is set at the pensioner rate, although facilities may charge less than this fee.

2.2.2 Community care

The two major programs which provide community care at low care level to people in their own homes are CACPs—Community Aged Care Packages and the HACC program—Home and Community Care. Services at high care level are delivered to home based recipients under the Extended Aged Care at Home program (EACH).

Community care programs are aimed at enabling the frail aged and those people with a disability to remain in their own homes for longer periods of time and thereby maintaining their independence. The services provided include care and support within the home and respite programs.

Of the 21 per cent of people aged 70 and over who currently use aged care services, about 7.9 per cent are in residential aged care, 0.7 per cent receive CACPs and 12.2 per cent receive HACC services.

Community Aged Care Packages

CACPs, funded entirely by the Australian Government with some user contributions, were introduced to provide a community alternative for frail older people whose dependency and complex care needs would qualify them for entry to an aged care home for low level care. CACPs are individually tailored packages of care services to frail older people assessed by an ACAT as requiring a range of care services in their own homes. The basis of funding is by daily subsidy for approved care recipients occupying approved care package places. The current subsidy rate is $11,465 per person per annum or $31.41 per client per day.

Recipients of care packages pay a fee to contribute to the cost of their package up to a maximum of 17.5 per cent of the basic rate of single pension. As at 20 September 2003, this contribution was $5.45 per day. Where a recipient has additional income over and above the basic pension, providers may charge an additional 50 per cent of the income above the basic pension.

[4] DoHA, *Report on the Operation of the* Aged Care Act 1997, op. cit.

The CACPs program is administered under the Act and Principles, regulating:

- approval of care recipients for the level of care a CACP can provide;
- the types of services and the quality of care to be provided; and
- the rights of both service providers and care recipients.

Typically, services provided include bathing, showering and personal hygiene, social support, laundry, transport, meal preparation and gardening.

The program has grown from a base of around 4000 places in 1996 to 27 850 operating places by 30 June 2003[5] and 900 service outlets. Expenditure in 2002–03 is estimated to be $248 million.

The Home and Community Care program

HACC is a joint Australian Government/state government program for the frail aged, people with disabilities and their carers. HACC services include community nursing care, allied health care, domestic assistance, personal care, meals on wheels and day-centre based meals, home modification and maintenance, transport, community-based respite care (mostly day care), counselling, support, information and advocacy.

Nationally, the Australian Government contributes approximately 60 per cent of program funds and maintains a broad strategic role. The states/territories provide the remaining 40 per cent, which in some states includes contributions from local government. State and territory governments are responsible for the day-to-day management of the program.

Currently, there are about 3500 HACC-funded services, providing services to about 583 000 people per year. In 2001–02, the Australian Government contributed $615 685 million to HACC services. Total expenditure, including state contributions, is expected to be just over $1108 million in 2002–2003.

The costs to users of different community care services vary, depending on the number of hours and the sorts of help needed. As at July 2003, the Australian Government provided a daily subsidy of $31.41, with a maximum recipient contribution of $5.29 per day. The subsidy is based on 17.5 per cent of the maximum basic rate of pension.

There is also a veteran specific HACC program, the Veterans Home Care program, which is run by the Department of Veterans Affairs with similar services to HACC.

5 DoHA, *Report on the operation of the* Aged Care Act 1997, op. cit., p. 7.

2.2.3 Flexible care

As well as providing community care under the Aged Care Act, the Australian Government supports several flexible care programs:

- Extended Aged Care at Home;
- Multipurpose Service Places;
- Innovative Pool Places.

Extended Aged Care at Home

The Extended Aged Care at Home (EACH) program commenced as a pilot program in the late 1990's to test the feasibility of providing high level care to people in their own homes. It has now been established as an ongoing program and, as at 30 June 2003, there were 450 allocated places. An additional 550 EACH packages are to be allocated in 2003 through the Aged Care Approvals Round.

Multipurpose Services

Multipurpose Service Places (MPS) are integrated health and aged care services that are individually tailored for rural and remote communities depending on their geography, population and care needs. They deliver a mix of aged care, health and community services in rural and remote communities, many of which could not sustain separate services. Each MPS is financed by a flexible funding pool, which receives contributions from states, territories and the Australian Government. The number and location of MPSs are shown in Table 2–1.

Table 2–1: Multipurpose services[6]

	No of Multipurpose Services	Operational aged care places
New South Wales	25	448
Victoria	7	265
Queensland	14	225
Western Australia	28	536
South Australia	6	251
Tasmania	3	85
Australia	**83**	**1810**

The program was developed as a Australian Government/state government initiative in the early 1990s in response to a range of health and aged care challenges faced by rural communities such as:

- isolation from mainstream services;
- cost inefficiency of delivering discrete services to small populations;

6 DoHA data

- lack of local residential and aged care services; and/or
- duplicated and inconsistent accountability requirements for the multiple funding streams which can be received by small services.

The program aims to provide integrated and flexible services by providing pooled Australian Government aged care and state government health funds to a single organisation which provides a range of services.

As at June 2003, there were 83 multipurpose services nationally. In 2002–03 the Australian Government allocated $37 million to the program as part of its flexible care places.

The MPS arrangement is between three parties, the Australian Government, the state/territory government and the Boards of Services/Management of the MPS. The state government provides funding for hospital services, community health, ambulance and community transport services. Australian Government funding covers aged care needs, assessed by area. Home and Community Care (HACC) services are jointly funded by the Australian Government and the state governments in a 60:40 ratio. Capital funding is provided by the state government. MPSs currently do not have to satisfy aged care accreditation requirements under the Act.

Recipients of aged care in an MPS are funded according to classification. High care residents are funded at approximately 97 per cent of an RCS level 3 and low care residents are funded at approximately 97 per cent of an RCS level 7. The level of need is reviewed every three years, but may be reviewed more frequently if necessary.

Regional Health Services

The Australian Government's Regional Health Services Program is designed to help small rural communities expand their local primary health care services. The program is based on a number of fundamental principles:

- Local solutions for local health problems.
- Flexible, innovative and integrated solutions promoting better health.
- Governments supporting improved access to health services, particularly in small communities.
- Australian Government, and state/territory and local governments collaboration.

The Regional Health Services Program's flexibility stems from the knowledge that no two communities are alike, and that there is no single solution for service-mix or activity. In order to find the right mix, the Regional Health Services Program allows communities to consider a mix of services including services applicable to the aged such as community nursing, podiatry, physiotherapy and nutrition and dietetics.

Innovative Care Pool

The Aged Care Innovative Pool is a national pool of flexible care places available for allocation to innovative services outside the Aged Care Approvals Round. The Pool provides flexible care subsidy for alternative care options when these are needed in particular circumstances or locations. The subsidy is provided for a limited time for a pilot service or project and also provides an opportunity to test innovative models of aged care service for specific target groups. The Innovative Pool is designed to test new approaches to providing aged care, not to provide on-going aged care services. Pilot projects that are approved under the Innovative Pool typically have clear client eligibility criteria, controlled methods of service delivery and are time-limited.

In 2001–2002 and 2002–2003, the Innovative Pool focused on the following objectives.

- Joint innovative care rehabilitation services pilots between the Australian Government and state/territory governments. These involve projects where the Australian Government provides funding for short term personal and nursing care and the state/territory government provides funding for intensive rehabilitation support. (These are known as ICRS pilots).
- Pilots addressing the interface between aged care and disabilities. These involve projects to meet the needs of people with disabilities who are at risk of being admitted to aged care because their increasing care needs cannot be met through disability support systems alone. They can also be used to address the needs of younger people with a disability who are inappropriately placed in residential aged care (Disability pilots).
- Dementia care proposals, designed to address the need for the provision of appropriate high care residential services for people with dementia-related high care needs who are not being catered for through the normal allocation of aged care places. Also, projects can address dementia care issues in flexible ways (Dementia pilots).
- Pilots addressing the needs of areas where the provision of aged care services presents a particular challenge, such as in rural and remote settings.

2.2.4 The allocation of places

The allocation of places (beds) is the basis on which facilities provide services and on which they are subsidised for those services. Increases in the numbers of places allocated is predicated on the growth of the aged population and balancing service provision throughout Australia. There is a total allocation of places, split into high care, low care and CACPs.

The Australian Government allocates beds on a needs-based planning framework or ratio which aims for a national provision of 100 residential places and CACPs per 1000 head of population aged 70 years and over. Table 2–1 shows the allocation of high and low care places throughout Australia.

Occupancy of places in 2002–03 was 96.1 per cent, compared with 96.4 per cent in 2001–02 and 96.2 per cent in 2000–01. The high occupancy rate means that potential residents have very little choice in reality about their preferred residential facility. There is also less possibility of transferring between facilities.

Table 2–2: High care/low care places by state

State	High care	Low care	Total	Population 70+ by State	% of places per head of 70 + population
NSW	29 718	22 079	51 797	641 472	8.07
VIC	18 725	18 950	37 675	468 795	8.03
QLD	13 438	13 632	27 070	318 193	8.51
SA	7 333	7 068	14 401	167 320	8.61
WA	6 260	6 170	12 430	155 729	7.98
TAS	2 287	1 701	3 988	48 296	8.26
ACT	663	852	1 515	20 249	7.48
NT	254	189	443	4 733	9.36
Totals	**78 678**	**70 641**	**149 319****	**1 824 787**	

Source: DoHA data

Notes: # ABS as at December quarter 2002; ** as at 4 September 2003

Aged Care Approvals Round

Each year additional residential, flexible and community care places are made available for allocation throughout Australia and providers apply for these places through the Aged Care Approvals Round. The increases are based on statistical and demographic information.

Providers bid for places as allocated under the Aged Care Approvals Round and are funded on the category of resident occupying the place. As at 30 June 2003, 197 396 residential care places had been allocated, as follows:

- 169 400 residential care places—either high care or low care;
- 27 996 CACPs.

The specific target ratios are 40 operational high care places, 50 operational low care places and 10 operational CACPs. The number of allocated places is 110.2 places per 1000 people over the age of 70 years or 178 636 in absolute terms, although a proportion of these is not operational at any one time. The operational ratio at June 2003 was 99.7 places per 1000 people aged 70 and over, or 150 786 residential care places and 27 850 CACPs.[7] As well, some residential care places are allocated as EACH packages which form part of flexible care places and some are allocated as MPS places.

[7] DoHA, *Report on the Operation of the* Aged Care Act 1997, op. cit., p. 5.

2.3 Ageing in place policy

Ageing in place as a policy was designed to enable, in those facilities which could offer appropriate accommodation and care, residents to remain in the same environment as their care needs increased.

Prior to the 1997 reforms, residents with low care needs were accommodated in hostels and residents with high care needs were accommodated in nursing homes. The funding arrangements for the two types of facility were different and once low care residents became high care, transfer to another facility was necessary.

A significant shift in focus underpinned the 1997 reforms. The new arrangements were based on a merged funding tool, the RCS, and a common regulatory scheme, with the ability for both high care and low care to be delivered in the same facility, subject to the fulfilment of certain conditions, including accreditation and certification requirements.

The capacity of individual facilities to accommodate ageing in place is variable and depends largely on the physical environment and the ability to staff the facility appropriately.

For residents, the advantages of ageing in place are significant and include less disruption and continuity of care in a familiar environment. For service providers, the challenges are greater and include:

- changed staffing mix, night staff requirements and consequential cost increases;
- certification costs and possible building upgrades/redevelopment costs; and
- fluctuating subsidies and accommodation fees due to changing resident profiles.

2.4 The providers of aged care

2.4.1 Provider profiles

The aged care industry can be characterised as follows:

- relatively small in size and scale of operation with a large number of very small private providers, operating between one and three facilities;
- very few large entities operating nationally or across state/territory borders;
- few publicly listed entities;
- the majority of the industry comprising religious, charitable or community organisations;
- state and local governments are significant providers.

As at 30 June 2003, there were 1593 approved providers operating 2958 facilities throughout Australia.[8] Facilities such as Multi-purpose Services are not captured by this data set, even though they are funded in part by the Australian Government.

[8] DoHA data.

Providers comprise private sector entities, local and state governments, community organisations, charitable and religious organisations and other not-for-profit entities. Almost two thirds of care is provided by the not-for-profit sector of the industry, 10 per cent by governments and the rest by the private for-profit sector. The relative proportions vary from one state to another.

The not-for-profits, in the form of religious, charitable, community and government providers, which vary widely in their corporate structures, include:

- charitable organisations incorporated under a state act;
- community-based entities established usually as trusts;
- war veterans associations linked to a registered club;
- local government and other linked community-based organisations, which often receive support in one way or another from the local government entity;
- state government organisations, the most significant of which is Victoria, which operates over 5900 beds.

It could be argued that there is a lack of national coherence in the sector. Few entities operate throughout Australia, although there are some major corporate entities emerging as providers of facilities in several states. There are some religious orders providing services throughout Australia, however, even these bodies tend to operate at a state level of organisation and not as national entities. The majority of providers remain within one state.

The industry can generally be characterised as having a relatively low level of sophistication; financial accountability and reporting is generally undeveloped and prudential arrangements are similarly dubious. However, this is not to say that all of the industry exhibits these characteristics—some entities, particularly the major religious organisations, have highly professional administrative and financial arrangements. However, the majority of the industry comprises small entities, often partnerships or sole traders, with a low degree of sophistication in administrative and financial terms.

Approved provider status

Under the 1997 reforms, only approved providers may offer subsidised residential aged care. Approved provider (AP) status is granted to corporate entities, state or territory governments or authorities or local government authorities on the basis of the fulfilment of certain conditions:

- their legal status and suitability to be an approved provider, which includes inter alia:
    - suitability of key personnel;
    - ability and experience in providing aged care;

- ability to meet relevant standards for the provision of aged care;
- record of financial management;
- previous conduct as a provider and general conduct;

- the processes approved providers must observe to be allocated places;
- the services they may provide; and
- the quality of services and buildings they must agree to provide and maintain over time.

However, under the transitional arrangements put in place with the 1997 reforms, approved operators or proprietors of approved nursing homes within the meaning of the *National Health Act 1953*, were accorded approved provider status, even if they did not meet the conditions listed above. Similarly, organisations that were approved operators under the *Aged or Disabled Persons Care Act 1954* were accorded approved provider status under the transitional arrangements.

This arrangement is particularly significant for those unincorporated associations and other forms of small operation outside the definition of corporation in the Aged Care Act. Should these types of operation face sanctions and lose their approved provider status, it is likely that they would not be able to regain their approved provider status under the current arrangements—ie if their approved provider status is revoked or lapses for any reason, a new application for approved provider status is required and the current conditions for approval of AP status would need to be fulfilled.

Providers are also subject to accreditation and certification requirements under the Act. Accreditation is about the quality of service provided to residents and organisations must be accredited to receive funding under the Aged Care Act. Certification is about the standard of buildings.

2.5 Fees and charges paid by residents

While the Australian Government is responsible for providing the majority of the funding for residential aged care, fees or contributions are also derived from care recipients themselves. The two main types of fees paid are care fees and accommodation payments. A full list of fees and charges is set out in Appendix H.

The Australian Government sets the maximum level of care fees that residents are required to pay. The *Aged Care Act 1997* does not allow providers to increase fees beyond prescribed maximum levels. There are two types of fees: basic daily care fees, paid by means tested pensioners; and income tested fees, paid by those who entered care on or after 1 March 1998 and who have receive a threshold level of income. Both types of fees contribute to the cost of care.

The maximum basic daily care fee is determined by pensioner status. As at September 2003, the fee for means tested pensioners was $26.47 (85 per cent of the basic age pension) and for non-pensioners $33.05 (Table 2–3).

In addition to the basic daily care fee, a daily income tested fee may be charged to pensioners, which will be a maximum of $20.47 for a part pensioner and nil for a full pensioner.

Non-pensioners pay a basic daily care fee of up to $33.05, plus a daily income tested fee of up to $46.36. The non-pensioner maximum income tested fee may apply if income is $70 620 for singles or $140 512 for couples per annum.

Table 2–3: Care fees for residents

Resident	Basic Daily Care Fee	Daily Income Tested Fee	Total Maximum Daily Care Fee
Full Pensioner	26.47	nil	26.47
Part-pensioner	26.47	Up to 20.47	Up to 46.94
Non pensioner	33.05	Up to 46.36	Up to 79.41

2.6 Accommodation payments

Accommodation payments are a contribution to the cost of accommodation paid by permanent residents. Concessional and respite residents and residents who have had a hardship determination do not make accommodation payments, but services receive supplements to compensate them for this. There are two types of payments—*accommodation bonds and accommodation charges*. Capital and prudential issues in relation to bonds are dealt with in Chapter 8.

2.6.1 Accommodation bonds

If a person is entering low care or an extra service place, that person can be asked to pay an accommodation bond, in addition to any daily care charges, providing the value of their assets is more than $28 500. Residents can choose to pay an accommodation bond as a lump sum, a regular periodic payment or both.

The service provider can keep a retention amount out of the accommodation bond, with the balance of the bond to be refunded to the resident or their estate on departure. Service providers may also retain any interest earned on accommodation bonds held by them.

Additional elements of the bond arrangement are:

- there is no maximum bond amount, but a person cannot be asked to pay a bond that will leave them with less than $28 500 in assets;

- there is a maximum, cumulative five year retention period, even if care is received from more than one provider;
- during that five years the provider can retain a maximum amount of $254.50 per month ($18 324 over the five year period) plus any interest on the bond;
- payments can be made by lump sum, periodic (fortnightly or monthly) or a combination of the two;
- payment of the bond cannot be required by the service provider during the first six months of entry, but interest may be charged if the bond is not paid by the due date.

2.6.2 Accommodation charges

Residents entering high care, other than in an extra service facility, pay an accommodation charge, in addition to any basic daily care fee and any income tested fee applied. They must be permanent residents, have assets above the minimum asset level of $28 500 and have entered into an accommodation charge agreement.

The amount of the accommodation charge is negotiated between the resident and the service provider, but the maximum amount per day is $13.91 (approximately $5 080 per annum) which residents with assets of $53 886 or more would pay. Residents with assets between $28 500 and $53 886 pay on a sliding scale. The accommodation charge is charged for a maximum of five years, is calculated on a daily basis and cannot be paid more than one month in advance.

2.6.3 Consumer understanding of accommodation payments

The level of consumer understanding of matters relating bonds varies. Trying to establish how much money might be needed for a bond and why there is such variation between facilities can be somewhat daunting and confusing.[9]

Concerns raised by consumers often relate more to the process of negotiating bonds rather than a rejection of the need to contribute to capital funding.[10] With increasing house prices there may also be threshold consequences that affect an increasing number of residents.[11] Although the circumstances cited may be legitimate under the Act, the concerns expressed further indicate the difficulties some consumers face in understanding capital arrangements.[12]

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9 Confidential Submission 73. There is also some evidence to suggest that consumers facing the decisions around entering a nursing home are less likely to have access to informed advice on financial matters including bonds. See J. Reed and D. Morgan, 'Discharging older people from hospital to care homes: implications for nursing', *Journal of Advanced Nursing*, vol.29, no.4, 1999, pp.819–25 and confidential submission 315.

10 Submission 287, p.22; see also Submissions 8, p.10; 94, p.6, and 99, p.1.

11 Confidential Submission 192.

12 Submission 206, p.19; and, for example, Confidential Submissions 113; 167; and 31.

Some prospective residents clearly understand the requirements and are creating family trusts to minimise their wealth and avoid paying a bond. Anecdotal evidence indicates some residents are 'less forthcoming, a little bit more devious with their assets' because they know the system; and of systematic spending by families to deplete a resident's assets. Evidence was also heard of the misuse of power of attorney to deprive residents of their remaining assets and even of daily 'spending money'.[13] On the other hand, some older people with financial constraints try to delay entry to care until they can be assessed as high care, a delay that may deprive them of needed care.[14]

Consumers and consumer representatives are concerned that access to care may be based not so much on need as the size of the bond and the length of time the bond will generate income from retention amounts. Some providers agree that such considerations can act as a disincentive to accepting a potential resident especially if the bond is approaching its 'use by' date in term of retention payments. This can be disadvantageous to residents wishing, or needing, to move between facilities with the 'old' bond diminishing consumer choice and contributing to consumer lock-in.[15]

In 2002–03 only 4.8 per cent of residents made accommodation payments through periodic payments. The Productivity Commission has suggested that the low uptake of this option possibly reflects a mismatch between demand and supply and that it is not likely to change under current arrangements.[16]

There is some evidence that the percentage of residents making periodic payments in part reflects the advice or requirements of specific providers as much as the choice of the potential resident. Consumers appear to have little awareness of the periodic payments option or they have the impression that they are more expensive than a lump sum payment, an impression reinforced by some providers.[17] Edina Aged Care, for example, advises that while bonds may be paid as periodic payments, the Government 'has provided for significant interest penalties to be imposed'.[18] The legislation requires providers to advise potential residents of payment options. However, little guidance is provided on the workings and/or benefits of periodic payments. The Department of Health and Ageing should address this information gap.

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13 See for example, Submission 250, p.13; See also Deborah Setterlund et al, 'Financial abuse within families: views from family members and professionals', paper presented at the 8th Australian Institute of Family Studies Conference, Melbourne, 12–14 February 2003; 'Elderly people and the law', Radio National, The Law Report, 2 September 2003, www.abc.net.au/rn/talks/8.30/lawrpt/stories/s936042.htm

14 Submission 206, p.12.

15 Submissions 206, p.19; 6, pp.ii–iii; 106, pp.11–12.

16 Submission 305, p.89.

17 Consumer calls to the Department's Helpdesk.

18 http://www.edina.uca.org.au/ac-information.htm; accessed 1 September 2003.

3. FINANCIAL APPRAISAL OF THE SECTOR

3.1 Introduction

Essential to a more comprehensive understanding of the social, economic and financial standing of the aged care industry is an analysis of the financial records of the entities providing aged care services. The Review called for a range of financial and other information from all providers of residential aged care facilities. The information sought, detailed the circumstances under which they were conducting their operations and their future needs. Specific information on revenues, costs, capital provision and balance sheet information for individual residential aged care homes and their wider corporate groups was important to make accurate assessments of the current funding situation in the industry and its future funding requirements.

For this analysis to stand up to scrutiny, it was essential to gain the participation of as large a sample of providers as possible. However the Review recognised that the willingness of many providers to be part of the exercise depended on strict confidentiality being adhered to in relation to the collection, storage and eventual uses to which the information would be put. In order to ensure the confidentiality of all financial information provided, the Review contracted a leading firm of public accountants, KPMG, to organise the processes for the submission of financial information. They were responsible for collecting, storing, analysing and de-identifying the financial data submitted to the Review, and have certified destruction of all the records dealing with submissions now the analyses are completed.

3.2 Response by industry

Financial submissions covering 912 facilities out of a total of about 2938 residential aged care facilities amount to a 31 per cent response rate. Of those 912 facilities, 224 were from providers who submitted a return for just one facility or residential aged care service (RACS). Some 83 providers submitted returns for two RACS. In either case they may have had other facilities for which returns were not submitted. Thus the sample does have a substantial proportion of providers who have multiple services. Some caution should be exercised as to what may be drawn about ownership from this information because any provider may be a subsidiary of, or associated with, another provider. The financial information sought related to the 2001–02 financial year in all respects except for balance sheet information where data was requested for the two financial years 2000–01 and 2001–02 in order to make some comparisons of the ongoing financial position of facilities.

The initial Table 3–1 provides a stratification of the responses from each Residential Aged Care Service (RACS) by state, sector and location. These are compared with the total population in each of the categories. The responses show the Northern Territory, Australian Capital Territory, Victoria, South Australia and Western Australia as having response rates higher than the national average. In contrast, the response rates from Queensland and Tasmania were lower than the overall average at 16 per cent and 21 per cent respectively.

For most analytical purposes ACT is included in New South Wales and Northern Territory in South Australia owing to the small number of observations in each territory. The small numbers of providers from Tasmania mean the need for caution when interpreting separate series from that state.

The stratification of the data reveals the following:

Table 3–1: Stratification by State, sector and locality

	Total population of RACS	Total responses	Responses as a % total RACS
State stratification			
ACT	23	9	39%
NSW	935	269	29%
NT	14	9	64%
QLD	503	81	16%
SA	295	110	37%
TAS	94	20	21%
VIC	814	319	39%
WA	260	95	37%
TOTAL	**2938**	**912**	**31%**
Sector stratification			
Charitable	252	110	44%
Community-based	578	196	34%
Local Government	83	27	33%
Private	701	132	19%
Religious	1051	350	33%
State Government	273	97	36%
TOTAL	**2938**	**912**	**31%**
Locality stratification			
Capital	1669	538	32%
Other Metro	217	60	28%
Remote	74	13	18%
Rural	978	301	31%
TOTAL	**2938**	**912**	**31%**

By sector, the response rates for the charitable, state government and community-based sectors were the highest at 44 per cent, 36 per cent and 34 per cent respectively. The religious and local government sectors also reported a higher than average response rate at 33 per cent. The private sector recorded the lowest response rate at 19 per cent.

In terms of locality, the highest response rate was from services in capital cities at 32 per cent. Services in rural and other metropolitan areas were not much different with response rates of 31 per cent and 28 per cent respectively. The lowest response rate was from services in remote areas at 18 per cent where total numbers are very small anyway. Apart from the last-mentioned category these differences are negligible.[1]

Using the initial summary of financial information undertaken by KPMG further analysis of the de-identified data was completed from a range of different perspectives. The results of these analyses are provided in tables shown later in this chapter as well as more comprehensively in Appendix A. They highlight most clearly that, no matter from which perspective the industry is examined whether by sector, size, location, or state, there is great variability across the country and the industry as a whole. The heterogeneous nature of the aged care industry stands out as its most notable feature. The Review cannot state categorically a certain financial characteristic as typical of the whole industry or in every part of Australia. There is a very rich vein of diversity.

Some sources of difficulty arose in the course of analysing the financial data reflecting a low response, particularly in Queensland and for private sector providers. Caution has been exercised when drawing out implications; for example, the small number of observations for Tasmania does not allow much stratification of data. Nevertheless, a better understanding of the variables influencing financial performance and some worthwhile benchmarks against which to measure operations of aged care providers have been secured. The empirical analyses provide insights to the workings of residential aged care services not previously available. Given the range of entities in residential aged care services, most clearly the distinction between for-profit and not-for-profit providers, comparative measures of financial performance must be gross of interest, tax and depreciation. The results illuminate the challenges being faced by boards and management on the provision of aged care.

Reservations about the results should be understood. Some not-for-profit organisations may have operating goals that diminish surpluses of revenues over costs because they choose to spend more on care and accommodation, or rely on a steady stream of donations. Nevertheless, taking the industry in the broad, operating surpluses should be a norm of experience for the majority of entities.

Not all the returns could be used in various analyses owing to deficiencies in the data provided, the lack of data in some instances and coverage including revenue and expenditure sums for activities other than residential aged care. In most work the samples drawn upon are 785 or 781. The difference between the lower of these two numbers and 912 is explained by some shortcomings in data and extensive coverage

[1] Although not shown in Table 3–1, there was little difference in the response rates for mainly high care, or low care or mixed facilities.

beyond residential aged care activities for 66 other services. This latter group may be thought of as comprehensive entities providing residential aged care along with retirement units and other services. However, for comparative analysis the main series to be worked had to be confined solely to residential aged care services.

Both the financial analysis and the efficiency studies point to substantial differences between the most successful participants and the weakest performers in the sector. It is well to recognise the analyses are based upon data in fiscal year 2001–02. They are at one point in time. During the many consultations and discussions around Australia, there emerged examples of how very badly placed residential aged care services in times past underwent restructuring to ensure their survival and then ongoing success.

3.3 General results

The results provided in the tables in this chapter are a summary of the many analyses undertaken by the Review. The information presented represents those elements of the operations of facilities considered most useful and instructive. They represent a major cost category for providers, such as labour costs, or earnings with a gross measure before interest, taxes, depreciation and amortisation. This EBITDA analysis offers an opportunity for providers to measure their financial performance in a sector neutral way without the influence of differential treatments of taxation, interest expenses, depreciation and amortisation that exists between the for-profit and not-for-profit sectors.

The following analysis of labour costs and EBITDA data has been compiled at an aggregate level for States, locality, sector and resident mix. A more detailed break-up of the data is presented in Appendix A. The data on labour costs and EBITDA is presented in a more comprehensive form, including details for each view of the number of services from which submissions were received and the standard deviation of observations.

There is also some brief mention of age of buildings. The degree of uniformity across the states and with each of them is notable. However, there are some exceptions.

3.3.1 Labour costs

By State and locality

Labour costs and associated on-costs on average make up around 66 per cent of the total expenses of aged care providers. There is significant variation between the States with these costs reported to be higher by providers in Tasmania at 75 per cent and South Australia at 69 per cent although the former State is based upon a small number of observations. In contrast, providers in Western Australia reported that their average labour costs were significantly below average at 59 per cent of total expenses. These results are summarised in Table 3–2.

Table 3–2: Percentage of total expenses as average labour costs by State

State	Percentage (%)	No of Services	Range of Averages by Sector (%)
NSW	68	261	56 to 80
QLD	67	53	63 to 69
SA	69	90	63 to 79
TAS	75	14	73 to 78
VIC	67	275	62 to 73
WA	59	92	53 to 64
Total		**785**	

The notion of a range of averages used in Table 3–2 and in subsequent tables should be understood. For example, the range of averages applying to New South Wales in Table 3–2 is the range recorded in each category for the sector in that State. This means it is the range across the averages for charitable, community-based, local government, private, religious and state operated services. The same range of averages applies to each category for a state, locality, size or resident mix as repeated in the various following tables. With resident mix, for example, it means high care, low care and mixed care.

By locality, capital city providers reported their average labour costs as lower than the overall average at 64 per cent of total expenses. The average labour costs by locality and the range of observations for each locality by State are summarised in Table 3–3.

Table 3–3: Percentage of total expenses as average labour costs by locality

Locality	Percentage (%)	No of Services	Range of Averages by State (%)
Capital	64	454	59 to 75
Other Metro	69	55	67 to 69
Remote	70	11	64 to 72
Rural	70	265	62 to 76
Total		**785**	

The figure reported for Perth providers at 59 per cent is notable in that it is the lowest figure for all localities across Australia. In comparison, rural providers reported the highest average labour expenses at 70 per cent of total expenses with a small number of these providers in Tasmania reporting even higher labour expenses at nearly 76 per cent. This was followed by a small number of South Australian providers in remote areas who reported labour costs around 72 per cent of total expenses. In contrast, a small number of Western Australian rural and remote providers reported that their average labour costs were around 62 per cent and 64 per cent of their expenses respectively.

By sector

The analysis by sector uses a break up of data into six categories covering facilities identified as charitable, community-based, local government, private, religious and State Government. The Victorian Government dominates the state-owned sector. On this basis, average labour costs were reported to be higher than the overall average for the community-based and State Government sectors at 69 per cent and 74 per cent respectively. The highest labour costs figures were reported by a small number of State Government other metropolitan providers at 78 per cent. The lowest overall average labour costs were reported by a number of Local Government providers at 62 per cent, with the lowest average within this category being recorded by a small number of rural local government providers at 61 per cent. Lower than average labour costs were also reported by providers in the private, religious, and charitable sectors. These results are summarised at a high level in Table 3–4.

Table 3–4: Percentage of total expenses as average labour costs by sector

Sector	Percentage (%)	No of Services	Range of Averages by Locality (%)
Charitable	65	80	64 to 71
Community-based	69	166	* to 70
Local Government	62	23	61 to 63
Private	65	115	64 to 68
Religious	65	308	63 to 71
State Government	74	93	69 to 78
Total		**785**	

* Not possible to provide a range figure due to confidentiality undertakings and/or the small number of relevant observations.

By resident mix

The analysis of labour cost data on resident mix by State and sector was undertaken on the basis of facilities having mostly a high care, low care or mixed care resident mix. The criteria for classifying homes used a threshold whereby 70 per cent or more of a service's residents needed to be classified as high care or low care for a service to qualify for that category. Services that have between 30 per cent and 70 per cent of their residents in both high care and low care are classified as mixed care.

On this basis, Table 3–5 shows that the data ranges from an average of 61 per cent of providers' total expenses being labour and on-costs in low care to approximately 72 per cent in high care. Average labour costs for providers with a mixed care resident mix fell between these limits at around 66 per cent of total expenses.

Table 3–5: Percentage of total expenses as average labour costs by resident mix

Reidnet mix	Percentage (%)	No of Services	Range of Averages by Sector (%)
High care	72	361	68 to 77
Low care	61	293	49 to 65
Mixed care	66	126	58 to 77
Total		**785***	

* Note: 5 observations not categorised by resident mix are included in the total figures

For providers with a mostly high care resident mix, private sector providers reported the lowest average labour costs at 68 per cent of average expenses. In contrast, State Government sector providers recorded the highest average labour costs at around 77 per cent of total expenses.

Mainly low care providers in the data set reported that a number of private providers had the lowest average labour costs at 49 per cent while community-based providers reported the highest average at 65 per cent of total expenses.

For providers with a mostly mixed care resident mix, private sector providers again reported the lowest average labour costs at 58 per cent of overall expenses while State Government sector providers reported the highest average at around 77 per cent.

In summary, the average percentage of total expenses that are labour costs range from 49 per cent for private providers with a mostly low care resident mix compared to around 77 per cent with State Government sector providers who cater mostly to a high care resident mix. The figure for private sector providers, however, is based upon a small sample size.

In the summary analysis of resident mix by State as shown in Table 3–6, the lowest labour cost figures for high care, low care and mixed care resident mixes were reported by Western Australia at 61, 58 and 58 per cent respectively. In contrast, a small sample of Tasmanian providers reported the highest labour costs for each of resident mix types with the highest number of 79 per cent being recorded for a small number of mainly high care providers in this State.

Table 3–6 Percentage of total expenses as average labour costs by resident mix

Resident mix	Percentage (%)	No of Services	Range of Averages by State (%)
High care	72	361	61 to 79
Low care	61	293	58 to 70
Mixed care	66	126	58 to **
Total		**785***	

* Note: 5 observations not categorised by resident mix are included in the total figures

* * Not possible to provide a range figure due to confidentiality undertakings and/or the small number of relevant observations.

3.3.2 EBITDA

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 has been used for this analysis because it removes the differential impacts of taxation, interest expenses, depreciation and amortisation on the for-profit and not-for-profit sectors. By removing the effect of the various financing and accounting decisions taken by providers due to these impacts it is possible to examine and analyse the profitability of the services in the financial data with a sector neutral technique and obtain a relatively good 'apples to apples' comparison.

The low overall EBITDAs figures are largely a reflection that 225 or 29 per cent of the services in the data set reported a loss in EBITDA terms. The results of the non-loss making providers are significantly different when reported separately for positive EBITDAs only.

By State and locality

The overall average EBITDA for services across Australia is $2 001 per bed year. As indicated in Table 3–7 and on a State basis, the highest overall EBITDA figure was reported by a small number of providers in Tasmania at $4 362 per bed year. This was followed by providers in New South Wales, Queensland and South Australia who also reported higher than average EBITDA figures per bed year than the overall average across Australia.

In contrast, Western Australia and Victoria providers reported averages below the Australian average. The latter reported the lowest average EBITDA at $310 per bed year. This result is heavily influenced by the negative EBITDA average for the State Government sector providers who represent 28 per cent of the sample size for that State.

Table 3–7: Average EBITDA per bed year by State

State	Avg EBITDA per bed year ($)	No of Services	Range of Averages by Sector ($)	Range of Averages by Locality ($)
NSW	3467	260	-4472 to 9925	* to 3725
QLD	3171	53	1940 to 3886	1237 to 6318
SA	2935	90	277 to 5511	-9520 to 4432
TAS	4362	13	2147 to 6946	* to 6120
VIC	310	275	-2857 to 4455	195 to 2618
WA	967	90	-4 to 3782	797 to 2339
Total	**2001**	**781**	**-2620 to 4007**	**-3860 to 3827**

* Not possible to provide a range figure due to confidentiality undertakings and/or the small number of relevant observations.

By locality, providers in other metropolitan localities on average reported the highest average EBITDA at $3 827 per bed year with a small number of Queensland providers in this class of locality reporting an average EBITDA of $6 318 per bed year on a low standard deviation. The next highest average EBITDA was reported by rural providers with an average of $2 244 per bed year which reflected a range of average EBITDA figures on a small number of providers in Tasmania at $6 120 per bed year to $195 per bed year in Victoria.

In contrast, the lowest overall average EBITDA by locality was reported by a number of remote providers at -$3 860 per bed year with a small number of these providers in South Australia reporting the lowest average EBITDA figure of -$9 520 per bed year. Recall the South Australian total includes the few from the Northern Territory. However, some caution needs to be exercised in interpreting these figures given the high standard deviations associated with most of the data on this table.

By sector

The lowest and most notable EBITDA figures were reported in the State Government sector with an average EBITDA per bed year of -$2 620 reflecting the losses recorded by State Government providers in Victoria and New South Wales.

By size

As indicated in Table 3–8, it is important to note that by size 51 per cent of providers in the data set fall into the 31–60 resident size bracket. However, the high standard deviations associated with most of the data associated with the analysis by bed size show there is significant variability in the average EBITDA per bed year figures reported between sectors and across the bed size ranges.

Table 3–8: Average EBITDA per bed year by size

	0–30	31–60	61–90	90+	Total
Avg EBITDA per bed year ($)	152	2526	3862	977	**2001**
No of Services	199	397	121	64	**781**
Range of averages by State ($)	-2042 to 3505	1330 to 6801	1326 to 5323	-2476 to 4897	
Range of averages by sector ($)	-4924 to 9268	219 to 3752	1549 to *	-982 to 4859	

* Not possible to provide a range figure due to confidentiality undertakings and/or the small number of relevant observations.

Overall, providers in the 61–90 resident size bracket reported the highest average EBITDA at $3 862 per bed year which is 93 per cent higher than the average EBITDA figure for all services of $2 001. By State within this size band, higher than average EBITDA figures were reported by providers in New South Wales at $5 323 per bed year.

The next highest EBITDA figures were recorded by providers in the 31–60 size bracket who reported an average EBITDA of $2 526 per bed year which is 26 per cent higher than the average reported for all services. In this size band community-based providers reported the highest average EBITDA at $3 752 per bed year. In contrast, State Government providers reported the lowest average EBITDA at $219 per bed year.

A lower than average EBITDA per bed year of $977 is reported in the 91+ resident size band, with negative average EBITDA figures being reported in this size band for providers in Victoria and Western Australia. By sector, there were also negative average EBITDA figures recorded by providers in a number of sectors. In contrast, a higher than average EBITDA of $4 897 per bed year, was reported by a small number of providers in South Australia in this size bracket.

Positive EBITDAs

As indicated in Table 3–9, positive EBITDA figures were reported by 556 or 71 per cent of the services that provided EBITDA information. On a state basis, South Australia and New South Wales had the highest percentages of services reporting positive EBITDA figures at 84 per cent and 81 per cent respectively. In contrast, Victoria reported the lowest percentage of services with positive EBITDA figures at 58 per cent.

In terms of locality, services in other metropolitan areas reported the highest percentage of services with positive EBITDA figures at 89 per cent. This was followed by capital city and rural providers who reported that 71 per cent and 68 per cent of their respective services reported positive EBITDA figures. Providers in remote areas reported the lowest percentage of services with positive EBITDA figures at 36 per cent. However it should be noted that the latter figure is based on a small sample size.

By sector, the community and charitable sectors reported the highest percentage of services with positive EBITDAs at around 80 per cent. In contrast, the state government sector reported the lowest percentage of services with positive EBITDAs at 38 per cent.

In terms of the size of services, the highest percentage of services with positive EBITDA figures were reported by services in the 61–90 resident size bracket at 77 per cent. This was immediately followed by providers with 31–60 residents who reported that 76 per cent of their services were positive. In comparison, the lowest percentage of services by size recording positive EBITDA figures were those in the 0–30 size bracket at 57 per cent.

By resident mix, 83 per cent of mixed care services reported positive EBITDA figures. This was followed by mainly low care services at 75 per cent. In comparison, providers with a mainly high care resident mix reported the lowest percentage of services with positive EBITDA figures at 64 per cent.

Table 3–9: Percentage of services who reported positive EBITDA figures by State, locality, sector and size

	No. Submissions used in financial analysis	No. positive EBITDAs	Percentage of total no. submissions (%)
State			
NSW	260	210	81
QLD	53	40	75
SA	90	76	84
TAS	13	10	77
VIC	275	160	58
WA	90	60	67
Total	**781**	**556**	**71**
Locality			
Capital	452	324	72
Other Metro	55	49	89
Remote	11	4	36
Rural	263	179	68
Total	**781**	**556**	**71**
Sector			
Charitable	80	64	80
Community	167	136	81
Local Govt	22	17	77
Private	112	84	75
Religious	307	220	72
State Govt	93	35	38
Total	**781**	**556**	**71**
Size			
0–30	199	114	57
31–60	397	303	76
61–90	121	93	77
91+	64	46	72
Total	**781**	**556**	**71**

3.4 Top performers and quartile analysis

The analysis in this section relates to the top 10 per cent and a quartile break-up of all providers in respect of their reported EBITDA data. Initially the quartile distributions for each of the main classifications is shown in Table 3–10 as well as the top 10 per cent of providers.

The data revealed in the composite Table 3–10 shows the numbers of providers in the top 10 per cent and each quartile as determined by their individual EBITDAs. The distributions are across the states, by the different sectors in the aged care industry, between different localities across the country, by size as measured by beds in each RACS and then, most importantly, by resident mix. In the last-mentioned category the determination of high care and low care reflects at least 70 per cent of residents being in that class of resident. When interpreting this material, the top 10 per cent of the providers as shown by these numbers are included in the totals for the top quartile.

Examples may help clarify what is being measured. Amongst the states New South Wales is the biggest contributor to the top quartile whereas Victoria dominates the numbers in the fourth quartile with 104 there against just 40 from NSW.

With various industry sectors, the community-based providers dominate the top quartile while state-operated facilities dominate proportionately the lowest quartile despite larger numbers of the religious appearing in this group.

Table 3–10: Numbers by State, Sector, Locality, Size and Resident Mix for Top 10 per cent and Quartile Groups according to EBITDA for each provider

State	Top 10%	1st Quartile	2nd Quartile	3rd Quartile	4th Quartile	Total
NSW (ACT)	35	93	63	64	40	260
Qld	6	19	14	9	11	53
SA (NT)	11	27	28	24	11	90
TAS	2	3	5	2	3	13
VIC	22	44	63	64	104	275
WA	2	9	22	32	27	90
Total	**78**	**195**	**195**	**195**	**196**	**781**
Sector	**Top 10%**	**1st Quartile**	**2nd Quartile**	**3rd Quartile**	**4th Quartile**	**Total**
Charitable	6	18	26	22	14	80
Community—based	21	58	40	45	24	167
Local Govt.	5	7	6	6	3	22
Private	11	26	33	30	23	112
Religious	29	74	76	78	79	307
State Govt.	6	12	14	14	53	93
Total	**78**	**195**	**195**	**195**	**196**	**781**
Locality	**Top 10%**	**1st Quartile**	**2nd Quartile**	**3rd Quartile**	**4th Quartile**	**Total**
Capital	35	95	120	126	111	452
Other Metro	6	22	16	11	6	55
Remote	1	1		3	7	11
Rural	36	77	59	55	72	263
Total	**78**	**195**	**195**	**195**	**196**	**781**
Size	**Top 10%**	**1st Quartile**	**2nd Quartile**	**3rd Quartile**	**4th Quartile**	**Total**
0–30	21	44	41	35	79	199
31–60	42	105	101	113	78	397
61–90	13	32	37	29	23	121
90+	2	14	16	18	16	64
Total	**78**	**195**	**195**	**195**	**196**	**781**
Resident mix	**Top 10%**	**1st Quartile**	**2nd Quartile**	**3rd Quartile**	**4th Quartile**	**Total**
High Care	33	83	78	81	118	360
Low Care	30	77	73	83	60	293
Mixed Care	15	35	44	31	18	128
Total	**78**	**195**	**195**	**195**	**196**	**781**

The locality estimates are dominated by just two groups; those located in capital cities and those in rural settings. Providers in rural settings are impressive for their

performances when compared with metropolitan facilities. The 'other metropolitan' category reveals a superior effort to their capital city brethren.

The size groupings point to a preponderance of small facilities ((30 beds) in the lowest quartile especially when viewed proportionately to the other three categories. There is little to choose between the relative positions on the next two size categories while the largest with more than 90 beds does not rank as well.

The resident mix categories point to the relatively weaker position for high care establishments as disclosed by the numbers in the lowest quartile. Mixed care operations appear to reveal the relatively most favoured quartile distribution.

This general representation of the numbers involved in the various classifications by quartiles plus the top 10 per cent of providers of services offers a succinct summary of the performances within the industry as well as illuminating the need for caution when making general claims about the condition of the industry. Much 'folklore' may be called into question.

Most important of all is the attention drawn to the presence of at least one provider, and mostly many more, in every line of entry amongst the top 10 per cent. For example, however large the number of high care establishments recorded in the 4th quartile (118) there were 33 of them in the top 10 per cent and 83 in the 1st quartile.

Another strong example lies with the providers in the rural settings. The impressions gained from many consultations and discussions in regional and metropolitan locations were of any number of very effective operations. These observations are confirmed by the quartile distribution for rural providers.

3.4.1 Top 10 per cent of services

The average EBITDA for services in the highest performing 10 per cent of services in EBITDA terms is more than six times the average EBITDA for all services at $13 350 per bed year. Around 45 per cent of these services are from New South Wales and some 28 per cent are from Victoria. These results and the range of observations by resident mix, sector and locality are summarised in Table 3–11.

Table 3–11: Average EBITDA per bed year in the top 10% of services by state, locality and sector

State	Average EBITDA per bed year ($)	Number of Services	Range of averages by: resident mix ($)	sector ($)	locality ($)
NSW	13 261	35	10 459 to 16 305	8 731 to 15 270	11 549 to 14 489
QLD	11 289	6	* to 14 293	* to 11 659	* to 12 171
SA	10 384	11	* to 11 620	* to 13 835	9 948 to 11 147
TAS	20 074	2	*	*	*
VIC	15 184	22	11 986 to 17 687	9 305 to 19 614	9 449 to 18 461
WA	10 501	2	*	*	*
Average	**13 350**	**78**			

* Not possible to provide a range figure due to confidentiality undertakings and/or the small number of relevant observations.

By resident mix, some 42 per cent of the services in this grouping were mainly high care services with an average EBITDA of $12 402 per bed year. The average EBITDA for mainly low care services which made up 38 per cent of this grouping was more than 17 per cent higher at $14 591 per bed year. In New South Wales and Victoria, the average EBITDA figures for low care services were 41 and 14 per cent respectively higher than their corresponding figures for their high care services. The remainder of the services fell into the mixed care category which recorded an average EBITDA of $12 955 per bed year. In this category, a small number of services in New South Wales and Victoria reported average EBITDA figures of $16 305 and $11 986 respectively.

By sector, the highest average EBITDA figure was reported by a small number of State Government services at $16 444 per bed year. This was followed by community-based services at $15 146 per bed year with Victorian services in this sector reporting a higher average at $18 790 per bed year. The next highest average EBITDA was reported by a significant number of services in the religious sector at $13 537 per bed year with New South Wales providers in this sector reporting an average EBITDA of $15 270 per bed year. In contrast, a number of private sector services reported the lowest average EBITDA figure of $10 003 for this grouping. These results and the range of observations by locality are summarised in Table 3–12.

Table 3–12: Average EBITDA per bed year in the top 10 per cent of services by sector and locality

Sector	Average EBITDA per bed year ($)	Number of Services	Range of averages by locality ($)
Charitable	10 292	6	9 637 to 11 600
Community	15 146	21	8 421 to 16 977
Local Govt	12 043	5	* to 12 945
Private	10 003	11	9 987 to *
Religious	13 537	29	10 835 to 14 674
State Govt	16 444	6	* to 17 432
Average	**13 350**	**78**	

* Not possible to provide a range figure due to confidentiality undertakings and/or the small number of relevant observations.

Services offered by the religious and community-based sectors respectively make up 37 per cent and 27 per cent of the services in the top 10 per cent grouping. More than 50 per cent of the services in the religious sector are based in capital cities and report an average EBITDA of $14 674 while more than three quarters of the community-based services in this grouping are based in rural areas which report an average EBITDA of $16 977 per bed year. These results for services based in rural places are impressive for their scale and are contrary to much folklore about residential aged care services.

By locality, 46 per cent of the services in this category are rural providers who reported an average EBITDA figure of $14 821 per bed year. Over 72 per cent of these services are from rural areas in Victoria and New South Wales who reported average

EBITDA figures of $18 461 and $12 133 per bed year respectively. Services in the capital cities which made up 45 per cent of the services in this grouping reported the next highest average EBITDA figures at $12 266 per bed year. More than half of these capital city services are based in New South Wales and reported a higher average EBITDA figure of $14 489 per bed year.

3.4.2 Top quartile of services

The average EBITDA for services in the first quartile being the top performing 25 per cent of services is more than four times the average EBITDA for all services at $9 116 per bed year. Geographically around 48 per cent of these services are based in New South Wales, 23 per cent in Victoria and 14 per cent in South Australia. These results and the range of observations by resident mix, location and sector are summarised in Table 3–13.

Table 3–13: Average EBITDA per bed year in the top quartile of services by state, locality and sector

State	Average EBITDA per bed year ($)	Number of Services	Range of averages by resident mix ($)	Range of averages by location ($)	Range of averages by sector ($)
NSW	8 962	93	7 928 to 9 871	7 921 to 9 649	6 761 to 12 945
QLD	7 811	19	6 678 to 9 006	6 923 to 9 932	7 547 to 8 338
SA	7 845	27	6 984 to 8 244	7 507 to 8 648	6 538 to 10 936
TAS	15 835	3	*	*	*
VIC	10 733	44	9 754 to 12 172	7 507 to 13 678	7 264 to 14 313
WA	7 126	9	6 111 to 9 112	6 161 to *	5 913 to 8 017
Average	**9 116**	**195**			

* Not possible to provide a range figure due to confidentiality undertakings and/or the small number of relevant observations.

In terms of resident mix, around 43 per cent of the services in the top quartile were mainly high care services with an average EBITDA of $8 726 per bed year. The average EBITDA for mainly low care services which made up 39 per cent of this quartile was 9 per cent higher at $9 500 per bed year. However, mainly low care services in Victoria and New South Wales reported that their average EBITDAs were 20 per cent higher than the average EBITDAs reported for high care services in these States. In contrast, a number of mainly low care Queensland services reported that their average EBITDAs were 25 per cent lower at $6 761 per bed year than the corresponding figures for high care services in that State. The remainder of the services in this quartile fell into the mixed care category with an average EBITDA of $9 194 per bed year.

By location, just under half of the services in the top quartile are based in the capital cities with an average EBITDA of $8 499 per bed year. Nearly half of these services are in New South Wales with an average EBITDA figure of $9 649 per bed year. This is followed by Victorian capital city services who made up 22 per cent of the providers in this category with an average EBITDA of $7 507 per bed year.

The high number of capital city services in the top quartile were followed by rural services who made up 39 per cent of the top quartile with an average EBITDA of $10 236 per bed year. Around 40 per cent of these rural services were based in New South Wales with an average EBITDA of $8 536 per bed year. This is followed by a significant number of Victorian rural services who reported a much higher average EBITDA of $13 678 per bed year. In contrast, the lowest average EBITDA figures in this quartile are reported by New South Wales and Queensland Other Metropolitan services at $7 694 per bed year. Again this is a reversal of a popular perception of aged care experiences.

By sector, 38 per cent of the services in the top quartile are from the religious sector reporting an average EBITDA of $9 149 per bed year. Around 61 per cent of these services are based in New South Wales with an average EBITDA of $10 303 per bed year. This is followed by community-based services who make up around 30 per cent of the quartile with an average EBITDA of $9 477 per bed year. Again this included a significant number of community-based services in New South Wales who reported an average EBITDA of $6 761 per bed year. In comparison, the lowest average EBITDA figures in this quartile were recorded by the charitable sector at $7 521 per bed year. These results and the range of observations by locality are summarised in Table 3–14.

Table 3–14: Average EBITDA per bed year in the top quartile of services by sector and locality

Sector	Average EBITDA per bed year ($)	Number of Services	Range of averages by locality ($)
Charitable	7 521	18	6 993 to 8 576
Community	9 477	58	6 454 to *
Local Govt	10 300	7	6 774 to 12 945
Private	7 992	26	7 905 to *
Religious	9 149	74	8 042 to 9 953
State Govt	11 305	12	* to 11 734
Average	**9 116**	**195**	

* Not possible to provide a range figure due to confidentiality undertakings and/or the small number of relevant observations.

Further analysis on the services in the top quartile indicates that 48 per cent of the rural services are operated by community-based providers who report an average EBITDA of $10 839 per bed year. This is followed by religious services who operate around 25 per cent of rural services in this quartile with an average EBITDA of $8 229 per bed year. The religious sector also stands out in the top quartile as operating 43 per cent of the services in the capital cities with an average EBITDA of $9 953 per bed

year. This is followed by the private sector which operates around 26 per cent of capital city services with an average EBITDA of $7 905 per bed year.

3.4.3 Second quartile of services

The average EBITDA for services in the second highest performing quartile is nearly twice the average EBITDA for all services at $3 655 per bed year. By State, this quartile consisted of an equal number of services from New South Wales and Victoria which in total made up around 65 per cent of the quartile. This was followed by services in South Australia and Western Australia which made up 14 per cent and 11 per cent of the quartile respectively. These results and the range of observations by resident mix, locality and sector are summarised in Table 3–15.

Table 3–15: Average EBITDA per bed year in second quartile of services by state, locality and sector

State	Average EBITDA per bed year ($)	Number of Services	Range of averages by resident mix ($)	Range of averages by location ($)	Range of averages by sector ($)
NSW	3 614	63	3 506 to 3 965	3 577 to 3 669	3 400 to 3 885
QLD	3 921	14	3 649 to 4 147	3 554 to 4 806	3 615 to 4 182
SA	3 735	28	3 504 to 4 114	3 525 to 3 793	3 324 to 3 852
TAS	3 556	5	*	*	*
VIC	3 626	63	3 396 to 3 889	3 490 to 3 810	3 246 to 4 715
WA	3 604	22	3 486 to 3 768	3 579 to 3 687	3 276 to 3 749
Average	**3 655**	**195**			

* Not possible to provide a range figure due to confidentiality undertakings and/or the small number of relevant observations.

By resident mix, some 40 per cent of the services in this quartile were mainly high care services with an average EBITDA of $3 603 per bed year. Importantly, low care services which made up 37 per cent of this quartile reported only a slightly higher average EBITDA at $3 627 per bed year. In New South Wales, a significant number of mainly low care services reported an average EBITDA of $3 525 per bed year which was only slightly higher than the average EBITDA reported by high care services in this State. Mainly low care services in South Australia and Queensland reported average EBITDA figures which were 17 per cent and 7 per cent higher respectively than their high care counterparts. In contrast, mainly low care services in Victoria reported an average EBITDA of $3 546 per bed year which was 8.8 per cent lower than the figure reported by mainly high care services in that State. The remainder of the services in the mixed care category reported an average EBITDA of $3 778 per bed year.

In terms of locality, around 62 per cent of the services in the second quartile were from capital cities who recorded an average EBITDA of $3 641 per bed year with the figures ranging from $3 574 in Victoria to $4 431 in Queensland. Around 64 per cent of these capital city providers were from Victoria and New South Wales.

A further 30 per cent of the services in this quartile were located in rural areas with an average EBITDA of $3 661 per bed year. The average EBITDA figures in these areas ranged from $3 435 for a small number of Tasmanian services to $3 810 in Victoria. Approximately 60 per cent of these rural services were based in New South Wales and Victoria.

By sector, 39 per cent of the services in the second quartile are from the religious sector reporting an average EBITDA of $3 640 per bed year with a range of $3 246 for Victorian services to $4 182 for a small number of services in Queensland. It should be noted that 60 per cent of these religious-based services are located in capital cities with nearly half of them located in New South Wales. The community-based sector made up the next highest number of services by sector at 20 per cent of this quartile with an average EBITDA of $3 443 per bed year ranging from $3 276 per bed year in Western Australia to $3 790 per bed year in Queensland. In contrast to the religious sector, 60 per cent of these community-based services are located in rural areas reporting an average EBITDA of $3 433 per bed year. These results and the range of observations by locality are summarised in Table 3–16.

Table 3–16: Average EBITDA per bed year in the second quartile of services by sector and locality

Sector	Average EBITDA per bed year ($)	Number of Services	Range of averages by locality ($)
Charitable	3 757	26	3 745 to 3 850
Community	3 443	40	3 425 to 3 678
Local Govt	4 438	6	3 885 to 4 715
Private	3 584	33	3 533 to 3 939
Religious	3 640	76	3 610 to 3 696
State Govt	3 983	14	3 756 to 4 153
Average	**3 655**	**195**	

3.4.4 Third quartile of services

The average EBITDA for the third quartile of services is slightly more than half that for all services in the data set at $1 044 per bed year. By State, the average EBITDA ranged from $980 per bed year in Victoria to $1 163 per bed year for a small number of services in Tasmania. Like the second quartile, this quartile again consisted of an equal number of services from New South Wales and Victoria which together made up around two thirds of the quartile. This was followed by services in Western Australia and South Australia which made up 16 per cent and 12 per cent of the quartile respectively. These results and the range of observations by resident mix, locality and sector are summarised in Table 3–17.

Table 3–17: Average EBITDA per bed year in the third quartile of services by state, locality and sector

State	Average EBITDA per bed year ($)	Number of Services	Range of averages by resident mix ($)	Range of averages by location ($)	Range of averages by sector ($)
NSW	1030	64	865 to 1702	934 to 1158	22 to 2006
QLD	999	9	504 to 1278	906 to 1186	-81 to 1340
SA	1110	24	825 to 1252	898 to 1361	* to 1564
TAS	1163	2	*	*	*
VIC	980	64	728 to 1292	742 to 1623	7 to 1425
WA	1154	32	987 to 1339	570 to *	916 to 1743
Average	**1044**	**195**			

* Not possible to provide a range figure due to confidentiality undertakings and/or the small number of relevant observations.

In resident mix terms, nearly 42 per cent of the services in the third quartile were mostly high care services with an average EBITDA of $943 per bed year ranging from $728 per bed year in Victoria to $1 278 per bed year in Queensland. A similar number of mostly low care services reported an average EBITA of $1 052 per bed year with Victorian, Western Australian and New South Wales services in this category reporting higher EBITDAs figures than their mostly high care counterparts. In contrast, a number of mostly low care South Australian services reported average EBITDA figures that were 34 per cent lower than their high care counterparts. The remainder of the services in the mixed care category in this quartile reported an average EBITDA of $1 285 per bed year. In this category, a number of New South Wales and Victorian services reported average EBITDA figures that were significantly higher than the averages reported by mostly high care and low care services in these States.

In terms of locality, around 65 per cent of the services in the third quartile were from the capital cities with slightly less than two thirds of these services being based in New South Wales and Victoria. The average EBITDA figure for services from the capital cities in this quartile is $1 093 per bed year with the figures ranging from $1 004 in New South Wales to $1 195 per bed year in South Australia.

Services in rural areas constituted 28 per cent of this quartile with an average EBITDA of $902 per bed year. The average EBITDA figures for these services ranged from $570 per bed year for Western Australia to $1 163 per bed year in Tasmania. The largest number of rural services is based in Victoria with an average EBITDA of $742 per bed year.

By sector, 40 per cent of the services in this quartile are from the religious sector with an average EBITDA of $1 216 per bed year. More than 70 per cent of these services are located in the capital cities with an average EBITDA of $1 172 per bed year. The private sector made up the next highest number of services constituting 15 per cent of this quartile with an average EBITDA of $928 per bed year. In contrast, a small number of Queensland private services in this quartile reported a negative average

EBITDA of -$81 per bed year. These results and the range of observations by locality are summarised in Table 3–18.

Table 3–18: Average EBITDA per bed year in the third quartile of services by sector and locality

Sector	Average EBITDA per bed year ($)	Number of Services	Range of averages by locality ($)
Charitable	1040	22	999 to *
Community	1163	45	1000 to 1220
Local Govt	303	6	7 to 896
Private	928	30	163 to 1068
Religious	1216	78	1172 to 1535
State Govt	273	14	* to 285
Average	**1044**	**195**	

* Not possible to provide a range figure due to confidentiality undertakings and/or the small number of relevant observations.

The lowest EBITDAs by sector in this quartile were reported by a number of local and State government services with average EBITDA figures of $303 and $273 per bed year respectively. The latter result largely reflects a number of marginal State Government services operating in rural areas in Victoria. The State Government sector will be discussed further in the next section.

3.4.5 Fourth quartile of services

The average EBITDA for services in the lowest performing quartile of services is -$5 771 per bed year. By State, the average EBITDA ranged from -$3 457 per bed year in Western Australia to -$7 169 per bed year in South Australia. Services from Victoria constitute 53 per cent of this quartile with an average EBITDA of -$6 521 per bed year. This was followed by services in New South Wales who made up 20 per cent of this quartile with an average EBITDA of -$5 639. These results and the range of observations by resident mix, locality and sector are summarised in Table 3–19.

Table 3–19: Average EBITDA per bed year in the fourth quartile of services by state, locality and sector

State	Average EBITDA per bed year ($)	Number of Services	Range of averages by resident mix ($)	Range of averages by location ($)	Range of averages by sector ($)
NSW	-5 639	40	-7 005 to -1 361	-6 044 to *	-11 262 to -1 991
QLD	-4 021	11	* to -3 610	-4 341 to -3 838	-5 609 to -2 652
SA	-7 169	11	-18 792 to *	* to -3 567	-8 827 to *
TAS	-3 633	3	*	*	*
VIC	-6 521	104	-8 547 to -4 760	-7 102 to *	-7 900 to -1 873
WA	-3 457	27	-3 869 to -1 737	-3 562 to *	-5 980 to -2 167
Average	**-5 771**	**196**			

* Not possible to provide a range figure due to confidentiality undertakings and/or the small number of relevant observations.

By resident mix, a significantly higher 60 per cent of the services in the fourth quartile were mostly high care services who reported an average EBITDA of -$6 249 per bed year with a range of between -$3 869 per bed year in Western Australia to -$7 223 in Victoria. The average EBITDA for mostly low care services which constituted 31 per cent of this quartile was -$4 268 per bed year. The losses for services in the mostly low care category were generally lower than those reported for their mostly high care counterparts with a number of services in Western Australia and Queensland reporting the lowest losses at -$1 737 and -$3 610 respectively per bed year. The remainder of the services in this quartile in the mixed care category reported an average EBITDA of -$7 644 per bed year. The majority of these services are located in Victoria and reported an average EBITDA of -$8 547 per bed year.

By locality, a small number of remote services reported the lowest average EBITDA figures in this quartile at -$8 544 per bed year. The next lowest average EBITDA figure is reported by services in rural areas at -$6 439 per bed year. This ranges from an average of -$3 232 per bed year for a small number of Western Australian services to -$7 102 for Victorian services. A significant number of capital city services which make up 57 per cent of the services in this quartile report the next lowest EBITDA of -$5 203 per bed year. The average capital city EBITDA figures ranged from -$3 562 in Western Australia to -$6 045 in Victoria. A number of capital city services in New South Wales also reported a similar EBITDA figure at -$6 044 per bed year.

The high number of negative EBITDA figures for Victorian services in this quartile is largely a product of locality and sector. This is because half of the services are located in rural areas and operated by the State Government providers which record the lowest average EBITDA by sector in this quartile at -$8 281 per bed year. In Victoria, the average EBITDA for the State Government sector is -$7 900 per bed year. The next highest level of losses in this quartile is reported by the Religious sector at -$6 186 per bed year with the average loss in Victoria only being slightly less at -$6 078 per bed year. These results and the range of observations by locality are summarised in Table 3–20.

Table 3–20: Average EBITDA per bed year in the fourth quartile of services by sector and locality

Sector	Average EBITDA per bed year ($)	Number of Services	Range of averages by locality ($)
Charitable	-4 204	14	-4 443 to *
Community	-2 941	24	-3 750 to -2 144
Local Govt	-5 010	3	*
Private	-2 569	23	* to -2 472
Religious	-6 186	79	-10 808 to -2 475
State Govt	-8 281	53	* to -8 121
Average	**-5 771**	**196**	

* Not possible to provide a range figure due to confidentiality undertakings and/or the small number of relevant observations.

3.5 Comprehensive providers

One group could not be included in the general appraisal of results from analysis of the EBITDA calculations for 781 because the data submitted from each covered more than the operations of an individual RACS. This group of 66 are comprehensive entities which reported results for activities in addition to their residential aged care commitments. These other aged care activities linked to retirement places and domiciliary commitments.[2]

In Table 3–21 a comparison is made between the average EBITDAs recorded in each state for those 66 comprehensive providers compared with the average EBITDAs shown in previous tables for the 781 ordinary providers in the main series. The results shown were consolidated for Tasmania and Western Australia owing to the very small numbers of providers from the two states recording comprehensive activities.

Table 3–21: Comprehensive and Ordinary Providers; Average EBITDAs by state and number of Comprehensive Providers

State	Number	Comprehensive Providers Average EBITDA ($) (66 RACS)	Ordinary Providers Average EBITDA ($) (781 RACS)
NSW	10	7 145	3 467
QLD	13	5 243	3 171
SA	10	12 363	2 935
VIC	28	1 558	310
TAS & WA	5	13 101	1 396
National	**66**	**5 642**	**2 001**

The startling general result is the near tripling of the average EBITDA for the comprehensive provider group as compared with the outcome for the residual aged care providers; this is $5 642 per bed per year compared to $2 001. With New South Wales and Queensland the results for the comprehensive series are double and near double those in the major series respectively. Victoria is the State with the largest number of comprehensive providers in the group, not far short of half the total number. While the EBITDA average is very low for these 28 comprehensive providers it is five times the value recorded in the main series. The difference is nearly matched for the result from South Australia where the difference is some four times between the two series. The combined result for Tasmania and Western Australia is drawn from just a few numbers, just five in total, and must be viewed cautiously.

The insight gained from this comprehensive series is the role of the comprehensive provider. It is well to recall how this series of 66 providers emerged from the data base. They were excluded from the main survey because the information supplied did

[2] An exercise similar to this comparison of average EBITDAs could be done for the percentage of total expenses absorbed by labour costs but the contrasts between the two series are not as striking as what follows for gross earnings.

not distinguish the sources of income so as to allow a specific series reflecting residential aged care activities alone. The numbers are small in relation to the size of the industry so strong conclusions should not be drawn. But there is nothing in the procedures leading to emergence of this group from the submission process which would suggest some bias.

3.6 Age of buildings

It was possible to collect data on the age of the buildings used in residential aged care. This information was provided by 728 providers with most of this number located in capital cities or in rural areas as is evident in Table 3–22. While there are a number of very old establishments in the industry the average age is just over 20 years. Apart from Tasmania where the sample is very small the age of buildings in rural locations is below the average age of buildings in each state. This points a level of activity in rural spheres impressive against the national record in almost every instance. The general evidence from series disclosed in Table 3–22 is of an industry in which building has been thriving for many years reflecting in most respects the rate of growth of the industry.

Table 3–22: Age of facilities by state and locality

	Total		Capital		Rural	
State	**Number**	**Average Age (years)**	**Number**	**Average Age (years)**	**Number**	**Average Age (years)**
NSW	219	23.0	116	27.8	72	17.2
QLD	56	16.6	17	15.8	31	16.2
SA	75	21.4	50	24.2	24	16.5
TAS	13	14.3	4	12.0	9	15.4
VIC	284	19.3	157	19.3	118	19.0
WA	81	18.5	66	19.2	13	16.1
Australia	**728**	**20.3**	**410**	**22.1**	**267**	**17.7**

New South Wales is carrying the oldest stock of facilities reflecting mainly the position in the capital city. A note of caution may be entered here because the age of the stock of facilities in the 'other metropolitan' category not shown in the table, is virtually the same as for the NSW rural facilities. If there is problem about ageing buildings, plant and equipment in New South Wales then it would appear to reflect conditions in Sydney rather than the state as a whole.

Queensland appears to have a relatively young building stock at 16.6 years. This average is deceptive because the great weight of explanation for this situation rests upon the outlays on new buildings by the private providers. Others in Queensland do not appear to have been building at anything like the same rate.

Other states do not exhibit the same degree of concentration of issues bearing upon age structures of buildings. Given the scale of building activity in residential aged care and

the relative stability in the age patterns between states, except perhaps for the situation with Sydney locations, there is evidence for thinking attention should be paid to replacement provisioning for buildings in this industry where there is now such emphasis on continuous improvement of facilities.

3.7 EBITDAs in Victoria and New South Wales

To facilitate further examination and to drill down on the EBITDA figures, the data for Victoria and New South Wales has been used to provide further detail on the 535 submissions for these two States out of the total of 781 overall used in the financial analyses. This represents 68 per cent of the services who provided financial data used in the analyses.

3.7.1 Victoria

Table 3–23 indicates that in Victoria, 160 or 58 per cent of the providers in this State reported positive EBITDA figures for their services. On average this figure was $4 794 per bed year. The highest reported EBITDA figures for this group was reported by community-based services which on average reported that their EBITDAs were $6 635 per bed year. In comparison, the lowest average EBITDA figure reported for this group of services was from a small number of Local Government providers at $3 274 per bed year.

By resident mix, Victorian services in this category with mainly high care residents reported an average EBITDA of $5 208 per bed year while services with a mainly low care resident mix reported an average EBITDA at $4 392 per bed year. These results are also further detailed in Table 3–23.

In contrast, Table 3–24 indicates that 115 providers in Victoria reported negative EBITDA figures on average per bed year. Overall for these Victorian services, the average EBITDA reported was -$5 929 per bed year. The highest reported negative EBITDA figures were offered by the State Government, with an average EBITDA figure of -$7 438 per bed year. In comparison, a small number of private providers in this grouping reported an average EBITDA of -$1 378 per bed year.

Table 3–23: Victoria—all providers with positive EBITDAs per bed year, by resident mix and sector

		Sector						
Resident mix*	Categories	Charitable	Community-based	Local Govt	Private	Religious	State Govt	Grand Total
High care								
	Average EBITDA per bed year ($)	3 440	6 934		5 969	2 766	5 855	5 208
	Number of services	8	7		14	7	14	51
	Standard deviation of observations	2 457	7 868		2 552	1 842	8 088	5 424
Low care								
	Average EBITDA per bed year ($)	1 831	7 336	3 000	2 668	3 094	5 443	4 392
	Number of services	3	18	5	7	30	12	75
	Standard deviation of observations	1 349	11 949	2 398	1 879	2 078	5 222	6 545
Mixed care								
	Average EBITDA per bed year ($)	5 634	5 502		3 517	4 801		5 061
	Number of services	3	13		2	15		34
	Standard deviation of observations	4 633	6 257		1 564	3 408		4 564
Total average EBITDA per bed year ($)		3 565	6 635	3 274	4 751	3 543	5 625	4 794
Total number of observations		14	38	6	23	52	27	160
Standard deviation of observations		2 920	9 436	2 248	2 717	2 590	6 658	5 802

* 'High care' and 'low care' categories refer to services that deliver predominantly high care or low care (over 70 per cent of residents) respectively. 'Mixed care' refers to services where there are between 30 and 70 per cent of residents in both high care and low care.

Note: Two observations included in total figures but not reported separately due to the confidentiality commitments on disclosure.

Table 3–24: Victoria—all providers with negative EBITDAs per bed year, by resident mix and sector

		Sector						
Resident mix*	Categories	Charitable	Community-based	Local Govt	Private	Religious	State Govt	Grand Total
High care								
	Average EBITDA per bed year ($)	-7 820	-4 238		-1 484	-5 933	-8 047	-6 680
	Number of observations	4	6		4	14	35	64
	Standard deviation of observations	12 463	2 667		1 369	6 465	7 853	7 359
Low care								
	Average EBITDA per bed year ($)	-2 738	-1 496	-4 062	-1 167	-5 504	-4 113	-4 219
	Number of observations	4	3	3	2	17	11	40
	Standard deviation of observations	2 266	1 364	3 224	566	4 806	6 148	4 711
Mixed care								
	Average EBITDA per bed year ($)		-1 947			-7 329	-11 248	-7 775
	Number of observations		2			5	4	11
	Standard deviation of observations		2 667			6 489	6 522	6 483
Total average EBITDA per bed year ($)-5 279		-3 074	-3 092	-1 378	-5 924	-7 438	-5 929	
Total number of observations		8	11	4	6	36	50	115
Standard deviation of observations		8 726	2 540	3 270	1 103	5 592	7 552	6 548

* 'High care' and 'low care' categories refer to services that deliver predominantly high care or low care (over 70 per cent of residents) respectively. 'Mixed care' refers to services where there are between 30 and 70 per cent of residents in both high care and low care.

Note: One observation included in total figures but not reported separately due to the confidentiality commitments on disclosure.

By resident mix, Victorian services in the negative EBITDA category with mainly high care residents reported an average EBITDA of -$6 680 per bed year. Services with a mainly low care resident mix had an average EBITDA of -$4 219 per bed year. Further detail on these results is contained at Table 3–24 above.

3.7.2 New South Wales

In New South Wales, 210 or around 81 per cent of the providers reported positive EBITDA figures for their services. As indicated in Table 3–25, the average EBITDA for these services across the State is $5 383 per bed year. The range of EBITDAs

across sectors in this group was more marked than in Victoria with the lowest average EBITDA figure reported at $3 766 per bed year and the highest average EBITDA figures at an average of $9 925 per bed year compared to a range of $3 274 to $5 625 per bed year in Victoria.

Table 3–25: New South Wales—all providers with positive EBITDAs per bed year, by resident mix and sector

		Sector						
Resident mix*	Categories	Charitable	Community-based	Local Govt	Private	Religious	State Govt	Grand Total
High care								
	Average EBITDA per bed year ($)	7 364	4 450		3 718	4 963	4 660	4 630
	Number of services	5	12		31	40	4	93
	Standard deviation of observations	1 505	2 461		3 137	3 568	5 538	3 359
Low care								
	Average EBITDA per bed year ($)	7 972	4 946	7 986		6 658		6 158
	Number of services	3	28	3		46		80
	Standard deviation of observations	1 869	2 466	4 163		10 623		8 234
Mixed care								
	Average EBITDA per bed year ($)	3 292	4 271	13 827	4 515	5 679		5 633
	Number of services	3	6	2	2	23		36
	Standard deviation of observations	2 229	2 597	13 538	3 565	4 905		5 164
Total average EBITDA per bed year ($)6 419		4 723	9 925	3 766	5 829	4 660	5 383	
Total number of observations		11	47	6	33	109	4	210
Standard deviation of observations		2 589	2 415	7 261	3 108	7 556	5 538	5 963

* 'High care' and 'low care' categories refer to services that deliver predominantly high care or low care (over 70 per cent of residents) respectively. 'Mixed care' refers to services where there are between 30 and 70 per cent of residents in both high care and low care.

Note: One provider not categorised by resident mix is included in the totals. There is also one observation included in total figures but not reported separately due to the confidentiality commitments on disclosure.

By resident mix, positive EBITDA services in New South Wales with mainly high care residents reported an average EBITDA of 11 per cent lower than the Victorian figure at $4 630 per bed year. In contrast, the average EBITDA figure for NSW services in this group with a mainly low care resident mix was 40 per cent higher than the corresponding Victorian figure at $6 158 per bed year. These results are detailed in Table 3–25.

In New South Wales, some fifty providers reported negative EBITDA figures with the average for this group being -$4 578 per bed year. As in Victoria, the highest negative EBITDA figures reported were from State Government providers at an average of -$9 690 per bed year. However, this figure is based on a small number of providers. In comparison, a small number of community-based providers in this grouping reported an average EBITDA of -$1 546 per bed year. It should be noted, however, that unlike in Victoria, the charitable and local government sectors are not represented in the negative EBITDA figures for New South Wales.

By resident mix, New South Wales services with negative EBITDAs and mainly high care residents reported an average EBITDA 15 per cent lower than the corresponding services in Victoria at -$5 662 per bed year. A larger differential was reported for New South Wales services in this grouping with a mainly low care resident mix who reported an average EBITDA 23 per cent lower than Victoria at -$3 232 per bed year. For further detail on these results see Table 3–26.

Table 3–26: New South Wales—all providers with negative EBITDAs per bed year, by resident mix and sector

		Sector				
Resident mix*	Categories	Community-based	Private	Religious	State Govt	Grand Total
High care						
	Average EBITDA per bed year ($)	-2 262	-3 177	-5 215	-9 690	-5 662
	Number of services	4	3	16	7	30
	Standard deviation of observations	1 738	4 239	10 622	10 435	9 418
Low care						
	Average EBITDA per bed year ($)	-1 137		-4 699		-3 232
	Number of services	7		10		17
	Standard deviation of observations	982		7 250		5 762
Mixed care						
	Average EBITDA per bed year ($)			-1 616		-1 361
	Number of services			2		3
	Standard deviation of observations			750		691
Total average EBITDA per bed year ($)		-1 546	-2 596	-4 774	-9 690	-4 578
Total number of observations		11	4	28	7	50
Standard deviation of observations		1 344	3 651	9 005	10 435	8 083

* ‘High care’ and ‘low care’ categories refer to services that deliver predominantly high care or low care (over 70 per cent of residents) respectively. ‘Mixed care’ refers to services where there are between 30 and 70 per cent of residents in both high care and low care.

Note: One observation included in total figures but not reported separately due to the confidentiality commitments on disclosure.

3.8 Appraisal

State, location, sector, size or resident mix does not influence the capacity of a service in the top 10 per cent in EBITDA terms. A large number of services in the top 10 per cent and top quartile are viable regardless of these factors. A large number of rural services are in the top 10 per cent and first quartile. Furthermore the analysis indicates throughout the quartiles rural services are not any worse off than services from other localities.

Similarly it is possible for mainly high care services to be represented in the top 10 per cent and top quartile categories although profit margins are likely to be higher for mainly low care services.

However, in the bottom quartile of services, sector, resident mix and size are important factors. Services were more likely to fall into this bottom quartile if they were provided by the state Government sector, particularly in Victoria, had a mainly high care resident mix and/or were in the 0–30 resident size band.

Table 3–27: Comparison of EBITDA by removing the effect of the state government sector, high care services and small services

By sector State	All Services ($)	All Services excl State Govt ($)	State Government Only ($)
NSW	3 467	3 818	-4 472
QLD	3 171	3 171	**
SA	2 935	2 807	5 111
TAS	4 362	4 362	**
VIC	310	1 541	-2 857
WA	967	967	**
Average ($)	**2 001**	**2 626**	**-2 620**

By Resident Mix State	All Services ($)	All Services excl Mainly High Care ($)	Mainly High Care Only ($)
NSW	3 467	4 678	2 120
QLD	3 171	2 864	3 604
SA	2 935	2 966	2 914
TAS*	4 362	1 519	8 911
VIC	310	1 545	-1 408
WA	967	2 496	-781
Average ($)	**2 001**	**2 894**	**956**

By Size State	All Services ($)	All Services excl 0–30 resident size band (4)	0–30 resident size band only ($)
NSW	3 467	3 610	2 884
QLD	3 171	2 999	3 505
SA	2 935	3 361	805
TAS*	4 362	5 664	n/a
VIC	310	1 571	-2 042
WA	967	1 123	245
Average ($)	**2 001**	**2 633**	**152**

* Caution must be exercised owing to a small number of observations

**Not applicable: no state operated facilities

n/a = Not available

The impact of these factors particularly in the fourth quartile on the overall averages across all quartiles is illustrated in Table 3–27. The prevalence of poor performers in the state government, high care and small size range of services has a negative effect on all services across the quartiles by bringing down the overall average EBITDA.

In the first part of Table 3–27 the analysis is based upon the separate treatment of state-operated facilities. These are found only in New South Wales, South Australia and Victoria. The average EBITDA for these facilities in each state are shown in the right hand columns as well as the national average, being -$2 620. In the first column the state and national averages for all services including state-operated facilities are shown. The middle column lists the state and national averages excluding the EBITDA results for state-operated facilities.

The conclusions to be drawn from this analysis follow. If the State government operations are removed from the analysis by sector the average EBITDA for all other services is increased by $625 to $2 626 per bed year. This is attributable to the low EBITDA figure for state government services of -$2 620 which drags down the overall average to $2 001 per bed year. The same can be demonstrated in relation to high care services with the overall average raised by $893 to an average of $2 894 per bed year instead of $2 001. When small size services are removed from the analysis, the overall average rises by $632 to $2 633 per bed year. It should be understood that these three effects are not additive. Indeed, the three may be thought of in the case of Victoria and some other states as coming down to the dominant influence of small size, but this may reflect too strong a position.

There is a wealth of information in this collection of data on the workings of providers. Most important of all the series is the one in Table 3–10 depicting their relative standing by quartile and the top 10 per cent. This result shows the scope for a provider to be in the two highest categories whatever the locality ownership, size and resident mix. There is no category or classification where a provider is handicapped from achieving a relatively high performance.

The implications are clear. Even allowing for a preponderance of high care, small size and state-operated facilities in the lowest quartile, there is a strong pointer to the dominance of management themes to explain relatively weak standing. There is nothing inherent in the circumstances of any provider which determines a poor outcome.

Significance attaches to the relatively strong performance of the rural providers. That location does not hamper many of them. This factor belies much of the folklore about residential aged care. Moreover, as noted earlier in this chapter, a lot of the weak aged care facilities in the rural setting are state-operated.

Attention has been directed to some special features of experiences in New South Wales and Victoria. However, the results in Queensland are of interest as they do not reflect the experiences and patterns in other states. Notably, the high EBITDAs recorded by Queensland high care providers in the bottom quartile, as shown in Table 3–27, reflected an outcome with high care, contrary to that of the same category providers in mainland states. For this and other reasons, such as the age of buildings owned by for-profit providers, the calculations may understate the value of EBITDAs.

4. ECONOMIC MODELLING, PRODUCTIVITY AND EFFICIENCY

The Review commissioned Access Economics to develop a model of the aged care industry, the Aged Care Dynamic Cohort Model (ACDCM). A description of this model, how it is formulated and what it does follows. The Review also commissioned the Centre for Efficiency and Productivity Analysis (CEPA) at the University of Queensland to conduct an efficiency analysis of the aged care sector based on financial data provided through the KPMG survey.

4.1 The Aged Care Dynamic Cohort Model (ACDCM)

In developing the ACDCM, Access Economics reviewed past experience with modelling aged care. In brief:

- Supply sides are usually less well developed. Supply is often seen as a planning requirement so the available international models tend to have weakly developed interaction between supply and demand.
- While it is agreed that informal care is important, almost all models exclude it.
- For all the models reviewed, unit costs were exogenous rather than the result of the interaction of demand and supply.
- Overall cost projections are usually most sensitive to population projections, age-specific dependency or disability rates, and changes in relative unit costs.
- None of the models provided a regional focus.
- Financing of care services was modelled in detail in only one model. That model looked at levels of individual insurance, the income and assets of the elderly, and eligibility of individuals to access public sources of funding.

These observations recognise the highly complex and relatively under-explored nature of the exercise. Access Economics was therefore breaking new ground in the modelling it undertook for the Review. In brief, the ACDCM can be used to estimate the private and public cost and revenue impacts of alternative economic and aged care policy assumptions over the next forty years.

Five specific aged care programmes are modelled—residential aged care (RACS, as well as the high care and low care components of RACS), Home and Community Care (HACC), a similar programme run for veterans (Veterans Health Care, VHC), Community Aged Care Packages (CACPs), and Extended Aged Care at Home (EACH).

The ACDCM is built around demographic projections for 18 cohorts (9 age groups by 2 genders) for 22 regions for the period 2001–02 to 2042–43. It comprises four modules: Macroeconomic/demographic, Demand, Supply and Financing.

The Macroeconomic/demographic module can create a variety of macroeconomic and demographic scenarios. From a given macro/demographic baseline, this module provides a platform on which the other three modules can simulate aged care sector scenarios.

The Demand module estimates the number of Australians:

- Who are 'fit and healthy'.
- Who are receiving formal care (RACS + EACH + CACPs + HACC + VHC).
- Who are receiving informal care only.

The split between the formal care categories (RACS, CACPs, EACH, HACC, VHC) and informal care is performed by an allocation formula.

That allocation is difficult as the aged care sector is highly regulated. Some regulations are more binding than others. In particular, the combination of the degree of taxpayer subsidy given to the more expensive forms of aged care and the official target numbers of places for some aged care programmes (numbers of beds for each 1,000 Australians aged 70 and over) means that the system is mostly supply-constrained. As a result, the official target numbers of places are a key building block in the model.

These regulations and policy targets pose particular challenges to modellers, such as the setting of official policy targets for the number of CACP places and beds for high and low care RACS facilities, and the provision of RACS, EACH, CACP, respite, HACC and VHC subsidies.

The ACDCM met these challenges by innovations which identify the unusual demand/supply interactions in aged care. Key regulations are modelled as constraints on the 'optimal' solution. (The ACDCM applies mathematical techniques to find the best solution to allocating aged care services given constraints.)

A constrained optimisation[1] is used to determine spending on aged care services across four streams (RACS + EACH, CACPs, HACC + VHC, and informal care). This reflects private prices and policy constraints (such as the numbers of RACS beds and CACP places).

The ACDCM can be set so as to provide binding constraints on the supply of high public cost aged care (RACS beds, EACH places and CACP places). Overflow demand generated from demographic/health status factors is channelled into HACC, VHC and informal care.

The ACDCM can be used to develop projections based on differing private prices for aged care services on a range of scenario assumptions.

[1] Based on a 'constant elasticity of substitution' (CES) system.

The aim of the Supply module is to calculate the 'unit cost'—minimising combination of factor inputs required to produce aged care at a given level of quality. That is, to choose that combination of labour, capital, land and materials which provides the lowest 'buck' per 'bang'.

The ACDCM has sophisticated cost functions which combine a powerful optimising framework with the flexibility to reflect historical market outcomes and regulatory constraints. The cost functions used in the model have two distinct levels.[2]

- Aged care service providers choose between individual inputs to create 'teams' of labour and capital.
- They choose how to combine these 'teams' to produce the required output at the lowest possible cost.

That framework means that, for example, there is a higher degree of substitutability between Registered Nurses (RNs) and Enrolled Nurses (ENs) than between RNs and buildings.

This results in three interlinked optimisation problems, subject to constraints, which the ACDCM model solves simultaneously to select the inputs used to produce each unit of output. There are separate cost functions for each of the following:

- RACS high care places
- RACS low care places
- EACH places
- CACP places
- HACC people
- VHC people.

Each of these cost functions is then applied at the regional level, where the prices of some inputs, such as land and nurses' wages, may vary.

Someone has to pay for aged care. That break up of payments made by taxpayers and aged care programme recipients is analysed within the Finance module. In a sense, governments are just a cipher, raising revenue then spending it. So the financing of aged care is an ongoing negotiation of cost sharing and cost shifting between different groups in society. There are several different forms of cost shifting:

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2 The CES productions function used in the ACDCM takes the form:

$$q = A\left(\sum \delta_i^{1/\sigma} x_i^{\frac{\sigma-1}{\sigma}}\right)^{\frac{\sigma}{\sigma-1}}$$

Where x_i is a vector of input quantities, q is output, and σ is the elasticity of substitution.

- Across generations: Governments and their agencies play an important financing role in shifting costs between and within generations.
- Across governments and government agencies: At the same time government agencies may attempt to shift costs on to each other (and therefore ultimately back to different groups of individuals)—a problem more evident in nations with Federal systems of government.
- Across income/wealth status: There are also tensions surrounding the degree of subsidy (directly, through the tax system, and indirectly, through private pricing) paid by high income/wealth families to low income/wealth families.
- Across health status: Sometimes the healthy (in this case, those who do not need aged care assistance) subsidise those who do need aged care assistance (for example, via insurance and tax arrangements). More generally, private agencies, including insurance companies and aged care service providers, also play a role in shifting the costs of aged care between different groups.

But ultimately all costs are borne by individuals, either as taxes paid by the population at large or as private prices paid by recipients of care. Financing issues essentially revolve around the allocation of the total cost between those recipients and taxpayers.

Each of the modules (notably underlying data sources) is discussed in more detail below.

4.1.1 The macroeconomic/demographic module

Macroeconomic Projections

Demographics provide a relatively stable foundation for projecting economic activity over coming decades. Other factors combine with population to determine actual economic activity. Chief among these other factors are:

- The willingness of a given demographic to engage in the workforce. This is the labour force 'participation ratio'. The ACDCM anticipates that there will be changes in the labour force participation rates of older workers in coming decades as a result of policy and labour market pressures (matching the Australian Government's assumptions used in its May 2002 Intergenerational Report (IGR).
- The ability of the economy to absorb into the workforce those who want jobs. Like the IGR, the ACDCM sees the unemployment rate falling to 5%. (The unemployment rate will never be zero, except in a static economy where people never change jobs.)
- Productivity growth—this the change in the amount of goods and services produced by each worker over time. This is a very important assumption over the 40 years simulated in this model. Productivity growth ultimately underwrites living standards.

The Budget Models

This module also contains models of the Australian Government and State Budget models. (The latter gives a combined result across all States and Territories.)

The Australian Government Budget model uses national economic growth and its sub-components to drive growth in both revenue and expenditure variables.

The State Budget model does the same, across different revenue and spending bases.

Demographic Projections

The demographic projections used in the ACDCM are based on Population Projections Australia 2002 to 2101 (ABS Catalogue 3222.0). These projections are broadly equivalent to (but more up-to-date than) those used by the Australian Government for its Intergenerational Report 2002–03. The projection series is Series B. (The model has the facility to combine a range of different projections.)

The age cohorts have been grouped in the ACDCM as follows:

0–19	This age grouping gives a handle on infant/youth dependency
20–54	This gives a handle on those of primary working age and the macroeconomy—this group is critical for the financing module
55–59	Not much demand for aged care, but important for early retirement/superannuation calculations and is an important feeder group for aged care demand
60–65	This group is at the fringe of the aged care system—dementia prevalence (DP) = 1%
65–69	This group may be a potentially underused workforce—DP = 2%
70–74	These are the aged—DP = 4%
75–79	Ditto, but rates of dependency start to pick up—DP = 8%
80–84	Ditto, and accelerate—DP = 16%
85+	The frail aged. The 85+ group is of growing importance—DP >=32%.

4.1.2 Demand module

There are six specific drivers of the demand for long-term care services:

- Regional demographics (building on Series B population projections).
- Health status.

- Private prices for aged care services.
- Income and assets.
- Level of access to informal carers.
- Preferences for particular types and standards of care.

Private prices are determined within the Finance module. Normally, a model would determine private prices based on the interaction of supply and demand. However, due to the heavily regulated nature of the aged care sector, the private price is determined by financing policies.

The other factors are 'exogenous' to a greater degree—that is, they are determined more by factors outside the ACDCM.

Regional demographics

Drawing on the ABS Series B population projections, the ACDCM divides Australia into 22 geographical regions, each of which can be viewed as an individual market for aged care services. These regions reflect two key dividing lines, (1) State/Territory; and (2) inner- and outer-urban, rural and remote. On the demand side this allows the ACDCM to capture the different age composition and projections for each region. On the supply side this allows the ACDCM to reflect different state wage outcomes, as well as different costs of land between remote and urban areas.

Regions are consistent with the Australian Standard Geographical Classification (ASGC) used by the ABS. Regions were constructed for the most part from Statistical divisions, with some Statistical Local Areas used in some cases.

Health Status

The ACDCM contains a series of health status indicators that are used in forecasting demand for aged care services. The first measure of health status used in the ACDCM relates to data from the ABS Survey Disability, Ageing and Carers (ABS Cat. 4430.0). In this survey, the extent of disability is based upon a person's ability to carry out basic tasks in the core activity areas of self-care, mobility and communication. These core activities are:

- Self-care—bathing or showering, dressing, eating, using the toilet, managing incontinence.
- Mobility—moving around at home and away from home, getting into or out of a bed or chair; and using public transport.
- Communication—understanding/being understood by others: strangers, family and friends.

There are four defined levels of core activity restriction, as follows:

- Profound—the person is unable to do, or always needs help with, a core activity task.
- Severe—the person sometimes needs help with a core activity task, or has difficulty communicating with family and friends.
- Moderate—the person needs no help, but has difficulty with a core activity task.
- Mild—the person needs no help and has no difficulty with any core activity tasks but makes use of aids and equipment, or cannot easily walk 200 metres, bend down to pick up objects.

This survey was used to calculate each cohort's likelihood of having a profound, severe or moderate core activity restriction.

The model also makes use of health status data on the prevalence of dementia. This data is sourced to Access Economics' 2003 report for Alzheimer's Australia. The dementia prevalence estimates are obtained from two data sources, a special data request from ABS Catalogue 4430.0 together with international meta-analyses from which Professor Anthony Jorm and others have derived previous Australian prevalence estimates. Prevalence projections to 2051 were obtained by applying the prevalence rates for each of the demographic cohorts to the cohorts as projected by the ABS for 2011, 2021, 2031, 2041 and 2051 (Series B, ABS, 2000).

The ACDCM may be adjusted to reflect alternative projections regarding age-specific disability rates—including the ability to model 'age from death' rather than chronological age[3]. The ACDCM baseline assumes that Australia's population will see improved age-specific disability rates in coming decades, with tomorrow's 80 year old healthier than today's. Age-specific disability rates are assumed to improve by 0.25% a year.

Living Arrangements

The modelling of household living arrangements provides a guide to likely 'spill over' effects between the formal and informal parts of aged care in response to changed scenarios. Informal care tends to be provided by friends and family, particularly women and daughters[4]. Projections of labour force participation rates—such as for older women—therefore affect informal care arrangements. (The model may be adjusted to reflect alternative 'attachment' assumptions.) The historical data sources used for the 'attachment' variables are as follows.

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3 See Pamela Kinnear, *Population Ageing, Crisis or Transition?*, Discussion Paper 45, Australia Institute, 2001.

4 The Allen Consulting Group and Stafford MacKenzie, 2002; Wittenberg et al, 1998.

Marriage and Living Children

The 2001 marriage figures are census figures, calculated from the number of respondents with a living spouse. ABS data on total births for women of completed fertility for 1981, 1986, 1992, 1996 and 2001 were used to inform history. The share of the aged with a living child was derived from historical births data and a set of current standard life tables. Once born, children were aged, and totals adjusted for the age-based chance of death in each year.

Informal Care

Two measures of informal care were identified within the living arrangements framework of the model—one measure is narrow, the other is a broad measure of informal care. Recipients of Carer Allowance (CA) and Carer Payment (CP) satisfy stringent qualification rules. To receive these payments carers must be providing constant care, which results in much smaller groups of recipients than the definition used in ABS Catalogue 4430.0. Data on recipients was obtained from Australia's Welfare (Australian Institute of Health and Welfare, 2001) using Centrelink data.

The definition of informal care used in ABS Catalogue 4430.0 is very broad. For example, assistance with home maintenance and with transport are considered to be informal care services. These figures provide an outer bound on access to informal care.

Formal Care

Access Economics was provided with two RACS-related databases by the Department of Health and Ageing (DHA). The first database focussed on the 'scores' of RACS residents; the second dataset focussed on RACS providers.

Each RACS resident is regularly assessed under the Residential Classification Scheme (RCS) and given a total score based on their specific requirements under 20 sub-headings. The resident's total score determines their RCS classification category (and Government subsidy schedules), where RCS 1 is the frailest and RCS 8 is the least frail. Administrative data on RCS records was combined with other data (including an ABS 'concordance' that maps postcodes to the 22 ACDCM regions) so as to provide an estimate of the proportion of each region's age and gender cohort that made use of RACS facilities, and their scores.

For the purposes of the Review, the 20 RCS questions were also grouped into 4 care streams—personal care; nursing; cognitive, emotional and behavioural (or CEB); and social needs. All RACS residents were assumed to receive an 'accommodation service'. The weights on each of the questions are the same as in the current RCS arrangements. The care stream data was matched to population data to allow estimates to be made of the care stream demand by region, age and gender.

Datasets on HACC, VHC, CACP and EACH programmes were used to estimate 'demand' use by region, age and gender.

Quality/real income effects

Demand for better quality aged care services is expected to rise with increases in community incomes. The ACDCM allows the modelling of these effects by linking the base level demand for aged care services with real incomes per head. Scenarios can be varied to reflect alternative assumptions as to the strength of this link.

4.1.3 Supply module

Measure of output

A sophisticated measure of output for the RACS system was estimated using the concept of total 'point nights'. This concept measures the product of RCS scores and the duration of residents' stay in RACS facilities.

RACS providers choose the amount of labour and capital to use subject to producing the target number of RCS point nights.

Output is produced using an additional CES cost function, with the parameters of the function calculated on the basis of historical information.

This results in two input demands which are then used as output targets in the lower level cost functions. Care staff hours are allocated for each of the modelled programmes. At the lower level in the supply side, input choice is subject to a series of quality constraints (such as the ratio of RNs per high care RACS resident). These constraints are applied to each of the inputs, and ensure that an appropriate mix of staff and level of care is available to aged care recipients. Each constraint can be altered, added or removed as desired.

Input Unit Prices and Factor Shares

There are up to 10 inputs (Medical Directors, Nurse Practitioners, RNs, ENs, other care staff, non-care staff, land, plant, buildings and material inputs). Each of these inputs enters into the cost of producing the 5 programmes (RACS, CACP, HACC, VHC and EACH). The unit cost of each of the 10 inputs is assumed to be the same for each of the programmes, except that (1) nurses' wages (both ENs and RNs) vary by State and Territory reflecting differences in awards; and (2) land costs vary by region.

The unit costs for labour and capital inputs have been handled slightly differently and are discussed separately.

Care Labour

Providers choose the hours of Registered Nurses (RNs), Enrolled Nurses (ENs) and other care labour to minimise cost subject to producing the number of units of labour required to meet the overall production target. Units of labour are produced using a CES cost function, with the parameters of the function calculated on the basis of historical information. This results in a unit cost of labour for use in the higher level cost function. Labour input costs are expressed as dollars per hour and include all labour 'on costs' such as payroll tax, workers compensation and superannuation.

Only the care staff categories enter the labour input part of the cost function. Each of the care staff categories (RNs, ENs and 'other care' staff) has an estimated wage rate per hour. The figures for RNs and ENs have been derived from data supplied at the State and Territory level by the Australian Nursing Homes and Extended Care Association for 1997–98. These figures have been aged and combined to obtain national average wage rates. The 'other care' staff wage rate has been estimated from the wage rate received by therapists. The methodology is the same as for nurses.

Unit costs allow the number of nurse hours (and other labour inputs) to be 'backed out' of each programme.

- Total expenditure on each programme is calculated.
- This is then multiplied by the share of each programme which is estimated to be comprised of labour inputs of a particular type. This provides a dollar estimate of labour inputs of each type.
- These dollar estimates are then divided by wage rates (that is, unit costs) to provide an estimate of the number of hours of each labour type employed in the production of each programme in each year.
- These total hours estimates may be converted into 'full time equivalents' (or FTEs) on the basis of estimated working hours for a full time employee.

Capital and Non-care Labour

Providers choose the amount of land, buildings and structures, plant and equipment and non-care staff used to minimise cost subject to producing the number of units of capital required to meet the overall production target. Units of capital are produced using a CES cost function, with the parameters of the function calculated on the basis of historical information. This results in a unit cost of capital for use in the higher level cost function.

Capital costs include buildings, plant and equipment and land. Buildings and land are particularly important in the provision of residential care facilities. They are less significant in the provision of services that are provided largely at the client's home. Land is examined in greater detail to allow for regional variation. The other capital inputs (plant, material and building costs) would be expected to be less variable

between regions. In the ACDCM, differences in land costs between regions have been captured by a land price index derived from data sourced to the Real Estate Institute of Australia (REIA).

As the ACDCM is an annual model, capital costs have been derived and annualised to make them comparable with other costs. Capital costs have been estimated from a 'national accounting' perspective. Depreciation of buildings and plant and equipment and the opportunity cost of land are relevant capital flows. However the division of the returns on capital between equity holders, lenders and land owners (rentiers) is only relevant as the financing decision.

Intermediate Input Costs

So as to keep the model of the aged care sector as simple as possible, it is assumed that the sector makes use of 'intermediate' goods and service inputs. In fully articulated input–output models of the Australian economy which describe every industry sector, the concept of intermediate inputs essentially melts away, as all production can be described in terms of its labour and capital (and import/export) inputs. However because the ACDCM has a particular focus on the aged care sector, a number of the inputs to it are summarised under the concept of intermediate inputs. These inputs (which include such items as food and laundry costs) are supplied by other industry sectors.

Cost Drivers—The Indexation Of Factor Input Costs

Factor input costs are indexed to grow over time according to rules consistent with current practice and/or the national accounting concepts. The ACDCM may be adjusted for alternative rules—such as changes to wage relativities.

Programme Cost Structures

Programme cost structures were gleaned from a variety of sources and have been incorporated in the ACDCM.

RACS

RACS facilities' costs are modelled in considerable detail. Four data sources were combined to assess Australian RACS factor shares.[5] Spending on RACS facilities was provided by a mix of Australian and State Government subsidies and private contributions—each with different low care: high care splits.

[5] These were the Bentley dataset (which provided a detailed breakdown of the dollars per bed day figures by low care, high care and mixed care facilities), the KPMG survey of nursing homes commissioned for the Aged Care Price Review, ABS *Community Services Sector* (catalogue 8696.0) and Laing and Buisson (2002).

The split of private contributions was chosen such that total spending was split 23:77 low care: high care. The total number of RCS points registered by low care patients (those with an RCS category of 5 to 8) came to 23% of all RCS points registered by all patients. As RCS points are a measure of resource use, this approach effectively 'looks through' institutional arrangements (whether they be low care, mixed or high care facilities) and instead focuses on the wellness of residents in RACS facilities.

Combining the estimated factor shares with total RACS spending provides an indication of the dollar cost and volumes of inputs use in the RACS sector.

CACP

A detailed database of CACP recipients for 2001–02 was provided by DHA. CACPs have the non-residency features of a HACC but the service-intensive features of low care RACS. CACPs are assumed to have the same capital, labour and material cost ratios as HACC.

Within the labour cost grouping, CACPs are assumed to have a similar weighting between the different staff categories as does low care RACS. Factor share calculations are used to generate dollar estimates of factor inputs. Dividing these costs by factor input costs provides estimates of volume inputs.

HACC

In the ACDCM, calibration of the Home and Community Care (or HACC) programme is based on data from the HACC National Minimum Data Set. Use by different age groups of the 21 HACC services was combined with the cost of providing a single unit ('unit cost') of each HACC service to provide estimates of the use of HACC by age cohort. The 21 HACC service streams were mapped to 8 input categories. (Medical Directors and Nurse Practitioners have not been included among these input categories.)

Each of the 21 service streams was fully allocated to 8 production input categories. Dividing these dollar costs by unit prices provides an estimate of the volume of units entering into the production of HACC services. For labour inputs (where wage rates were estimated), the volume of hours can be converted into a number of 'full time equivalent' (or FTE) employees.

VHC

The Veterans Health Care programme (VHC) is an alternative to HACC for many Veterans, although it is a smaller programme. Data from the Department of Veterans' Affairs was used to calibrate the VHC estimates and take-up. Detailed production estimates for VHC were benchmarked to the HACC data and methodology.

4.1.4 Finance module

The ACDCM has the ability to simulate the effects of varying aged-care programme financing arrangements both within the current financing framework (that is, by varying existing fees, subsidies, bond, and charges paid to providers, thresholds and rates in income testing, and so on) as well as to model options outside the current financing framework.

Aged care funding

Data on contributions to the cost of providing aged care by individuals and governments were obtained both from work undertaken by the Productivity Commission, and from consultations with the Department of Health and Ageing and with the Review.

Incomes and Assets

Many aspects of financing involve income and means testing of government assistance, or the phase in of taxation or insurance arrangements. In order to model these policies detailed estimates of income and asset distributions were needed for each cohort in the model.

Data on pension recipients within Residential Aged Care

Within the current financing arrangements for residential aged care, recipients of an Australian Government pension are subject to a different set of rules and payment levels. The ACDCM has the capacity to model these different levels of fees and subsidies, using data on the share of residents who receive a pension.

The baseline scenario uses historical data provided by the Department of Health and Ageing and assumes that relative pensioner numbers in given age cohorts fall over time in response to the operation of the Superannuation Guarantee (with the latter pattern benchmarked to NATSEM modelling done for the Aged Care Price Review).

The Cohort Lifetime Accumulated Savings Projector

Access to Government aged-care related benefits/entitlements and subsidies depends to a large degree on an individual's (or couple's) incomes and assets. In order to project the income and asset distributions of the ACDCM cohorts over the 40 year forecast period, a separate model of asset accumulation was developed. The Cohort Lifetime Accumulated Savings Projector (CLASP), takes macroeconomic projections from the main model, and estimates average levels of income and assets for each decile in each year in the model[6].

This feature of the ACDCM appears expand the horizons of aged care models. CLASP takes estimates of income by age and by decile for the Australian population and applies growth rates obtained from wage measures within the model to project income distributions through time. A series of wage and pension shares by age are also applied to split pension income from wage and other income to allow pension income to be excluded from income tests.

CLASP allows individuals to accumulate assets in two ways. Savings out of income are added to assets, while the stock of existing assets earns a return, which increases the value of assets held. Savings are calculated on the basis of income, with average saving rates applied to the income distribution in order to calculate assets accumulate in each year. The model applies a conventional 'life-cycle' pattern of saving and dissaving (people of working age accumulate assets faster depending on the presence of children) and begin to draw heavily on assets to provide for retirement expenses.

Within this pattern of saving, the CLASP model applies a separate pattern of accumulation for housing assets. Individuals do not begin accumulating housing assets until around 25, after which they accumulate a small amount each year until the age of 50. This represents the paying off of a mortgage over a period of time.

At the time of retirement, a large superannuation payout is received, and a proportion of this is devoted to paying off the remainder of the mortgage, and is therefore transferred into housing assets. After retirement, housing assets are run down slowly, as older individuals look to move to smaller residences.

The return on assets is set at the rate of growth in nominal GDP, and applies both to housing and non-housing assets. Such returns increase the value of assets held.

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6 Income data within the model is in terms of estimated continuous distributions of the form:

$$CDF = \frac{e^{\alpha+\beta(1n(x))}}{1+e^{\alpha+\beta(1n(x))}}$$

The parameters, α and β, are estimated by a weighted least squares procedure.

CLASP Data

Private incomes and assets have been modelled with simplified distributional assumptions and within a rigorous accounting framework. The distributions are broadly consistent with current aggregates. The means of these distributions are assumed to grow over time in line with growth in macroeconomic aggregates.

This approach accords with published research to date on Australia's wealth distribution. They were compiled with the input of Taxation Statistics (ATO) and Household Expenditure Survey (ABS) data.

4.2 Efficiency of the sector—CEPA analysis

Aged care services are supplied by for-profit concerns and a range of charitable, community, religious and government operators. Informal carers also form part of the supply equation. Aged care services are funded by governments, notably the Australian Government and by private resources. Regardless of the public/private split, the aged care sector needs to aim to keep total costs as low as possible.

In an industry with many not-for-profit operators, large government subsidies and subject to considerable regulation, the best proxy for the behaviour of aged care operators may be that they minimise costs rather than maximise profits. Under this view, aged care operators look to meet demand at the lowest possible cost, taking advantage of the fact that some inputs can be substituted for others. In effect, they seek the cost-minimising combination of factor inputs required to produce aged care at a given level of quality. That said, many operators are currently operating well within the 'efficient frontier' of production at minimum cost.

In the effort to minimise the cost of supplying aged care services, operators of aged care services are able, to an extent, to choose the level and mix of their labour and capital inputs in order to minimise their cost structure. This can involve substitution within capital inputs, capital–labour substitution and substitution within labour inputs. For example, where land is more expensive, operators may choose to build multi-storey buildings, thereby incurring higher building costs but lower overall costs. In as far as scale can reduce building costs then this is also a factor within the control of operators, subject to regulatory constraints (including the current supply constraints). Similarly, where enrolled nurses or care workers can do some of the work that would otherwise be done by registered nurses then labour substitution can generate cost savings. With land prices and the wages of trained nurses having the potential to become relatively more expensive over coming decades, operators may use less of these inputs in an effort to keep costs down. For example, spending more on the design and construction of a new residential care service may reduce both labour and land costs. However, this cost minimisation occurs subject to a series of regulatory constraints, including the quality standards established by the Australian Government

and the Government's commitment to commitment to equity of access, which may result in aged care services of sub-optimal size in rural and remote areas. In addition, there are the various requirements of the state and territory governments as well as the role of local government, especially in respect of building approvals.

The efficiency of each entity in an industry and of the regulatory structure within which it operates are major drivers of the entity's cost structure. The efficiency of aged care services can be discussed in terms of:

- technical efficiency
- scale efficiency
- allocative efficiency
- dynamic and regulatory efficiency.

4.2.1 Technical efficiency

Technical efficiency is a measure of the relative performance of services in converting inputs (labour and capital) into outputs (days of care). The input-oriented technical efficiency of an aged care service measures the extent to which a service can reduce its input usage and yet produce the same level of outputs. Input-oriented measures of technical efficiency are more suitable to the aged care sector as it is currently regulated, because the output levels of aged care services are generally not a decision variable. The number of consumers is determined through budgetary constraint, and demand generally exceeds supply, as indicated by the occupancy rates.

Analysis conducted for the Review by the Centre for Efficiency and Productivity Analysis at the University of Queensland indicates that there is a high level of technical inefficiency in the residential care sector (see Table 4–1).[7] The average level of technical inefficiency is around 17 per cent (on a conservative estimate). That is, there is scope for a reduction of 17 per cent in input usage, while maintaining the same output levels.

[7] The Review commissioned the Centre for Efficiency and Productivity Analysis at the University of Queensland to examine the efficiency of, and opportunities for productivity improvement in, the residential care sector. The Centre analysed the financial data provided to the Review by approved providers and also the results of the last seven years of the annual survey of the industry conducted by Bentleys MRI/ James Underwood and Associates.

Table 4–1: Technical efficiency of residential care services by class, ownership and location

	Mean	Median	Std. Dev.
Australia	0.83	0.84	0.13
State			
NSW/ACT	0.87	0.87	0.11
VIC	0.79	0.8	0.15
QLD	0.80	0.86	0.20
SA	0.86	0.85	0.10
WA/NT	0.86	0.87	0.11
TAS	0.82	0.83	0.16
Locality			
City	0.84	0.85	0.13
Other Metro	0.84	0.86	0.15
Rural	0.82	0.83	0.14
Remote	0.76	0.76	0.05
Sector			
For-profit	0.89	0.94	0.14
Not-for-profit	0.84	0.84	0.12
Government	0.75	0.74	0.15
Chain			
Yes	0.83	0.85	0.14
No	0.83	0.84	0.13

Average technical efficiency varies slightly by jurisdiction, but this may in part be an artefact of variations in other key characteristics. For example, the lower average efficiency score achieved by Victorian operators may be an artefact of the larger number of government services in that State.

For-profit residential care services have an average efficiency score that is considerably higher than the national average as well as the averages for not-for-profit and government-run residential care services. The difference is even more marked with respect to their respective median scores.[8] Moreover, not only is the average efficiency of for-profit services higher but they also define a more efficient production frontier. Put another way, for-profit services are over-represented amongst the group of best practice services, which define the production frontier of efficient practice. The greater efficiency, on average, of for-profit services and their greater contribution to best-practice is confirmed by the international literature.[9]

There appears to be only a slight difference between chain and non-chain services, but this may be an artefact of several large quasi-chains operating in the not-for-profit sector. Members of these quasi-chains act, in essence, like individual operators. The

[8] It is important to note that the greater efficiency of for-profit homes is not explained by a diminishment in the quality of care.

[9] JS Nyman & DL Bricker, 'Profit incentives and technical efficiency in the production of nursing home care', *Review of Economics and Statistics*, vol. 71, November 1989, pp. 586–594.

JL Fizel & TS Nunnikhoven, 'Technical efficiency of for-profit and non-profit nursing homes', *Managerial and Decision Economics*, vol. 13, 1992, pp. 429–439.

international literature confirms that there are significant multi-plant economies in residential care markets.[10]

Residential care services in cities appear to have higher efficiency scores than those in rural areas (especially with respect to the median efficiency score), which in turn appear to have significantly higher efficiency scores than remote services. Some of the lower efficiency in rural and remote areas may represent the higher costs of employing skilled labour in those areas. The Government's policy commitment to equity of access to high quality care may necessitate the establishment of sub-optimally efficient services in those areas. These issues are considered further in the discussion of regulatory inefficiency below.

Several characteristics of residential care services, other than jurisdiction, locality, sector and membership of a chain, appear to influence their efficiency. First, residential care services with higher certification scores tend to be more inefficient. This is not unexpected, given that a higher quality of amenities is likely to be more expensive. Secondly, and perhaps counterintuitively, services with more beds per room tend to operate more inefficiently. However, this may be a consequence of these services being older with concomitant higher maintenance costs or poorer design layouts. Thirdly, services that accommodate a higher percentage of respite care recipients appear to be more inefficient. This is consistent with the higher administration burden occasioned by respite care. Fourthly, services with higher proportions of Aboriginal and Torres Strait Islander residents or culturally and linguistically diverse residents appear to have higher costs, because of the extra time and costs that may be associated with providing culturally appropriate care. Fifthly, services with a higher proportion of concessional residents appear to be more efficient. This may be because these services tend to offer a more streamlined homogeneous service rather than the variety of additional and extra services that some residential care services make available to higher income residents on demand. Finally, on data available those services deemed to 'cut corners' on quality may appear to operate more efficiently. However, this is only a weak effect. More importantly, there is no evidence that the services operating at peak efficiency (on the production frontier) were achieving efficiency by 'cutting corners' on quality.

If all residential care services were to operate at optimal technical efficiency then the combined public and private cost of residential care could be reduced by 17 per cent ($1.1 billion in 2002–03). In the alternative, the level of output of the sector (the number of people cared for) could be expanded by 17 per cent (23 100 people in 2002–03) at no additional public or private cost. Of course, policy constraints may mean that not all services can operate at optimal technical efficiency. As noted above, some of the lower efficiency in rural and remote areas may, for example, represent the

[10] JL Fizel & TS Nunnikhoven, 'The efficiency of nursing home chains', *Applied Economics*, vol. 25, 1993, pp. 49–55.

higher costs of employing skilled labour in those areas. The Government's policy commitment to equity of access to high quality care may necessitate the establishment of sub-optimally efficient services in those areas. These issues are considered further in the discussion of regulatory inefficiency taken up later in this document.

4.2.2 Scale efficiency

Scale efficiency is a measure of the degree to which a service could improve its productivity by changing its scale of operations to the optimal scale. It is possible that some aged care services are too small and are operating on the increasing returns to scale part of the production function, and some aged care services are too large and are operating on the decreasing returns to scale part of the production function.

The Centre for Efficiency and Productivity Analysis found that the average level of scale inefficiency in the residential care industry to be is around 7.0 per cent (see Table 4–2). That is, on top of any gains from improved technical efficiency, there is scope for a further reduction of 7.0 per cent in input usage, while maintaining the same output levels, through conversion to optimal scale.

The level of scale efficiency was reasonably constant across jurisdictions and sectors and most localities. The only noticeable exception was the lower scale efficiency score (0.88) in remote areas. This suggests that the aged care services in remote areas are probably too small in their scale of operations. Again, however, this may be a consequence of the policy commitment to equity of access. If this is the case then it provides a measure of the additional support that needs to be provided to these services to support this policy goal.

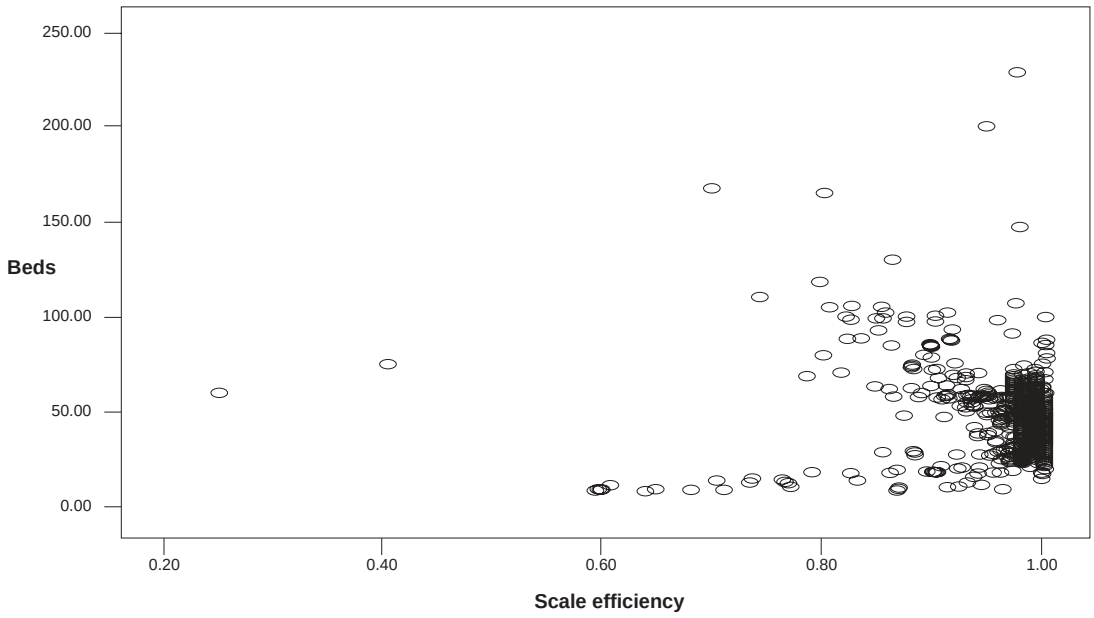
Table 4–2: Scale efficiency of residential care services by class, ownership and location

	Mean
Australia	0.93
State	
NSW/ACT	0.92
VIC	0.92
QLD	0.92
SA	0.94
WA/NT	0.94
TAS	0.98
Locality	
City	0.93
Other Metro	0.93
Rural	0.92
Remote	0.88
Sector	
For-profit	0.92
Not-for-profit	0.93
Government	0.91
Chain	
Yes	0.92
No	0.93

Figure 4–1 attempts to determine the optimal size of residential care services by plotting scale efficiency against size. The strong line of services at the bottom of the plot indicates how scale efficiency declines dramatically as the size of the home falls below thirty beds. On the other hand, most of the services in the thirty to sixty bed range have scale efficiency scores near one (that is, they are operating at optimal scale). However, the plot also makes it clear that there are scale inefficient services at all size up to and exceeding 120 beds.

If all residential care services were to operate at peak scale efficiency then the combined public and private cost of residential care could be reduced by 7.0 per cent ($469.4 million in 2002–03) on top of the savings made from improved technical efficiency reported above. In the alternative, the level of output of the sector (the number of people cared for) could be further expanded by 7.0 per cent (9500 people in 2002–03) at no additional public or private cost.

Figure 4–1: Scale efficiency versus number of beds



4.2.3 Allocative efficiency

Allocative efficiency is a measure of whether the observed input-mix is optimal, given the input prices prevailing in the market. It is possible that a particular aged care service may be technically efficient (that is, it uses the minimum feasible set of inputs to produce the given set of outputs), but is allocatively inefficient because it selects a sub-optimal input mix. On measure of allocative efficiency is the presence or otherwise of economies of scope within a service's operation.

In order to investigate the presence of economies of scope, or otherwise, within residential care services the Centre for Efficiency and Productivity Analysis examined the potential gains from the separate production of the four service groups that are offered within residential care services:

- accommodation services;
- personal care and social services;
- nursing services; and
- dementia (challenging behaviour) services.

The analysis indicates that in general it was best to provide these services in bundles rather than individually. However, while there was economy of scope in offering both personal care and social services and dementia (challenging behaviour) services in the same residential care service, residents receiving dementia (challenging behaviour) may best be provided for in specialised facilities directed to that particular need. However, this appraisal must be treated cautiously because of conditions additional to dementia-specific aspects being experienced by residents.

Other issues of allocative efficiency occur across the health sector, though cost shifting, and between aged care sector programs. These are discussed in the next section.

4.2.4 Regulatory inefficiency

Currently aged care services are heavily regulated, with respect to quality, quantity and price.[11] These regulatory arrangements stem, at least in part, from fears about the vulnerability of consumers to exploitation and unsafe practices. That vulnerability is most pronounced in the risk exposure of their wealth because they do not have opportunities to earn income to offset any loss of wealth.

As a general principle, regulation can be expected to affect a wide range of economic outcomes. First, it can diminish the extent of competition between service operators and, in particular, make it more difficult for prospective service operators to enter the market. Secondly, it can restrict consumer choice and reduce the consumer's ability to bargain over price. Thirdly, it can reduce cost consciousness and hence efficiency in service delivery, and stifle innovation in service design and delivery. Finally, it can adversely restrict enterprise mix and investment in the sector.

There are several reasons why regulation may be regarded as necessary. First, aged care activities are prone to market failure. The key service suppliers have a huge knowledge advantage that consumers cannot easily bridge. This is especially so of consumers who, through frailty, cannot perform as discerning consumers in the usual

[11] Regulation is any restriction on voluntary action. Moreover, subsidy rates and associated rules are regarded as part of the regulatory environment as they restrict or distort the operation of the market.

sense. Thus in competitive terms, the relationship between the consumer as principal and the operator as agent is inherently asymmetric. There are also other factors that reinforce this information asymmetry. In particular, regardless of the consumer's state of knowledge, once committed to receiving some services the consumer is largely 'locked in' and at the supplier's mercy—given the large financial and non-financial transaction costs involved in changing operators.[12]

Secondly, there can be side effects of regulatory steps taken to tackle the market failure referred to above that warrant further corrective regulation. For example, certain forms of professional regulation (licensing) introduced to guard consumer safety can have the undesirable effect of reducing the contestability of the supplying industry, requiring additional regulation, for example by empowering a special board to hear complaints.

Thirdly, as can occur with any product, there are likely to be some people who cannot afford adequate service or adequate advice about what services are available. If society deems that everybody has a right to a certain minimum service, some people will need to be supported, whether by regulations forbidding suppliers to deny service to the economically disadvantaged, or by mandatory pricing structures that cross-subsidise the economically disadvantaged, or by selective subsidies for the target group. Yet, once the Government subsidises or regulates a service, it can face consequential problems. Consider subsidisation. In brief, if nothing else is done, the subsidisation of a service will lead to an increase in consumer demand, the emergence of more suppliers and a lower regard on the part of suppliers for cost containment. If these effects are not to lead to a budget blowout, some way must be found for keeping the suppliers in check and restricting the provision of the subsidised services to the most deserving cases. This restriction can be imposed through the direct limitation of supplier numbers, or through the insistence on very high qualifications for staff, or through rationing subsidies by consumption quotas (for example, per person limits on amount receivable), or through strict gatekeeping arrangements. Unfortunately, each of these methods can diminish supplier competition and in effect create licences (or permissions to operate). These licences or permissions then take on a market value and some of the subsidy goes into servicing the capital tied up in the licence or permission. This increases the cost of care and reduces the proportion of the subsidy available to the consumer. In the alternative, demand for services can be restrained by increasing private price (the proportion of the total cost that the consumer pays). However, this can have adverse impact on the access to services by the economically disadvantaged.

The cost containment problem can also be tackled through direct price controls. But these too can produce their own problems through creating an incentive for suppliers

[12] As a part of its deliberations, the Review commissioned the Allen Consulting Group to undertake an international and intersectoral comparative study of the degree and type of Government involvement in the regulation of quality in the service sector.

to reduce quality. Governments can address the latter problem through the introduction of parallel service quality standards or quality supervision. However implementing these can be administratively expensive. Moreover, they can also become de facto entry restrictions that diminish competition, stifle innovation etc.

In essence, the regulation of residential care services can be a slippery slope, with an act of regulation not only decreasing the overall efficiency of the sector but also leading to further efficiency sapping regulation.

A number of specific features of the current aged care financing and funding arrangements, each with its own clear policy justification, lead to market failure and hence to inefficiency in the industry. First, supply is heavily constrained. Undoubtedly, this constraint allows the Australian Government a degree of control over expenditure. However, it stifles market pressure on operators in the industry to innovate and become more efficient. It also decreases choice to residents. Market based mechanisms, including price signals, can offer the same control over expenditure without stifling market pressure.

Secondly, private price is also heavily constrained. Clearly, this constraint provides considerable protection to residents. However, operators of residential care services are presenting from differentiating quality by appropriately pricing services. This constraint also acts to keep the proportion of the cost of care borne by the Government at an unnecessarily high level. It is possible to use other mechanisms to protect access for residents with limited means while both allowing operators to set market based fees and simultaneously increasing the sustainability of the system by decreasing over time the proportion of the cost of care borne by the Government.

Thirdly, the merit good nature of aged care militates against the Government's ability to exercise its monopsony purchasing power. This is because a decision by the Government to cease purchasing care from a particular operator can have severe effects for the clients and staff of that operator, and the surrounding community. Moreover, concomitant on the Government's role as monopsony purchaser is pressure to accept responsibility for increases in costs. This allows operators an easy alternative to the search for efficiencies in their operations. The industry's response to increases in the cost of nurses is a clear example of this transfer of responsibility. Alternative purchasing arrangements (eg vouchers or brokerage agencies) can place greater pressure on operators to achieve efficiencies and deliver quality by allowing purchasing choices to be made at a micro rather than service level.

Fourthly, the purchaser/user disjunction gives operators and consumers incentives to incur costs that they do not have to bear. One mechanism to reduce consumer moral-hazard problem would be to increase in the number of consumers who are funding a significant proportion of their own care. The moral hazard issue could also be addressed (for consumers) by replacing the current subsidy arrangements by vouchers,

thereby sheeting home the economic consequences of care choices to consumers. For operators, the issue could be addressed by selling places on the open market, where possible, rather than bestowing them on operators.

Fifthly, the uneven playing field between for-profit and not-for-profit operators also militates against the development of an optimally efficient industry. Governments offer tax and other advantages to not-for-profit operators to support their charitable purposes. However, in an industry where not-for-profit and for-profit operators are in direct competition these advantages can impact adversely on the operation of the market because not-for-profit operators do not bear the costs of operating at sub-optimal efficiency. In the alternative, these advantages can allow not-for-profit operators to turn their cost advantage into additional services and higher standards. This can translate into pressure on the Government to increase funding across the board so that all operators can deliver services at the quality achieved by not-for-profit operators. This ratcheting of the cost of 'basic care' can continue indefinitely.

Sixthly, other policy goals of the Government bear upon aged care. They are the equivalent of community service obligations. For example, the Government's commitment to the principle of 'geographic equity of access' means that rural and remote services are established and supported when often too small to achieve minimum efficient size.

Of economic and fiscal interest is whether it is possible to achieve these quasi-community service obligations through alternative market-based mechanisms. For example, the requirement to care for concessional residents could be made a 'tradeable commodity'. This would allow some operators to specialise in caring for these residents while others sought higher returns from other residents. Because the 'right' to care for concessional residents would trade at a negative price in effect the higher paying residents would still subsidise the concessional residents but the value of the concessional subsidy would be set by the market at its true value. An alternative approach would be to replace the current set price arrangements with a tender for the delivery of care in a region. If a requirement was placed on the tender bids that they cater for a given number of concessional residents then the market would again determine the true value of the concessional subsidy.

A similar approach could be taken to tendering for care in rural areas where the true value of the viability supplement would be determined. A third approach would be to establish a primary market in licences in the same way as a secondary model exists already. In essence, operators would pay the Australian Government for the right to access the subsidy funding stream. In effect, the derivative market would equalise any inequities in the subsidies paid by the Government. Where these subsidies (together with user charges) are greater than the market price of care then operators will pay for the licences and the Government will recoup its overpayment. Where the subsidies (together with user charges) are less than the market price of care (in rural areas for

example) the Government will need to pay operators to take licences off its hand. This would again, in effect, set the true price of the viability supplement. The market price of concessional residents would also be built into any bids for licences if the concessional ratios were placed as conditions on the licences.

5. DEMAND FOR AND SUPPLY OF AGED CARE SERVICES

A survey of the literature leaves little doubt that demand for aged care services will rise in Australia in the near to medium term. This is by no means a purely Australian phenomenon and many nations are now focusing on this issue. Japan, followed by Europe and Australia, can expect a rapid increase in demand for aged care services in the coming decades. The United States and United Kingdom can expect more moderate increases—mainly because their populations have already aged further than the Australian population.[1]

There are six key influences on demand for aged care services, three demographic and three economic. The three key demographic elements are:

- growth and ageing of the population and, in particular, the older population;
- changes in the health expectancy of older people; and
- changes in older people's living arrangements and their access to informal care.

The three key economic elements are:

- older people's preferences for particular types and standards of care;
- the level and distribution of the income and assets of older people; and
- the private price of, and the level of public subsidy provided for, aged care services.

5.1 Demographic influences on demand

The Australian population is now ageing relatively rapidly, albeit from a lower base age than many other countries.[2] Currently, in Australia there are 2.5 million older people, by which is meant those 70 years of age and older. Over the next four decades, the number of older people will increase by 164.6 per cent to 6.7 million (see Figure 5–1). The rate of increase will be highest in the next two decades. By 2022–23, there will be 4.7 million older people in Australia.

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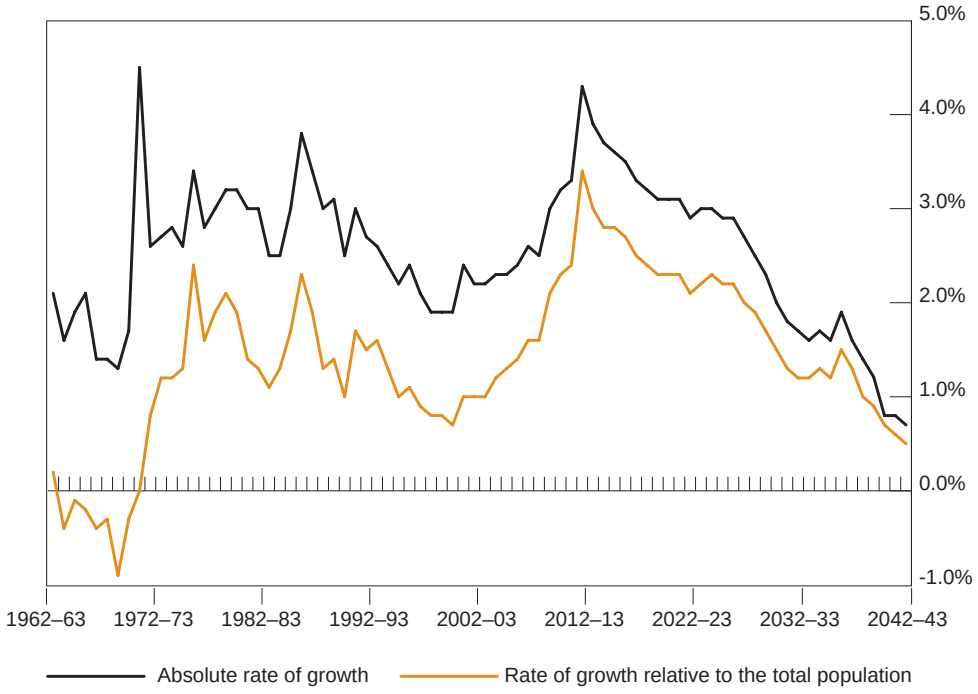
1 G Hugo, 'Seven Likely Future Population Trends', *CEDA Bulletin*, October 1998. D Lakdawalla & T Philipson, 'The Rise in Old-Age Longevity and the Market for Long-Term Care', *The American Economic Review*, March 2002, pp. 295–306. Organization of Economic Cooperation and Development, Ageing in OECD Countries—A Critical Policy Challenge, OECD, Paris, 1997. World Health Organisation, Current and Future Long-Term Care Needs (An analysis based on the 1990 WHO study 'The global burden of disease and the international classification of functioning, disability and health'), The Cross-cluster Initiative on Long-term Care, Noncommunicable Diseases and Mental Health Cluster, World Health Organization, 2002 at http://www.who.int/ncd/long_term_care/harwood.pdf.

2 The Review has used the Australian Bureau of Statistics' mid-range (Series B) projections for its analyses of the impact of the growth and ageing of the older population on the demand for aged care services (Australian Bureau of Statistics, Population Projections, 2002 to 2101, Cat. No. 3222.0, Series B, ABS, Canberra, 2003). Historical demographics are taken from: Australian Bureau of Statistics, *Australian Historical Population Statistics*, Cat. No. 3105.0.65.001, Table 19, ABS, Canberra, 2003.

Figure 5–1: Rate of growth of the older population, in absolute terms and relative to the total population, 1962–63 to 2042–43



5.1.1 The growth and ageing of the population

These population trends have important implications. They represent potentially increasing and changing demand for aged care services. Demand for aged care services increases with age, primarily because disability increases with age (Figure 5–2).[3]

Before age 60, fewer than 40.0 per cent of men have a disability. After age 75, more than 60.0 per cent of men have a disability. For women, disability onset is slower, with the 40.0 per cent threshold not reached until age 70.

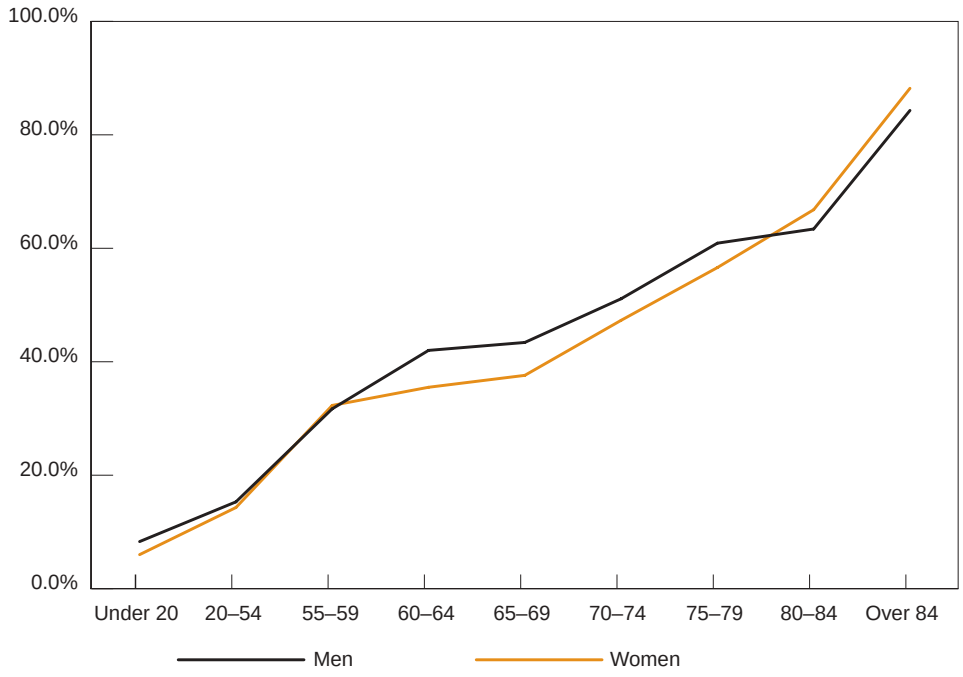
The ageing of particular sections of the population also has the potential to place additional pressure on the aged care system. For example, additional aged care services may be required to meet the needs of people with disabilities as they age. As a person with a disability gets older, they do not lose their need for specialist disability support.[4] Older people from culturally and linguistically diverse backgrounds are more likely to experience language reversion—that is, to forget their acquired English—if they have a

[3] The measures of disability used in the Review are taken from Australian Bureau of Statistics, *Disability, Ageing and Carers*, Australia, Cat. No. 4430.0, ABS, Canberra, 1999.

[4] Australian Institute of Health and Welfare, *Disability and Ageing—Australian Population Patterns and Implications*, AIHW, Canberra, 2000.

cognitive impairment. This may increase demand for alternative aged care services and may increase the complexity and cost of those services.[5]

Figure 5–2: Prevalence of disability, by age cohort, men and women, 2002–03



5.1.2 The changing health expectancy of older people

The changing health expectancy of older people is another key factor in the demand for aged care services that is consistently identified in the international literature. Between 1901–10 and 1999–2001, life expectancy at birth for Australian men increased from 55.2 years to 77.0 years and for Australian women increased from 58.8 years to 82.4 years. This increase is mainly attributable to advances in social conditions and medical technology. The ABS's medium case population projections (Series B) assume that life expectancy at birth will continue to increase from its 1999–2001 level to 84.2 years for men and 87.7 years for women in 2050–51. As discussed in the previous section this increase, combined with a rising median age of the population, will place rising pressure on the demand for aged care services.

Health expectancy measures the number of years of life a person will be free from chronic and severe illness. What this measures are the limits to a person's ability to carry out daily tasks and tend to their personal needs. Thus mortality and morbidity

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5 Access Economics, *The Dementia Epidemic: Economic Impact and Positive Solutions for Australia*, Access Economics, Canberra, 2003.

6 T Waidmann & K Manton, *Measuring Trends in Disability Among the Elderly: An International Review*, Urban Institute, Washington DC, 2000.

measures are combined into one factor. Health expectancy adjusts life expectancy (the total number of years a person may live) to reflect departures from good health during this time.

A recent comprehensive review of the international literature relating to health expectancy found that the most defensible conclusion was that age-specific disability rates are falling in most industrialised countries.[6] In the United States, where several surveys have been used to estimate disability trends, a growing body of evidence points toward declines in disability rates among older people, and no sustained increase in disability rates has been observed.[7] Similarly, in other industrialised countries, survey data point to an increase in the proportion of their life older people can expect to live without disability. The countries where disability among older people appears to be declining include France, Belgium, Taiwan, Italy, Netherlands and Switzerland. In countries where no substantial decline is apparent, including Australia, Canada and the United Kingdom, there is no consistent evidence that disability rates are rising.[8]

The OECD has also found that most cross-country evidence shows trends towards better functional health in older populations, although the magnitude of the gains and their significance need further assessment. In the OECD countries where measurement of Disability Free Life Expectancy (DFLE) can be made with reasonable homogeneity, DFLE represents between 45.0 to 80.0 per cent of life expectancy of those at age 65. Furthermore, in most countries, DFLE at age 65 is increasing, although the results are less clear in Australia, New Zealand and Norway.[9]

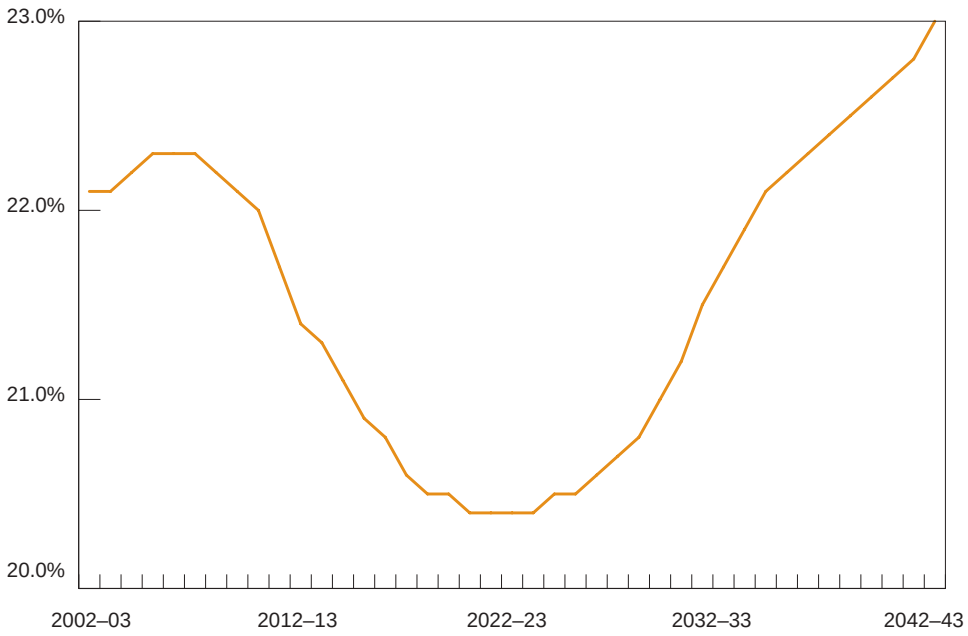
Although the literature suggests there is no clear evidence that age-specific disability rates are falling in Australia, it should be noted that this conclusion is concerned with the cohort aged at least 65 and may mask improvement within this age cohort. Figure 5–3 illustrates the effect a slight improvement in age-specific disability rates (of 0.25 per cent a year) would have on the prevalence of disability amongst the older population. Here, the ageing of the population, and the differential age-specific disability rates within the older cohort, mask the improvement in age-specific disability rates up to 2007–08, and after 2026–27. Although the disability rate for each age cohort decreases each year, the disability rate for the older population as a whole increases because of the relatively higher growth of the very old population with its higher rate of disability.

7 V Freedman & L Martin, 'Understanding Trends in Functional Limitations Among Older Americans', *American Journal of Public Health*, vol. 88, no. 10, 1998, pp. 1457–1462.

8 C Mathers, 'Trends in health expectancies in Australia, 1981–1993', *Journal of Australian Population Association*, vol. 13, no. 1, 1996, pp. 1–16.

9 S Jacobzone, E Cambois & J Robine, 'Is the Health of Older persons in OECD Countries Improving Fast Enough to Compensate for Population Ageing?', *Economic Studies*, No. 30, OECD, Paris, 2000.

Figure 5–3: Incidence of severe or profound disability in the older population, 2002–03 to 2042–43



The weight of international evidence is that the disability-free years of older people increase along with life expectancy. On the other hand, severe disability tends to be concentrated in the last two to four years of life, regardless of how long a person lives. This suggests that a healthier old age and increasing longevity will not necessarily diminish demand for services, as demand for residential care tends to be concentrated in the final two years of life. On this view, a healthier old age and increasing longevity only delays rather than reduces demand.[10] A recent study in the United States found that 'the expected cumulative health expenditures of elderly persons, despite their greater longevity, were similar to those for less healthy persons'.[11] The demographic effects discussed in the previous section, together with a slight improvement in all age-specific disability rates, will capture this delay in demand. The latter effect has been factored into the Review's analysis of demand through the assumption of an improvement in all age-specific disability rates of 0.25 per cent a year.

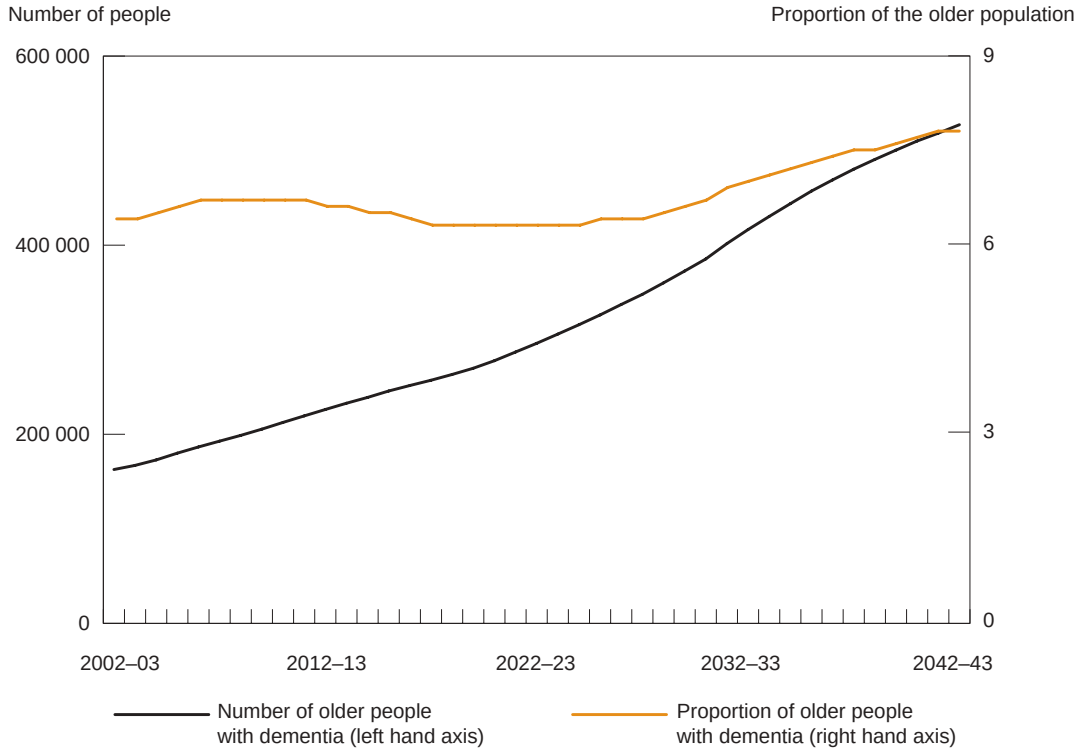
Another area in which the health status of older people is changing is with respect to dementia. The prevalence of dementia may double every five years after age 65. Older people who have a form of dementia as their main clinical condition are more likely to have a profound or severe core activity restriction—99.5 per cent versus 31.6 per cent

[10] P Kinnear, *Population Ageing, Crisis or Transition?*, Discussion Paper No. 45. Australia Institute, Canberra, 2001.

[11] J Lubitz, Liming Cai, E Kramarow & H Lentzner, 'Health. Life Expectancy, and Health Care Spending among the Elderly', *The New England Journal of Medicine*, vol. 349, no. 11, 11 September 2003, pp. 1048–1055.

for the disabled population more generally.[12] This increasing prevalence of dementia will have implications for the demand for aged care services (Figure 5–4). The prevalence of dementia among older people will increase by 22.5 per cent between 2002–03 and 2042–43. Most of this increase will be in the last two decades of that period (11.5 per cent between 2022–23 and 2032–33 and 11.6 per cent between 2032–33 and 2042–43). The slight increase (3.4 per cent) in the prevalence of dementia in the next decade will be offset by a slight decline in prevalence (4.8 per cent) between 2012–13 and 2022–23. These estimates should be treated with some caution owing to reservations about the incidence of dementia in an ageing population.

Figure 5–4: Number of older people with dementia, 2002–03 to 2042–43



The changing health expectancy of older people may also lead to demand for new care modalities—for example, the provision of intermittent residential care for older people with chronic and complex conditions requiring intermittent intensive support.[13] The aged financing and funding arrangements will need to be able to respond flexibly to these developments to encourage innovation in service delivery.

[12] Australian Bureau of Statistics, *Disability, Ageing and Carers, Australia*. Table 10.

[13] Australian Health Care Agreement Reference Group on the Interface Between Aged and Acute Care, Report to the Australian Health Ministers' Conference, Health Ministers' Coordination Unit, Australian Department of Health and Ageing, 2002 at http://www.health.gov.au/haf/interface.pdf.

5.1.3 Older people's access to informal support

The role of informal carers in the delivery of aged care services in Australia is regarded, by international comparisons, as very significant. As the OECD puts it, in Australia and some other countries, 'carers are slowly becoming a central point in the strategic analysis of long-term care systems'.[14] A broad summary measure of access to informal care has been previously attempted internationally through estimates of the 'caretaker ratio'. This ratio measures the number of women aged between 50 and 64 (the main ages of responsibility for an older person) for every person aged at least 80.[15] In Australia, the 'caretaker ratio' is projected to fall from 2.5 potential carers per person aged at least 80 in 2002–03 to 1.0 in 2042–43. The 'caretaker ratio' is of limited usefulness because most carers are not women aged between 50 and 64. In March 2001, just one third of those caring for someone aged at least 80, where the carer was in receipt of Carer Payment or Carer Allowance, were women aged between 45 and 64.[16] The usefulness of the 'caretaker ratio' can be expected to weaken further as labour force participation rates for women in this age group rise, leaving these women less able to supply informal care.

Informal care is dominated by access to a spouse and other immediate family, living in the same household or nearby. These informal resources are expected to come under strain as a result of lower marriage rates, smaller families and shifting attitudes towards the role of in-family carers. The projected continuing decrease in the size of families will mean that future older people will have access to fewer potential informal carers.[17] The continuing increase in the number, and proportion, of people who do not have children will also increase the number of people without access to informal carers. Similarly, with increased formal labour force participation among women, the ability of women to provide informal care may be reduced, as the opportunity costs of providing informal, unpaid care increase.

In summary, the three demographic drivers can be expected to substantially increase demand for aged care services over the next four decades by as much as three or five times. The ageing of the population seems to be the most significant demographic driver. The fall in the proportion of the older population who have access to informal care will also be a significant driver of demand for formal aged care services not necessarily in residential care. The growth of the population will slightly increase demand for aged care services but may be almost completely offset by the improving health of older people.

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[14] Organization of Economic Cooperation and Development, *Ageing and Care for Frail Elderly Persons: An Overview of International Perspectives*, Labour Market and Social Policy, Occasional Paper No 38, OECD, Paris, 1999, p. 20.

[15] DT Rowland, *Ageing in Australia*, Longman Cheshire, Melbourne, 1991.

[16] Australian Institute of Health and Welfare, *Australia's Welfare 2001*, AIHW, Canberra, 2001, p. 212.

[17] R Wittenberg, L Pickard, A Comas-Herrera, B Davies & R Darton, *Demand for Long-Term Care: Projections of Long-Term Care Finance for Elderly People*, Personal Social Services Research Unit, London School of Economics/Kent University/University of Manchester, 1998.

5.2 Economic influences on demand

Demand is also affected by preferences, which in turn are a function of the income and tastes of older people. The economic influences on demand, especially in a situation of constrained supply and price, tend to affect the quality and type of care sought rather than the overall quantity of care sought.

5.2.1 Older people's preferences

The international literature has identified several trends in the type of care older people prefer. In particular, most older Australians (around 60.0 per cent of those aged at least 70) have expressed a clear preference to remain in their own homes supported by a range of services.[18] Internationally, there is evidence that older people's preferences appear to be moving toward the use of formal rather than informal care in their home. In the United Kingdom, the Royal Commission on Long-term Care found that older people 'would rather remain independent of [informal care] networks in securing the bulk of their care'.[19] Similarly, in the Netherlands it appears that 'the emphasis on independence for elderly people means that, when they require long-term care, they prefer to bring in professional help than call on their relatives'.[20] Given the current supply constraints in residential care, it is unlikely that the constrained demand for that care is affected by these changing preferences.[21] However, the Review's modelling takes them into account through the ability to vary the elasticities of substitution between residential and community care, and formal and informal care.

As living standards in the general community increase, consumers are also likely to demand an increase in the quality of aged care services. The Review's modelling has therefore assumed that the average quality of aged care services will increase at the same pace as living standards in the wider community. Such an increase in quality might be expected to increase demand for services. However, as this demand factor is a function of relative standards, this would only be the case if the quality of aged care services increased at a greater rate than living standards in the wider community. If the relativities of institutional and community living standards are maintained, then improved quality, of itself, will not increase demand for services.

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18 J McCallum, *Submission to Senate Inquiry into Superannuation and Standards of Living*, 3 May 2002.

19 Royal Commission on Long-term Care, United Kingdom, With Respect to Old Age: Long-term Care—Rights and Responsibilities, Research Volume 1, no. 28, The Stationary Office, London, 1999.

20 The Netherlands. Social and Cultural Planning Office, *Survey of demand for housing and care for the elderly*, Social and Cultural Planning Office, 1997, p. 3.

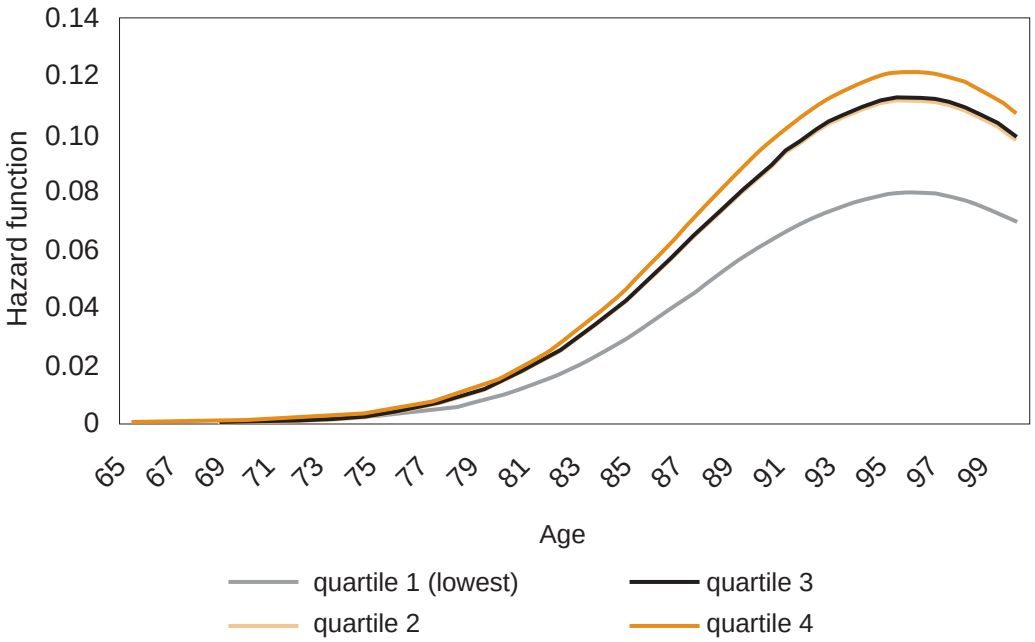
21 Technically it is only subsidised care services that are supply constrained, but given the high cost of residential care this is, in effect, a constraint on the supply of care services.

5.2.2 The income and assets of older people

Leaving aside the issue of quality, an increase in the wealth and incomes of older people may increase demand for aged care services. Spending more on care services helps in maintaining a level of independence and quality of life. On the other hand, demand for aged care services may be viewed as a necessity and spending on care may be undertaken only when needed. In this case, an increase in the wealth and incomes of older people would not necessarily increase demand for aged care services. To complicate the issue further, the international literature suggests there is a relationship between the wealth and income of older people and their health status.[22] In this case, older people with lower levels of wealth and income can be expected to demand relatively more aged care services than those with higher levels of wealth and income.

Analysis conducted for the Review by the National Centre for Social and Economic Modelling (NATSEM) suggests that older people with higher levels of income currently make greater use of (low-level) residential care services than those with lower levels of income (Figure 5–5).[23] The restriction to low level services is appropriate in this analysis as these offer greater scope for a person to incur substantial private costs through the payment of accommodation bonds.

Figure 5–5: Demand for low-level residential care services, by age and income quartile



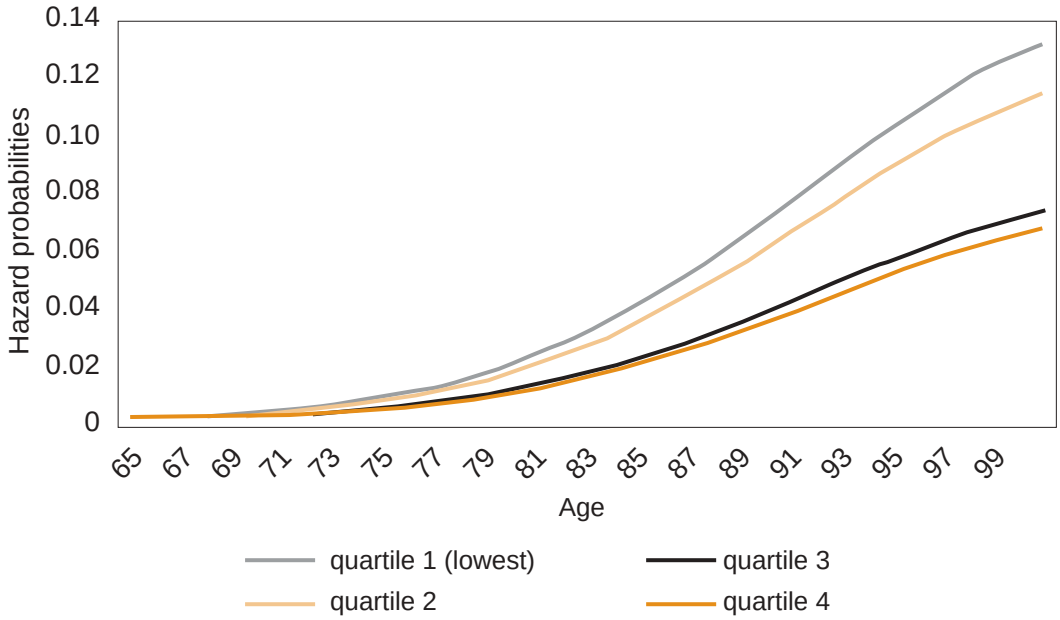
[22] E van Doorslaer, A Wagstaff H Bleichrodt, 'Income-related inequalities in health: Some international comparisons', *Journal of Health Economics*, vol. 16, no. 1, 1997, pp. 93–112.
RG Wilkinson, 'Class mortality differentials, income distribution and trends in poverty 1921–1981', *Journal of Social Policy*, vol. 18, no. 3, 1989, pp. 307–35.

[23] The Review's projections of the income and wealth of older people and their influence on demand for residential care are derived from a model developed for the Review by the National Centre for Economic and Social Modelling (see Discussion Paper 2).

Figure 5–5 compares the likelihood of use of low-level residential care services by income quartiles. It shows that persons in the bottom quartile have the lowest likelihood of use of residential care services, followed by those in second quartile, with persons in third and highest quartiles the greatest likelihood of use of residential care services.

However, NATSEM's analysis points to older people with lower incomes being relatively more likely to seek high-level residential care services (Figure 5–6). Given the current lack of price flexibility in high-level residential care, this finding supports the view that health and economic status are correlated.[24]

Figure 5–6: Demand for high-level residential care services, by age and income quartile



5.2.3 Private prices and the level of public subsidy

The extent to which demand for residential care services is sensitive to private price is debatable. At the lower end, some studies indicate that demand is relatively inelastic with respect to price, with demand decreasing by only 0.16 per cent for every 1.0 per cent increase in the price of care. At the higher end, some studies have found much greater price elasticity of demand, with demand decreasing by 2.3 per cent for every 1.0 per cent increase in the price of care. This considerable difference in predicted elasticity is mainly due to the highly subsidised nature of residential services. This high level of subsidisation distorts demand because the benefit individuals receive is leveraged by the subsidy and this leverage dilutes the influence of price on demand. Moreover, the price pressure can be applied to the subsidiser rather than the consumer thereby diffusing as well as diluting its effect on demand.

[24] See also: AE Headen, 'Economic Disability and Health Determinants of the Hazard of Nursing Home Entry', *Journal of Human Resources*, vol. 28, no. 1, 1993, pp. 80–110.

A recent study in the United States has disaggregated the effect of subsidies to investigate the underlying price elasticity of demand.[25] The study found that the price elasticity of demand for nursing home services amongst private payers was -0.98. That is, for every 1.0 per cent increase in the private price of nursing home care, demand for that care decreases by 0.98 per cent. Interestingly, the study also found that the price elasticity of demand is considerably smaller for people with a high level of disability (-0.36) than for people with a low level of disability (-1.92).

The Review has taken a conservative approach to the price elasticity of demand in its modelling and has assumed an elasticity at the lower end of the estimates in the international literature (-0.5).

5.3 Implications for demand

Aged care services do not currently operate in a competitive market; the supply of services is constrained. The supply of residential care services and community care packages is determined by a ratio, which provides 40 high-care residential places, 50 low-care residential places and 10 community care packages for every 1000 people aged at least 70. The supply of HACC services is subject to a budget cap. Because of these constraints, the demographic and economic determinants of demand discussed above, do not influence supply but rather on the private price paid by individuals. Again, because private financial-price is also regulated, the impact is on the private non-financial price. That is, they affect waiting times.

A useful way of considering these issues is to examine the impact on excess demand for formal care services. Excess demand is a measure of the number of older people who, at the prevailing subsidised private price, would accept a place in a residential care service or a community care package but are unable to find a place or package. Note that those in the excess demand category are not without any services—they are essentially contained in the ranks of those receiving HACC services or informal care whilst waiting for residential care or a community care package.[26]

Figure 5–7 illustrates the impacts of the demographic and economic demand factors discussed above on excess demand by considering six scenarios. In the first, very vanilla, scenario the size and age structure of the population, age-specific disability

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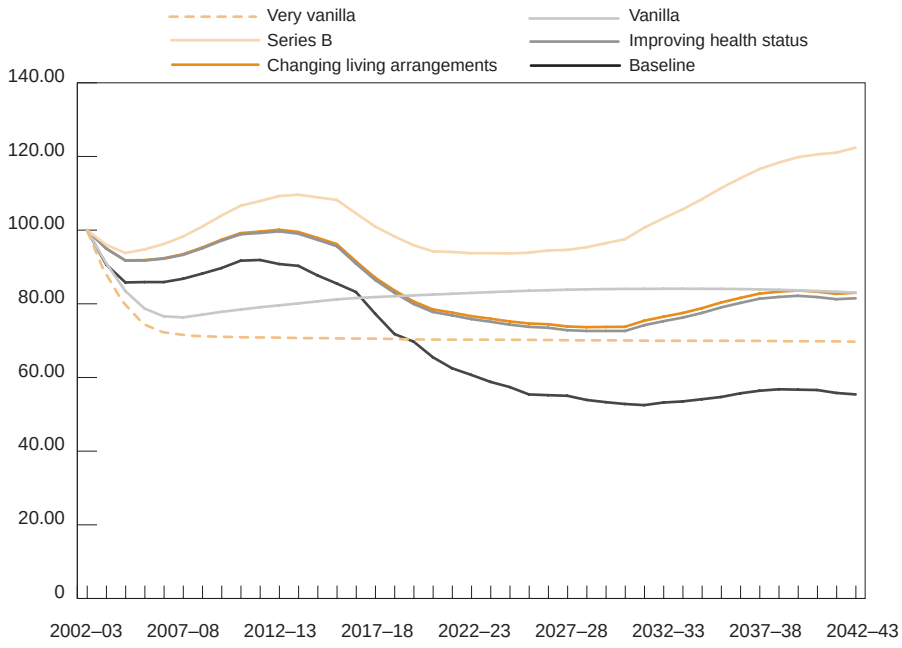
[25] JD Reschovsky, 'The roles of Medicaid and economic factors in the demand for nursing home services', *Health Services Research*, vol. 33, no. 4, 1998, pp. 787–813.

[26] The Review's estimates of excess demand are derived from the Aged Care Dynamic Cohort Model. They are based on the results of the ABS's 1998 Survey of Disability Ageing and Carers and on assessments of eligibility for subsidised residential care services and community care packages by Aged Care Assessment Teams. See: Australian Bureau of Statistics, *Disability, Ageing and Carers*, Australia. Cat. No. 4430.0, ABS, Canberra, 1999; and Lincoln Gerontology Centre, *Aged Care Assessment Program National Minimum Data Set Report: July 2000–June 2001*, Lincoln Gerontology Centre, Latrobe University, 2002 at http://www.ageing.health.gov.au/reports/download/acapmds01.pdf.

rates and living arrangements are all fixed at their 2002–03 levels. This scenario establishes the baseline level of excess demand inherent in the current supply constraints. The level decreases over the first few years as places already allocated come on stream and increase provision levels to the planning ratio. In the second, vanilla, scenario the size of the population grows in line with the ABS Series B projections but the other factors remain fixed at their 2002–03 levels. The level of excess demand in this scenario is slightly above that in the very vanilla scenario because some regions are currently overprovided against the planning ratio. As the population increases, these regions become less overprovided and this increases the overall level of excess demand slightly.

Figure 5–7 Drivers of excess demand for intensive care, 2002–03 to 2042–43 (0 = non excess demand, 100 = excess demand at 2002–03 level)



In the third, Series B, scenario the size and age structure of the population both grow in line with the ABS Series B projections but age-specific disability rates and living arrangements remain fixed at their 2002–03 levels. A comparison of the Series B and vanilla scenarios illustrates the effect of the changing age structure of the population on excess demand for aged care services. The level of excess demand will increase because of the ageing of the population—in particular because the very old population (those aged at least 85) grows at a faster rate than the population aged at least 70 until 2014–15. After this time, the effect of the post-First World War baby boom begins to subside and there is a decade or so during which the level of excess demand can be expected to decrease. The level of excess demand will then begin to increase again around 2026–27, because of the ageing of the post-Second World War baby boomers.

In the improving health status scenario, the size and age structure of the population grow in line with the ABS Series B projections and all age-specific disability rates improve by 0.25

per cent each year, but living arrangements remain fixed at their 2002–03 levels. The fall in age-specific disability rates impacts significantly on the level of excess demand, as it ensures that the growth rate of demand relative to the growth rate of the population aged at least 70 falls over time. In the living arrangements scenario, the share of the older population without access to informal care from a living spouse or child increases in line with the trends discussed above. These changes in living arrangements have only a small impact on excess demand. The final, baseline, scenario illustrates the impact of the economic drivers of demand, in particular the increasing private price of aged care services and the increasing wealth of older people.

In sum, pressures on the aged care sector will ease over the long term under current policies if health status improves and taxpayers are willing and able to continue to finance the same level of provision of aged care services. However, as discussed in the next two chapters, the latter assumption is problematic because even maintaining provision at current levels would require a real and substantial increase in expenditure.

Moreover, as illustrated above, even assuming that the health status of older Australians does improve and that Australian taxpayers are willing and able to continue to finance the same level of provision of aged care services, there will still remain a degree of excess demand for aged care services.

5.4 The allocation of places

The place allocation process controls the distribution of residential aged care places in an environment where the number of aged care places is restricted by the benchmark planning ratio.

The bed allocation process does two things. First, it ensures that the growth in the number of aged care places is in line with growth in the aged population. Second, it facilitates balance in the provision of services between metropolitan, regional, rural and remote areas, as well as between people needing differing levels of care.

5.4.1 The planning ratio

Allocation processes and provision ratios were developed in the 1970s to control the growth of nursing home places. The allocation process and the provision ratios were adjusted in the 1980s and 1990s in order to achieve a better mix of care types, to include the rationing of hostel and community care places. The process is described briefly in Box 5–1.

The policy goal of the process for allocating new places is to attain and maintain a ratio of 40 operational high care residential places, 50 operational low care residential places and 10 operational Community Aged Care Packages (CACPs) for every 1000 people aged at least 70 across Australia.

Decisions about where and how many places are to be allocated in any year are made in three stages as described below.

1. Initially, the Minister for Ageing determines the number of new residential and CACP places to be allocated to each state and territory for the financial year. The decision takes into account state and territory populations, the total number of places which have already been allocated, and the types of services which are either operational or are provisional allocations.
2. The Secretary then determines how places should be distributed among the regions. The distribution is based on the planning benchmarks, advice from Aged Care Planning Advisory Committees (ACPACs) and additional qualitative and quantitative information regarding the care needs of older people.
3. The final stage is the allocation of places to approved providers.

Box 5–1: The bed allocation process

Each financial year the Minister for Ageing determines the number of new residential, community and flexible care places available for allocation in each state and territory. The Minister's determination is based on:

- calculations, produced by the Department, of the places required to meet the planning ratio based on current aged care provision, Australian Bureau of Statistics (ABS) population projections and the target ratios at the state and territory and regional levels;
- policy advice by the Department; and
- political and budgetary factors.

Once the state/territory allocations are determined, allocations to regions within states are made by the Department, with reference to the advice of Aged Care Planning Advisory Committees (ACPACs). ACPACs operate in each state and territory and consist of Australian Government and state government representatives and non-government members with knowledge of the operations of aged care services, the perspective of consumers and the requirements of people with special needs.

The Secretary first distributes the available places in each state and territory amongst the regions within the state or territory, then determines the proportion of the places in each region that must be provided to specific kinds of care recipients. These places are advertised and approved providers wishing to supply aged care services may apply for one or more of these allocations through separate applications for each allocation.

Applications for each allocation of places are assessed to decide which application, if approved, would best meet the needs of the aged care community in the region. This process includes the consideration of a range of factors, primarily focusing on the capacity of the provider to provide appropriate facilities and care, but also including whether the allocation would improve the viability of an aged care service through restructuring, increase the ability of the aged care service to offer continuity of care or increased diversity of choice to current and future care recipients.

Following this competitive assessment, an allocation of places can only be made to a provider who is approved for the relevant care type and who is not under sanction. An allocation of places to an approved provider is a provisional allocation if the provider is not ready to provide care immediately; for example, if the facility is still being constructed. A provisional allocation is valid for two years, although the Secretary can extend the provisional allocation if circumstances warrant. A provisional allocation takes effect (in other words, becomes an operational place) when the Secretary determines that the approved provider is ready to provide care; the provider can then receive subsidy for care recipients occupying that place.

Special needs groups

Providers wishing to provide care for special needs groups (that is, Aboriginal and Torres Strait Islanders), those from culturally or linguistically diverse backgrounds, people living in rural and remote areas, the financially and socially disadvantaged, and veterans, can apply through the Aged Care Approvals Round process for places targeted to specific needs groups in specific regions in each state or territory.

5.4.2 Surrender, revocation and relinquishing of places

Providers may relinquish operational places which are no longer needed or surrender provisional allocations. The Secretary may also revoke allocated places if they have not been used for the purpose of their allocation for a continuous period of 12 months.

The revocation provisions are required to ensure that allocated places continue to be available for the provision of care to those who need it; that where places are not being used they are available for reallocation to another provider. Places are also able to be transferred to another provider with the approval of the Secretary.

5.5 The outcome of the planning process

The issue for determination is whether the allocation process effectively meets demand by region and need.

In May 2002, the Minister for Ageing announced the quantum of places to be allocated in the 2002 Aged Care Approvals Round, with 8231 new places worth $180 million made available for allocation in 2002–03. The majority of these places (6665) were included in the Regional Distribution of Places, approved by the Secretary of the Department of Health and Ageing. These places are advertised.

The remaining 1566 places are allocated through national programs such as the Multi-purpose Service Program, the Extended Aged Care at Home (EACH) Program, Innovative Service Trials and for emergencies.

Applications for places were advertised in July 2002 and successful applicants were announced on 26 November.

The 2002 Round resulted in 350 providers being granted more than 6500 places worth $144 million in recurrent funding. The places were allocated as follows:

- 2206 high care;
- 3373 low care; and
- 982 CACPs.

Almost 50 per cent of places were allocated to services in rural, remote and regional Australia. In addition, $34.32 million was provided in 75 capital grants throughout Australia, 90 per cent of which went to rural, remote and regional Australia.

At this date, overall, there were 99.7 operational places per 1000 people aged 70 and over. Of these operational places, CACPs accounted for 15.5 while high care places were 42.2 and low care places were 42.0. In terms of allocated places, the overall ratio was 110.2, comprising 45.8 high care places, 48.8 low care places and 15.6 CACPs. Allocated and operational CACPs are closely aligned because they are able to be utilised immediately. The greater variation in allocated and operational high care and low care places can be explained by the length of time taken to become operational.

It is noted that while no state or territory (except for the Northern Territory) meets the ratio for residential care in terms of operational places, the overall ratio of 100 places per 1000 population of over 70 years is still achieved, largely because the number of CACPs significantly exceeds the target in every state and territory.

The Northern Territory has a considerably different profile from other states and territories, reflecting the care needs of Aboriginal and Torres Strait Islander people aged 50 years and over. These places are allocated under the special needs provisions, suggesting that the ratio of 100 places per 1000 population may not be appropriate in this context.

Table 5–1 sets out the place allocations as at 30 June 2003.

Table 5–1: Allocated and operational residential places and CACPs per 1000 people 70 years and older, 30 June 2003, by state and territory

	High care	Low care	Total residential	CACPs	Total Places
Allocated places					
New South Wales	48.8	45.1	93.9	15.3	109.2
Victoria	42.5	51.1	93.5	15.4	109.0
Queensland	44.4	50.6	95.1	14.6	109.7
Western Australia	44.0	53.4	97.4	15.7	113.1
South Australia	47.4	48.9	96.2	15.8	112.1
Tasmania	48.0	45.9	93.9	17.1	111.0
Australian Capital Territory	38.9	49.8	88.7	18.6	107.3
Northern Territory	82.8	58.0	140.8	120.6	261.4
Australia	**45.8**	**48.8**	**94.6**	**15.6**	**110.2**
Operational places					
New South Wales	45.9	37.1	83.0	15.2	98.3
Victoria	38.1	43.2	81.3	15.3	96.6
Queensland	40.8	47.4	88.2	14.6	102.8
Western Australia	39.3	45.9	85.3	15.7	100.9
South Australia	44.4	43.3	87.7	15.7	103.4
Tasmania	47.2	38.8	86.0	17.1	103.0
Australian Capital Territory	32.6	46.8	79.4	18.6	98.0
Northern Territory	67.8	46.1	113.9	117.5	231.3
Australia	**42.2**	**42.0**	**84.2**	**15.5**	**99.7**

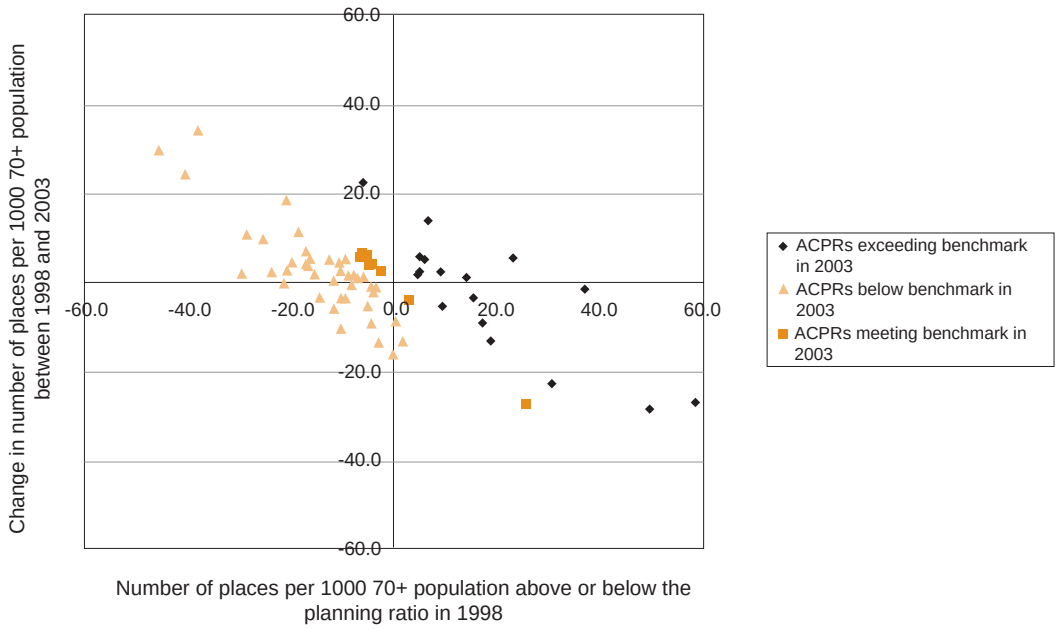
Note: The ratios in the table are based on the estimates of the population aged 70 years and over as at 30 June 2003 from the Australian Bureau of Statistics 1998 Population Projections, Series 3. The higher levels of provision in the Northern Territory address the care needs of Aboriginal and Torres Strait Islander people aged 50 years and over.

Source: Department of Health and Ageing 2003b[CC1]

5.5.1 Allocations since 1997

Under the current place allocation system, instituted in 1997, allocations have steadily been moving towards the ratio. Figure 5–8 plots that movement.

Figure 5–8: Change in operational ratios for residential care for Aged Care Planning Regions (ACPRs) from 1998 to 2003 (excluding the Northern Territory)



At the regional level, Figure 5–8 plots, for each Aged Care Planning Region, the number of places above or below the target ratio in 1998 on the x axis, against the change in the operational ratio between 1998 and 2003 on the y axis. This indicates the extent to which new residential care places were made operational in those Regions that needed them to meet the target ratio. It should be noted that CACPs are not included in this analysis. It can be argued that if the planning process is operating effectively, the points should appear:

- in the top left quadrant, representing those regions that were under-bedded in 1998 and subsequently had an increase in their operational ratio by more places being made operational;
- in the bottom right quadrant, representing those regions that were exceeding their operational ratio and subsequently experienced a reduction, most likely occurring through an increase in the 70+ population leading to a downward change in the ratio, or through places being transferred to a different region.

Figure 5–8 shows that while the overall trend is evident, there are still many regions that fall outside the two desirable conditions.

The analysis can be extended by examining whether the planning regions met the benchmark in 2003. The square points in Figure 5–8 denote planning regions where

the operational ratio in 2003 meets the benchmark (within two places); the diamond points denote those that exceed it; and the triangle points denote those that are below it. The notable features in the figure are that:

- several regions that underwent a large increase in their operational ratio are still below the benchmark;
- many regions that were below the benchmark in 1998 have undergone a decrease in their operational ratio; and
- several regions that were exceeding the benchmark in 1998 increased their operational ratio even further above the benchmark.

As at June 2003, only 12 per cent of the planning regions were within two places of the benchmark, while 26 per cent were over and 62 per cent were under the benchmark. However, a comparison with the results for June 1998 (six per cent within two places of the benchmark; 26 per cent over; and 68 per cent under the benchmark) indicates that over the five years, more regions were meeting the benchmark. Additionally, over the five years, 62 per cent of planning regions moved closer to the benchmark.

Additionally, in all states and territories, places were allocated to regions which were already over the benchmark and where special need was identified in sub-regions or communities of interest, leading to a distorted distribution of places.

These results are not impressive owing to the time taken to reach the equilibrium goal. With the average length of stay in residential aged care not much more than two years, two 'generations' of residents complete their aged care tenure before the perceived equilibrium needs at the time of entry of the first of these generations is achieved. This approach to planning lacks timeliness and responsiveness.

Activation of places

Places are allocated provisionally to approved providers if the provider is not ready to provide care immediately; that is, where a building has not yet been constructed. There is evidence of considerable delays in provisionally allocated places becoming operational.

At 30 June 2003, the longest standing provisional allocation was made in December 1988 of 30 low care places for a special needs group in Sydney. These places are expected to become operational in October 2003. The next longest standing provisional allocation is one of 10 low care places made on 3 June 1997 for an Aboriginal and Torres Strait Islander service in Queensland. A small number of provisional allocations remain from allocations made on 28 May 1998.

A total of 5231 provisionally allocated mainstream places, amounting to 2.7 percent of all mainstream allocated places or 34.1 percent of mainstream provisional allocations,

were more than two years old at 30 June 2003. These provisional allocations have substantially increased from the 1302 reported at 31 December 2002 as there are a large number of residential allocations remaining from allocations made on 11 January 2001 and in the 2000 round. There are 807 places not yet operational from the 2000 round.

The activation of almost two thirds of the 5231 places may have been delayed by such problems as planning approval, land availability or site problems.

The inability of the allocation process to fully account for delays in the activation of places skews allocations for subsequent years, and may increase the tendency to pool places in regions where places are allocated but not operational. In regions where CACPs are substituted for non-operational places, there is a further skewing effect. Over time, this will increase uncertainty in the allocation process and will make the target ratio more meaningless.

5.6 Evaluation of the planning process

In the shorter term (until 2015–16), the level of excess demand will lie above that inherent in the current policy. This is because the current level of provision is below the provision ratio and because increase in demand due to the ageing of the population will outstrip the increase in provision over the next fifteen years. Over the next few years the current level of under-provision against the ratio will be rectified as places already allocated come on stream. For a decade or so after that, however, the rapid increase in the very old population will again increase the level of excess demand. This suggests that the current planning arrangements should be modified in the medium term so that provision tracks the very old population rather than the population aged at least 70.

The overall planning ratio has been in place since the 1985 Nursing Homes and Hostels Review, with minor modifications as to the relative weight given within the overall ratio to low level residential care and community care.[27] At the time the ratio was introduced, it was acknowledged that there was no generally accepted optimum level of provision of places. However, there were a number of indications that the then current provisions were sufficient for the then and projected needs. First, there had been an overall rapid increase in the place–population ratio since 1973 of 10 beds per 1000 aged at least 65. Second, international comparisons showed that Australia was among the highest provision countries, although not the highest. Third, there was mounting concern that older people were prematurely seeking residential care services of greater intensity than they needed because of the lack of support and assistance which could be provided in their own homes. Finally, evaluation of existing waiting lists indicated that the number of persons who needed immediate placement to be very low.

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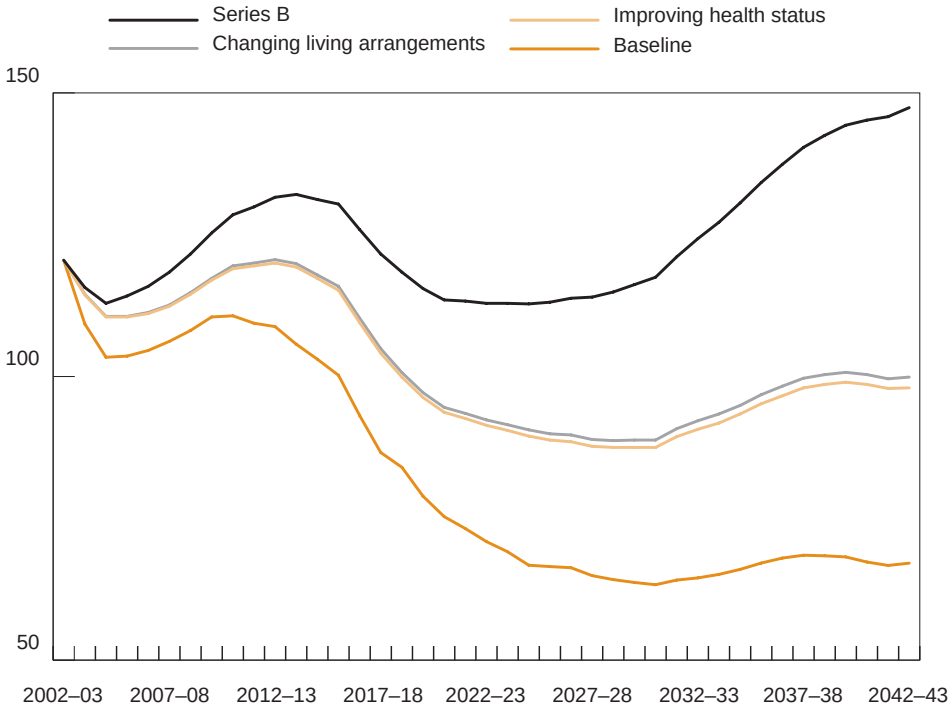
[27] Australian Department of Community Services and Health, *Nursing Homes and Hostels Review*, AGPS, Canberra, 1986.

Figure 5–9: Drivers of excess demand (adjusted) for intensive care, 2002–02 to 2042–43—(0 = non-excess demand, 100 = excess demand at 2002–03 level)



The overall ratio was chosen as the overall number of hostel and nursing home places ranged from 81 per 1000 persons aged at least 70 in Victoria to 115 per 1000 persons aged at least 70 in South Australia. The internal ratio (then set at 40 per cent nursing home and 60per cent hostel places) was based on the number of extensive nursing care residents per 1000 people aged at least 70, which ranged from 35 in New South Wales to 49 in West Australia. Since the introduction of community aged care packages in 1992 the Government has reduced the target for the provision of hostel places on three occasions. Each time the Government has reallocated resources to community aged care packages.

5.6.1 Implications for the balance of care ratios

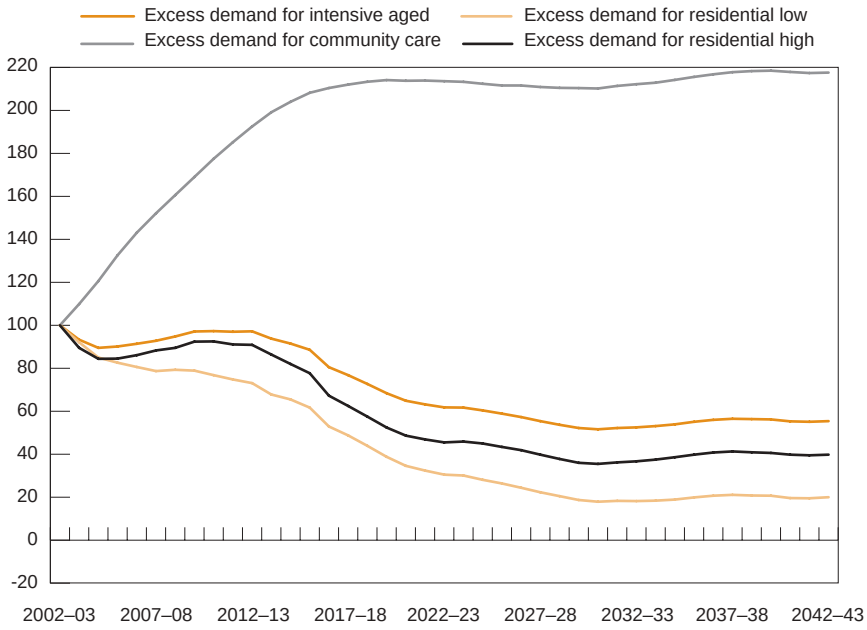
Issues arise with respect to the appropriateness of the current internal split within the overall provision ratio. First, ageing in place means that a proportion of allocated low care places are occupied by consumers of high care services.[28] On 30 June 2003, some 50.2 per cent of operational places had been allocated as high care places and yet 64.2 per cent of consumers were receiving residential services at the high care level. Second, the Resident Classification Scale gives greater weight to dementia than the Resident Classification Assessment Instrument previously used in nursing homes.

[28] Australian Institute of Health and Welfare, 'Ageing in Place', *Bulletin 1*. AIHW, Canberra, 2002.

Consequently, many residential care consumers who would previously have received care in hostels and been classified as requiring low level care are now identified as requiring high level care.[29] Each of these considerations suggests the internal ratio should be reweighted away from residential low care towards residential high care. In addition, the increasing demand for community care suggests the internal ratio should be reweighted away from low care towards community care packages.

However, as Figure 5–10 shows, excess demand for both residential high care and residential low care will fall in the coming decades under the current planning arrangements. This would indicate that it is unnecessary to increase the current allocation to residential high care (assuming that residential places allocated as low care can continue to be used for ageing in place). Adding further to the flexibility and uncertainty is the capacity of providers having beds in place prior to 1997 to switch freely between high and low care so long as facilities are appropriate to high care needs.

Figure 5–10: Excess demand for intensive aged care services, 2002–03 to 2042–43 (0 = non-excess demand, 100 = excess demand at 2002–03 level)



The balance between residential low care and community care packages, and indeed between residential high care and community care packages, is more problematic. Excess demand for community care packages will increase substantially over the next

[29] The Review's modelling assumes that 35.0 per cent of residential low care places are occupied by consumers of residential high care services at any one time to account for the effect of ageing in place and the increased emphasis given to dementia.

decade. This is because the number of packages currently provided is significantly above the provision ratio. Over the next decade, growth in the number of packages will be lower than in the population aged at least 70 and as a consequence excess demand for community care packages will increase. It will then remain reasonably steady until after 2025–26 when excess demand will decrease due to the improving health and economic status of older people.

5.7 Comment

On present indications, the overall planning ratio may be adequate for the short to medium term. Several shortcomings have been identified in preceding sections of this chapter. Given the uncertainties of demand for domiciliary aged care through one form of support package or another and its relationship to use of low care facilities, flexibility in allocation arrangements appears to be all important over the next five years.

Recommendations 1 and 2 therefore support the continuation of current planning arrangements, albeit with enhanced flexibility capability.

Another reason for caution when proclaiming the suitability of allocation arrangements relates to the capacity of some providers to meet the 2008 building requirements. There may be a need for scope to call for a prompt building of new facilities by those in a position to erect new facilities quickly.

6. GOVERNMENT FINANCING OF AGED CARE

Currently, the cost of aged care services is met by the Australian Government, which contributes 68.4 per cent, by individuals, who contribute 26.2 per cent and by state and territory governments, which contribute 5.4 per cent. The continuation of existing policies implies the maintenance of broadly similar financing proportions across the public and private sectors in the foreseeable future.

However, there are a number of problems with the continuation of the current financing arrangements (Table 6–1). First, the capacity of the Australian and state and territory governments to pay is projected to decline over coming decades, partly due to demographic costs outside aged care, and partly due to a faster relative rate of increase in health care costs. Second, the capacity of older consumers to contribute to the cost of their care will increase in the future. This reopens the issue of the appropriateness of the current means testing arrangements.

The *InterGenerational Report* also noted these issues, which imply that existing social policies will, other things being equal, lead to large federal and state deficits in coming decades.

6.1 The Aged Care Dynamic Cohort Model

The Aged Care Dynamic Cohort Model (ACDCM), discussed in detail in Chapter 4, aimed to:

- encompass the broad features of the current aged care system;
- allow for analysis of a range of alternative policies and health/disability trends;
- provide projections into the future;
- avoid preconceptions to the extent possible, allowing value judgements to lie with the model user more than the model builder.

That model informs the following discussion.

Table 6–1: Financing aged care, Government and consumer contributions, 2002–03 to 2042–43

($b)	2002–03	2012–13	2022–23	2032–33	2042–43
Nominal GDP	**735.768**	**1225.882**	**1941.341**	**3013.584**	**4630.327**
Cost of provision (assuming current practices)					
Residential care	6.654	12.638	26.019	52.007	93.993
CACPs and EACH	0.337	0.447	0.717	1.220	1.836
HACC	0.863	1.624	3.133	6.182	10.901
Other programs	0.434	0.552	0.699	0.887	1.128
Total cost	**8.288**	**15.261**	**30.568**	**60.296**	**107.858**
Status quo funding					
Australian Government (current arrangements)					
Residential care	4.312	6.540	10.771	17.379	24.825
CACPs and EACH	0.288	0.359	0.540	0.857	1.205
HACC	0.637	1.253	2.465	4.849	9.538
Other programs	0.434	0.552	0.699	0.887	1.128
Total	*5.670*	*8.703*	*14.475*	*23.972*	*36.696*
Private					
Residential care	2.077	3.835	8.545	18.741	36.389
CACPs and EACH	0.050	0.078	0.147	0.297	0.531
HACC	0.043	0.081	0.157	0.309	0.545
Total	*2.170*	*3.994*	*8.849*	*19.348*	*37.465*
State Government					
Residential care	0.264	0.440	0.697	1.083	1.663
HACC	0.183	0.290	0.512	1.024	0.817
Total	*0.447*	*0.730*	*1.209*	*2.107*	*2.480*
Total status quo funding					
Residential care	6.654	10.815	20.013	37.203	62.877
CACPs and EACH	0.337	0.436	0.687	1.155	1.736
HACC	0.863	1.624	3.133	6.182	10.901
Other programs	0.434	0.552	0.699	0.887	1.128
Total	**8.288**	**13.428**	**24.533**	**45.426**	**76.641**
Shortfall (additional funding required from Australian Government or elsewhere)					
Residential care	0.000	1.823	6.006	14.805	31.116
CACPs and EACH	0.000	0.010	0.030	0.065	0.100
HACC	0.000	0.000	0.000	0.000	0.000
Other programs	0.000	0.000	0.000	0.000	0.000
Total shortfall	**0.000**	**1.833**	**6.036**	**14.870**	**31.216**

(% of GDP)	2002–03	2012–13	2022–23	2032–33	2042–43
Cost of provision (assuming current practices)					
Residential care	0.90	1.03	1.34	1.73	2.03
CACPs and EACH	0.05	0.04	0.04	0.04	0.04
HACC	0.12	0.13	0.16	0.21	0.24
Other programs	0.06	0.05	0.04	0.03	0.02
Total cost	**1.13**	**1.24**	**1.57**	**2.00**	**2.33**
Status quo funding					
Australian Government (current arrangements)					
Residential care	0.59	0.53	0.55	0.58	0.54
CACPs and EACH	0.04	0.03	0.03	0.03	0.03
HACC	0.09	0.10	0.13	0.16	0.21
Other programs	0.06	0.05	0.04	0.03	0.02
Total	*0.77*	*0.71*	*0.75*	*0.80*	*0.79*
Private					
Residential care	0.28	0.31	0.44	0.62	0.79
CACPs and EACH	0.01	0.01	0.01	0.01	0.01
HACC	0.01	0.01	0.01	0.01	0.01
Total	*0.29*	*0.33*	*0.46*	*0.64*	*0.81*
State Government					
Residential care	0.04	0.04	0.04	0.04	0.04
HACC	0.02	0.02	0.03	0.03	0.02
Total	*0.06*	*0.06*	*0.06*	*0.07*	*0.05*
Total status quo funding					
Residential care	0.62	0.57	0.59	0.61	0.57
CACPs and EACH	0.32	0.34	0.47	0.65	0.81
HACC	0.12	0.13	0.16	0.20	0.24
Other programs	0.06	0.05	0.04	0.04	0.04
Total	**1.13**	**1.10**	**1.26**	**1.51**	**1.66**
Shortfall (additional funding required from Australian Government or elsewhere)					
Residential care	0.00	0.15	0.31	0.49	0.67
CACPs and EACH	0.00	0.00	0.00	0.00	0.00
HACC	0.00	0.00	0.00	0.00	0.00
Other programs	0.00	0.00	0.00	0.00	0.00
Total shortfall	**0.00**	**0.15**	**0.31**	**0.49**	**0.67**

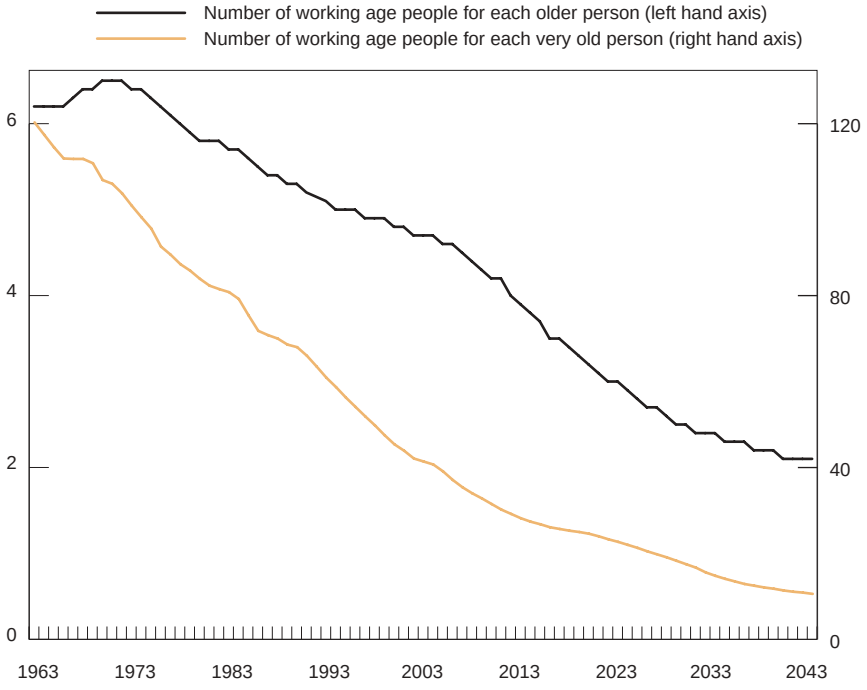
Note: Projections in this table and this chapter are derived from the Aged Care Dynamic Cohort Model developed for the Review by Access Economics. See Chapter 4.

6.2 The Australian Government's capacity to contribute

In order to assess the capacity of future governments to maintain required funding levels and so to assist older Australians to purchase the aged care services they need, it is necessary to briefly consider the long run macroeconomic outlook for Australia. The demographics discussed above provide a relatively stable foundation for projecting economic activity over coming decades. Other factors combine with population to determine actual economic activity, including labour force participation, the unemployment rate and productivity growth. The long-run effects of these factors are also well understood.

Useful, if incomplete, headline indices of the sustainability of the current aged care financing arrangements are the ratios of the sizes of the older and very old populations and the working age population—those aged between 20 and 64 (see Figure 6–1).[1] Australia currently has almost five working age people for every older person. By 2043, that ratio will have more than halved to just over two. Currently there are more than 40 working age people for every very old person. By 2043, this ratio may have reduced to just over 10. This decrease in the support ratio need not be a cause for immediate concern. However, in the short term, it will continue to be offset by increased productivity and improved labour force dynamics.

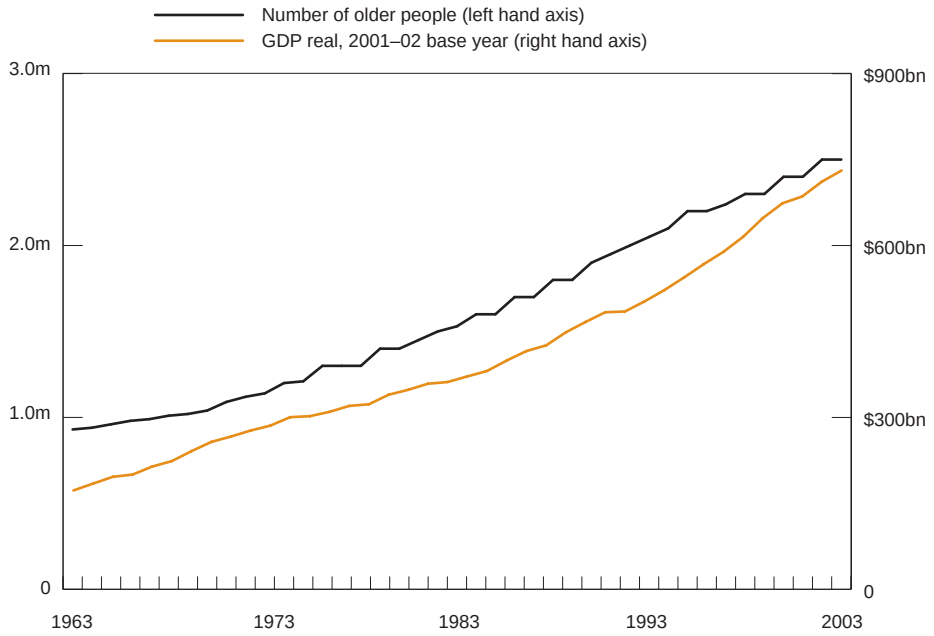
Figure 6–1: Headline indices (employment) of the sustainability of aged care financing, 1963 to 2043



[1] The working age population is often taken to be those aged 15 to 64. This definition does not accord with current educational norms. The full time labour force participation rate of those aged between 15 and 19 is currently only 20 per cent and, as the IGR notes (page 11) the principal age for education is between five and 24. A useful discussion of alternative dependency measures and their implications is provided in P Crowley & G Cutbush, *Ageing Gracefully: An Overview of the Economic Implications of Australia's Ageing Population Profile*, Australian Government Department of Health and Aged Care, Canberra, 2000.

Two other headline indices of the sustainability of the current arrangements to support older people are the ratios of GDP (in real terms) to the sizes of the old and very old populations. Over the last four decades, Australian GDP has grown in real terms at around the same rate as the population of older Australians (Figure 6–2), with the rate of real GDP growth exceeding the rate of growth of the older population in each year in the last decade. The very old population has consistently grown faster than real GDP.

Figure 6–2: Real growth in GDP and the older population, 1963 to 2003

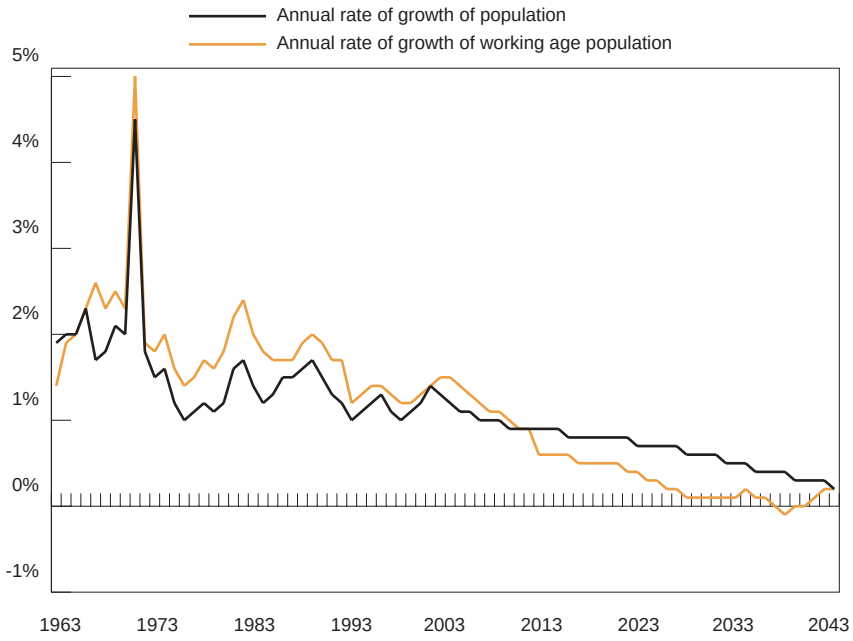


In the medium term, GDP is unlikely to grow as fast as even the older population. To understand why this is the case it is useful to consider each of the components of GDP growth in turn, namely the rates of change of:

- the size of the population;
- the labour force participation rate (the proportion of the population in the labour force);
- the employment rate (the proportion of the labour force in employment); and
- the productivity of employees.

As Figure 6–3 indicates, the rate of increase of the Australian population will continue to decline over the next four decades. The decline in the rate of increase of the working age population is even more dramatic, with no real growth in the working age population after 2035.

Figure 6–3: Annual growth rates of the population and the working age population, 1963 to 2043



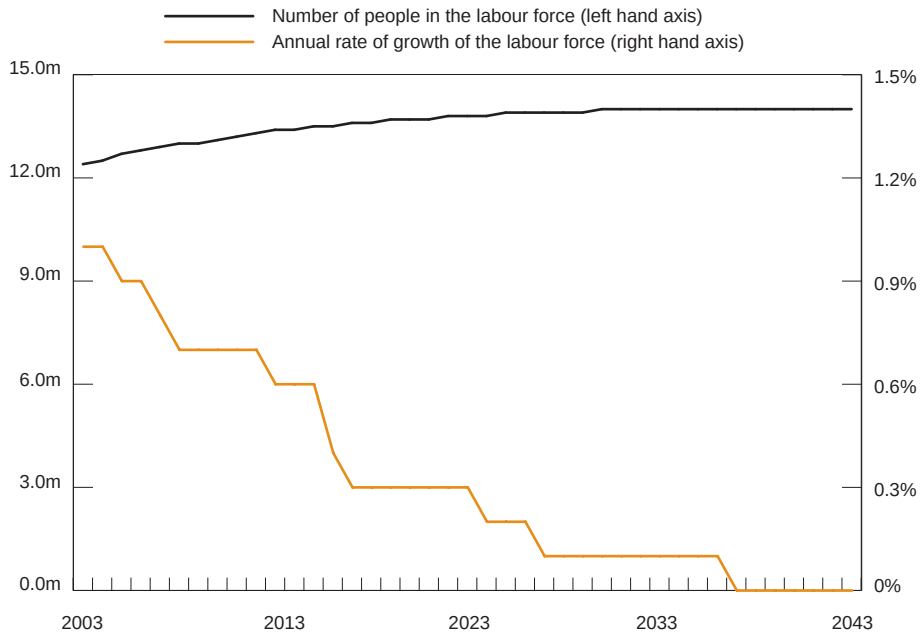
It is likely that there will be changes in the labour force participation rates of older workers in coming decades as a result of policy and labour market pressures. The overall labour force participation rate will therefore probably increase in the medium term (as more women enter the workforce) but decrease in the long term (with the ageing of the population). Based on recent trends, the Review's modelling has assumed annual changes in the participation rates of the various demographics (Table 6–2).

Table 6–2: Assumed annual change in labour force participation rate, by demographic cohort

Age group	Under 20	20 to 54	55 to 60	60 to 84	85 and over
Annual change	0.00%	0.04%	0.07%	0.49%	0.00%

Figure 6–4 illustrates the effect of these assumptions (together with the growth in the population) on the size of the labour force over the next four decades. Over the next 40 years the labour force will grow by only 13.0 per cent (compared to the 164.6 per cent growth in the number of older people).

Figure 6–4: Growth of the labour force, 2003 to 2043

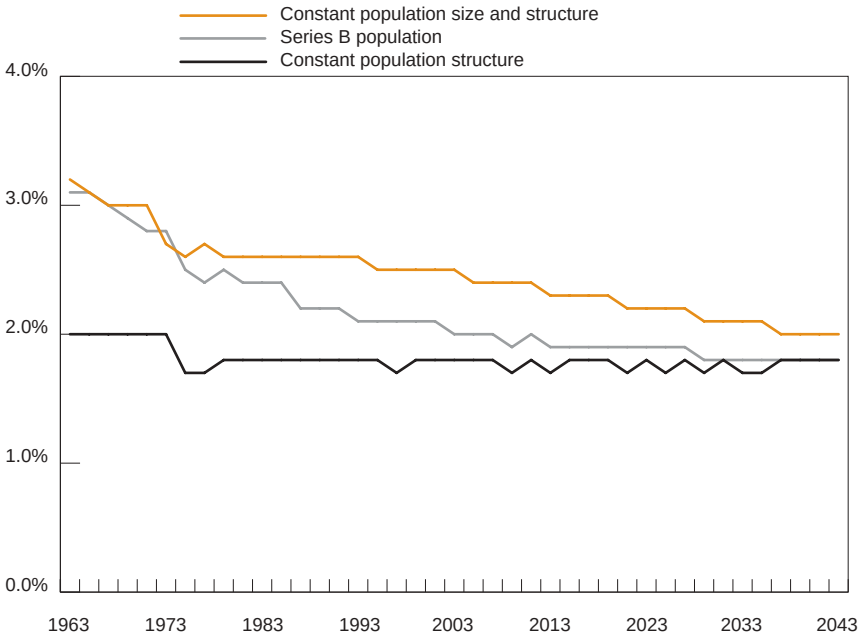


The productive labour force (the labour force in employment) is also unlikely to grow any faster than the labour force as a whole over the next four decades. Indeed, the employment rate—the ability of the economy to absorb those who want jobs into the workforce—is currently at, or near, its structural maximum—the 'natural' rate of unemployment. To abstract from the dynamics of unemployment, the Review's modelling has assumed that the unemployment rate falls to the 'natural' rate of unemployment over the next five years and then remains at that level throughout the period under consideration. The Review has accepted the IGR assumption that the 'natural' rate of unemployment is five per cent.

The final factor affecting GDP growth is productivity—the growth in the amount of goods and services produced by each worker in a given time period. Although productivity growth is unlikely to perform significantly better over the next four decades than the annual growth achieved over the last couple of decades, it is also unlikely to be significantly lower. The Review has therefore assumed, in line with the IGR, that productivity in the Australian economy will grow at 1.75 per cent a year over the next four decades. This is a very important assumption over the long run of forty years. For example, an immediate halving of the unemployment rate (through higher employment) would add only a third to economic activity after 40 years, the same as a minor lift in productivity growth (say from 1.75 per cent to 2.0 per cent). Productivity growth is the ultimate underwriter of living standards.

Figure 6–5 provides a useful summary of the drivers of GDP and the sustainability of the current arrangements to support older people by considering three scenarios.

Figure 6–5: Effects of population growth, ageing and productivity on GDP growth, 2003 to 2043



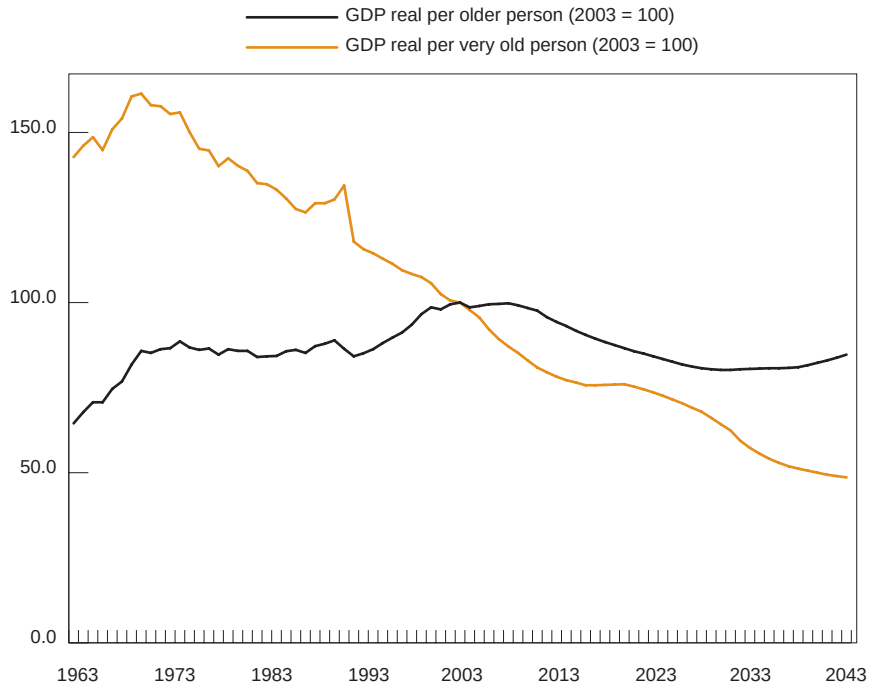
The first, very vanilla, scenario assumes that the size and age structure of the Australian population remains fixed over the next four decades. In this scenario, output growth equals productivity growth plus the effect on labour supply of participation and unemployment rates changing in line with the equivalent changes in the IGR. As the latter changes peter out after a decade, on-going long term output growth equals productivity growth at 1.75 per cent. The second, vanilla, scenario assumes that the size of the Australian population grows in line with the ABS projections but there is no change in the age structure of the population. In this scenario, output growth benefits from the effect on labour supply of growth in the Australian population. As the growth rate of the latter declines over time, the initial boost to output growth is eaten away. By 2043 there is little population growth in the Australian economy, so the output growth rate has moved close to the 'base rate' implied by productivity growth. The third, Series B, scenario uses the ABS Series B projection for the size and composition of the Australian population. In this scenario, output growth is reduced again due to the effect on labour supply of the ageing of the baby boomers. The more rapid retirement among that group than average reduces the worker population ratio in Australia. From 2035 there is little employment growth in the Australian economy, so output growth rates move close to the 'base rate' implied by productivity growth.

Two features of these results stand out. First, economic growth will slow with or without ageing, simply due to slower population growth seen in the vanilla scenario. Second, most of the national economic effects of ageing occur between 2015 and 2025, as seen in the Series B scenario. The sharpest slowing in GDP growth rates (compared

with an economy without an ageing population) occurs during the years of maximum retirement by the baby boomers, from 2015 to 2025.

The ratio of GDP (real) to the size of the old population will continue to increase (slightly) for the next five years. After that, the ratios of GDP (real) to the sizes of the old and the very old populations will decrease steadily until 2036. Real growth in GDP will then again begin to outstrip growth in the old population, although not the very old population (Figure 6–6). However, it will not be until 2023 that the economic dependency of the older population will be greater than it was between 1973 and 1993.

Figure 6–6: Headline indices (GDP) of the sustainability of the current arrangements to support older people, 1963 to 2043



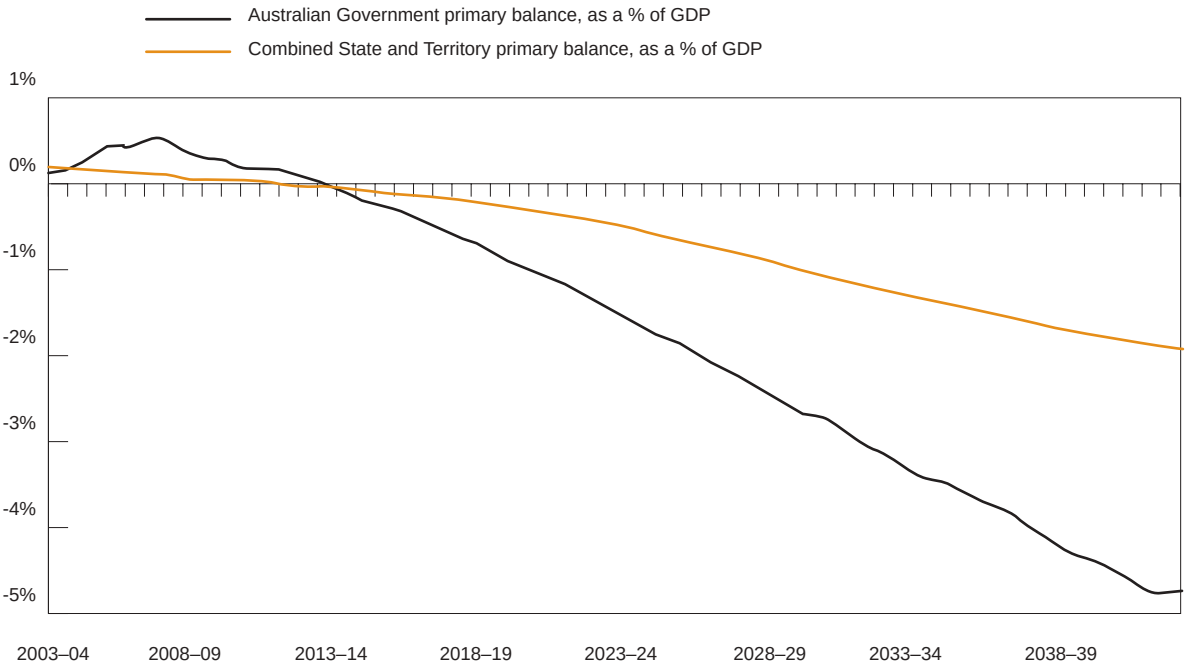
The broad implications of these demographic and economic trends for the Australian economy and society, and for the Australian and state and territory government budgets, are summarised in Table 6–3.

Table 6–3: Implications of ageing for the Australian economy and Australian society

Decade	Impact
2000s	Labour supply and economic growth start to slow down
2010s	Retiree numbers rising fast, pension outlays start to increase
2020s	Health outlays start to rise even faster
2030s	Residential care demands increase at greater rate
2040s	**Demographic trends reach new plateau**

The ageing of the population will hurt both state and Australian Government finances (Figure 6–7). It will create a growing deficit on primary balance for both levels of government, essentially due to rising health costs and falling education expenses (in relative terms). However, state finances are rather less affected. Most of the economic negatives for the Australian Government hit early, as the baby boomers retire (and so leave the labour force). But most of the state budget negatives hit later, especially in hospital costs. That is why the worsening in the state and Australian Government positions does not occur at comparable rates until the 2020s. There are also some potential state budget positives, such as reduced pressure on education spending, which hit early. There is less potential for education savings at the Australian Government level. That suggests that, in relative terms, ageing has a rather later and smaller impact on state budgets than the Australian Government Budget.

Figure 6–7: Australian Government and state and territory (combined) primary balances, 2002–03 to 2042–43



The Australian Government will not be able to maintain its share of responsibility for the funding of aged care services for older people (that is, fund the shortfall identified as well as its currently projected contribution) without running up significant deficits. Put another way, tomorrow's taxpayers will not be able to pay for today's policies without either increases in tax rates and tax bases or cuts to other spending. The likelihood is some combination of the two.

In order to understand the extent to which tax rates would need to increase for the Australian Government to fund the identified shortfall, the Review has modelled the

introduction of a Medicare-style levy designed to meet the shortfall. Alternative tax financing arrangements are of course possible. For example, all personal income tax marginal rates could be raised proportionately. The Medicare-style levy rate is variable and has been determined by a 'fiscal reaction function', which raises the Medicare-style levy rate to move the shortfall back towards zero. In order to close the shortfall, the Medicare levy would need to be raised by 1.5 per cent in 2002–03. That is, current expenditure in 2002–03 is equivalent to the revenue that would be raised by an increase in the Medicare-levy of 1.5 per cent. Moreover, this increase in the rate would need to itself steadily increase to 3.13 per cent by 2042–43, with a 17.3 per cent increase in the first decade and 21.0 per cent, 25.0 per cent and 16.3 per cent increases in each of the following decades.

Costs to the economy are also reflected in costs to the Australian Government Budget, with lower growth hurting revenues such as personal and other direct and indirect taxes. These effects form a negative feedback loop; trying to close deficits by raising taxes weakens the economy, and so weakens revenues. The increases in personal tax outlined above would have a significant effect on the Australian economy, shaving 0.4 per cent off GDP in 2042–43.[2] Hence this scenario shows a lower Australian Government Budget deficit, but at a considerable cost to the Australian economy.

6.3 Consumer capacity to contribute

Currently, consumers of aged care services contribute to the cost of services through fees paid to service providers. In the case of HACC, these fees account for less than five per cent of the cost of HACC services. In the case of community aged care packages, fees cannot be greater than 17.5 per cent of the basic pension plus a proportion of the consumer's private income. In the case of residential care services, residents contribute to the cost of their care and accommodation through capped income-tested daily fees paid for services and asset-tested accommodation payments paid as a capital contribution. Assuming current user charging arrangements remain in place, the total contribution of consumers to the cost of residential care, through capped income-tested care fees and accommodation payments, will increase from $2.1 billion in 2002–03 to $36.4 billion in 2042–43.

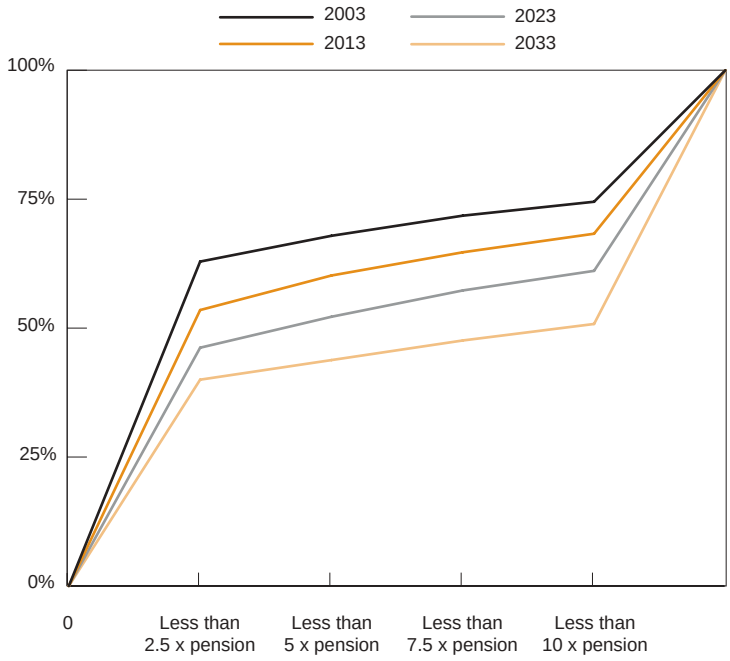
This represents an increase in real terms of 174.3 per cent, from 0.3 per cent of GDP to 0.8 per cent of GDP. Most of the real increase in consumer contributions will occur between 2013 and 2033. Over the next decade, consumer contributions will increase in

[2] Static studies suggest that the marginal deadweight loss for increases in personal income tax is around 18 per cent (see, for example, E Diewert & D Lawrence, 'New Zealand's Excess Burden of Tax', *Agenda*, vol. 2, no. 1, 1995, pp. 27–34). This has been used as a benchmark deadweight loss in the Review's modelling to allow for the deadweight cost of a higher Medicare-style levy. The resource costs of higher personal taxes eat into workforce participation.

real terms by 10.5 per cent, compared to 39.9 per cent and 40.8 per cent in the second and third decades.

As a proportion of the total cost of care, the contribution of consumers will increase from 31.2 per cent in 2002–03 to 38.7 per cent in 2042–43. This increase reflects the growing wealth of older Australians. This results in a greater number of users of residential care services having the financial capacity to make a greater contribution to the cost of their care. Figure 6–8 illustrates how the level of assessable assets of older Australians will increase over the next three decades.[3]

Figure 6–8: Assessable asset profile of older people, 2002–03 to 2032–33



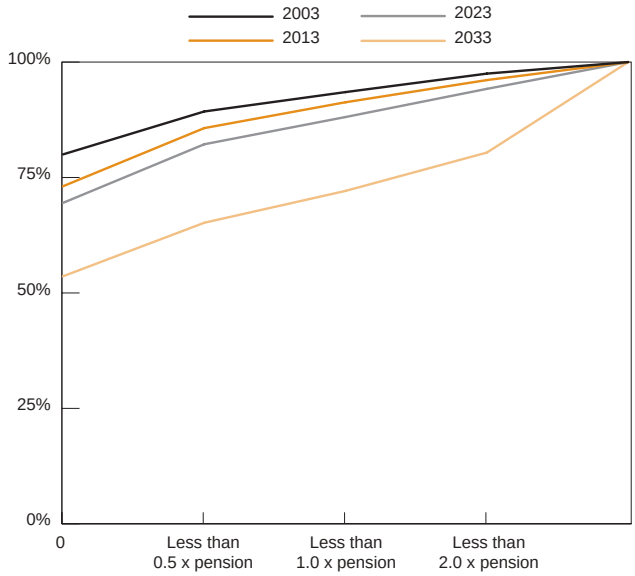
Currently, only 56.0 per cent of older people have assets worth more than 10.0 times the annual pension and 29.4 per cent have assets worth less than 2.5 times the annual pension. By 2032–33, some 75.5 per cent of older people will have assets worth more than 10.0 times the annual pension (an increase of 34.9 per cent) and only 18.5 per cent will have assets worth less than 2.5 times the annual pension (a decrease of 37.0 per cent). If the value of the family home is excluded from the value of an older person's assessable assets if it is occupied by the older person or their spouse, then currently only 25.5 per cent of older people have assessable assets worth more than 10.0 times the annual pension. Some 62.9 per cent of older people have assessable assets worth less than 2.5 times the annual pension. By 2032–33, some 49.2 per cent of

[3] The value of the family home is excluded from the value of an older person's assessable assets if the older person or their spouse occupies the home.

older people will have assessable assets worth more than 10.0 times the annual pension (an increase of 92.9 per cent), but 40.0 per cent will still have assessable assets worth less than 2.5 times the annual pension (a decrease of 36.5 per cent).

Figure 6–9 illustrates how the level of assessable income of older Australians will increase over the next three decades.[4]

Figure 6–9: Assessable income profile of older people, 2002–03 to 2032–33



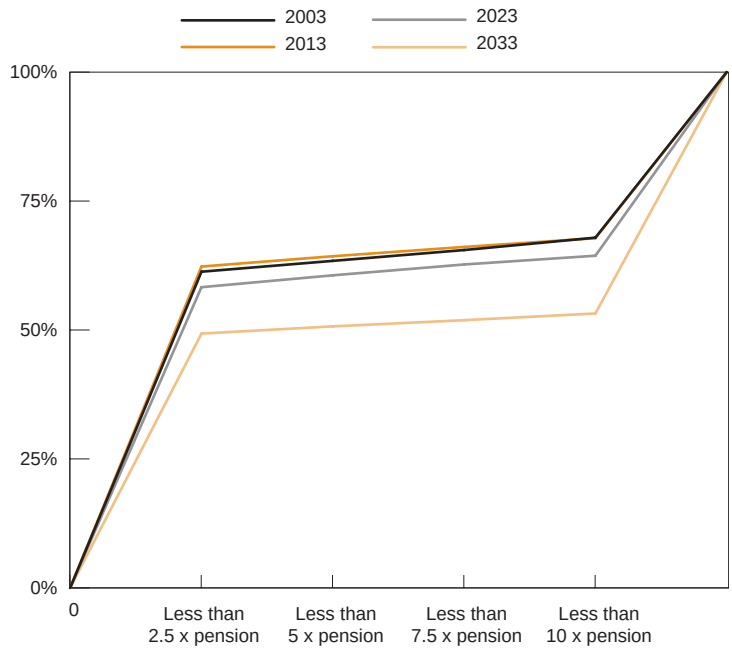
Currently, some 80.0 per cent of older people have no assessable income and only 2.5 per cent have assessable income of more than 2.0 times the annual pension. Remembering that these older people, if pensioners, have total income equal to three times the annual pension plus the pension income test free area. By 2032–33, some 19.6 per cent of older people will have assessable income worth more than 2.0 times the annual pension (an increase of 682.3 per cent), but still 53.6 per cent will have no assessable income (a decrease of 33.0 per cent).

Three caveats need to be kept in mind when considering this broad picture. First, although older Australians will on average have considerably higher levels of income and assets in the future, there will still be a considerable number of older Australians with almost no assets and little or no assessable income. As noted above, in 2032–33, 40.0 per cent of older Australians will have assessable assets of less than 2.5 times the pension and 53.6 per cent of older Australians will have no assessable income.

4 For a pensioner: assessable income = total income—maximum basic pension—the pension income test free area. For a non-pensioner: assessable income = total income—the pension income test free area.

Second, consumers of residential care services are, in general, older and therefore have fewer assets and lower incomes than average older Australians.[5] Figure 6–10 illustrates the assessable asset profile of older consumers of residential care services.

Figure 6–10: Assessable asset profile of consumers of residential care services, 2002–03 to 2032–33



Currently, 64.9 per cent of older consumers of residential care services have assessable assets worth less than 2.5 times the annual pension. This proportion will not fall much over the next two decades, with 59.1 per cent of older consumers in 2022–23 still having assessable assets worth less than 2.5 times the annual pension. This represents a decrease of only 8.9 per cent in the two decades. In the third decade, however, the rate of decrease will accelerate and, by 2032–33, only 50.6 per cent of older consumers will have assessable assets worth less than 2.5 times the annual pension.

At the other end of the scale, currently 29.6 per cent of older consumers of residential care services have assessable assets worth more than 10.0 times the annual pension.[6] This proportion will increase slowly over the next two decades and then more rapidly in the third decade. By 2032–33, some 45.0 per cent of older consumers will have assessable assets worth more than 10.0 times the annual pension.

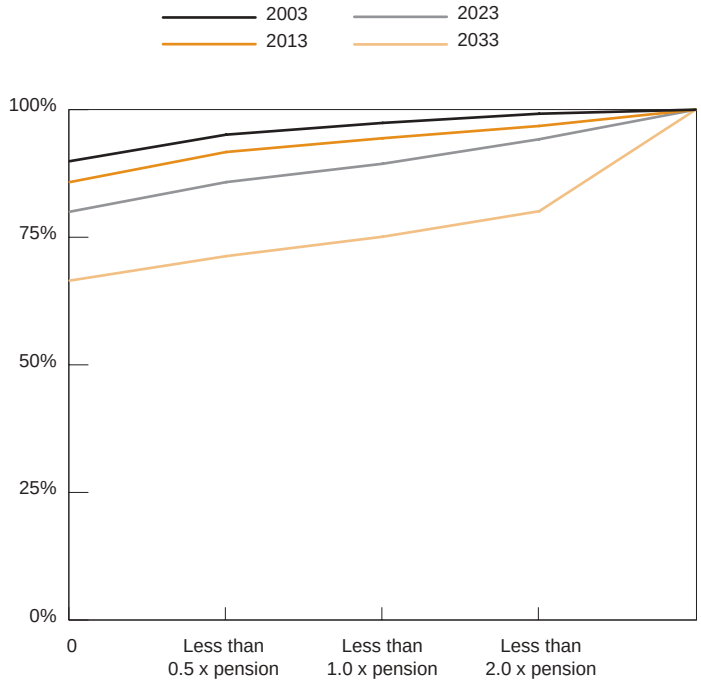
Figure 6–11 illustrates the assessable income profile of older consumers of residential care services. Currently, 91.6 per cent of older consumers of residential care services

5 The oldest old are poorer for two reasons. They come from an earlier generation in which less wealth accumulation occurred and they have consumed more of their wealth since retirement.

6 Interestingly, a greater proportion of older people in residential care services have assessable assets worth more than 10.0 times the annual pension than of older people in general.

have no assessable income. This proportion will not fall much over the next two decades, with 80.2 per cent of older consumers in 2022–23 still having no assessable income. This represents a decrease of only 12.5 per cent in the two decades. In the third decade, however, the rate of decrease will accelerate and, by 2032–33, only 66.9 per cent of older consumers will have no assessable income. At the other end of the scale, currently only 0.7 per cent of older consumers of residential care services have assessable income worth more than 2.0 times the annual pension. By 2032–33, this proportion will have increased to 19.3 per cent.

Figure 6–11: Assessable income profile of consumers of residential care services, 2002–03 to 2032–33



The final caveat to the analysis of the income and assets of older people concerns regionality. Evidence suggests older people living in non-metropolitan areas of Australia have lower assets and income than their urban counterparts. In terms of assets, a higher percentage of older people living in rural areas have very low assets compared to those living in urban areas. Some 31.5 per cent of rural older people have total assets of less than 2.5 times the annual age pension compared to 29.5 per cent of older people living in urban areas. In contrast, only 25.7 per cent of older people living in remote areas have total assets of less than 2.5 times the annual age pension. At the high end of the scale, the percentage of older people with total assets of more than 10.0 times the age pension is lower in rural areas (52.4 per cent) than in urban areas (56.5 per cent). Interestingly again, older people living in remote areas are more likely than those in urban and rural areas to have total assets of more than 10.0 times the pension (58.7 per cent). The regional differences are less pronounced when only assessable assets are included, indicating that the main difference in the wealth profile

between rural and urban older Australians is the value of the family home.[7] The differentials in total income are not as clear, perhaps because the age pension provides a minimum income regardless of regionality. However, the evidence still points to regional differences. Some 89.0 per cent of older people in rural areas (and 88.8 per cent of older people in remote areas) earn no more than the annual single age pension plus the pension income test free area, compared to 87.0 per cent in urban areas.

6.4 Financing the deficit

As Table 6–1 shows, the current aged care financing arrangements will be in deficit to the order of $31.2 billion (0.6 per cent of GDP) by 2042–43. As discussed in Section 6.2 (and in the IGR), the Australian Government will not be able to cover this deficit without imposing a significantly higher burden on future taxpayers. On the other hand, the current indexation arrangements mean that the Australian Government's contribution to aged care will only increase in real terms from 0.77 per cent of GDP to 0.79 per cent of GDP over the next four decades. The Government's contribution to residential care will decrease over the same period (from 0.59 per cent of GDP to 0.54 per cent of GDP) despite a 190.4 per cent increase in the number of consumers of residential care. Section 6.4.1 below considers the implications of maintaining the level of the Australian Government's contribution in real terms. Another option to close the deficit is to recognise that the capacity to contribute of some older people in the future will be greater than that currently recognised by the means testing arrangements. This would suggest that the current arrangements should be revisited, an option that is considered in Section 6.4.2. Operators, the third party in the financing equation, also have a role to play through the achievement of greater efficiency in service provision. This contribution is considered in Section 6.4.3.

6.4.1 Maintaining the Government's contribution

The Australian Government's contribution to the cost of residential care services is currently determined by four factors:

- the number of consumers of subsidised residential care services;
- the income of those consumers, as the Government's contribution is income tested;

[7] Some 62.7 per cent of older people living in urban areas have assessable assets worth less than 2.5 times the annual pension. This is broadly similar to the 64.1 per cent and 62.0 per cent of older people in rural and remote areas, respectively, who have assessable assets worth less than 2.5 times the annual pension. At the high end of the scale, some 25.9 per cent, 24.9 per cent and 24.9 per cent of older people living in urban, rural and remote areas have assessable assets worth more than 10.0 times the annual pension.

- the frailty of those consumers, as the basic subsidy paid by the Government depends upon the operator's appraisal of the consumer against the eight-category Resident Classification Scale; and
- other consumer-specific and service-specific factors, which are recognised by a variety of supplements (for example, the pensioner and concessional supplements, and the payroll tax and viability supplements).

Abstracting away any growth in the number of residents, any change in the frailty of residents and any other changes in resident mix leaves the unit price of the Government's contribution, which is measured by the eight payment categories for the Government's basic subsidy. Currently the Australian Government indexes the unit price of its contribution to the cost of residential care services through a cocktail index made up of 25 per cent of the Consumer Price Index (CPI)[8] and 75 per cent of the Safety Net Adjustment Index. The latter is derived from the Australian Industrial Relations Commission's annual Safety Net Review—Wages.[9]

6.4.2 Stronger means testing arrangements

As the income and wealth of older Australians increase and the capacity of the Australian Government to meet the needs of older people decreases, it is important to revisit the principles that underlie the current means testing arrangements to determine if they are still appropriate. Aged care services lie at the nexus of health and welfare services. The means testing arrangements that currently apply in aged care draw from the experience of both of those sectors.

The Australian Government's welfare arrangements and, in particular, its income support arrangements are best described as a social assistance scheme operating between current taxpayers and current pensioners and secured by community consensus. The defining features of the welfare arrangements are as follows.

- Universality—eligibility does not depend upon past contributions and there is no administrative discretion as to the form or amount of the pension.
- Equity—all pensioners are entitled to the same maximum rate of pension (subject to a means test), rather than having the level of an individual's pension linked to previous income or contributions, or otherwise individually determined.
- Encouragement of self-provision—the maximum rate of the pension is set at a level that encourages self-provision. Self-provision is further encouraged and rewarded through the concessional taxation treatment afforded to superannuation, the income test free area, the tapered income test and the generous assets test.

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8 Australian Bureau of Statistics, Consumer Price Index: Australia, Cat. No. 6401.0, ABS, Canberra, September 2003. Australian Bureau of Statistics, *A Guide to the Consumer Price Index: 13th Series*, Cat. No. 6440.0, ABS, Canberra, 1999.

9 Australian Industrial Relations Commission, *Safety Net Review—Wages 2003*, AIRC, 2003 at http://www.e-airc.gov.au/wage2003/.

- Maintenance of real value—the real value of the maximum rate of the pension is maintained through regular and transparent indexation arrangements.
- Means testing—the rate of the pension actually paid depends upon the means of the pensioner. The means test includes an assets test and an income test. The value of the pensioner's home (when occupied) is excluded from the assets test.
- Integrity protections—the means test includes measures to ensure its integrity, including deeming and gifting provisions. The deeming provisions ensure that pensioners make maximum use of their private earning capacity and counter practices designed to minimise income to maximise pension entitlement. The gifting provisions prevent the disposal of assets without adequate return.
- Targeted concessions—the pension arrangements include additional concessions, including rent assistance and the Pensioner Concession Card which, inter alia, gives access to most medicines at a concessional rate. These concessions recognise the fact that many of the problems confronting older people are not resolvable solely by the payment of pensions and that the needs of some older people are such that special measures have to be taken to meet them.

The principles that underlie the Australian Government's blended health financing arrangements are similar to those that underlie the welfare arrangements. Additional features include the following.

- Affordability—the cost of care should be affordable to individuals. This involves the Australian Government underwriting some of the cost of essential care for all people and supplying additional assistance where individuals are unable to afford the cost of their care or to make use of the mainstream financing arrangements.
- Personal and social responsibility—individuals are given a sense of personal and social responsibility through, for example, the use of co-payments.
- Objectivity—access to Australian Government assistance is subject to a clinical necessity requirement.
- Means testing—access to more extensive assistance is subject to a means test. Moreover, in general, the means test applicable to health benefits tends to be more onerous than that used for income support payments.
- Quality—the financing arrangements seek to raise the level of care and treatment.
- Sustainability—the arrangements contain automatic checks and controls on costs so that the Australian Government had adequate control over the cost of the arrangements.

Aged care services, and especially residential care services, offer a mix of services. Nursing care, for example, is clearly a health service while hotel and accommodation services are not. The financing arrangements, in particular the public/private payment mix, for residential care services need to take into account the differing approaches taken in the wider economy to health and welfare services.

The public/private financing mix for hotel and accommodation services needs to accord with the wider approach to welfare service. In particular, the financing of these services should be seen as an individual responsibility, with the Australian Government only supporting those older people unable to provide for themselves, and only supporting them to the extent that they are unable to provide for themselves. Moreover, the level of public support for these welfare services in residential care services should not exceed that provided to older people in the community. In essence, this means that the Australian Government's support for the provision of welfare services in residential care services should be restricted to the payment of pensions and, where necessary, rent assistance to older people. Older people in the community are expected to meet these expenses themselves, out of their private means or out of income support payments, and the same should be true of older people in residential care services.

The situation with respect to health services is more complex, not least because of the variety of approaches taken to the financing of health services already. For example, all Australians are entitled to free public hospital care and, in addition, have the option of taking out private hospital insurance which subsidises access to less essential services. All Australians are entitled to subsidised pharmaceuticals, but the level of the subsidy depends upon the financial circumstances of the individual and all individuals are required to make a regulated co-payment. However, not all pharmaceuticals are covered by the subsidy arrangements and individuals can take out private insurance against the cost of these pharmaceuticals. With respect to medical services, all Australians are entitled to a standard non-means-tested subsidy, but unlike pharmaceuticals the level of co-payment is not regulated and bulk-billing means that some people do not make a co-payment at all.

The situation is made more complex by the variety of personal care services offered in residential care services that seem to be neither hotel and accommodation services nor clearly health services. These services arguably fall into the category of ancillary services, the financing of which in the community is considered to be a private responsibility, noting, however, that the community does tend to offer a strictly means-tested safety net of basic ancillary services for those unable to afford to provide for themselves.

This analysis would seem to suggest that the public/private financing of residential care services should be considered under three headings.

- Hotel and accommodation services—these should be seen as a personal responsibility. Australian Government support should be restricted to the level of services that can be provided by income support payments and should only be available through those payments to those who qualify for them. Individuals should be able to use their private resources to purchase additional hotel and accommodation services.

- Personal care services—these should be seen as primarily a personal responsibility, with a limited suite of basic necessary services available at Australian Government expense on a means-tested basis to those who are independently assessed as needing them. Individuals should be able to use their private resources to purchase additional personal care services.
- Health care services—basic necessary services should be provided free of charge to all those who are independently assessed as needing them. A specific co-payment is unnecessary as the bundling of services, together with the financing arrangements for hotel and accommodation and person care services, means that the individual has already made a considerable private contribution. Individuals should be able to use their private resources to purchase additional health care services.

These arrangements would appear to meet the general principles of health and welfare financing. They offer objectively assessed, universal, affordable, equitable access to quality basic services, but do so in a way that encourages self provision and ensures personal and social responsibility. They make use of the strategy of targeted concessions to ensure that the financing arrangements are sustainable to Government.

Two issues need to be addressed, however, if these arrangements are to fit within the current ethos governing health and welfare services. First, an individual's purchasing capacity needs to be maintained over time. Second, the means test needs to be appropriately aligned with the pension arrangements. This includes integrity protections similar to those that apply in the income support arrangements, to ensure that older people make maximum use of their own resources. The data in Table 6–4 illustrates how the proposed arrangements might operate in an idealised payment arrangement.[10]

Table 6–4: Average cost of service streams

	Low care			High care		
	Average cost share	Average annual cost	Maximum annual cost	Average cost share	Average annual cost	Maximum annual cost
Accommodation services	47%	$12 000	$12 000	24%	$12 000	$12 000
Personal and social services	33%	$8 500	$11 000	46%	$23 500	$25 500
Health services	**20%**	**$5 000**	**$8 000**	**30%**	**$15 000**	**$18 000**

All individual consumers would be responsible for the cost of their accommodation services. This would equate to 85 per cent of the pension plus the entire value of rent assistance in the case of pensioner consumers and to an equivalent amount for other consumers. The Australian Government would provide a subsidy to the operator of the residential care service for the cost of the health services provided to the consumer.

[10] The data are derived from the Access Economics ACDC Model of the industry (Review Discussion Paper 1).

The level of this subsidy would vary according to the health needs of the consumer and would be up to $8000 for low care residents and $18 000 for high care residents. The cost of the third category of services, personal and social needs services, would be the joint responsibility of the consumer and the Australian Government.

The current means testing arrangements in residential aged care, a subsidy reduction of 25 per cent of income above the income free area, mean that no resident can be asked to pay more than 255 per cent of the pension in fees. This has the effect of restricting their maximum contribution to their personal care costs to around $17 000, so that the Australian Government can be called on to provide up to $8500 towards the personal care costs of an individual in high care, no matter how wealthy they are. On the other hand, a high income individual receiving low level care can be asked to pay not only for all of their accommodation and personal care but also for all or most of their basic health services. Neither of these outcomes is on all fours with the policy position outlined above.

It seems to the Review, therefore, to be more equitable to lower the upper threshold on the contribution that individuals can be asked to make to $23 000 in the case of low care residents and to increase the threshold in the case of high care residents to $25 500.[11] Indeed, in the interests of administrative simplicity and without stretching the policy position outlined above too far, it might be appropriate to introduce a single threshold of $25 500 for all residents.

Having established the upper threshold, it remains to establish a lower threshold and the rate at which Australian Government subsidy is withdrawn. Since pensioners are allowed to have private income of up to around $3000 (the income test free area) before the pension is reduced, it seems appropriate to allow the same lower threshold for aged care services. In establishing the rate at which Australian Government subsidy is withdrawn it is important to keep in mind the other calls upon an individual's resources. For example, the amount of age pension that an individual receives is already reduced by 40 per cent of the private income of the individual above the income test free area. Currently, the means testing arrangements reduce the level of Australian Government subsidy by 25 per cent of the individual's private income above the income test fee area. Arguably this rate of reduction could be greater. At the 25 per cent rate, an individual receiving high level residential care would not be called upon to meet the full cost of the Australian Government's subsidisation of their accommodation and personal and social services until their private income exceeded $105 000. Moreover, even after taking full responsibility for the basic cost of accommodation and personal and social services they would be left with $79 500 to purchase a higher level of service if desired.

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[11] Note: the discussion here concerns the contribution the individual makes to reducing the payment to the operator of the aged care service by the Australian Government. No comment is made at this stage as to whether providers should be allowed to charge fees in excess of these levels.

A tiered tapered arrangement may be more appropriate, with the Australian Government subsidy reduced by 25 per cent of the private income above the income test free area and below a defined level of, say, twice the pension and then by 50 per cent of any private income above this level. In this case an individual would pay the full cost of their accommodation and personal and social services whenever their income exceeded $68 000. Moreover, even after paying the full basic cost of those services they would be left with at least $42 500 with which to purchase a higher level of service if desired. If the tiered tapered arrangement was stricter, say 75 per cent of income above twice the pension, then individuals with incomes above $53 000 would be required to meet the full cost of their accommodation and personal and social services. After meeting the basic costs, they would be left with at least $29 500 with which to purchase a higher level of service if desired.

In the short term, these changes would do little to reduce the level of the Australian Government's contribution. In the longer term, however, given the improvement in the income profile of older people in the coming decades, these changes will require more older people to take a greater responsibility for their accommodation and personal care services. Moreover, it will do this in a way that is affordable to the individual. Currently 6.9 per cent of older people have income greater than twice the pension (2.8 per cent of older consumers of residential care services). The tiered tapered arrangements outlined above (at the 50 per cent rate) would have reduced the Australian Government's contribution by $32.7 million in 2002–03 (some 0.5 per cent of the total cost of provision). By 2042–43, however, the arrangements would reduce the Australian Government's contribution by $1.2 billion (some 2.2 per cent of the total cost of provision). At the 75 per cent rate the effect would be half as much again. This measure would, therefore, go some way to improving the sustainability of the financing arrangements.

Another issue with the current means testing arrangements is that they do not include any integrity measures. Individuals can gift away assets before entering residential care to avoid the asset test on accommodation payments and can place assets in non-income producing accounts in order to avoid the income test. It seems more appropriate, and administratively simpler, for the same integrity arrangements that apply to the pension's means test to be applied to the aged care means test. These measures would serve to further improve the long term sustainability of the aged care financing arrangements.

6.4.3 The operator's contribution

Operators, as well as purchasers and consumers, have a role in the financing debate. Providers need to seek efficiency, and financing and purchasing arrangements need to encourage efficiency.

It has been asserted that operators of residential care services are unable to substitute labour for technology, or significantly improve workforce practices to improve productivity. On the basis of this, it is concluded that they cannot match the productivity gains made in the acute care sector where technology and workforce reforms have significantly reduced unit costs.[12] However, the analysis by the Centre for Efficiency and Productivity Analysis of the financial returns of low care services over the last seven years indicates that these services have achieved, on average, total factor productivity growth of around 2.0 per cent each year. In other words, output growth has been 2.0 per cent above the growth in inputs during the last seven years. In the financial years 1999–2000, 2000–01 and 2001–02 total factor productivity growth was 8.0 per cent, 6.0 per cent and 7.0 per cent respectively.

[12] Australian Institute for Primary Care (La Trobe University), *Residential Aged Care Funding: Fourth Report*, National Aged Care Alliance, Canberra, 2003.

7. THE SUPPLY OF AGED CARE SERVICES

In 2002–03, the total cost of supplying formal aged care services (residential care services, community care packages and HACC) was $7.8 billion, representing 1.1 per cent of GDP. This is projected, assuming the continuation of current policy, to grow to $106.8 billion (2.3 per cent of GDP) by 2042–43. Table 7–1 provides a breakdown of this expenditure against the major service streams.

Table 7–1: Total cost of supplying formal aged care services, by service stream, 2002–03 to 2042–43 [current policy arrangements]

($m)	2002–03	2012–13	2022–23	2032–33	2042–43
Residential high care	5174.5	9830.0	20 262.8	40 612.6	73 500.9
Residential low care	1531.8	2907.5	5961.3	11 804.5	21 233.0
Community care packages	265.5	339.8	522.3	842.4	1184.5
HACC	862.8	1624.3	3133.3	6182.0	10 900.6
Total sector	**7834.6**	**14 701.6**	**29 879.8**	**59 441.5**	**106 819.0**

Over the next 40 years, the total cost of supplying formal aged care services will more than double in real terms, growing by 113.1 per cent. Most of this growth will be concentrated in the middle two decades. Over the next ten years, the cost of supplying formal aged care services will only grow by 10.8 per cent in real terms, compared to 28.2 per cent and 28.3 per cent in the following two decades. Currently, the cost of supplying residential aged care dominates, accounting for 85.9 per cent of the cost of all formal aged care services. This domination will continue and increase slightly over the next 40 years. By 2042–43, the cost of supplying residential aged care will account for 88.7 per cent of the cost of all formal aged care services.

The growth in the cost of supplying aged care services is determined by two factors; first, growth in the number of services delivered and, second, growth in the average unit cost of those services. The estimates are assuming current policy arrangements.

7.1 Number of services delivered

Currently, the supply of residential care services and community care packages is constrained by the provision ratio, which provides 40 high-care residential places, 50 low-care residential places and 10 community care packages for every 1000 people aged at least 70. The supply of HACC services is constrained by a budget cap. Figure 7–1 shows projected numbers in each service stream under the current constraints. Figure 7–2 provides a ‘close up’ of the projected volumes for residential care services and community care packages.

Figure 7–1: Projected recipients of formal aged care services, by service stream, 2002–03 to 2042–43

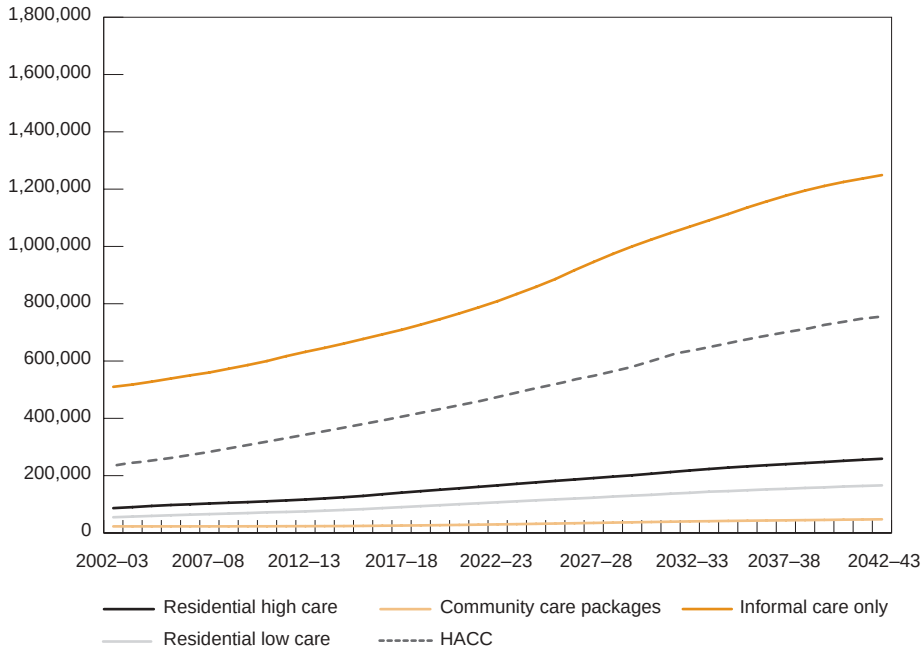
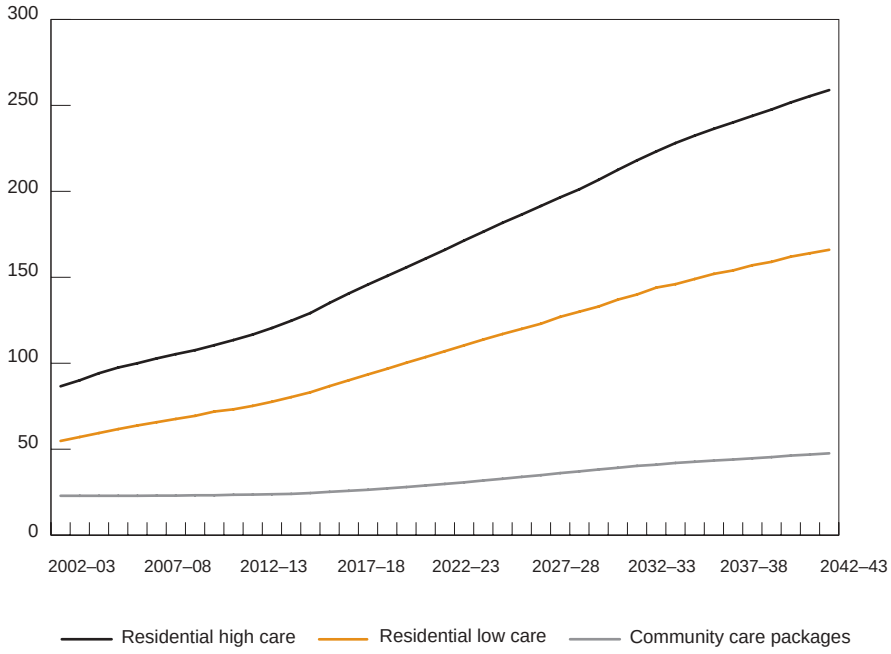
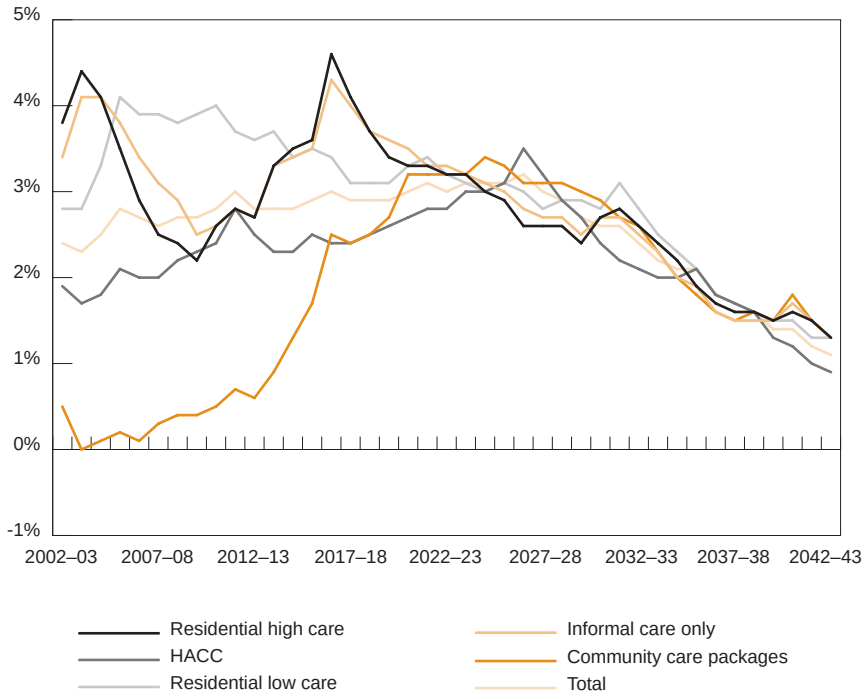


Figure 7–2: Projected recipients of intensive aged care services, by service stream, 2002–03 to 2042–43



Because of the provision ratio, the number of people receiving residential care services and community care packages grows at the same rate as the population aged at least 70. The number of older people receiving HACC services grows at a faster rate because of the real growth currently built into the HACC program budget. Figure 7–3 indicates the growth rates in recipient numbers for the various service streams. Growth rates will generally slow over the immediate forecast period. This is because the number of allocated residential care places and community care packages currently exceeds the ratio. As these places become operational, the level of provision will approach the ratio, and growth in the level of provision will slow before picking up over the next decade. Growth will peak in about 15 years for residential care and a little later for community care packages and HACC. Growth in 'informal care only' recipients is expected to drift down over the next few decades. This is due to the fall in excess demand noted above as relative health status improves and the declining growth in the availability and willingness of informal carers.

Figure 7–3: Growth rates in recipient numbers, by program, 2002–03 to 2042–43



7.2 Unit costs

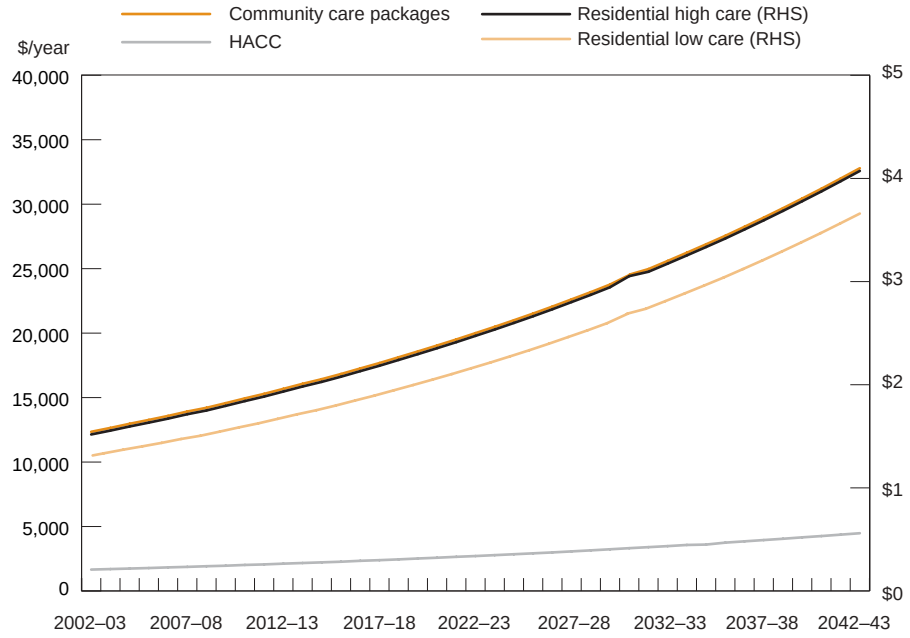
The unit cost of services is driven by the cost of labour, the cost of capital, the cost of materials and the effect of regulatory constraints. The service stream unit costs in 2002–03 are estimated to have been:

- $1528 per recipient of HACC aged 65 or over;
- $12 832 for each community aged care package;

- $27 313 for each residential care low care recipient;
- $54 120 for each residential care high care recipient.

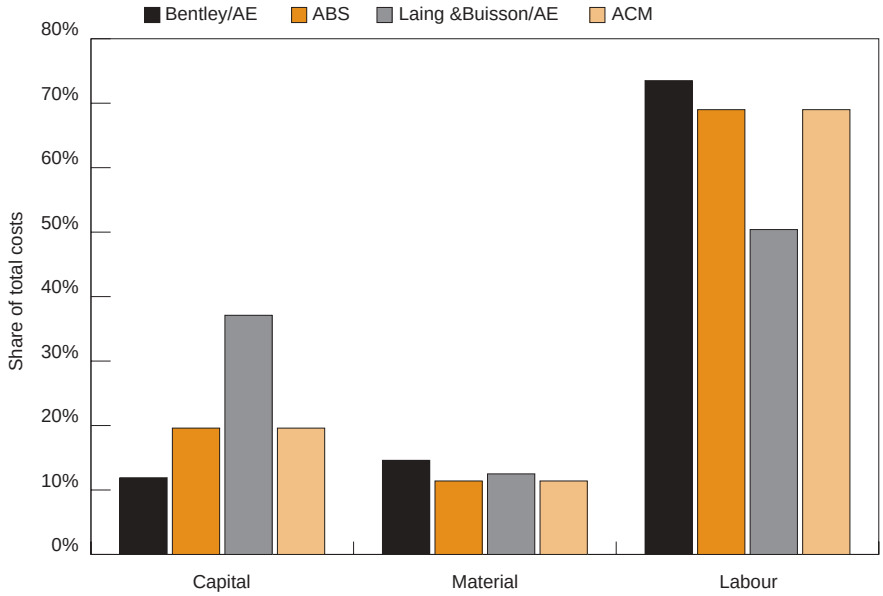
Figure 7–4 shows current and projected unit costs for the major service streams. The residential care unit costs have been converted to dollars per RCS point night (where the latter draws from the Resident Classification Scale scores). Costs in the aged care sector can be expected to rise a little faster than the CPI, owing to its reliance on labour and capital inputs where relative costs may rise over time, such as nurse wage costs, land costs and the cost of improved technology. Moreover, as was noted in the previous chapter, consumers of aged care services and the community are likely to demand that the quality of aged care services improve in line with living standards in the general community increase. The Review's modelling has therefore assumed that the average quality of aged care services will increase at the same pace as living standards in the wider community.

Figure 7–4: Projected unit costs for formal aged care services, by service stream, 2002–03 to 2042–43



At the broadest level, the cost of operating residential care services can be divided up between labour costs, capital costs and intermediate material costs. The labour and capital inputs represent the value-added by the industry. Intermediate costs represent the value added by industries supplying inputs to the residential care services. Figure 7–5 illustrates four different estimates of the allocation of residential care costs according to these three factors.

Figure 7–5: Factor shares of production cost in residential care[1]



Significant cost differences emerge once residential care services are sorted according to their resident mix. For example, the employment of care staff is several times higher for operators of high care residential services. However, a 75/25 split is a reasonable reflection of the cost structure of the residential care sector.

7.2.1 Labour costs

Labour costs are the major component for all aged care services. They account for about three-quarters of residential care costs and a slightly proportion of HACC costs, with the latter higher due to relatively less reliance on higher capital-intensive service streams such as accommodation. Over the long term, labour costs in the economy as a whole can be expected to rise at a rate equal to inflation plus productivity growth. As in the IGR, the Review assumes that labour costs grow by 2.5 per cent a year for CPI growth, plus an additional 1.75 per cent a year for labour productivity growth. However, the wages of skilled nurses (a major component cost for most aged care service streams) should rise faster than average wages. Health care will be one of the faster growing industries over the next few decades. The number of 'frail aged' is

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1 Data are drawn from:

(1) Bentleys MRI & James Underwood and Associates, 2001–02 Aged Care Survey Report, James Underwood and Associates, Brisbane, 2003.

(2) Laing and Buisson. Care of elderly people: market survey 2003, Laing and Buisson, London, 2003

(3) Australian Bureau of Statistics, Community Services: Australia 1999–2000, Cat. No. 8696.0, ABS, Canberra, 2001.

(4) The 2002–03 financial data provided to the Review by approved providers

expected to increase by nearly four times over the same period. Other things being equal, this will increase the demand for a range of aged care services. It will also increase the 'derived demand' for factor inputs, including skilled nursing. Figure 7–6 illustrates the expected increase in the number of staff and the expected change in the mix of staff that will be demanded by the aged care industry over the next 40 years.

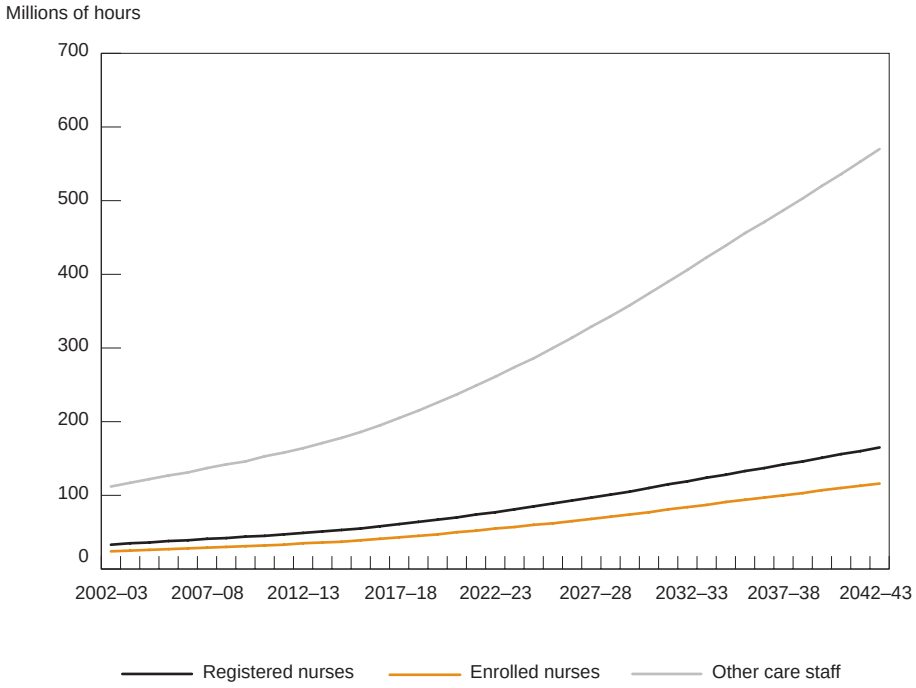


Figure 7–6: Care staff by service stream (hours)

Ordinarily such a large change in demand would be expected to have a number of impacts. For example, the price of those factors complementary to the provision of aged care services, such as nurses' wages, would be expected to rise relative to economy-wide wage levels. On the other hand, the price of those factors substitutable with the provision of aged care services would be expected to fall relative to economy-wide wage levels.

Given the shortage of workers available in this field, individual employers can be expected to offer higher wages to fill vacancies. Indeed wages are likely to be pushed up before any 'full employment' of readily available nurses is even reached, due to factors such as:

- location of employment—some parts of Australia (or even parts of some cities) may have a relative shortage of nurses, which are not filled by available nurses in other areas due to travel costs or relocation costs;
- differing skill sets within the broader nursing profession that may have relative shortages; and
- some workplaces may be considered more 'desirable' than others, so an increase

in positions at such may only be filled by higher wages.

All other developed economies are in a similar position to Australia. Increasingly there is a global market for care workers. For example, the United Kingdom has recently been targeting Australian health care workers to help reduce the shortage of health care workers in the United Kingdom. As with all global forces, increasing competition for limited resources may force more rapid adjustment upon domestic economies than otherwise.

An analysis of sectoral employment and wage growth trends conducted for the Review by Access Economics shows that short term demand pressures can lead to a response from wages, depending of course on the amount of readily available labour not working in the sector when a demand surge occurs. Figure 7–7 shows employment and wage growth over time for the construction industry, and Figure 7–8 shows employment and wage growth over time for the accommodation, cafes and restaurants sector.

The charts show that employment growth has been quite cyclical over the past fifteen years or so for both these sectors, which has also led to some significant variation in average wages paid, often with a lag. The charts show both average weekly earnings (AWE) and average weekly ordinary time earnings (AWOTE). The key difference between the two wage measures is that the former includes overtime payments, which can vary considerably as demand conditions vary. The charts generally show higher peaks and lower troughs in growth for average weekly earnings, with employers using overtime to manage variations in demand. So a sharp increase in demand for nurses would be likely to result in higher wages paid in the short term, partly via overtime payments, and partly as employers seek to attract new staff from the limited pool of available workers.

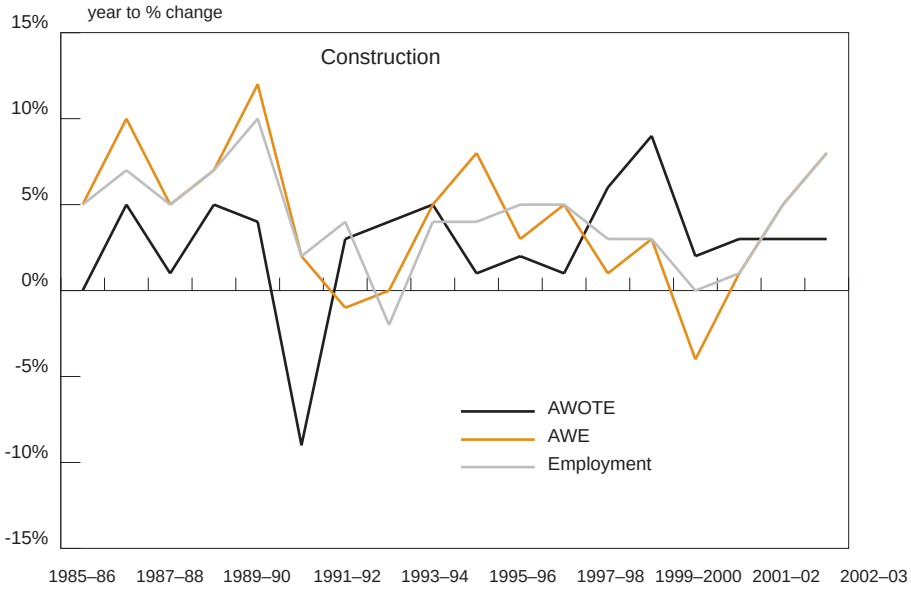


Figure 7–7: Employment and wage growth—Construction industry

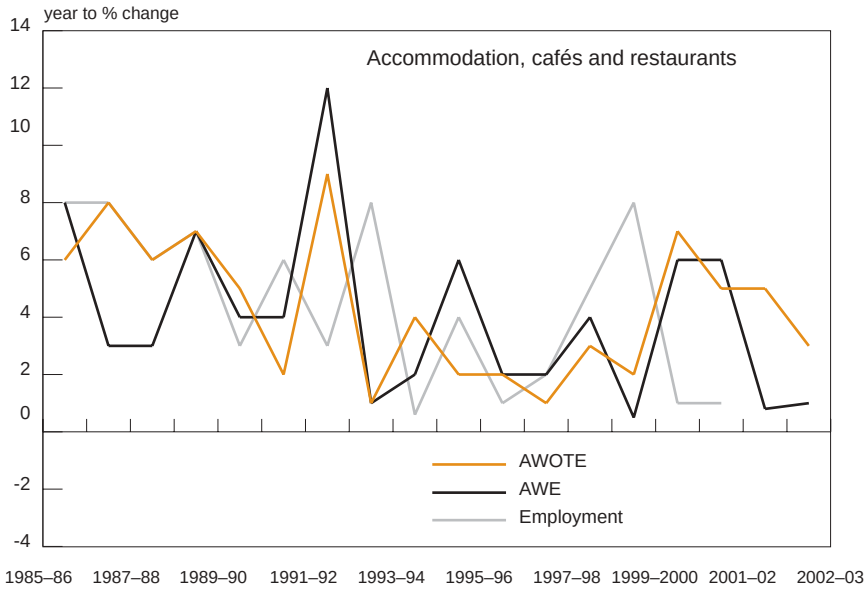
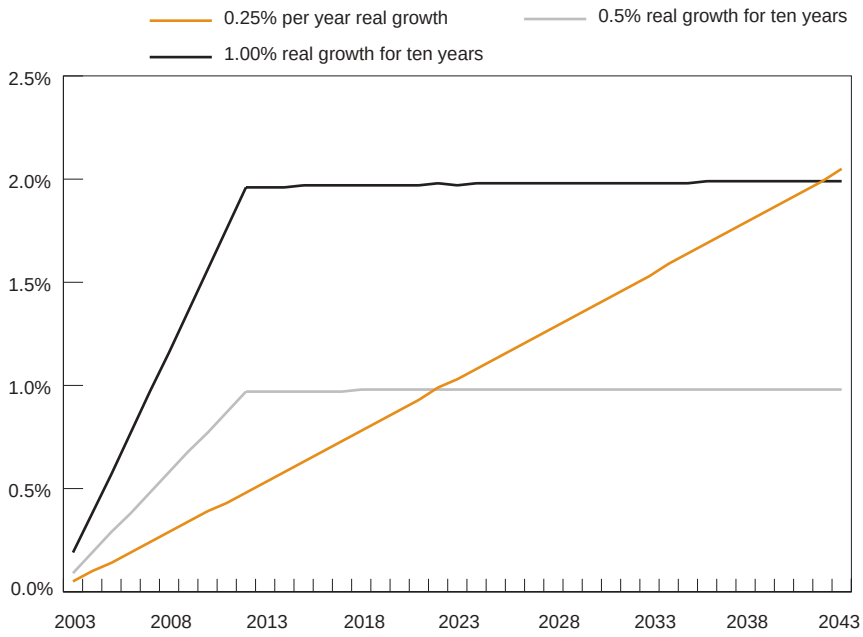


Figure 7–8: Employment and wage growth—Accommodation, cafes and restaurants sector

While short-term changes in demand conditions are likely to produce a response via wage growth, the higher wages may not be sustained over the longer term as more people (aware that positions are available) become qualified and enter the industry/profession. Such a supply side response would drive relative wages back down again. Over the longer term, the wages that nurses might receive relative to other occupations or professions will not be driven so much by demand pressures. Rather, they may be based more on the relative attractiveness of nursing as a career, including the skills required in nursing and the period of time required to obtain those skills.

On balance, the Review has assumed that the unit labour costs of nurses will grow faster than average wages in the economy, by 0.25 per cent a year. Across a 40-year time horizon, that assumption sees nurse wage rates rise by 10.5 per cent in relative terms. As Figure 7–9 illustrates, this would increase the cost of supplying aged care services by 2.05 per cent in 2043. Figure 9 also considers two other scenarios. In the first, nurse wages increase by 0.5 per cent per year faster than average wages until 2013 and then rise with average wages. This would increase the cost of supplying aged care services by 0.98 per cent by 2043. In the second scenario, nurse wages increase by 1.0 per cent per year faster than average wages until 2013 and then rise with average wages. This would increase the cost of supplying aged care services by 1.99 per cent by 2043.

Figure 7–9: Additional cost of supplying aged care services due to real growth in nurse wages



7.2.2 Capital and other costs

Aged care services require, to a greater or lesser extent, capital as well as labour inputs. Capital inputs include land, buildings, plant and equipment and working capital. Of these, the first two, land and buildings, are particularly important in the provision of residential care services and less significant in the provision of home care services, with community care services probably somewhere in between. Box 7–1 outlines the depreciation of buildings and plant and equipment. The opportunity cost of land are also relevant capital flows.

Box 7–1: Estimated costs of building aged care homes

The review estimates that operators of residential care services require capital of between approximately $74 000 and $85 000 per place in order to establish a residential care service, excluding the cost of land and site-specific costs. This consists of between $60 000 and $65 000 for building, $5000 and $7500 for fittings, $3815 and $6910 in working capital, and $4800 and $5200 in professional fees. The average cost of land is estimated at $8300 per place, but varies significantly depending upon location.

The Review obtained evidence on the cost of building residential care services from submissions to the Review, the Department's annual survey of building activity, Rawlinsons Construction Cost Guide, a report by Rider Hunt commissioned by the Review, the survey of financial data conducted for the Review by KPMG and other publicly available information.

Land

The cost of land required by a residential care service is determined by two factors: the amount of land required and the unit cost of land. The former varies depending on whether the home is multi-storey and on the degree of outside area. However, it is reasonable to assume that a single storey building will have a footprint of about 50 per cent of the available block. Given the current average floor area per bed, it appears reasonable to assume that providers will require around 90 square metres per bed, for single storey residential care services.

Box 7–1: Estimated costs of building aged care homes (continued)

The unit price of land varies by region from over $300 per square metre in inner Sydney to under $20 in rural Tasmania. A weighted average of land prices outside the Melbourne and Sydney inner urban areas provides an estimate of around $95 per square metre or $8300 per place.

Land is not consumed and so it is not necessary to provide a return of this investment to the operator of the residential care service.

The cost of land can be expected to rise by more than the CPI however. Unlike the other factors, 'unit' land costs do not benefit from the cost-saving benefits of productivity growth over time. Indeed land—as with other essentially non-reproducible items—can be expected to become relatively scarcer as ordinary goods and services become more common. As a first approximation, the cost of land can therefore be expected to increase in line with the CPI plus real GDP growth (that is, land costs can be assumed to grow in line with nominal GDP).

Buildings

The cost of building an aged care home varies significantly depending on a range of factors including the gross floor area per resident, the number of residents per room and per ensuite, the quality of the finish, the scale of the home, the building location and the need to accommodate particular resident needs (for example, those of dementia sufferers).

It is noted that while there is no mandatory minimum gross floor area per resident in the Australian Government certification requirements for residential care services, this may be specified in state and territory government regulations. The evidence analysed by the Review suggests that a gross floor area per resident of between 40 and 50 square metres is typical.

On the basis of the evidence analysed, the Review considers that it is possible to build an aged care home that meets the 2008 certification requirements for between $60 000 and $65 000 per bed (building costs only).

Fittings

Fittings in aged care homes include laundry equipment, kitchen equipment, resident care equipment, lifting equipment, rehabilitation equipment, basic recreational/lounge room furniture and basic dining room furniture. Most aged care homes allow residents to bring furniture from their previous place of residence and thus bedroom furniture might only include the cost of the bed (depending on care level) and some storage space.

Obviously, the cost spent on fittings varies depending upon the quality and extensiveness of facilities provided by the home. The Review's analysis indicates that the cost to fulfil the basic requirements of residents is approximately $5000 to $7500 per place.

Working capital

Because residential care services are currently paid in advance they arguably do not require working capital. However, a reasonable estimate of the working capital requirement is given by one twelfth of the annual turnover per place. That is, between $3815 to $6910 per place. The amount of the working capital requirement would increase with the cost of care.

Professional fees

Professional fees for the design and administration of building contracts are estimated to be between $4800 and $5200.

Within residential care the level of capital input required is determined by regulation, by consumer demand and by the choices of operators. The first two factors are concerned with the quality of accommodation and relate to the gross floor area per resident, the

number of residents in each room, and the number and scope of facilities provided in the residential care service. Operator choice also affects the level of capital investment required, through capital–labour substitution and through market differentiation.

The costs of buildings, plant and equipment, and materials are all linked in the long run to the CPI, although history suggests that equipment costs in aged care may rise faster than this in the short term because of improving technology. The cost of land is likely to rise by more than the CPI because, unlike the other factors, unit land costs do not benefit from the cost-saving benefits of productivity growth over time. Indeed land—as with other essentially non-reproducible items—can be expected to become relatively scarcer as ordinary goods and services become more common. For this reason the Review has assumed that the cost of land will increase with CPI plus real GDP growth (that is, land costs grow in line with nominal GDP). Land and building costs also vary markedly by location. Since the 1997 structural reform of aged care, the residential care industry has engaged in considerable building activity (Table 7–2).

Table 7–2: Estimated Building work in residential aged care, 2000–01 to 2002–03

	2000–01	2001–02	2002–03
New building work			
Proportion of homes that completed new building work in the year	3.3%	2.4%	3.4%
Proportion of homes with new building work in progress at the end of the year	2.7%	3.2%	3.6%
Estimated new building work completed in the year	$232.7m	$232.5m	$421.6m
Estimated new building work in progress at the end of the year	$318.4m	$293.7m	$416.8m
Rebuilding work			
Proportion of homes that completed rebuilding work in the year	1.1%	0.6%	1.0%
Proportion of homes with rebuilding work in progress at the end of the year	2.6%	1.8%	1.5%
Estimated rebuilding work completed in the year	$74.1m	$72.5m	$82.9m
Estimated rebuilding work in progress at the end of the year	$260.7m	$232.6m	$153.0m
Upgrading work			
Proportion of homes that completed upgrading work in the year	17.3%	18.4%	18.9%
Proportion of homes with upgrading work in progress at the end of the year	9.5%	8.9%	7.8%
Estimated upgrading work completed in the year	$195.9m	$243.5m	$316.9m
Estimated upgrading work in progress at the end of the year	$191.3m	$272.3m	$371.9m
Planned building work			
Proportion of homes that were planning new building work	16.1%	10.4%	7.7%
Proportion of homes that were planning rebuilding work	9.2%	3.8%	2.0%
Proportion of homes that were planning upgrading work	29%	21.0%	16.9%

Note: New building is defined as work relating to a new building to accommodate new or transferred aged care places; rebuilding work is defined as the complete demolition and reconstruction of an approved service on the same site; upgrading work is defined as renovation or refurbishment of an existing service including extensions.

Source: Department of Health and Ageing, unpublished data based on annual surveys of building activity in the residential care sector.

It is clear that, despite expressed misgivings about access to funding by providers, significant levels of investment in new buildings as well as rebuilding and upgrading works are being undertaken, and the expectation is for this expansion to continue.

Table 7–2 shows an estimated total of $821.4 million of new building, refurbishment and upgrading work completed during 2002–03, involving an estimated 22.8 per cent of all residential aged care services. Furthermore an estimated $941.7 million of work was in progress at 30 June 2003. This estimate points to a concentration on new and larger homes because it was spread across a much lesser proportion of total facilities at about 11.7 per cent. There are good reasons to be confident about the progress of new building as well as refurbishment by one means or another. At June 2003, 24.7 per cent of homes were planning new building work.[2]

The Review estimates that, over the next 10 years, the capital requirement of the sector, to meet the growing demand for residential care services, will be in the order of $9.2 billion.

Return on investment

The appropriate measure of the cost of capital itself is the weighted average cost of capital (WACC) of the cost of debt and the required return on equity, weighted by the aged care service's debt equity ratio. The WACC encapsulates information on the opportunity cost of funds, coupled with information on the relative risks faced by operators of aged care services.

The cost of debt is directly observable in the economy and is lower than the cost of equity, reflecting the lesser degree of risk facing debt holders. The cost of debt can be determined by adding a debt premium and a transaction cost to the risk-free rate observed in the market.[3] Based on these considerations, and recent regulatory decisions, the Review has assumed that the total (nominal) cost of debt is 6.55 per cent.

The cost of equity can be estimated by the Capital Asset Pricing Model (CAPM), which estimates a required return to equity providers in the light of the undiversifiable risk shouldered by investors. CAPM predicts what compensation equity holders will require given the degree to which returns in the aged care industry are correlated with the overall market, since this determines the extent to which the industry risk can be diversified away. Many of the key parameters of the CAPM calculations are generic—

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2 Building activity data for 2002–03 are preliminary and subject to further refinement following detailed analysis of the survey results.

3 The risk-free rate can be estimated from the return on Government bonds (a risk free investment). The average return on five-year Commonwealth bonds in September 2003 was 5.25 per cent. The debt margin can be estimated on the basis of the margins implied by corporate bond issues, The historical evidence points to a high credit raring for bond issues in aged care, which implies a premium at the lower end of the scale, say 120 basis points. Transaction cost premiums are typically of the order of 10 basis points.

for example, the company taxation rate (assumed to be 30 per cent) and the proportion of imputation credits actually distributed (assumed to be 50 per cent). The key industry-specific parameters concern the sector beta (the correlation between risk in the industry and risk in the market as a whole) and the gearing ratio. In estimating these parameters, the Review has examined the published betas of listed residential care service operators in the United Kingdom and the United States[4], and companies involved in residential care in Australia (Table 7–3).

Table 7–3: Correlation between risk in the aged care sector and risk in the market as a whole

Company	Country	Equity beta	Debt equity ratio	Asset beta
Trinity Care plc	UK	0.27	237.8%	0.08
Univent plc	UK	0.31	26.7%	0.24
Matrix Healthcare plc	UK	0.68	353.4%	0.15
Beverley Enterprises IN	US	0.93	107.9%	0.45
Manor Care Inc	US	0.99	34.1%	0.74
National Healthcare Corp	US	0.34	70.5%	0.20
DCA	Aus	0.73	11.0%	0.66
Prime life	Aus	1.05	88.0%	0.59
Ramsay Health care	Aus	0.73	32.0%	0.57
Average		**0.67**	**106.1%**	**0.41**

Given these assumptions, the Review estimates the nominal post-tax return that equity providers would require in order to invest in aged care to be 9.8 per cent. This implies a nominal pre-tax weighted average cost of capital of 9.3 per cent.

However, these returns do not allow for the specific risks faced by the industry. Use of a WACC based on CAPM assumes all risks have been taken into account in the assessment of cash flows of the project or business. Thus it assumes that the assessment of revenue and cost projections take into account the impact of possible upsides and downsides—that is, they are based on the expected value of all possible outcomes, rather than on the most likely outcome. Operators of aged care services, and their capital providers, tend to use a higher cost of capital (often called a capitalisation rate) which includes an allowance for diversifiable risk, instead of using the actuarial

4 PricewaterhouseCoopers LLP, *Study into Rates of Return on Private Finance Initiative Projects in the United Kingdom for the Office of Government Commerce*, PwC LLP, London, 2002 at http://www.pwc.com/uk/eng/about/svcs/pfp/pwc_rorstudy.pdf.

5 Commonwealth Competitive Neutrality Complaints Office, *Rate of Return Issues*, Productivity Commission, Canberra, 1998.

expectation of cash flows. This margin reflects the difference between the expected value of outcomes and the most likely outcome. The Review has allowed an additional component in the WACC of 0.7 per cent to account for this risk, giving a nominal pre-tax weighted average cost of capital of 10.0 per cent.[5] This implies that equity holders will actually require a nominal post tax return on investment of 10.9 per cent.

This rate of return is slightly lower than the average rate of return on equity earned in Australian industries (around 15.0 per cent in 2000–01). This reflects the lower risk profile of the aged care industry, which receives the majority of its funding from the Australian Government and which operates in a growing market. Australian industry returns in 2000–01 varied from 7.0 per cent for the heavily regulated utility sector to 20.0 per cent for private community services sector. So, the suggested return is in the lower mid-range of Australian outcomes. Returns on equity earned in the aged care accommodation industry in the United Kingdom and the United States are below the level the Review suggests for Australia. In the United States, the average return on (book) equity of nursing and personal care facilities was 5.1 per cent in 2002.[6] However, it should be noted that the low level of returns in the United Kingdom and the United States have resulted in a number of bankruptcies in both countries On the other hand, several operators in the United States made quite high returns.

Return of investment

As noted above, another integral part of the cost of providing aged care services is the cost of the capital actually consumed in the production of those services. Some parts of the capital investment in aged care services, land and working capital, are not consumed while others, plant and equipment and buildings, are consumed. The appropriate mechanism to build these costs into the pricing arrangements is through an allowance for depreciating assets that is repaid over the assets' useful life.

Division 40 of the *Income Tax Assessment Act 1997* allows taxpayers to claim a capital allowance for depreciating assets, this represents capital expenditure incurred by a taxpayer on plant (depreciating assets). Capital allowances are tax deductions that compensate taxpayers for the obsolescence and wear and tear of an asset. Division 43 of the *Income Tax Assessment Act 1997* allows taxpayers to claim capital works deductions, commonly known as building allowances, to write off certain capital expenditure incurred on the construction, acquisition or refurbishment of income producing buildings. Expenditure that is incurred on repairs and maintenance is a revenue expense and, as such, is subject to different provisions.

Capital allowances and capital works allowances defer the payment of tax on profits by reducing assessable income. The deductions are recouped through balancing

6 This is based on returns from 15 303 active corporations. Book equity is based on the book value used for income tax reporting purposes and is affected by the predominant accounting method.

adjustments and capital gains tax when the asset is sold. Only the amount of the actual loss in value of the asset is protected. However, there are substantial timing advantages to be made in claiming the deductions.

For pricing purposes, the rates of the capital allowances and capital works allowances should reflect the effective life of assets used in an industry. A small number of types of plant and equipment used in residential care services have had their effective lives determined by the Australian Taxation Office; this in turn determines the relevant capital allowances for these items (for taxation purposes).[7] On average, it seems appropriate to allow a capital allowance of around 8.0 per cent for plant and equipment in the aged care sector—this represents an average effective life of 12.5 years for plant and equipment.

Over the last three years the residential care industry has, on average, built or rebuilt 4.0 per cent of its infrastructure each year—this implies an effective life of 25 years and a capital works allowance rate of 4.0 per cent. Although it is possible to build this rate into the pricing arrangements, the full advantage of this rate cannot be achieved by for-profit operators without increasing the income tax capital allowance rate for residential care services from its current level of 2.5 per cent to 4.0 per cent.[8] The Review draws attention to this feature because of the differential impact in an industry where so many participants are exempt from taxation. This aspect is heightened by the requirements for continuous improvement in the industry. Hence, the Review judges a need exists for the depreciation allowance to be reviewed on equity and efficiency grounds.

The impact of increases in non-labour costs

The Consumer Price Index (CPI) measures the changes in the price of a fixed basket of goods and services acquired by metropolitan private household consumers.[9] Because the expenditure classes and the higher level subgroups and groups that make up the structure

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7 Income Tax (Effective Life of Depreciating Assets) Amendment Determination 2003 (No. 2)

8 Over the years, the level of Capital Works Allowances claimable has varied from 0.0 per cent to 2.5 per cent to 4.0 per cent per annum, reflecting past government policies whether to stimulate or slow down the investment/building economy. The capital works allowance currently applicable in the residential aged care sector is 2.5 per cent (representing an effective life of aged care buildings of 40 years).

9 The basket of goods comprises a range of items typically purchased by households. The basket of goods is divided into eleven major groups each representing a specific major area of household expenditure: Food; Alcohol and tobacco; Clothing and footwear; Housing; Household furnishings, supplies and services; Health; Transportation; Communication; Recreation; Education and Miscellaneous. These groups are in turn divided into 34 subgroups and the subgroups into 89 expenditure classes. Each expenditure class in the basket of goods is weighted according to its level of use in a typical metropolitan private household. Measures of the relative share of expenditure on each of the 89 expenditure classes are taken from the Household Expenditure Survey—Australian Bureau of Statistics, *A Guide to the Consumer Price Index, 14th Series*, Cat. No. 6440.0, ABS, Canberra, 2003.

10 Australian Bureau of Statistics, *Australian Consumer Price Index: Concepts, Sources and Methods 2003*, 14th Series, Cat. No. 6461.0 para 5.14, ABS, Canberra, 2003.

of the CPI are based on typical metropolitan private household expenditure patterns, they do not represent the kind of expenditure that is incurred in other kinds of living situations.[10] In particular, there are a number of areas of expenditure that have little or no relevance to expenditure patterns incurred by residential care services. In addition the weighting given to some expenditure groups and subgroups are deficient in that they do not recognise the higher level of expenditure incurred in these areas in an institutional setting compared to a private household. Some of the items in the CPI basket are not expenditure items that the operator of the residential care service incurs. Rather they are met personally by the consumer or not at all, because the consumers of residential care services are not able to exercise certain classes of discretionary expenditure due to age, illness and frailty. Items that are personal expenses to consumers themselves, and therefore not part of the cost structure of an a residential care services, include tobacco, clothing and footwear, health services and hairdressing and personal care services. Items that are unlikely to be consumed by consumers of residential; care include meals out and take away foods; urban transport fares most of the sport and other recreation category; holiday travel and accommodation; education and child care.

Together these items account for over a quarter of the current CPI. Price movements in these expenditure categories that were out of line with price movements in other expenditure categories could therefore seriously misstate the movement of costs in residential care. The Review therefore constructed a new Residential Care Non-Labour Cost Index by reweighting the remaining items in the CPI basket to reflect the expenditure likely to occur in a residential care service. It turns out, however, that this reweighting does not significantly affect the movement of the CPI. Between June 2000 and September 2003 the CPI increased by 12.6 per cent, while the new Residential Care Non-Labour Cost Index increased by 12.8 per cent. The Review has, therefore, continued to use the CPI in its projections of the increase in non-labour costs.

7.3 Indexation and pricing

This approach to pricing may be extended to a broader appraisal of indexation. Current indexation arrangements were introduced in 1995 reflecting moves away from an awards-based system to one where wage increases are based on individual agreements between employers and employees and recognise productivity gains.

These changes from an input cost model were determined by financial and accountability concerns reflecting a move away from input cost pricing to an outcome based framework. This strategic shift was to be sustained with abandonment of a centralised wage fixing system for enterprise bargaining where wage increases were based on productivity gains and agreements between employers and employees at the workplace level. The changes applied to all Commonwealth Own Purpose Outlays, hence the term COPO indexation. The new policy affected 183 programs and represented about one quarter of the Commonwealth's budget in 1995.

The Wage Cost Index (WCI) provided under the new arrangements is based on a range of index mixes depending on the weighting of wage costs (ie 40 per cent, 60 per cent, 75 per cent and 90 per cent) and other costs in the particular program being reviewed. There are ten indices currently in use with the weightings for individual programs depending on how expenditure is apportioned between wage and other costs. The WCI used for residential aged care subsidies has one of the higher weightings for wage costs, at 75 per cent.

7.3.1 Measurement

The WCI used for residential aged care subsidies and supplements is WCI_9 which is a weighted index of 75 per cent Safety Net Adjustment (SNA) as determined by the Australian Industrial Relations Commission (AIRC) from time to time and 25 per cent Consumer Price Index (CPI) to the March quarter. Subsidy rates and supplements are indexed on 1 July each year.

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. Thus the pricing process is not transparent. There is potential for a lagged adjustment as the expected prices are corrected in the next annual round.

The COPO indexation arrangements came into effect with respect to residential aged care funding from 1 July 1996. From this date the nexus between variations to state-based nursing home rates and state award increases encompassed in the CAM element of funding was broken, and subsidy rates were thereafter indexed in accordance with the Wage Cost Index 1 (WCI_1) for all nursing homes though on still existing differential bases.

7.3.2 Other adjustments

The structural reforms embodied in the *Aged Care Act 1997* consolidated the previously separate nursing home and hostel systems into a single funding and classification structure using the Resident Classification Scale (RCS). The new structure was based on providing funding matched to the care needs of residents and focussed on the outputs that the Australian Government needed to purchase in order to ensure that quality care was being provided rather than the cost of funding inputs.

There is an argument that to some extent efficiencies are already being realised by government in the industry in terms of certification and accreditation requirements. The imposition by government of an overarching continuous improvement objective, especially in relation to the prospective 2008 building certification standards, within a heavily regulated market, limits the normal discretionary decision-making capacity of businesses to increase prices to cover increasing costs due to changes in external policy or regulation. This may further strengthen the argument that there are

limitations to the capacity of employers to fund wages growth, however, this claim warrants closer examination.

Without the capacity to increase the wages of nurses in the aged care sector providers argue that they are having increasing difficulties in attracting and maintaining suitably qualified nursing staff to the sector. This is compounded by the Australia-wide (indeed world-wide) shortage of nurses.

The Australian Government continues to emphasise that it does not set wages for nursing staff through either the award or enterprise bargaining structures. Employment and industrial award issues are matters between staff and providers at the enterprise level, or as determined by the federal or state industrial tribunals, under the relevant Australian Government or state regulatory framework.

Although this represents the policy objective, there are a number of forces at play in the industrial relations and wage setting arena acting as disincentives to engage in enterprise bargaining in a meaningful and committed way. These disincentives act to bolster claims by industry that it has limited capacity to enter into enterprise bargaining arrangements with staff but the claims need to be examined on their merits.

Most employees in the aged care sector are covered by state or private sector awards as a result of the historical state-based CAM/SAM funding system existing prior to the current arrangements under which wage costs under relevant award increases were incorporated in the funding formula. Unions covering these workers have been reluctant to embrace enterprise bargaining, preferring to continue to seek improvements in wages and conditions through the award system.

This raises the issue of why employers would willingly forgo opportunities to negotiate on their own terms in an enterprise bargaining mode, rather than subject themselves to decisions made by a third party arbitrator against which there is no appeal, and to which they are then bound in any resulting agreement. These situations where AIRC intervention has been sought, beg the question as to whether moral hazard is not playing a part here. If employers were operating in a wholly market-based user-pays system, and not receiving the bulk of their funding from the Australian Government there would be considerably greater incentives on them to keep the enterprise bargaining open, and to try harder to reach agreements with their employees.

The current funding arrangements provide a disincentive to this happening. It is much easier for employers to complain that they have no ability to enter into enterprise bargaining arrangements because they have no capacity to pay because the Australian Government is not funding to an adequate level.

7.3.3 Industry capacity to pay

There may be some merit in the case put by industry that efficiencies are already being realised by government in the industry through certification and accreditation, limiting

their scope to cope with other cost increases in a regulated market. Yet the evidence from the financial data collected by KPMG and the efficiency studies referred to earlier, tell otherwise. The experiences differ widely between providers by category as well as by state.

A proportion of funding is derived from outside government subsidies. Resident fees and charges are indexed either to the Consumer Price Index (CPI) or the Male Total Average Weekly Earnings (MTAWE), whichever is greater. Then there are retention monies from accommodation bonds. The limit to the value of bonds that can be charged is what the market will bear subject to a minimum asset level that each resident must be able to retain. Interest earned through investment of residents' bond balances is at market rates.

The labour cost estimates discussed in Chapter 3 provide an extraordinary insight not previously available, into labour costs in relation to total costs. For the purposes of any appraisal of indexation, most important of all is the variability of the labour cost to total cost ratio between and within states. Differences by locality, sectors within the industry and resident mix are no less impressive.

Given this evidence there are no grounds for thinking any conventional indexation procedure, whatever the precise measure used, would satisfy the perceived needs of many providers. Half or more might judge their position not to have been met. Changed indexation arrangements would merely form the basis for yet another round of complaints and claims for more funding.

The strategy developed for the Review is to foster efficiency and productivity in order to secure reductions in the real costs of aged care, especially in the residential sphere but not exclusively so.

In place of further adaptation of existing indexation arrangements a new approach is recommended. This is a Conditional Incentive Supplement applying over the next four years, in addition to existing indexation arrangements, but subject to review as to the productivity and efficiency gains secured during that time. Given the analyses developed within the Review, providers should be able to develop appraisals of their performance. The Productivity Commission is well placed to conduct the Review.

The concepts of productivity and efficiency should be understood as embracing commitment to workforce training and enterprise bargaining. Recommendation 13 spells out the commitment. Recommendation 14 complements the earlier recommendation by providing for expansion of the existing aged care information infrastructure. The Australian Institute of Health and Welfare should be active in the collection of data to illuminate choices for residents and their families as well as industry data, especially collections helping reveal efficiency and productivity measures.

8. CAPITAL GENERATION, PRUDENTIAL REGULATION AND GOVERNANCE

8.1 Capital generation

Providers' capacity to generate capital is affected by the arrangements set down by the legislative framework, the wider context of capital funding for aged care, the sources of capital that can be brought to the industry and the levels of funding from these sources. Optimising capital depends on a range of factors including characteristics of the industry, residents and financial markets, practices within the industry (including the current use of accommodation bonds as capital) and prudential matters. No less important is considering how the current arrangements affect residents, their families and the community's support for aged care.

As 2008 becomes closer there is again debate around the adequacy of capital arrangements to meet the requirements and the overall level of capital needed for growth to meet increased demand.[1]

There is a dearth of information about the sources of funds to support expenditure on buildings, plant and equipment. Historically, there was reliance on donations and bequests as well as government capital grants. All these have diminished relatively in recent decades to be offset by borrowings, mainly from banks, and private equity sources with the for profit entities. There has been little recourse to private debt placements let alone raisings directly in the capital market.

In the past five decades there has been considerable reliance on drawing upon funds from residents. In an important sense, many participating facilities in earlier decades drew their financial substance from what may now be thought of as accommodation bonds. Prior to the 1997 Act, hostels required entry contributions and this practice was embodied in the new arrangements so perpetuating what amounted to long-standing funding.

However, there was no similar arrangement in the nursing home sector. What was in place prior to the Aged Care Act was provision for 'exempt institutions', who were allowed to require payment of equivalents to accommodation bonds. What is now termed 'extra service high care' is the revised version of the previous exempt institution provisions.

Thus there is no issue in principle for distinguishing between high care and low care in allowing the application of accommodation bonds or some like instrument.

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[1] See, for example, Submissions 8, p.18; 131, p.1; and 35, p.2.

The most desirable outcome would be to have accommodation bonds applicable to standard high care on the same basis as applies now to extra service high care and all low care places. However, the Review has observed the recent decision to extend the proportion of high care extra service places to 15 per cent. Another possibility would be to further extend the proportion to 30 per cent. This could stimulate greatly the flow of resources into new high care facilities though it might not aid directly the concessional and assisted residents requiring high care.

A further possibility would be to remove constraints on the provision of extra service places entirely. The places would not form part of the annual allocation. There would be no subsidies available, but providers would still be required to fulfil accreditation standards. This means providers would be free to set their own fees and charges. The major strategic objective from this approach would be to enhance the supply of residential aged care places.

8.1.1 Accommodation payments

Accommodation payments are a contribution to the cost of accommodation and are paid by permanent residents. Only homes that are certified as meeting minimum building standards can charge an accommodation payment.

An accommodation bond is effectively a no-interest loan from the resident to the provider (a form of corporate debt), the level of which is negotiated between the resident and provider. Residents may opt to pay a periodic payment in lieu of a bond, equivalent in value to a lump sum bond, plus interest at a maximum rate set by Government. Periodic payments make regular contributions to cash flow for a period of five years. Alternatively, a resident may pay a combination of a periodic payment and a lump sum bond.

An accommodation charge is effectively a daily rent payment with the maximum rate set by Government according to a formula related to the resident's level of assets. Accommodation charges also provide additional monthly income that contributes to cash flow for a period of five years.

Residents' capital contributions from bonds, periodic payments, accommodation charges and concessional subsidies may be invested by the provider to generate interest and/or borrowed against. Prospective lenders/financiers take into account this capacity of accumulated bonds to leverage additional income to cover debt repayment.[2] Such additional income can be substantial depending on the value of bonds held and invested.

Accommodation bonds may be used to meet the costs of servicing funds raised by debt or equity, to retire debt, or to improve the quality and range of aged care services. At all times providers must manage the investment and expenditure of bonds in such a

[2] Submission 260, p.2.

manner as to ensure they are able to repay the balance of a bond if the resident dies or moves out of the facility. There are no restrictions on where bonds can be held but approved providers must comply with the prudential requirements specified in the Act.

Accommodation bonds are, therefore, unlike any other bond arrangements. The concept is complex and the level of understanding among consumers and some providers is variable. Residents may have difficulty in understanding that providers do not receive the full value of bonds and there are still some providers who appear to treat accumulated bonds as assets, not corporate debt.

8.1.2 Ability to generate capital

Providers' ability to generate capital is influenced by a wide range of factors. These factors relate to geographical location, characteristics of the organisations involved in providing care and their access to financial markets, and the characteristics of residents including:

- the mix of services provided
- location of homes (urban, rural, remote) and relative economic conditions
- resident profile
- the mission and the philosophy of the organisation
- organisational structure as a separate legal entity, a subsidiary in a larger group or linked to other providers by management contracts for accounting, finance and education activities
- management and financial expertise within organisations being boards and management in the case of corporate entities, and owners in the case of partnerships and individual proprietors
- the financial advice being offered to providers and consumers
- access to funding through financial intermediaries
- the performance of the financial institution where the bond capital is invested.

With all this specification of possibilities, the central point is the importance of funding through accommodation bonds is paramount in low care and the lack of provision in standard high care explains the shortcomings in putting in place high care facilities.

8.1.3 The mix of services provided

Bonds may only be charged for low care or for high care with extra service while accommodation charges apply to standard high care. The private and state government sectors provide the bulk of their services in the high care sector while religious, community, charitable and local government operate proportionately more homes in low care than in high care. The private sector has 84.2 per cent of its active services in

the high care sector, whereas the local government sector has 78.8 per cent of its active services in the low care sector and the religious sector 63.8 per cent. The explanation for this concentration on high care places is the prohibition of private providers from offering low care services until the past 10 years. High care places are slightly more concentrated in metropolitan areas.[3] In June 2002, only 3.0 per cent of high care places (2 605 residents) were extra service, a gradual increase from 2.24 per cent in 1999. In addition, 0.45 per cent of low care places (224 residents) were extra service compared to 0.09 per cent in 1999.[4]

While the mix of services operated by a provider is directly relevant to their capacity to attract bonds more critical is the mix of places held by individual providers and residents' capacity to pay. Although private providers operate mostly high care places, they attract the highest proportion of high value bonds and the lowest proportion of low value bonds.

8.1.4 Location of homes

Slightly more high care services than low care services are located in capital cities, with other metropolitan, rural and remote areas having slightly higher proportions of low care services relative to high care. Over half of active services in capital cities are high care, whereas in both rural and remote areas high care constitutes less than 40 per cent of active services.

The capacity to attract bonds and the value of bonds is influenced by the economic conditions and, consequently, real estate prices in an area. One provider referred to the 'capital drought' in rural areas faced with significant fluctuations in economic conditions. The Uniting Church with homes spread across Western Australia considers that the notion of funding capital through bonds in rural areas is fundamentally flawed, not least because there are particular difficulties when assets are tied up in the business of a working farm.[5]

Departmental data shows that homes in capital cities have access to higher value bonds than those in rural and remote areas. In 2002–03, the majority of new bonds (53 per cent) taken by capital city homes were valued between $50 001 and $100 000 with 11 per cent valued below $50 000 and 36 per cent valued above $100 000. Similarly, the majority of bonds for rural homes were valued between $50 001 and $100 000 (55 per cent) but a significant proportion (34 per cent) were valued below $50 000 and only 10 per cent valued over $100 000. The differences are even more telling in

3 Review of Pricing Arrangements in Residential Aged Care, *Background Paper No. 1: Context of the Review*, Commonwealth of Australia, 2003, p.22.

4 DoHA unpublished data.

5 See also Submission 295.

remote areas, with 43 per cent of bonds valued between $29 521 and $50 000, and only 24 per cent above $50 000.

The average bond agreed by new residents in capital cities in 2002–03 was $110 493, considerably higher than the average bond in rural ($74 628) and remote ($41 385) areas. Averages in the ACT, NSW and Victoria were over $100 000; Qld, WA and SA had averages between $70 000 and $80 000 while the Tasmanian average was $65 547.[6] These figures mask the actual range of values. Some providers in Tasmania, for example, state that some bonds taken in the 2002–2003 financial year have been as low as $9 000 while the Brotherhood of St Laurence has some quite small bonds, around $4 000 or $5 000.

8.1.5 Resident profile

Many providers actively manage their resident profile to optimise bonds. Others may seek to manage their profile but have limited opportunities to do so given residents' financial resources and their length of stay. On the other hand, some providers choose to take residents on the basis of need.

Managing the resident profile is an integral part of assessing potential residents and waiting lists. However, what may be regarded as prudent management by some providers may be seen as 'cherry picking' by others. This causes some tension across the sector especially where resident choice, or actually gaining access to care are jeopardised. As it was put to the Review, the result of cherry picking for some frail older people is that 'they never get picked':

> …restricted competition in the supply of places and the fact that providers can retain all interest earned on the full accommodation bond amount, gives incentives for providers to target those residents who have the capacity to pay large accommodation bonds, in order to boost revenues.[7]

For some providers, such as those servicing the homeless or remote Aboriginal communities, the notion of managing their client profile to optimise bonds is irrelevant. At Wintringham:

> …in two of our hostels (McLean Lodge which opened in 1993 and Wintringham Port Melbourne which opened in 1996), 78% of our residents came to the hostels with less than $10,000 in assets and an astonishing 60% had less than $1,000. With a client base as poor as ours, it is clearly impossible to be able to use accommodation bonds to subsidise new hostel developments.[8]

Most providers in the Northern Territory also have difficulty generating bonds. Only 23 per cent of homes derive income from accommodation bonds (which equated to just

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6 DoHA, *Census of Aged Care Homes 2003*.

7 Submissions 8, p.ii; 35, p.4; 305, p.88.

8 Submission 282, p.3.

3 active services in June 2002).[9] The total value in bonds held in Northern Territory homes in 2002–03 was around $500 000. Over 90 per cent of Frontier Services clients are concessional residents so there is no ability to fund building within the available resources. They currently operate in deficit which further restricts ability to borrow.[10]

Residents are staying in care longer. The proportion of people staying between 2 and 5 years rose from 23 per cent in June 1999 to 23.4 per cent in June 2002. Those staying for more than 5 years increased from 13.6 per cent in June 1999 to 14.6 per cent in June 2002.[11] Among the long stayers are a substantial number of residents (44 624) who had a permanent admission before 1 October 1997.[12] While the number of pre-1997 residents is falling overall, some homes still have a sizeable proportion of residents quarantined from paying bonds or charges which places severe constraints on financial planning.[13]

Of increasing concern to providers is the impending impact on income as more bond-paying residents reach the maximum five-year period over which accommodation charges may be levied. As at June 2002, 14.6 per cent of residents had a completed length of stay of more than five years, while a further 23.4 per cent had already completed between two and five years stay.[14] As it is now more than five years since accommodation bonds and charges were introduced some homes are experiencing an appreciable decrease in income from the retention amounts and accommodation charges. Further, the time limits on retention payments and accommodation charges are seen as illogical when concessional residents continue to receive the concessional resident supplement without time limit.[15]

8.1.6 The mission or philosophy of the organisation

Some religious, charitable and community providers have argued that requesting bonds from some residents, or in some circumstances, may not be compatible with the mission or philosophy of the organisation. This issue was aired eloquently at consultations in Perth between several providers with both business acumen and a strong sense of mission. While the providers in the discussion might see the extension of bonds to high care as appropriate provided the requirements apply to all high care residents, some of them considered that to privilege some residents could be incompatible with their mission. Whether to convince the Board and the community to accept bonds for high care, or to raise low care bonds closer to a market rate, posed moral dilemmas especially in communities where there has traditionally been strong fundraising to support facilities.

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9 DoHA, *Census of Aged Care Homes 2003 and DoHA*, unpublished data.
10 Submission 135, p.1; see also Submissions 151 and 77.
11 Review of Pricing Arrangements, *Context of the Review*, p. 5, 11.
12 DoHA, unpublished data.
13 Submission 185, p.3.
14 Review of Pricing Arrangements, *Context of the Review*, Table 6.
15 Submissions 247, p.6; and 39, p.1.

Elouera Gardens, for example, is committed to admission on the basis of need alone with no review of assets until after an offer of a place has been accepted.[16] In contrast, the Illawarra Retirement Trust, a community organisation with Public Benevolent Institution and Gift Recipient Status, sees bonds as the preferable way of raising capital. Where possible the Trust avoids commercial borrowing (and is prevented by its status from accessing equity funding) which it considers would divert funds from providing care. Hence the Trust believes that all residents who have the financial capacity should contribute their share provided that they can be offered a range of options suited to their circumstances.[17]

8.1.7 Organisational structure

For providers that are part of a larger corporate entity there may be opportunities for inter-entity capital loans or transfers. While such practices are common among for-profit organisations, they are less common among not-for-profit organisations.

Omega (Australia) and Principal Healthcare Finance Pty Limited, subsidiaries of Omega Worldwide, for example, provide asset management and management advisory services as well as equity and debt capital to their nursing homes. The companies also invest in less than majority positions in firms by providing them with local secure capital. Some churches operate within a centralised structure with bonds held as part of an overall capital fund. Facilities operated by the Uniting Church in New South Wales have access to the Church's Property Trust which is responsible for managing and repaying all accommodation bonds. Others, such as the Baptist Churches, operate totally independently.[18]

Organisations with a portfolio approach to aged care may use capital created in one part of the portfolio to cross-subsidise other forms of care, especially high care. However, as the discussion in Perth mentioned above demonstrated, such an approach does not necessarily fit with the philosophy and mission of some religious and charitable organisations: to meet demand for services, developing retirement villages would provide a mechanism to generate capital but it would also mean moving away from their non-profit motives.

8.1.8 Management and financial expertise

The management and financial expertise within aged care facilities bears directly on their capacity to attract bonds and capital and to optimise the interaction between bonds and other sources of capital and bonds and operational costs. Lending institutions are as interested in the competence of board members as they are in the financial viability of facilities. Evidence received during the consultations indicates

[16] Submission 218, p.2.
[17] Submission 134, pp.9–10.
[18] See, for example, Submissions 164 and 172.

that it is not unusual for banks to require evidence of the governance expertise of every board member and may seek changes in membership before they will consider lending capital in support of capital expenditure.

8.1.9 The financial advice being offered to providers and consumers

Financial advisers are increasingly influencing decisions around bonds. Such advice assists consumers to minimise their capacity to pay bonds or accommodation charges, providers to maximise bond opportunities, and often results in the Australian Government picking up the bill for increased subsidies.

Specialist accounting firms are advising on ways to reduce the financial impact on families of older people entering residential aged care and to maximise their access to pensions and subsidies by:

- Recommending that religious and charitable providers make use of exempt deposit funds which are not subject to Centrelink deeming.
- Recommending to residents that they pay the provider an 'interest free loan' (with no retention amounts applicable) or an additional bond in lieu of fees to minimise deemed income and maintain full pension entitlements.
- Assisting potential residents to structure a family trust in such a way that they get a living allowance but have no access to assets to pay a bond.
- Providing advice on maximising options for attracting bonds in high care (other than extra service) including through transferring low care bonds to high care in lieu of an accommodation charge as the resident moves from low care to high care.

Reverse equity mortgages and similar instruments are being promoted as a way of enabling more residents to make their own capital contribution without having to sell their homes.[19] This type of instrument is not new but has risen to prominence in recent years because the risks have been judged benign in the steady growth economy experienced for the past decade and more. While in the past such products have not proved popular with older Australians, there appears to be renewed interest with new products coming onto the market in recent months.[20] The Commonwealth Bank, St George, and the WA-based Police & Nurses Credit Society are all offering reverse mortgages.[21] Even so, knowledge of such products in Australia is patchy and there are suggestions that consideration should be given to the adequacy of the regulatory

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[19] See, for example, Submission 285, p.35.\

[20] 'Market ready for reverse mortgage concept', http://uninews.unimekb.edu.au/articleid_450.html , 19 March 2003; 'Breaking news: halfway home', http://brw.com.au/stories/20030605/19142.aspx accessed 17 October 2002; Veronica Sheen (COTA), 'Home equity conversion: getting the policy right and getting the product right for older Australians', paper presented to 'Changing Needs, Growing Markets Conference', Sydney, 18 February 2002.

[21] 'Cashing in on new loans for old', The Age, 13 September 2003, www.theage.com.au/text/articles/2003/09/12/1063341771023.htm; 'St George launches Seniors Access Home Loan', 10 December 2002, www.stgeorge.com.au/media_centre/news/2002/ZZZN501E09D.asp

framework surrounding reverse mortgages as has already occurred in the United Kingdom.[22] While such products may increase consumer choice to some extent, their development is a matter for the market with individuals deciding whether such products suit them.

8.1.10 Banks

Banks are more interested in providing loans to both for-profit and not-for-profit providers in the aged care industry and there is growing confidence that many of the providers in the not-for-profit sector are capable of managing their businesses to adequately service debt. Attendees at Consultations stated that BankWest in Western Australia and the National Australia Bank are both increasing their business with the aged care sector. Westpac and the ANZ had established specialist aged care units for some years.

In general, banks are prepared to lend to aged care providers who have a sound business case, on the basis of an 'on completion valuation' taking into consideration the provider's various sources of equity. As a general rule, banks prefer a lending ratio of 65 per cent. Not all banks are enthusiastic and some providers have had difficulty because banks' understanding of the aged care industry is variable. Even though bed licences are commanding a market price, the bank lending ratio against them is low (30 to 40 per cent) compared with normal lending covenants because there is no title attached to a bed allocation.

Some providers believe the key to engaging with the banks is to be more effective in explaining the industry to them and in demonstrating capacity to service debt. This means that not-for-profit providers are tackling a significant cultural shift to enable them to, as one provider put it, 'competently face the executives of a major bank' and demonstrate a strong business case.

Historical circumstances may make some providers less attractive to the financial markets. A number of the older religious and charitable organisations occupy perpetual Crown grant land. In consequence, the value of the land (often now in prime CBD locations) can not be realised through sale nor can it be taken into account in negotiating loans.[23] Homes operated by State Governments may also be at a disadvantage. In Victoria, Government sector providers have very limited access to borrowing. While there is no outright prohibition on borrowing, a facility must put a strong business case to Treasury for approval. Given the client profile of many of the

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[22] Richard Reed and Karen M. Gibler, 'The case for reverse mortgages in Australia: Applying the USA experience', paper presented to the 9th Annual Pacific Rim Real Estate Society (PRRES) Conference, Brisbane, 19–22 January 2003; Review of Pricing Arrangements in Residential Aged Care, *Background Paper No. 3: Long-Term Aged Care—International Perspectives*, Commonwealth of Australia, 2003, pp.26–27.

[23] See, for example, Submission 151.

Government operated homes and consequentially their limited access to substantial bonds, Treasury approval is rarely given.

8.1.11 Comment

The debate over the relative roles of the public and private sectors in financing and providing aged care services has started in many countries. Unlike Australia, for-profit operators have played a largely insignificant role in the provision of aged care services in many OECD countries up until now. However, many countries, including the United Kingdom, Japan and Germany, have been increasingly developing policy incentives to encourage the private provision of aged care services. Increased competition is generally thought of as a means of improving efficiency and quality through increased accountability and choice. However, the unusual institutional features of the market for aged care services have important implications. As the evidence from the United States indicates, improved competition in the market for aged care services would still require careful regulation on quality standards and control over the appropriate level of publicly funded care.

The perceived capital funding dilemmas experienced in the industry can only be understood in the context of the regulatory milieu of a cottage industry. The immediate funding issues are taken up with the major role of accommodation bonds as the funding instrument for residential aged care This concentration on accommodation bonds is a special feature of the residential aged care industry. It is an inheritance from the modes of financing associated with the historical basis for growth of retirement villages and hostels in previous generations.

In as much as the regulatory arrangements evolved for residential aged care had fostered this cottage industry and handicapped any corporate involvement, access to capital funding was frustrated. For profit entities were prohibited from offering low care facilities until about ten years ago. As the Commonwealth reduced its capital grants, the accommodation bond became the instrument for generating funding for investment in new services. The size of the great bulk of providers inhibited access to the capital markets directly while their balance sheets would not have engendered confidence in financial intermediaries such as banks. Prior reliance on Commonwealth capital grants may have done little for a disciplined approach to capital management and the accumulation of reserves; quite the contrary because expectations of continued access to these funds did not foster provisioning for depreciation and replacement. Generosity of governments in past decades cannot justify neglect.

A preference for bonds may indicate a lack of understanding of periodic payments or an analysis of the provider's short and long-term business case. Either way, real consumer choice may be constrained. Providers could be more willing to support informed consumer choice if faced with the prospect of competing for residents. However, while the industry continues to enjoy high capacity rates it is likely that

there will continue to be limited negotiation with residents around their preferred mode of payment.

A handful of providers prefer periodic payments because they are administratively more simple to manage than lump sum bonds and do not incur the costs and risks associated with the prudential management of bonds. Periodic payments provide instant cash flow and earn a better interest rate for the provider (8.78 per cent for residents entering care in the 1 October to 31 December 2003 quarter down from 8.82 in the previous quarter and compared with around 4.5 per cent on invested bonds). In the current low interest rate environment and with the value of the family home increasing in many areas, it is surprising that the periodic payment option is not more frequently favoured.

Changes could be made to arrangements for periodic capital payments to bring them in line with, or blend them with, daily payments. Such a move would improve consumer options for contributing to the capital needed to maintain their 'home' and improve cash flow for servicing debt.[24]

The current notion of a bond that is at once a no interest loan and a source of fees through retention payments is confusing to residents and some providers alike. Bonds should be fully refundable and free of retention payments. Introducing rental type payments would provide an alternative capital stream clearly separate from corporate debt and treated in a manner similar to any other fees no matter how they are derived. To ensure that providers continue to receive a comparable level of capital contributions, the rental payments would be premised on a similar basis to the existing periodic payment: a component equivalent to interest on a lump sum equivalent (nominal bond); and a component to cover the cost of servicing debt per bed. No time limit would apply.

8.2 Accommodation bonds and prudential issues

Accommodation bonds and charges were established as a source of capital for approved providers for the purpose of capital replacement. As at June 2003, an estimated $2.7 billion in bonds was held by the industry, and approximately $124 million in accommodation charges had been received, from which around $90 million in retention amounts was deducted by providers in 2002–03. The value of bonds refunded by providers in 2002–03 was around $733 million, a proportion of which relates to residents moving from low to high care. Where a refunded bond can

[24] Submission 134, p.10. In considering this option residents would need to accept that they could carry greater risk in relation to fluctuations in the cost of capital as they would with their own home.

[25] Department of Health and Ageing, *Census of Aged Care Homes 2003*, Commonwealth of Australia, 2003. This information presents a partial analysis of the responses from the survey that informs the Census. The overall response rate was 85.6 per cent. Where applicable, monetary amounts have been weighted to estimate a total value for each category listed.

be replaced by a new bond of equivalent or higher value there is the prospect of a further full five years income from retention amounts and ongoing interest.[25]

In terms of accommodation charges in the same period, the private sector derived $47 million, the religious sector $36 million, the community sector $14 million, the state government sector $7 million, the charitable sector $14 million and local government $5 million. The extent to which income from accommodation charges is spent on capital upgrades is unknown.

During the course of the Review, advice was sought from the Australian Securities and Investment Commission (ASIC) and the Australian Prudential Regulation Authority (APRA) on the status of accommodation bonds and whether they might be a form of financial product. At issue was whether or not the special form of corporate debt generated as an accommodation bond was a financial product coming under the scrutiny of either ASIC or APRA.

While it seems clear that accommodation bonds are not within APRA's jurisdiction, the same cannot be said about the status of these bonds as a financial product akin to a debenture and thus potentially within ASIC's area of interest. The significance of that possibility lies in the associated requirement for licensing of those offering the financial product. Under section 911A(1) of the *Corporations Act 2001* a person who provides a financial service, ie deals in a financial product, is generally taken to be carrying on a financial services business and therefore requires an Australian Financial Services Licence. However, under section 766C(4) of the Act provides that a transaction entered into by a body corporate is specifically not taken to be 'dealing' in a financial product if the transaction only relates to the body corporate's own debentures.

The implication of this requirement for the management of aged care facilities who take bonds means that they may need to hold an Australian Financial Services Licence, depending on the structure of their facility and whether or not the approved provider is considered to be 'dealing' in a financial product. Such a licence requires a Certificate of Competency authorised by ASIC. While the status of accommodation bonds may be arguable in law, the most effective outcome for the conduct of the industry at this time will be to set up separate provisions for the monitoring of accommodation bond monies.

8.2.1 Prudential regulation of accommodation bonds

While the Act sets out some prudential reporting obligations, it does not specify a mechanism for the holding of accommodation bond balances, nor is there any underwriting mechanism currently in place. If an approved provider goes into liquidation, under the Corporations Law residents who are owed accommodation bonds rank with other unsecured creditors.

There are some minimal prudential requirements under the Act. Approved providers (APs) who hold accommodation bonds are required to submit an annual prudential statement to the Department, signed by the AP and certified by an independent auditor or accountant. This statement must advise:

- whether the accommodation bond balances required to be refunded during the year have been refunded in accordance with the Act;
- whether the AP has had enough insurance throughout the year to cover losses arising from fraud, loss of earnings, fire, flood or other reasonably insurable events that may affect the provider's ability to refund accommodation bond balances; and
- whether the AP can repay liabilities for accommodation bond balances that can be expected to fall due in the following financial year.

Prudential compliance reports are due four months after the end of the financial year. If the reports are not received, providers receive a reminder notice. If reports still are not received, it is up to decision makers in the state and territory offices to either issue a warning or a notice of non-compliance. If a notice of non-compliance is issued, it could result in sanctions being imposed. The possible sanctions are outlined in section 66(1) of the Act and include revocation of or restriction on the approved provider's approval or revoking or suspending the allocation of some or all places, or varying the conditions to which the places are subject.

However, it is not clear that the Department of Health and Ageing undertakes any further investigation into the matters raised in the compliance reports.

8.2.2 Comment

There is an amount of $2.7 billion currently held by approved providers as accommodation bonds and only limited prudential arrangements in place to protect those funds, pending return to the resident or resident's family. The Department of Health and Ageing only deals with the approved provider and has no information about the entity, partnership or individual holding the provider authority and any other associated entities.

The accommodation bond has been an important source of funding in low care residential facilities,. This funding approach is found also in high care Extra Service places. The large sums of money held in these bonds and the lack of a comprehensive arrangement for the monitoring and supervision of the management of these funds is a major source of concern. It is important to recall management must be highly risk averse because they have no prospect of future earnings to recoup losses from failure to repay bonds.

Given the mechanisms by which the fundraising through these bonds is provided for within legislation, the government may be deemed to be exposed to moral hazard. This

possibility should not be set aside lightly even though no substantial concerns have arisen in recent years. There is an obligation on government to ensure these funds are not exposed to risk of any loss. The position as it currently stands is that where sole traders and partnerships go bankrupt or companies go into liquidation, there is little protection for those entitled to reimbursement of bond monies paid.

It is possible that, in some states, retirement village legislation provides some protection for care recipients who have paid accommodation bonds. For example, the Victorian Retirement Villages Act contains an important protection in respect of in-going contributions, whereby a statutory charge is created over the retirement village land.[26] This feature contrasts with the unsecured nature of accommodation bonds generally. However, the position may not be the same in every state. It also does not offer any protection to those residents in facilities which occupy leasehold land, a commonplace situation in Victoria. Hence, information on the status of the landholding on which the facility is located should be in the public domain and made available to all potential residents. Recommendation 9 proposes the establishment of a guarantee fund to address these concerns.

Bonds currently operate in a context in which the Government largely controls the sources and levels of income providers may access. There is little flexibility for providers and consumers to negotiate mutually appropriate modes and levels of payment. The Review is firm in its stance that providers should have greater flexibility in attracting and managing their income and negotiating arrangements with potential consumers.

Consumers need to be more aware of the ways in which they may contribute to funding capital expenditure. There should be a consistent range of choices for residents regardless of whether they are in low care or high care. Access to care should not be jeopardised by a 'one-size-fits-all' approach by providers in negotiating capital contributions. While making provision for a reasonable capital contribution, residents and their families need the option of choosing which form of contribution best meets the needs of the resident and the resident's spouse who may be still living in the family home. Recommendation 19 provides for an amended accommodation payments arrangement.

8.3 Accountability and governance

There is a range of obligations under the *Aged Care Act 1997* in relation to providers' governance and accountability, particularly in relation to gaining approved provider status. Eligibility for approved provider status is set out in detail in the Residential Care Manual, published by DoHA.

[26] See P Hanks, Regulation of residential aged care: Selected legislation and regulation which an aged care provider must comply with, Paper prepared for the Review

Briefly, to be eligible as an approved provider, the applicant must satisfy the Secretary that they are a corporation, and that none of their key personnel[27] is a disqualified individual.[28] The Secretary must also consider:

- the applicant's record of financial management
- the methods that the applicant uses, or proposes to use, in order to ensure sound financial management
- if the applicant has previously provided aged care, its record of financial management relating to the provision of that aged care.[29]

These requirements refer only to those applying for approved provider status after 1 October 1997, as providers operating before 1997 were 'grandfathered' and were not subject to the revised eligibility requirements.

Under the first of the Accreditation Standards, providers are also required to have management systems that are: '...responsive to the needs of residents, their representatives, staff and stakeholders, and the changing environment in which the service operates.'[30] The standard covers a number of areas but includes three key points:

> 1.2: **Regulatory Compliance**—The organisation's management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards and guidelines.
>
> 1.3: **Education and Staff Development**—Management and staff have appropriate knowledge and skills to perform their roles effectively.
>
> 1.5: **Planning and leadership**—The organisation has documented the residential care service's vision, values, philosophy, objectives and commitment to quality throughout the service. [31]

The Act does not require providers to disclose either their financial position or their internal management structures on an ongoing basis. While the accreditation process does require this type of disclosure, it appears to be linked more to quality of care rather than to the financial viability or the state of the organisation.

In addition to certain requirements under the *Aged Care Act 1997*, providers are subject to varying degrees of financial disclosure requirements, depending on their corporate status.

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[27] Key personnel include those responsible for executive decisions of the applicant, anyone else who takes part in management of the applicant, any person responsible for nursing services, any person responsible for day to day operations. See Section 8–1, *Aged Care Act 1997*.

[28] Individuals convicted of an indictable offence, insolvent under administration, or of unsound mind. See Section 8–1, *Aged Care Act 1997*.

[29] See Section 8–3, *Aged Care Act 1997*.

[30] Aged Care Standards and Accreditation Agency, 'Accreditation Standards' at http://www.accreditation.aust.com/accreditation/standards.html#1

[31] Aged Care Standards and Accreditation Agency, 'Accreditation Standards' at http://www.accreditation.aust.com/accreditation/1

8.3.1 User rights and availability of information

One of the objectives of aged care policy is maximisation of choice. A corollary to this is the availability of information about a service and/or the approved provider in charge of the service. Relevant information includes financial information. It is essential that care recipients and their families have available to them information about the financial performance of a facility, given the substantial amounts in accommodation bonds and/or accommodation charges which may be paid to an approved provider. The availability of financial performance information will be more important once the sector is given more flexibility and able to offer services outside the Aged Care Act and for which care recipients may be paying additional fees.

8.3.2 Comment and future directions

The lack of information in the Department of Health and Ageing about an approved provider's financial situation and ongoing viability is problematic given that the Secretary is required to consider the financial viability of a service in making certain decisions under the *Aged Care Act 1997*.

Further, a clear objective of aged care policy is enhancing choice. This can only be achieved if care recipients or potential care recipients have available to them sufficient information on which a valid choice can be based. Such information includes financial information.

The Review judges that measures should be put in place firstly to improve financial management within the industry, secondly to improve governance practices generally and thirdly, to ensure that financial information is available to stakeholders.

Recommendation 15 refers.

9. ENTRY INTO CARE

This chapter discusses the profile of aged care recipients, their assessment for entry into care and the special circumstances of some care recipients, which bears on access to care and the kinds of care received.

9.1 Profile of aged care recipients

In 2002–03, 184 095 people received permanent residential care, 34 025 people received residential respite care, 31 186 received care through a Community Aged Care Package (CACP), and an estimated 700 000 people received services through the Home and Community Care (HACC) program.

The profile of aged care residents as at 30 June 2003 was:

- just over 50 per cent of aged care residents were over the age of 85;
- 72 per cent of residents were female;
- 56 per cent of all female residents were over the age of 85;
- 37 per cent of male residents were over the age of 85;
- 90 per cent of residents were in receipt of a full or part pension—74 per cent received a Centrelink pension and 16 per cent received a DVA pension; and
- 6215 residents were under the age of 65, or 4 per cent of all residents.

Specific comment needs to be made about aged care recipients in the Northern Territory. While the age profile is generally consistent across the other states and territories, the Northern Territory gives a different picture, largely as a result of the higher proportion of indigenous people. Generally speaking, the age profile of care recipients is much younger and a higher proportion of recipients access respite care rather than full-time residential care.

There are proportionately more high care residents than low care, 62 per cent and 38 per cent respectively, and only 2 per cent were RCS category 8. The proportion of high care residents has increased over the last few years from 57.8 per cent in 1998 to 61.8 per cent in 2000, most likely due to the increased availability of community care services.

9.2 Eligibility for care

Under the *Aged Care Act 1997*, responsibility for assessing the eligibility of people for Australian Government subsidised aged care is delegated to ACATs. The assessment for residential care is predicated on the following basic principles.

- Aged and disabled people should, as far as possible, be supported in their own homes, in their own communities.

- Aged and disabled people should be supported by residential services only where other support systems are not appropriate to meet their needs.
- Services should be provided in an atmosphere and using processes which promote rehabilitation and restoration of function. The manner in which services are provided should develop and enhance personal freedom and independent functioning of all residents.
- Services should be based on a recognition that for many people the change to a less supported residential service or to a community-based support service will be a possible and desirable outcome.[1]

A person is eligible to receive residential care if that person has a condition of frailty or disability requiring at least low level continuing personal care and is incapable of living in the community without support. If a person is not an aged person, they can still be deemed to be eligible if there are no other care facilities or services more appropriate to the person's needs.[2] At times, people who are not frail aged nevertheless qualify for residential aged care because there are no other services available to them to meet their care needs. Typically such people will be severely disabled young people or those with special needs, as defined under the Act or Principles.[3]

In accordance with these aims, the Act provides for the provision of a number of aged care places for particular groups of people. People with special needs are identified under the Act as people from Aboriginal and Torres Strait Islander communities, people from non-English speaking (culturally and linguistically diverse) backgrounds, people who live in rural or remote areas, people who are financially or socially disadvantaged, and veterans (including spouses, widows and widowers of veterans).[4]

9.2.1 Entry to care—the Aged Care Assessment Program (ACAP)

The ability to provide subsidised care is not unlimited. Australian Government policy therefore requires that subsidised care should go to those who need it most and for whom it is appropriate. Potentially eligible residents therefore have their care needs assessed by ACATs under the Aged Care Assessment Program (ACAP).

ACATs are funded by the Australian Government through the provision of grants to State and Territory governments to operate ACATs (Aged Care Assessment Services in Victoria). There are currently approximately 120 ACAT teams operational throughout Australia.

The aged care assessment results from the application of a nationally consistent set of eligibility principles. The core objective of the Aged Care Assessment Program is to

1 DoHA, *Aged Care Assessment Program Operational Guidelines*, Commonwealth of Australia, 2002, p. 11.
2 Section 5(5), *Aged Care Act 1997*, p. 125.
3 Section 11(3) *Aged Care Act 1997*, p. 32 and the Aged Care Principles, Pt 2A, p. 88.
4 Section 12(5) *Aged Care Act 1997*.

comprehensively assess the needs of frail older people and to facilitate access to available care services appropriate to their needs. ACAT assessments are free of charge to the person being assessed. The target population for ACATs is all residents within their region who are 70 years or older and all indigenous residents over 50 years of age.

As 'gatekeepers', ACATs are responsible for ensuring that services and Australian Government expenditure are targeted to people genuinely in need. ACATs also have a responsibility to inform consumers of the care options available and to help them choose services most suited to their needs.

ACAT objectives

An ACAT assesses the eligibility of a potential care recipient to determine, first, whether they are eligible for care and, second, at what level the care should be provided (ie low or high care). ACATs take a multi-disciplinary approach to the assessment, assessing the medical, physical, psychological, social and restorative care needs of older people and providing information and assistance to facilitate access to care services. A person may be approved to receive residential, community and/or flexible care.

The ACAT will consult with a person to determine the most appropriate services to meet that person's identified needs and will determine whether they are eligible for one of the following levels of care:

- residential, either high or low care, or residential respite;
- community (CACP); and/or
- flexible care (ie. EACH package-type care).

ACATs also assess residents where care needs are assessed by providers to have moved from low care to high care.

Assessment takes place prior to entry to a facility and remains effective for 12 months and cease on departure from the facility, if care needs change significantly or where a resident requires an extended hospital stay. Annual re-appraisals are required for all existing residents.

If a facility requires a resident to be re-evaluated outside that time frame they must demonstrate that the resident has significantly increased care needs (ie. that there has been a two-category shift).

9.2.2 Australian Government funding for ACATs

Through the Aged Care Assessment Program (ACAP), the Australian Government provides grants to state and territory governments to operate 119 ACATs, and an

5 Evaluation and minimum data set functions for ACT are undertaken by NSW.

Evaluation Unit in each jurisdiction except the ACT.[5] Funding includes components for training and dementia support for assessment.

The Minister for Ageing and Aged Care approves allocations to individual ACATs based on a national funding model. Following concern that the funding model used up to and including 2002–03 no longer resulted in equitable distribution, a new needs-adjusted, population-based funding model has been developed.

Funding for distribution in 2003–04 is based on the new model. It also includes $2.5 million one-off funding provided in the 2003–04 Budget (pending completion of the Review) which is being distributed to the under-funded ACATs. Aggregate funding to states and territories is summarised in Table 9–1.

Table 9–1: Aggregate Australian Government ACAP funding by states and territories, 2003–04

	ACAT $m	Evaluation Unit $m	Training $m	Total $m	% of total	Dementia $m
ACT	0.47	(a)	(b)	**0.47**	1.02	0.00
NSW	15.75	0.29	(b)	**16.01**	34.72	0.42
NT	0.69	0.05	0.05	**0.79**	1.72	0.00
QLD	7.61	0.19	0.02	**7.81**	16.91	0.20
SA	4.05	0.13	0.01	**4.19**	9.08	0.11
TAS	1.17	0.06	0.02	**1.24**	2.69	0.03
VIC	11.28	0.27	0.05	**11.60**	25.11	0.30
WA	3.79	0.19	0.05	**4.04**	8.75	0.09
National Data Repository				**0.11**		
Total(c)	**44.8**	**1.2**	**0.21**	**46.31**	**100.00**	**1.16**

Source: DOHA unpublished data. (a) ACT evaluation funds included in NSW figure; (b) ACT and NSW training funds included in ACAT funding; (c) Variations due to rounding

The financial contribution of the states and territories to ACATs

The states and territories also contribute resources to the ACATs through funding, access to specialist staff to support assessments and access to infrastructure services, access to facilities and to in-patient facilities and rehabilitation services. It is not possible to state accurately the extent of state and territory funding as not all states and territories provide data on the value of their contributions to the Aged Care Assessment Program.

9.2.3 Profile of assessments

In 2001–02, ACATs undertook 197 865 assessments compared with 193 930 in the previous year, an increase of 2.1 per cent. The overall assessment rate was 110 per 1000 people aged 70 years and over.[6] Of these, only 34 assessments (0.02 per cent) were the subject of an appeal.[7]

6 Lincoln Gerontology Centre, *ACAP National Minimum Data Set Report, July 2001 to June 2002*, p. 1.

7 DoHA, *Report on the Operation of the* Aged Care Act 1997, 1 July 2002 to 30 June 2003, p. 15.

Overall, by far the majority of assessments (70.2 per cent) take place in locations other than hospitals. In most states, less than 30 per cent of assessments take place in hospital, except for WA and Victoria with 39.4 and 34.6 per cent, respectively. The number of assessments undertaken in hospitals continues to decline; 27.9 per cent compared with just over 31 per cent in 1999–2000 and 2000–2001, and 34.2 per cent in 1994–95. This represents an average of about 0.7 per cent per year over the period.

The majority of clients (50.1 per cent) assessed by ACATs continue to live in the community with some form of domiciliary assistance as is indicated by ACATs' recommendations for long-term living arrangements in 2001–2002. A further 41.9 per cent were recommended for residential care. The remaining 8.0 per cent had died, cancelled, transferred or were recorded as 'other' or 'unknown'. These figures continue the national trend towards an increased proportion of recommendations for community-based care and a lower proportion of residential care recommendations.[8]

Across jurisdictions there is considerable variation in the mix of recommendations between residential and community care . The relative proportion of community recommendations has increased in all jurisdictions since 1995–96, with the exception of Tasmania and the Northern Territory. While the proportion had fallen in the Northern Territory, it had the second highest level of community recommendations (after the ACT and just ahead of Western Australia), in part reflecting the high proportion of Aboriginal and Torres Strait Islander clients and younger clients assessed. The pattern was reversed for the other jurisdictions. South Australia, Tasmania and Queensland were above the national average for residential care recommendations and well below for community care. This may reflect the fact that clients in these states are referred to ACATs at a later stage when they are more likely to need residential care. Even so, there have been major increases in community recommendations in both South Australia and Queensland.[9]

The Minimum Data Set on which the above analysis is based includes data on living arrangements and recommendations for changes in arrangements. Some 34.2 per cent of clients living in the community were recommended for residential care, 19.1 per cent for low level care and 15.2 per cent for high. Of those recommended for residential care, a higher proportion were living alone (38.5 per cent) than living with other people (33.3 per cent) or living with a spouse only (28.6 per cent). The report suggests that for those living alone, this is often for psycho–social as well as physical dependency and personal care needs. Another reason may be that their home is no longer suited to support through community services and that a recommendation for residential low care reflects a lack of suitable housing alternatives.[10]

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8 Lincoln Gerontology Centre, op. cit., p. 49. Follow-up studies show that the majority of recommendations are adhered to.

9 Lincoln Gerontology Centre, op. cit., pp. 49–53.

10 For example, lack of space for lifting equipment or steps impeding use of a walking frame.

9.2.4 Facilitating access

ACATs' involvement with clients may continue beyond assessment and the making of a recommendation. This may involve active assistance in finding and accessing the services recommended. Table 9–2 shows the level of continuing assistance provided by ACATs in each state and territory in 2001–02.

Table 9–2: ACATs' ongoing client support

	No further support %	Monitoring only %	Active assistance %	Unknown %	Number
NSW	36.9	23.9	34.2	4.9	65 919
Victoria	51.0	22.5	21.8	4.7	53 951
Queensland	37.7	46.4	15.4	0.5	28 782
South Australia	76.0	15.3	4.2	4.6	15 820
Western Australia	45.3	26.3	25.0	3.4	25 336
Tasmania	25.5	68.0	5.3	1.2	4 563
Northern Territory	35.9	44.2	19.2	0.7	735
ACT	52.2	44.2	1.4	2.2	2 759
Total	**45.0**	**27.8**	**23.3**	**3.9**	**197 865**

Source: Table 20, ACAP National Minimum Data Set Report—June 2001 to June 2002.

Nationally, in 2001–02 active assistance was provided to 46 103 clients (23.3 per cent) compared with 24.1 per cent in 2000–01. For a further 55 006 (27.8 per cent), ACATs were involved only in monitoring whether or not the care plan had been implemented. The majority of clients, 89 039 (45.0 per cent), received no support beyond assessment, an increase from 43.2 per cent in 2000–2001 and 39.8 per cent in 1999–2000.

Ongoing support varied considerably across jurisdictions with 22 544 clients (34.2 per cent) in NSW receiving active assistance whereas, in SA, where recommendations more frequently are for residential care, only 644 clients (4.2 per cent) received further assistance.[11] While there were also low rates of active assistance in the ACT, Tasmania, Queensland and the Northern Territory, there were higher levels of monitoring. In Queensland and Tasmania this was in part due to a centralised waiting list system that requires ACAT monitoring.

9.2.5 Low care—high care assessments

The Review is tasked with considering whether the requirement for an ACAT assessment before moving a resident from low to high care should be replaced by administrative rules. ACATs are required to assess low care residents whose care needs have increased to the extent that the provider considers they need high care. Concerns around the effectiveness of ACATs in managing this requirement were among the most frequently raised issues in submissions and at consultations, with providers claiming that delays in

[11] Lincoln Gerontology Centre, op. cit., p.70.

[12] See, for example, Submissions 77, 106, 110, 332 and 293.

assessments, combined with back-dating rules, cause significant loss of income.[12]

In 2001–02, ACATs made 25 065 assessments in residential care, an increase of 238 following a drop of close to 1500 in the previous two years.[13] The reported data do not specify the reason for these assessments making it impossible to establish the extent to which they relate to shifts from low to high care. Nationally, 62.5 per cent of residents assessed in low care were recommended for high care, an increase of 1.4 per cent on the previous year.[14] Rates varied significantly across states and territories with a low of 40.6 per cent in Western Australia (where 54.3 per cent were recommended to remain in low care) while Tasmania (92.8 per cent), the ACT (83.7 per cent) and Queensland (72.3 per cent) were well above the national average.[15]

The Review heard that there are inconsistencies between ACATs within states and territories in these assessments. There is a view, expressed strongly in Queensland which has an above average upgrade rate, that in many cases ACATs simply 'rubber stamp' shifts from low to high care on the grounds that residential care staff are in the best position to assess the care needs of the resident.

9.2.6 Comment

The Review considers that the assessment arrangements could be streamlined. Three processes are concerned with whether clients are receiving care suited to their level of need and that Government subsidies are targeted appropriately: ACATs assessments, validations and, more broadly, accreditation. There could be greater clarity and better delineation of the relative responsibilities of these processes by:

- ACATs focusing primarily on initial entry to care and on supporting consumers in making informed care choices. ACATs would no longer assess residents whose care needs increase from a low level to a higher care level.
- RCS validators being responsible for monitoring the appropriateness of any shift from low to a higher level of care.
- Accreditation having a greater focus on the appropriateness of care planning and the quality of care received by individual residents.

Under this scenario providers would have discretion to apply for increased subsidy for those increasingly frail residents who are ageing in place to fund a higher level of care immediately, knowing that any such application could be a trigger for a validation visit. This would be consistent with the Review's wider recommendations about providers taking more responsibility for decision making in the conduct of their business. If the

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[13] Lincoln Gerontology Centre, op. cit., pp. 55–56. Table 17a shows that 21 999 residents in low care who received ACAT assessments of which 13 752 were recommended for a high care facility and 7097 for a low care facility. As above, the purpose for which the assessments were sought is not specified.

[14] Lincoln Gerontology Centre, op. cit., p.5.

[15] Lincoln Gerontology Centre, op. cit., p.56.

RCS validator considered that a shift from low care to a higher level of care was not warranted, the provider should be required to repay all of the higher rate of subsidy received. Furthermore, the requirements of a two category shift should be abandoned because it has differential financial effects. **Recommendation 4** supports the removal of the requirement for an ACAT assessment of residents whose care needs have changed.

Assessment for transfer

The Review considered whether an ACAT assessment may still be desirable for a resident to move from a stand-alone low care facility to a high care facility operated by another approved provider (eg a move to a dementia-specific facility) or to another facility operated by the same approved provider in another location.[16]

Currently, if a provider is no longer able to provide the care appropriate to a resident's needs, an assessment must be undertaken by an ACAT or by two other medical or health professionals, one of whom must be chosen by the resident or the resident's representative and who must be independent of the approved provider.[17] Further, the provider and/or ACAT must actively seek a suitable place for the resident in another facility.

On balance, the Review considers that there is no reason to change the existing system. Given the possibility of an adverse validation and loss of subsidy, another provider may be unwilling to accept a resident without an assessment. This could act as a disincentive and a barrier to residents receiving a higher level of care as their level of frailty increases.

9.2.7 Resourcing of ACATs

ACATs' responsibility as gatekeepers to Australian Government subsidies for residential care is critical. More needs to be done to simplify the process of accessing services and to enable older Australians to make more informed choices about the wide range of care services appropriate to each individual's needs. The capacity of ACATs must be strengthened, not least to ensure that assessments are multi-disciplinary. At times, and in certain locations, it will be necessary to bring in appropriate expertise, for example, in relation to clients with neuro-degenerative diseases. **Recommendation 3** sees the additional funding in the 2003–04 Budget as ongoing to support an expanded role for ACATs.

The Review considers that a single assessment service for both community and residential care is essential to improving choice and smoothing access to more integrated care. Such a single assessment service would involve:

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16 A co-located or campus facility may have different street addresses on what is fundamentally the same location. On the other hand, an approved provider may have a chain of facilities across one or more states.

17 *User Rights Principles*, Section 23.5, Security of tenure; leaving residential care service.

- more focused definition of eligibility criteria across the range of services and consistent application of the criteria;
- increased emphasis on enabling consumers to make informed care and support choices;
- increased emphasis on support services to maintain and enhance functioning, including (but not limited to) rehabilitation following acute episodes;
- progressive assessments to ensure services keep pace with needs as clients become more frail and do not enter residential care unnecessarily; and
- stronger case management and supported by appropriate information systems.

The Review notes that a Community Care Assessment Service has been proposed in the context of the Community Care Review,[18] based on an expanded role for ACATs .

9.3 Dementia

The issue of dementia requires detailed scrutiny, partly because of the substantial incidence of the set of neurodegenerative diseases familiarly known as dementia, and partly because the situation offers many insights to matters of funding and diagnoses applicable to other conditions afflicting the elderly.

9.3.1 Impact of dementia

Dementia is an issue of increasing importance to the Australian aged care system, health system and population as a whole. It is the fourth leading cause of death in those aged 65 years and over.[19] Depending on progression, the most common symptoms are difficulty with familiar tasks such as driving or shopping, communication, self-care and memory problems, confusion, wandering, personality changes, depression, delusions, apathy and withdrawal. Unless the dementia sufferer dies from a co-morbidity, dementia eventually leads to death. Dementia is inherently progressive and rates of progression vary significantly depending on the type of dementia and the individual. Care needs increase along the dementia 'pathway' necessitating flexible, responsive care planning.

While projected estimates of dementia in Australia vary in the timeframes and presentation of their estimates,[20] they are consistent in their message. Dementia will most likely increase exponentially with age so that in a little over a decade it could be the largest source of burden of disease in Australia.

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[18] DoHA, *A New Strategy for Community Care*, Consultation Paper, March 2003, p. 24.

[19] KHW Gaminiratne, 'Dementia deaths among the elderly in Australia: recent trends, 1981–95', Paper Presented at the 8th National Conference of the Australian Population Association, Adelaide, 1996, accessed at www.alzheimers.org.au.

[20] See also Submission 206, p.13; Alzheimer's Australia website at www.alzheimers.org.au; Anthony Jorm, 'Dementia: a major health problem for Australia' *Alzheimer's Australia Position Paper 1*, September 2001, p. 4.

In 2002, an estimated 162 300 Australians were diagnosed with dementia and that prevalence had increased in all age cohorts over the period since 1993 as revealed in Table 9–2. Some 106 000 of the total were women, half of whom were over the age of 85 years. There has been a substantial increase in the number of people under 65 years, estimated at 6600 in 2002. In part, this may be attributed to the earlier ageing of Aboriginal and Torres Strait Islander peoples. The AIHW notes that there are no Australian incidence studies: estimates have been made using information from overseas epidemiological studies. It is estimated that, in 2002, 34 000 additional people became affected by dementia.[21] However, all these calculations should be treated with caution.

Table 9–2: Estimated prevalence of dementia in Australia, 2002 and 1993

Age Group	Males 2002		Females 2002		Total 2002		Total 1993
	'000	%	'000	%	'000	%	%
0–24	-	-	-	-	-	-	-
25–64	4.3	0.2	2.3	0.1	6.6	0.1	0.1
65–74	12.1	1.9	7.6	1.1	19.7	1.5	1.2
75–84	20.7	5.7	34.1	6.8	54.8	6.3	6.0
85+	19.1	22.8	62.0	33.6	81.1	30.2	23.4
Total	**56.3**	**0.6**	**106.0**	**1.1**	**162.3**	**0.8**	**0.6**

Source: Access Economics, based on ABS special data request and international meta-analyses. Note standard error may be relatively higher for the 25–64 age groups. Prevalence under 24 was not statistically significant, Access Economics, Dementia Epidemic, p. 31.

By 2051, prevalence is projected to increase to 581 300 people, having passed the half-million mark around 2041.[22] Like all forecasts with very lengthy time horizons, these calculations should be treated as projections from current trends, themselves subject to error.

9.3.2 Costs of dementia

Dementia is expensive for the Australian health sector and economy more broadly, as well as a financial burden for patients and their carers. Total direct health costs of dementia in 2002 were estimated at $6.5 billion, of which $2.8 billion was for the residential care sector and $174 million for the home and community sectors. Indirect financial costs included a loss to the government of around $490 million in potential taxes from carers of those with dementia, and $52 million worth of welfare payments to them (Table 9–3).[23]

Total direct and indirect expenditure on dementia is projected to rise from 0.91 per cent of GDP in 2002 to 3.3 per cent of GDP in 2051.[24] These estimates do not take into

[21] AIHW, *The impact of dementia*, pp.13–14

[22] Access Economics, *The Dementia Epidemic*, p. 32.

[23] These figures are based on estimates of dementia based on the Rosewarne dementia index which may over-estimate the prevalence of dementia and does not take into account the level of costs incurred because of co-morbidities

[24] Access Economics, *The Dementia Epidemic*, p. 50.

account costs associated with home-based dementia care. Nor do they allow for potential technological and medical advances or policy changes that may alter the impact of dementia in the future.

The non-financial costs to individuals and their families are no less significant. Informal carers also bear a lot of the burden of dementia. Most carers are of workforce age but many are unable to participate in the workforce: 59 per cent of carers of workforce age do not participate at all. Therefore, they often have low incomes and generally worse physical and mental health than non-carers. They also face less tangible problems such as social isolation, broken sleep and grief at loss of the loved one's future hopes and plans.[25]

Table 9–3: Summary of direct and indirect financial costs of dementia, 2002

	Real cost $ million	Transfer payments $ million	Total $ million	Per person With dementia $	% GDP 2002	% GDP 2051
Direct health costs	*3,235.9*		*3,235.9*	*19,938*	*0.45*	*1.6*
Including residential care	2,847.1		2,847.1	17,542*		
Home and community care	174.8		174.8	1,077*		
Indirect financial costs						
Lost earnings (patients)	355.3		355.3			
Mortality burden	8.8		8.8			
Tax foregone (patients)		102.2	102.2			
Value of carers	1,713.2	324.4	2,037.6	12,555	0.28	1.0
Tax foregone (carers)		489.7	489.7			
Welfare payments		52.0	52.0			
Aids and modifications	119.8		119.8			
Subtotal indirect financial costs	2,197.2	968.3	3,165.4	19,504	0.44	1.6
Total financial costs	**5,607.9**	**968.3**	**6,576.1**	**40,519**	**0.91**	**3.3**

* The averages, per person, with dementia in residential care and per person with dementia at home receiving formal services are $36 547 and $2 554, respectively.

Source: Access Economics, Dementia Epidemic, p 50

9.3.3 Implications for care

According to Alzheimer's Australia, the assessment, treatment and care of neuro-degenerative diseases in high care facilities could overtake the utilisation of hospital services with a consequent impact on long-term pricing and funding.[26] Unlike many acute care illnesses, dementia is irreversible. Dementia can be long term and require intensive staff time, but not the same kind of intensive care called for in acute settings.

[25] This issue is discussed in more detail in Access Economics, *The Dementia Epidemic*, p. 24.
[26] Submission 206, p. 13.

Challenging behaviours

Residents may exhibit 'challenging behaviour', behaviour that is 'dangerous, harmful, distressing or disturbing to self or others'. Challenging behaviours can lead to a disruptive environment, decreased quality of life, increased risk of injury for other residents, and burnout and injuries to staff resulting in workers compensation claims. International studies have shown that challenging behaviours can be a distinct factor in the cost of care. Such behaviours can be alleviated by more appropriate care.[27]

Brodaty's model of management of behavioural and psychological symptoms of dementia (BPSD) categorises the severity and types of care for people who exhibit challenging behaviours. For some 1700 people (1 per cent of all dementia sufferers) with 'very severe' and 'extreme' BPSD, Brodaty considers that cared in specialist psychogeriatric units and intensive specialist care units, respectively, is required. While a further 10 per cent (16 000) may exhibit 'severe' BPSD, Brodaty suggests that they and others with less severe behaviours may be cared for in dementia-specific nursing homes or general nursing homes.

The costs involved in providing appropriate care for residents with BPSD relate to the care interventions required, the frequency of interventions, and the need for constant supervision. A resident who is mobile, wanders, has dementia and challenging behaviours (not once but many times a day) may well require constant supervision, continuous staff intervention, redirection and intervention to prevent risks of falls, episodes of aggression and increased anxiety levels. The resident is also likely to resist care and hence require considerable time and effort from staff to meet care needs.

In the 2002–03 Budget the Australian Government provided $10 million over four years to expand the capacity of Psychogeriatric Care Units to provide specialist support to aged care workers and community carers looking after people with dementia. An evaluation of the operation of the Units is under way. Early results indicate there is still a level of apprehension among care workers about working with people even with less severe challenging behaviours.[28] Support such as that provided by the Psychogeriatric Care Units is critical to ensuring that nursing and personal care staff have the confidence and skills to give ongoing care to people with challenging behaviours.

In general, residential aged care is not designed for people with dementia who have very severe or extreme BPSD or are physically violent (Brodaty's Tiers 6 and 7). In part, this is because of concerns about legal liability, the safety of other residents and staffing requirements. The Benevolent Society, most of whose residents would fall into Brodaty's 'severe' and 'moderate' BPSD categories, agrees that people exhibiting extreme behaviours should be cared for in psychiatric hospitals.[29] Given the small total numbers

[27] Submission 256, pp. 3–5.

[28] Personal communication from the consultant conducting the evaluation.

[29] Submission 121 and subsequent discussions.

people affected (probably less than 2000 across Australia) providing accommodation in psychogeriatric or neurobehavioural units will not be viable in many locations. There will be times when residential care facilities may be the only source of care, at least until specialised care can be located and accessed.[30]

Under the User Rights Principles (Sections 23.4 to 23.6) facilities have discretion to decide if they can no longer provide care appropriate to an individual's needs. This decision requires independent assessment of the level of need required and assurance that alternative care is available. The importance of involving staff from Psychogeriatric Care Units in care planning for people perceived as extremely challenging and in decisions around moving to another facility is critical.

Care for people with BPSD varies across states and territories reflecting historical arrangements for mental health, the availability of service infrastructure specific to services for older people with mental health and challenging behaviours, and the existence of partnership initiatives between the Australian Government and the state or territory. In most states, services are aligned with health services. In Victoria, Psychogeriatric Nursing Homes are part of a comprehensive mental health system for older people. Mostly the services are seen as providing 'interim care' with an assumption that the resident will return to residential care when their condition permits or physical frailty becomes the primary concern. This raises the issue of user rights in such transfers. Although the Victorian Psychogeriatric Nursing Homes are a part of mental health services, in keeping with security of tenure obligations under the *Aged Care Act 1997*, residents are assisted with their relocation.

9.3.4 Appropriate care

Dementia is inherently progressive and rates of progression vary significantly depending on the type of dementia and the individual. Care needs increase along the dementia 'pathway' necessitating flexible responsive care planning. People in the final stages:

> ... are mute, immobile, have developed a flexed posture position, are doubly incontinent, require feeding and need continual turning to prevent pressure sores. Disorders relating to dementia severity, such as cachexia, dehydration, aspiration pneumonia and sepsis from decubitus ulcers or urinary tract infections are the major immediate causes of death, as well as age-related diseases such as myocardial infarction, stroke and cancer.[31]

While evidence to the Review often highlighted the need to adapt care when a resident exhibits challenging behaviours, there is no less a need to respond to gradual deterioration as the disease progresses. Many of the physical care needs of people with dementia are similar to those of other frail elderly. However, caring only for physical

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[30] DoHA, *Report of the Working Group on Dementia Specific Aged Care*, Commonwealth of Australia, 2003, pp. 16, 21.

[31] Qizilbash and Lopez-Arrieta, 'Common medical problems', p. 739. See also, Victorian Department of Human Services, *Dementia—Care and Support in Victoria. 2000 and Beyond*, State of Victoria, November 2000.

needs fails to acknowledge 'the underlying disease process that leads to degeneration of cognitive functioning' and the impact this has on a person's identity, emotional well-being, quality of life and the inexorable erosion of independence.[32]

Despite the already strong demand for dementia care in residential settings, industry knowledge of appropriate care appears to be variable. While there is a need for more research into effective care, not all providers seem to be abreast of current best practice. Nor do some providers recognise that appropriate care for people with dementia realistically can no longer be regarded as an optional service.

A recent study of care in three Australian dementia-specific facilities rated as 'commendable' in relation to dementia care identified a range of positive approaches to care. In view of the multiplicity of causes and types of dementia and the variability of how the dementia pathway affects individuals, Australian and overseas evidence indicates that care centred around each person is essential: there is no 'one size fits all' approach.[33]

This is all the more necessary in light of Australia's mixed population. As Australia's population of migrant origin ages, services will need to understand and accommodate their past lives and experiences in order to provide appropriate dementia care. There is a consistently increasing proportion of clients from diverse backgrounds presenting for ACAT assessments, rising from 12.2 per cent in 1994–94 to 14.6 per cent in 2001–02. This includes a steady increase in the number of people 70 years and over. People from non-English speaking backgrounds may lose their command of English with progression of dementia, reverting to their original languages. Their English may come and go from day to day, or traumatic early experiences can have unexpected manifestations.

People with pre-existing psychiatric illness and those with younger-onset dementia often find it more difficult to find residential care. They commonly have behavioural problems, other social problems and, in the case of younger people, also have superior physical fitness which can cause problems in relation to their behaviour. Former homeless and socially isolated people, whether from the suburbs of a capital city or the mining towns in the northern outback, can find difficulty adjusting to the confines of residential care.[34]

At Karingal Home for the Aged in Devonport, Tasmania, care for residents with dementia is largely integrated with care for other residents. To minimise the effect of 'sundowners' wandering on non-dementia residents, an Evening Care Group operates (see Box 9–1). Stability of staffing arrangements is seen as critical to the success of the group.

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[32] M Cecchin & S Jarrad, *Personal and Possible: Achieving quality dementia care in residential aged care services, Paper prepared for Alzheimer's Association of Australia*, commissioned by Australian Department of Health and Ageing, March 2001, pp. 4–5.

[33] ibid.

[34] Submission 256, p. 5; see also Submission 281, p. 8.

Box 9–1: Karingal Home for the Aged Evening Care Group

An assessment of an individual's needs and problems is carried out before they are recommended for inclusion in the group. Not everyone with dementia is suitable.

The group meets each week day, 7 days a week, from 3pm to approximately 8pm. A lounge room equipped with kitchen facilities including an oven was eventually chosen. Group numbers were set at a maximum of 8 people but generally accommodates 6 to 7. The number of residents participating depends upon the group dynamics and the degree of difficulty/behaviour of the members of the group.

The purpose of the group is to simulate normal afternoon/evening activities done in any ones own home, ie. preparing a meal, eating together, watching news and other general activities.

Typical session involves some simple activity such as craft, listening to music, reminiscing, cooking for about an hour. Meal preparation then may occur. Sometimes they prepare their own meals or the kitchen may prepare it and sometimes a takeaway meal is purchased as a 'treat'. After a meal, they watch the news, may discuss news events, and participate in some quiet activity (eg. reading, music). From 6pm onwards residents are taken to bed depending on their preference with the group finishing between 7.30pm to 8pm.

One Carer runs the programme each evening. There are 4 to 5 staff who are consistently rostered to this programme each working 2 to 3 days at one time. It is important to keep the regular staff involved to maintain stability for the residents but at the same time not allowing the staff to 'burn out' due to the often difficult nature of the work. Over the years this has been found to be the best staffing arrangement. Each staff member brings some different skills to the group which also helps prevent a boredom developing for the residents.

Other Staff are able to go about their work of caring for other residents without becoming frustrated and stressed caring for a dementia resident as well as other residents.

Agitation, restlessness, intrusion and other abnormal behaviours are significantly reduced. The residents are more relaxed and settle better when going to bed. Other residents are not disturbed by someone else intruding into their room and are able to receive their care when required rather than having to wait for a staff member who may have to deal with an agitated, restless resident.

Overall everyone benefits. The benefits have been proved many times over when for various staffing reasons; the group is cancelled so that the Carer can be used to replace staff 'on the floor'. The residents of the group are then left on their own, wander and become agitated and create extra work for the staff 'on the floor'. Management requests that the group not be cancelled …!

Source: Information supplied by Karingal Home for the Aged (Submission no 53)

Disturbed behaviour may be triggered or exacerbated by the environment in facilities or social environmental characteristics. Hospital-like surroundings in some residential facilities may not be appropriate for people with challenging behaviours[35] and care staff who resort to chemical and physical restraints may trigger even more emotional distress and disturbed behaviour. Research conducted in 2000 found that some 16 per cent of aged care homes surveyed used measures of restraint 'often or regularly'.

[35] Submission 256, pp. 5–7.

However, around 48 per cent 'rarely' or 'never' used chemical or physical restraints, around 36 per cent used them 'sometimes'.[36]

9.3.5 Dementia-specific facility design

Issues frequently debated are the appropriate size and configuration of facilities suited to dementia care and the fact that dementia care is labour intensive. The issues are inter-dependent and critical to the cost of care. Careful design of facilities and the fostering of social environmental characteristics can contribute to successful dementia care and help modify challenging behaviours.

Care is provided for people with dementia in mainstream residential care facilities, dementia-specific wings, stand-alone dementia facilities, psychogeriatric units, and psychiatric hospitals. The Australian Government does not fund dementia-specific places, nor does it routinely identify facilities that offer dementia-specific care or have secure dementia wings.[37] Available estimates indicate that around 92 per cent of people with dementia in high care facilities are in 'mainstream' areas, eight per cent in dementia-specific areas; in low care, 85 per cent of dementia residents are in mainstream areas, 15 per cent in dementia-specific areas. Only five per cent of low care and six per cent of high care beds are dementia-specific.[38]

These figures tell us relatively little about where on the dementia pathway these residents are, overall or in individual facilities, or the range of services providers may need to make available for their residents. While some providers make every endeavour to adapt care to the needs of individual residents, others prefer residents at similar stages of dementia and make it clear that residents developing challenging behaviours do not fit their client profile.

Debate around the optimum size of dementia units focuses on balancing the care environment and viability considerations, with varying optimal, or practical, numbers of residents being proposed. Among providers willing to seriously tackle dementia care there is strong endorsement of small numbers of residents in units, each with their own room and with access to small scale communal areas. Unobtrusive security features enable residents' sense of independence and mean that staff interaction is less intrusive.

[36] Submission 256, pp. 6–7; Access Economics, The Dementia Epidemic, p. 61.
[37] Len Gray, *Two Year Review of Aged Care Reforms*, Commonwealth of Australia, 2001, p. 218.
[38] Access Economics, *The Dementia Epidemic*, p. 30, citing Rosewarne et al.'s estimates.

Box 9–2: Design for person centred care

Our design is driven by our Person Centred model of care for our resident. This paradigm of care for people suffering from dementia requires our facilities to provide individual space, privacy, maximum freedom and minimum control.

It is a model of care that resonates with our residents, their relatives, our staff and our mission. From this care philosophy the following principles of design inform our capital development briefs:

- care and service will be provided within a socially normal and domestic approach;

- privacy and dignity is central to the provision of care;

- the built environment should be aesthetically pleasing and non-intrusive;

- safe environment for staff;

- maximisation of access and involvement for families and friends; and

- all facilities incorporate dementia care design principles.

These principles and the residents needs have lead [us] to conclude that individual ensuite rooms are necessary. If funding does not allow for an individually ensuite room then it is a conscious decision to compromise best practice in care. Individual rooms allow appropriate care for dementia sufferers. Confusion is reduced; occasions of anxiety are reduced; space is available for individual expression; a secure environment is provided and pressure on staff is reduced. For very frail residents the private room becomes a haven for the family when visiting. Nor are residents sharing rooms where one of the occupants is dying.

Stand-alone dementia-specific facilities are few. For both viability and care reasons providers are seeking ways to integrate dementia units into larger facilities while maintaining a unit scale conducive to a 'calm and homelike environment'. The design of the ADARDS Nursing Home in Hobart demonstrates how innovative design can combine the two. Although ADARDS is a stand alone facility, the design principles are transferable to a dementia wing of a larger facility. This is borne out by the design examples provided in Design for Dementia.[39] In view of residents' support for ageing in place and the desirability of a stable and familiar physical environment to support care, most new facilities should incorporate dementia design principles in at least part of the facility.

[39] Stephen Judd, Mary Marshall and Peter Phippen, *Design for Dementia*, Hawker Publications, 1998. First published in The Journal of Dementia Care.

Box 9–3: ADARDS design for dementia care

The ADARDS Nursing Home is a 36-bed facility for the residential care of people with dementia and the most difficult (or challenging) behavioural problems. Admission is limited to ambulant people with dementia who have disorders of behaviour such that no other residential facility can look after them. Residents leave when:

- behaviour has settled so that another suitable facility can accept them; or

- the resident becomes permanently non-ambulant.

Some unique features of the design have attracted world-wide interest. The home can be configured either as four self-contained houses, or as four wings of a single ward around a nursing station. There are camouflaged doors, a system that alerts the night nurse when a resident gets out of bed, disguised closets and fecal drains in resident suites, and gardens with animals and birds.

By day the doors at the end of the four bedroom wings are locked, and entry to each house is by doors that lead from the core to the verandas. The verandas lead directly to the living rooms; the bedroom wings may thus be bypassed. Note that the central corridors, verandas and connecting passages form wandering loops.

One closet door in each bedroom is camouflaged so that clothes can be stored and remain folded. The other closet has a normal door and contains clothes that can be 'rummaged'. A beam across each bedroom activates a buzzer and light at the night-nurse station. This permits the night staff to react quickly when a resident gets out of bed. The en-suite attached to each bedroom contains a hand basin, shower and toilet. Beneath the shower is a grid covering a drain connected to the sewage system. Excrement may thereby be sluiced down. The ensuite can be closed off by a sliding door.

At night the doors at the end of the bedroom wings are opened, and those from the bedroom wings to the living areas closed. This gives a configuration of 36 beds, with each nine-bedroom wing opening onto the night-nurse station and General Purpose room. Total floor area is 1686m2. Building cost, including fixed equipment, hard and soft landscaping (but excluding loose furniture and fittings and professional fees) was A$1 600 000 (1991).

Designing for dementia care has been said to cost more. In part this may be attributable to seeking designs from architects with little previous involvement with dementia design. There is now a growing body of Australian design experience and no longer a need to 're-invent the wheel' for each new facility.

9.3.6 Staffing for dementia

The Aged Care Standards and Accreditation Agency requires that management and staff have appropriate knowledge and skills to perform their roles effectively.[40] This requirement encompasses the provision of care for people with dementia.

There is no doubt that responsive, person-centred care is time intensive, not least because people with advancing cognitive degeneration need constant 'cueing' and

[40] Aged Care Standards and Accreditation Agency, 'Accreditation Standards' at www.accreditation.aust.com/accreditation/standards.html.

supervision. Further, as noted above, elderly people with dementia often also have age-related co-morbidities (high blood pressure, cataracts, hip fractures); problems related to the type of dementia (vascular dementia associated with heart disease, blood pressure, diabetes); and problems related to the severity of the dementia (incontinence, feeding, immobility, pain, falls/fractures). In the final stages, as with other frail elderly people, palliative care may be needed. Hence, depending on the individual dementia resident, nursing care of varying complexity may also be necessary.

Facilities such as the Italian Benevolent Foundation access dementia care training provided by Alzheimer's Australia combined with identifying and fostering staff at all levels who have the mind-set to work flexibly with people with dementia. Others, such as ADARDS, provide in-house training for all direct care staff. The quality of training in leading Australian institutions is attested by their international standing and the ways their advice is sought.

Even with access to training, not all nursing staff have the capacity make the shift from 'care according to the schedule' to 'person-centred care'. Some providers offer staff incentives to help ensure dementia residents have consistent, familiar care staff with skills and training in dementia care. Incentives may be financial (including paying for extra training, providing an allowance to encourage staff to spend extra time with residents), 'social' incentives (such as providing child care facilities or paying for child care requirements, etc), or ensuring supportive environments and attention to rostering to diminish staff burn-out. However, high staff turnover is not conducive to the development of staff training schedules.

9.3.7 Funding dementia care

The Review heard claims that the RCS was not adequately weighted to provide funding commensurate with dementia care needs; it better meets the needs of frail physically dependent residents.[41] In the light of consultations and discussions around Australia this claim has merit. Yet resolution of some queries about funding is not that simple. Answers are not straightforward. As noted already dementia is usually a progressive disease passing though number of stages and depending on illnesses which are co-morbidities with dementia.

This commentary concentrates on one most difficult aspect of dementia. This is the specific group requiring assessment for supplement funding is the ambulant resident revealing challenging behaviour very frequently during the course of a day. The existing RCS arrangements do not meet this condition because the existing questions fail to relate to high intra-day frequency of challenging behaviour. This is evident from the ABARE Report[42]. The RCS twenty questions assessment schedule has questions 9

[41] Submission 206, p. 14; See also Submission 256, p. 7.

[42] ABARE, *Aged Care Data: Statistical Analysis*, November 2003

to 14 bearing upon challenging behaviours. With the D rating being a measure of the most severe situation with a resident, Questions 12, 13 and 14 are the only ones recording substantial numbers in the D category. The most significant of the three was Question 14 which is about other behaviour which points to this catch-all category picking up behaviours not otherwise readily attributable in the more precise questions. This in turn suggests the need for additional or supplementary questions in case of those with severe indications of dementia so as to establish the extent of the severity.

Establishing the value of a supplement is made all the more difficult by reason of the co-existing conditions other than dementia. A dementia supplement might be of relatively small value if the resident is rated in the RCS 1 and 2 categories because the daily subsidy paid for each resident is a very substantial value. The additional payment might be no more than $6 per day. Yet not all ambulant dementia residents exhibiting challenging behaviour on a frequent basis each day are to be found in the highest RCS categories. The lesser categories receive much lower daily subsidies than the two highest. There will be ambulant and challenging residents in RCS categories 3 to 6. Given the much lower daily payments across those categories there may well be incentives to avoid taking this type of resident. There is some reason to think a bias in selection hampers what can be done for this type of resident. This is not surprising when a dementia supplement called for might be as high as $60 per day in that situation. This particular example of the potential variability of a given supplement across categories serves notice of the potential for development of funding arrangements towards specific conditions rather than general categories.

Whatever may be achieved by adaptation of existing RCS categories to needs for greater effectiveness in specifying conditions on which funding is made available, the approach still amounts to an assessment of the resident's needs in relation to funding rather than to the care needed. Hence any commitment to a dementia supplement does not obviate a need for much more co-operative work on aged care planning for the dementia-specific residents. Consultations on dementia requirements are an urgent commitment in which geriatricians and those from specialist RACS with international standing should be the core membership.

9.3.8 Research

Given current costs and predictions of the increased needs in future, dementia appears to be the 'poor cousin' when it comes to research. A survey of published research found that despite resulting in high health system costs, dementia attracted only 13 per cent of grant funding and resulted in only 8 per cent of research publications.[43] Biological research related to dementia dominated.

[43] Anthony Jorm et al., *Research Priorities in Mental Health, Centre for Mental Health Research,* Australian National University, November 2001, pp. 4, 79; see also Jorm, 'Dementia: a major health problem', p. 5.

The paucity of research and evaluation on dementia care services has also been noted by the Working Group on Dementia-Specific Aged Care. The Group identified a lack of an evidence base to support care and support for people with mild dementia and those with severe behavioural problems (Brodaty's Tiers 1 and 2, 6 and 7), including:

- the identification by GPs of their needs in the areas of dementia diagnosis, use of medications, EPC items (assessment, care planning and case conferencing), referral to specialists and services available for people with dementia;
- the impact on people with dementia, their carers and the aged care system of delaying entry into residential aged care;
- ways to delay, prevent and/or cure dementia; and
- the identification of barriers to extending service provision to meet dementia care in the future.[44]

The Australian Government is giving increased priority to dementia-related research. In 2002, the National Health and Medical Research Council (NHMRC) provided over $5 million for 46 projects primarily focusing on the cause and cure of dementia. Cause and cure will also be the focus of an NHMRC sponsored Dementia Research Capacity Building Workshop that will encourage more collaborative, multi-disciplinary dementia-related research.

The Review judges the highest priority is research to inform effective care and services for people with dementia. More accurate prevalence and incidence data is essential to establish future demand for dementia related services and to provide a baseline for assessing future strategies for management of dementia and related conditions. Funding should be provided for a comprehensive prevalence and incidence study; and the Department of Health and Ageing should fund further data matching studies to enable a better understanding of dementia pathways and related service needs.

Recommendation 20 refers.

9.4 Palliative Care

Evidence put to the Review indicates that residential aged care facilities are increasingly being called upon to provide complex treatments, including palliative care, to their residents. Providers argue that the subsidy levels are inadequate to cover this intense level of care. Catholic Health Australia suggest that 'short stay terminal care residents are receiving palliative care services'; this meant that a specific funding category for those receiving this level of care.

[44] DoHA, *Report of the Working Group on Dementia Specific Aged Care*, pp. 13–14, 21.

By their very nature, residential aged care facilities will be the setting where many elderly people die. Palliative care may be required by residents who have a terminal disease such as cancer, or by residents who are dying from the ageing process[45]. Specific funding could be targeted at those with a terminal illness only, or could be used more broadly to account for residents who reach the end of life stage and have similar care needs. However, it may be difficult in the latter case, where people may experience a steady decline of functioning, to determine when eligibility for palliative care funding would apply. If it applied only to those with a terminal illness, then this creates problems of equity with residents having similar care needs but dying from the effects of ageing.

The location where palliative care is offered may not be a matter of choice for the long-standing resident. This decision to end one's days in what may have become familiar surroundings may best be left to the individual and family in consultation with the senior staff in the RACS and medical advice. In many locations choices may be limited or non-existent. Hence some awareness of the commitments implied by the provisioning for palliative care must be noted.

There is an issue about the role of residential aged care facilities providing palliative care for those people who might otherwise be served by the acute care sector or specialist palliative care services. For example, an older person residing in their own home is admitted to hospital, diagnosed with terminal cancer and then requires palliative care. Is admission to a residential aged care service under these circumstances, when the primary need is for palliative care, the most appropriate outcome? The National Palliative Care Strategy[46] states that a person who is dying should be able to choose the setting of their care, suggesting that those who choose to enter a residential aged care service for palliative care should be able to do so. However, in its description of the various settings, the Strategy categorises residential aged care services as the 'home' of some people who are receiving palliative care, rather than an in-patient service. This implies that palliative care would be provided within a residential aged care service to existing residents whose condition becomes terminal, rather than the residential aged care service specifically offering palliative care.

If residential aged care services are becoming the primary source of palliative care for older people, then there may be issues of cost-shifting between the States and the Australian Government regarding the responsibility for funding palliative care services.

The central question is whether there is any fundamental difference in the type or level of care between palliative care and the care provided to highly dependent people who

[45] Linda J Kristjanson, Christine Toye and Sky Dawson, 'New dimensions in palliative care: a palliative approach to neurodegenerative diseases and final illness in older people' *Medical Journal of Australia*, vol. 179, 2003, pp. S41–S43

[46] Commonwealth Department of Health and Aged Care National Palliative Care Strategy, Commonwealth of Australia, October 2000.

have not yet necessarily reached the end of life stage. If the evidence suggests that there is no clear distinction, then specific funding may be better formulated in terms of the particular care need (for example, pain management) rather than in terms of palliative care. This would maintain the principle of assessment on the basis of need for care, rather than on a care recipient's estimated survival time, which is implicit in describing specific funding arrangements for palliative care.

Accepting a fundamental difference exists the need is to secure some measure of the costs in terms of the subsidy per bed day. In a 60 bed facility the subsidy might amount to about $5 per bed per day given the average length of stay of residents but any estimate is highly sensitive to the proportion of residents entering aged care from acute care. The palliative care situation calls for a similar approach to that put forward in relation to dementia appraisals. There should be consultations with geriatricians, palliative care specialists and providers long experienced in palliative care to establish the basis for appraising needs and costs.

9.5 Rural and remote areas

Historically, those in rural, regional and remote areas were deemed face a number of difficulties with service delivery and access to services. The most significant challenges faced in service delivery have included:

- additional costs and limited economies of scale, particularly in remote areas;
- staff recruitment and retention;
- supporting populations dispersed over large areas;
- a lack of basic infrastructure; and
- long distances to be covered by both providers and clients with very limited public and community transport.[47]

These challenges are balanced to some extent by the very strong support often found within the community for aged care services, often the major employer in small communities.

Given the evidence on the relatively strong economic and financial performance of rural providers the targeted capital grants in the rural sphere should be adapted to the general strategy for development of the industry. Targeted grants should be based on proposals for consolidation and restructuring of existing facilities into larger groups. This does not necessarily mean loss of single ownership. It may mean entities establishing a co-operative back office company to secure gains in managerial accounting, technological and educational arrangements not available to any one entity acting alone.

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[47] Department of Health and Ageing (DoHA), *Finding Solutions: Delivering quality aged care in rural and remote Australia*, Commonwealth of Australia.

9.5.1 Aged care in rural, regional and remote Australia

Approximately one third of aged care places are located in rural and regional Australia and almost half the 6561 new places allocated in the 2002 Aged Care Approvals Round were allocated to regional, rural and remote areas.[48] However, this distinction reflects a very wide definition of rural. The allocation process ensures that aged care places are provided in rural and remote areas in proportion to the number of older people who live there. The aim of the process is equitable distribution of facilities within each state/territory as well as between states/territories.

Aged care providers in remote areas are invariably government, church or other charitable institutions. The sector is unattractive to private providers as there is insufficient profit available to them to warrant the significant capital investment required. The facilities are generally much smaller than average. Even the traditional church and community sector organisations are experiencing difficulty in maintaining viability, notwithstanding the ability of some providers to cross-subsidise.

In many regional areas the average age of the population is significantly higher than metropolitan Australia, with consequential impacts on the demand for aged care services.

9.5.2 Funding

Lower house values and relatively stable property markets mean that some rural residents do not have significant assets. The intergenerational transfer of farms is exempt from Centrelink means test gifting rules, under the retiring farm assistance scheme. For these reasons, facilities in rural and remote areas do not have the same capacity as metropolitan facilities to attract large numbers of accommodation bonds and/or bonds of any appreciative value. Across Australia, the average amount of each new bond was $98 775 in 2002–03 and $82 989 in 2001–02.[49] Bonds as low as $14 200 were quoted by rural providers for 2001–02.[50]

Distinctions should be drawn between aged care recipients in rural and remote areas. Generally concessional or assisted residents in rural areas are little different in terms of proportions of all residents from the metropolitan locations. The higher proportion of concessional residents with a low asset base found in the remote areas limits a provider's ability to make funding provisions for capital expenditures.

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48 DoHA, *Report on the Operation of the* Aged Care Act 1997, *1 July 2002 to 30 June 2003*, Commonwealth of Australia, 2003.

49 DoHA, *Report on the Operation of the* Aged Care Act 1997.

50 Submission 110.

9.5.3 Residents with special needs

Rural and remote services may have more difficulty in providing appropriate support for residents with special needs such as dementia, psychiatric disabilities, intellectual disabilities and acquired brain injury. Access to allied health care professionals such as physiotherapists, occupational therapists, podiatrists, GPs and chemists may also be more limited.

Building construction costs are significantly higher in rural and remote areas. It is possible that premiums of between 10 per cent and 70 per cent above metropolitan costs apply, with higher percentages applying in remote locations. In addition, there may be increased construction costs related to the geographic location of a facility, such as the installation of heating or cooling. Costs specific to facilities located in a tropical environment include cyclone-proof building design.

Operational costs, including electricity, water, fuel, communications and technology, are also generally higher in remote areas. This is true also for some rural areas. These higher costs may result partly from lack of competition between suppliers and tradespeople, and from transport costs. Necessary supplies and services such as medicines, incontinence aids and laundry services are more expensive due to freight costs. Services also pay premiums for food, particularly fresh food.

The problem of staff shortages across the aged care sector is exacerbated in rural and remote areas. The availability of a skilled workforce is limited, with consequences for the recruitment and retention of staff. It may be necessary to provide such incentives as housing support to attract staff. There is also difficulty in securing management expertise, especially governance experience.

Education and training may also involve increased costs. Training is generally not available locally, and providers must send staff to training facilities or bring the training on site, paying for trainer's travel costs, time and accommodation. However, satellite transmissions should remedy many of these shortcomings.

9.5.4 Submission comment

A number of submissions claimed that there is inequality of access across regions, with limited choice and availability in rural regions. They argued that older people are often forced to relocate to distant residential care facilities because there are no facilities or insufficient places available in their immediate area.

Some submissions have argued that bed shortages are a problem, with long waiting lists in many rural towns. They state that older people are forced to relocate to a facility some distance away because there are no places available at their home location or there is no facility in the vicinity.

While most providers agreed that the viability supplement was vital, many considered that the supplement was not sufficient. A common issue for rural and remote providers currently receiving the viability supplement is the threshold facility size at which the supplement is reduced. They argue that the number of beds is too low, and prevents smaller facilities from expanding to meet demand. For example, at consultations in Darwin, if an 18 bed low care facility were to build an additional badly needed 6 high care beds, there would be a consequential decrease from $19.00 per day to $11.00 per day in their viability supplement.

9.5.5 Australian Government capital funding: concessional supplements and targeted grants

Since 1997 the Australian Government has sought to withdraw progressively from providing capital across the board while seeking to encourage capital from other sources. At the same time the Government has provided capital contributions and targeted capital where other sources are limited and capital is most needed to support upgrading and growth. The following supplements are primarily aimed at ensuring access to services through a capital component of certain supplements and some targeted capital grants.

Concessional resident supplement

The concessional resident supplement recognises income forgone by providers because such residents are excluded from paying accommodation bonds or charges. Nearly 65 000 residents receive this supplement including 50 per cent of post-1997 residents who are concessional or at least 'assisted'. In 2002–2003, the Australian Government paid a total of $212.7 million in concessional supplements. There is no legislative requirement that providers must spend income from concessional supplements on capital works, despite the supplements being a form of payment in lieu of income received from bonds or charges.

Viability supplement

In addition, some rural and remote homes receive viability supplements ($13.5 million in 2002–03) in recognition of the difficulties faced in relation to isolation, small size and high cost structures and where small services are largely caring for financially disadvantaged people and other groups with special needs.

The Review is concerned that the structure of the eligibility criteria creates a disincentive for services to put more beds on line. In particular, the thresholds present in the service size criteria mean that even putting one extra bed on line can lower a service's viability supplement by a considerable amount. For example, if a 19-bed service with an eligibility score of 100 adds an extra bed (and hence the eligibility score drops to 90), the service's income through the viability supplement would

decrease by nearly $50 000 a year. This flaw in the eligibility mechanism must be remedied since it discourages services in remote areas from expanding even if there is a demand for more beds. This disincentive effect works against the attainment of any reasonable economic size.

Eligibility for the viability supplement must not be explicitly based on the size of the service. The viability policy must only be to ensure that people in remote areas and from special needs groups have access to care. However, remote services are generally small and determining eligibility on the basis of remoteness should apply. Otherwise, eligibility criteria relating to service size allows small services in accessible areas to claim the supplement while not being part of either target group of the government's policy. However, it is noted that the size of the service may contribute to the eligibility of small services that are catering to a special needs group, even if the service is located in a highly accessible zone. In this case, the rate of viability supplement payable is usually quite low.

The challenge in the design of the eligibility criteria is targeting adequate supplementary funding to those services small due to necessity, while not subsidising services which are inefficient in their current configuration and which do not contribute to expanding access to care in areas where needed.

Recommendation 11 provides for enhanced viability supplement arrangements.

Targeted capital grants

In 2002–03, $35.7 million targeted capital funding was available to assist mostly rural and remote facilities with upgrading and to provide transitional capital funding for homes needing financial assistance to enable them to maintain certification. In the 2002–03 Budget, additional capital funding of $100 million ($25 million per annum over four years) was provided for grants with availability extended to high care homes in urban fringe areas. Hence, a total of $139.7 million will be available over the forward years to 2006–07, with funding beyond that estimated to continue at around $13 million per annum.

However, the results of the analyses of performances by various types of providers offered in Chapter 3 show rural providers recording earnings compensible to providers in other locations. Rural locations are not relatively handicapped with many listed in the top 10 per cent and the first quartile in the examination of gross earnings presented in Table 3–10.

In light of this information, there are grounds for distinguishing the rural sphere from the remote regions in Australia. This means adapting existing policies towards rural providers to ensure commitments to gains in productivity and efficiency apply equally to them as to metropolitan providers.

Recommendation 12 confirms the continuation of targeted capital assistance.

9.6 The elderly homeless

One of the most difficult groups to place in residential aged care is the elderly homeless, a predominantly male group. Many elderly homeless people may have some disability, alcohol dependency, multiple cognitive problems, poor health status, poor nutrition, premature ageing and social isolation. Often they may be subject to physical danger. Where residential aged is available they enter at an earlier age than the general population.

Homeless older people may experience discrimination in the aged care system. Mainstream residential aged care services generally do not have the resources or the skills to provide accommodation, care and support for this 'special needs group'.[51] They are often reluctant to accept the elderly homeless, given the extent of the challenge associated with looking after them. While the elderly homeless attract a concessional resident supplement, they generally have no ability to pay an accommodation bond, compounding the problem of access to mainstream services.

When addressing the concept of the elderly homeless the central idea should be about those experiencing chronic long term homelessness and subject to personal vulnerability, thought of as exposure to physical harm and exclusion from access to personal private facilities. Those people falling within this definition are likely to be the most difficult of people to take into residential aged care, owing to their idiosyncrasies in personal behaviour bringing handicaps to living in a stable community. These features may explain why much support for the elderly homeless is directed to those who are less challenging in their behaviours.

9.6.1 Access to services

The major welfare agencies have recognised the need to provide services targeted at homeless people, and particularly at the elderly homeless. The issue of elderly homeless people has been recognised as a particular problem in Victoria, where a number of organisations specialise in providing accommodation for people who are homeless. For example, Wintringham is a not-for-profit welfare organisation providing housing and care to frail and elderly people, many of whom are homeless, or at risk of becoming homeless. The company is guided by the principle that its elderly residents are elderly before they are homeless and are therefore entitled to receive the same standards of care applicable to the rest of the community.[52]

There is a common view among a number of advocates and researchers that older homeless people face barriers in accessing mainstream housing and other services for the elderly. The aged homeless may have lifestyles and values that are very different

[51] Victorian Association of Health and Extended Care (VAHEC), *Homeless Elderly in Residential Care, Issues Paper*, VAHEC, August 2001.

[52] See www.wintringham.org.au.

from those of older people accessing mainstream services resulting in a cultural 'mismatch' between the services available and older people who are most in need.[53]

The elderly homeless experience difficulty gaining access to residential care services under the ACAT referral system, possibly as a result of:

- a perceived lack of residential care catering for the needs of this client group
- a possible lack of understanding about the needs of the elderly homeless and hence a reluctance to refer those suffering premature ageing to residential aged care
- a general reluctance to admit elderly homeless to mainstream residential care services due to negative images, including unruly behaviour, excessive drinking and personal hygiene issues.[54]

The current RCS system requires residents to be assessed against a number of criteria. It is arguable whether the RCS is an appropriate tool for the assessment of those residents who were homeless prior to entry and exhibit certain behaviours. It has been put to the Review that these behaviours require specific care resources not recognised by the RCS. It may be that the intensive level of care and one-on-one support required by such care recipients is provided only with difficulty under the current funding structure.

Organisations with a high proportion of elderly homeless residents often have an additional financial burden. Concessional residents pay 85 per cent of the age pension in fees to assist in meeting the cost of their care. In organisations where over 90 per cent of residents were homeless prior to admission, a situation often arises where residents spend more than 15 per cent of their pension on various addictions (alcohol or other substances), leaving less than 85 per cent of the age pension to pay the home for their care.

This situation may help explain the acceptance into residential aged care of the less deprived among the elderly homeless. There will be a reduced prospect of disturbances between themselves and other residents.

Access to capital through borrowings or fundraising is often not a realistic option for facilities providing residential aged care services for the most deprived elderly homeless. The organisations have little means by which to service a loan and fundraising is difficult when competing with more appealing causes such as cancer research or a children's hospital.

9.6.2 Comment

The elderly homeless clients of residential aged care accept residential care services with varying degrees of tolerance. Often housing is of the most relevance and interest

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53 Department of Family and Community Services (FACS), *SAAP Monograph—Older SAAP Clients*, Commonwealth of Australia, February 2003.

54 VAHEC, *Homeless Elderly in Residential Care*, op. cit.

to the bulk of the elderly homeless. When aged men and women living in night shelters or boarding houses move to an aged care facility, they may not recognise that they require care and support. However, they do place a very high priority on a private, lockable room from which they will not be evicted and which affords protection from physical violence.[55]

There may be other options for the elderly homeless aimed at averting access to the acute hospital system and preventing them from premature admission to an aged care facility. For example, one service provider in Victoria has successfully delivered Community Aged Care packages into supported accommodation (state or community owned housing) settings, thereby demonstrating that it is possible to provide quality aged care services through the interaction of housing and aged care.

Nothing advanced so far addresses the conditions experienced by the most deprived of the elderly homeless. They are all too easily lost from sight yet all the commentaries on the existence of homelessness do not ignore the plight of the elderly numbered amongst them. Given the funding problems noted earlier there are very substantial grounds for providing for the special needs of the most deprived of the elderly homeless by way of targeted capital grants. This provision relates to the proposals advanced in Recommendations 6 and 12.

9.7 People from Aboriginal and Torres Strait Islander communities

The Aged Care Standards and Accreditation Agency is charged with ensuring that '... care is delivered with understanding of and sensitivity to the impact on lifestyle based on a person's cultural and linguistic background'.[56] Standard 3.8, under 'Resident Lifestyle', requires of providers that 'individual interests, customs, beliefs and cultural and ethnic backgrounds are valued and fostered'.[57]

The importance of country to Indigenous populations cannot be underestimated. Access to services within an indigenous person's own area is of fundamental significance to them.

9.7.1 Challenges for providers

People from Aboriginal and Torres Strait Islander communities are recognised as having special needs when it comes to aged care. While Indigenous people do not

[55] Submission 281.

[56] DoHA, 'Quality of Care for Older Australians—Support for Aged People from all Backgrounds' at www.ageing.health.gov.au.

[57] Aged Care Standards and Accreditation Agency, 'Accreditation Standards' at www.accreditation.aust.com.

make up a large percentage of the total permanent residential care population, 5 per cent as 30 June 2002,[58] they have lower life expectancy than the non-Indigenous population, and experience earlier onset of chronic disease. They therefore require aged care at an earlier age and form part of the potential client group from age 50.

There are also other cultural challenges. For example, the population of the Kimberley region is around 50 per cent Aboriginal. Some facilities in the area (such as Fitzroy and Halls Creek) have a 100 per cent Aboriginal resident population (others have around 75 per cent). Such facilities provide:

> … a service that is culturally appropriate [and] not an 'add on' that can be applied to a mainstream service—it requires a different way of operating that suits the needs of the residents concerned. [59]

Provision of care appropriate to Aboriginal residents requires additional staff time from that in mainstream services and can include the following:

- having male and female staff on each shift so that gender taboos can be respected when providing personal care;
- maintaining a high percentage of local Aboriginal staff—which requires ongoing training; collecting staff for work; a pool of casual relievers to allow for cultural demands placed on staff; allowing staff's children into the workplace, etc;
- ensuring that residents regularly return to their country/community;
- facilitating access of traditional healers to the facility; and
- considerable liaison with other local community organisations and the school to ensure regular visits/social opportunities for the Fitzroy community to maintain contact with its elders who are residents of the hostel.[60]

Services in areas like the Kimberley region also suffer from the costs of delivering care in remote areas. Consumer Shopping Basket Surveys show that goods in the Kimberley are up to 175 per cent the cost of goods in Perth.[61] Other very remote areas experience similar cost of living premiums.

Facilities in these areas experience similar staffing problems common to other facilities in that nurses are scarce, training and education are more problematic and specialist nursing staff is difficult to find. Wages parity is an issue for registered nurses (RNs) and carers in Aboriginal aged care, where wages are lower than those in Aboriginal Medical Services and state-funded hospitals.[62]

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[58] Table 2.6—Permanent residents, Indigenous status by sex and state/territory, AIHW, *Residential Aged Care in Australia 2001–02. A statistical overview*, Aged Care Statistics Series Number 13, Commonwealth of Australia 2003, p. 33.

[59] Submission 288, p. 2.

[60] Submission 288, p. 2.

[61] Submission 288, p. 1.

[62] Submission 288, p. 2.

Current strategies

The Australian Government's Aged Care Strategy for Aboriginal and Torres Strait Islander people aims to:

> …improve the flexibility and viability of services for indigenous people. New pilot projects established in rural and remote areas focus on delivery of flexible care to indigenous people in their own communities. This will reduce the need for people to leave their local communities for distant urban centres to receive aged care services.[63]

As mentioned previously, flexible care means that services are provided with a mix of community care and residential places that can change as community needs vary. Funding is on an annual basis, which allows for flexibility and stability.[64]

At 30 June 2003, 480 flexible funding places were offered under the Aboriginal and Torres Strait Islander Care Strategy (places under the Strategy are outside the Aged Care Act). It is estimated that there are also in excess of 700 places available for Aboriginal and Torres Strait Islander people funded under the Aged Care Act and most but not all of these are in Indigenous-specific homes.[65] During 2002–03, an additional $3 million in capital funding was allocated to the flexible care services in rural areas for urgent upgrading requirements.[66]

In the 2003 Aged Care Approvals Round, 116 CACPs and up to 180 residential places were allocated for provision to applicants seeking to provide services to Aboriginal and Torres Strait Islander people.[67]

9.8 People from culturally and linguistically diverse backgrounds

While the majority of those in residential aged care were born in Australia, there is a substantial proportion of those in care, currently approximately 15 per cent, and people who may qualify for care, who were born outside Australia and who have culturally specific needs that need to be addressed by service providers.

According to the AIHW, older people from culturally and linguistically diverse backgrounds (CALD) backgrounds are expected to increase by 66 per cent over a 15 year period, while the Australian born population is expected to increase by only 23 per cent. In 1996, of the CALD population aged 65 and over, 16 per cent were aged 80 and over, compared with 23 per cent of Australian-born. These figures are expected to

63 DoHA, 'Quality of Care for Older Australians—Support for Aged People from all Backgrounds' at www.ageing.health.gov.au.

64 DoHA, 'Aboriginal and Torres Strait Islander Aged Care Strategy' at www.ageing.health.gov.au.

65 DoHA, *Operation of the* Aged Care Act 1997, p. 15.

66 DoHA, *Operation of the* Aged Care Act 1997, p. 27.

67 DoHA, *Operation of the* Aged Care Act 1997, p. 16.

rise by 2011 to 26 per cent and 28 per cent respectively. The CALD population is therefore ageing more rapidly than the Australian-born population.[68]

The NSW Aged Care Alliance is of the view that people from diverse language and cultural background under-utilise aged care services[69] and it appears that statistics would confirm this.[70] [CC1]For those from a non-English speaking background, 16.3 residents per 1000 people used residential care, whereas for those from an English speaking background the figure is 25.5 residents per 1000 people.[71]

More than 120 ethnic community organisations are funded by the Australian Government to provide aged care. Many CACPs are also set aside specifically for those from culturally and linguistically diverse backgrounds.[72] In the 2003–04 Aged Care Approvals Round, 930 new residential care places (out of a total of 8666) and 151 CACPs (out of a total of 861) were allocated for people from culturally and linguistically diverse backgrounds.[73]

It is recognised that being from a culturally and linguistically diverse background can lead to feelings of isolation, and several of the Community Visitors Scheme auspices are specifically focused at people from diverse backgrounds, with many community visitors involved in the Scheme as a whole being bilingual.[74]

The Australian Government also funds the Partners in Culturally Appropriate Care (PICAC) initiative, under the auspices of the Ethnic Aged Care Framework. The Framework seeks to:

- improve the partnerships between aged care providers, culturally and linguistically diverse communities and the Department of Health and Ageing; and
- ensure the special needs of older people from diverse cultural and linguistic backgrounds are identified and addressed.[75]

A PICAC organisation, funded in each state and territory, facilitates linkages between the aged care sector and culturally and linguistically diverse communities, to '... identify and address issues relating to the delivery of culturally appropriate aged

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68 AIHW, 'Rise in number of older immigrants expected', *Media Release*, 13 June 2001.

69 Submission 36, p. 5.

70 Defined as those born in Australia, Ireland, United Kingdom, New Zealand, United States of America, Canada and South Africa.

71 Table 2.16 'Age- and sex- specific usage rates for permanent residents, by English-speaking status, based on country of birth, 30 June 2002, in AIHW, *Residential Aged Care in Australia 2001–02. A Statistical overview, Aged Care Statistics Series Number 13*, Commonwealth of Australia 2003, p. 49.

72 DoHA, 'Quality of Care for Older Australians—Support for Aged People from all Backgrounds' at www.ageing.health.gov.au

73 DoHA, *Operation of the* Aged Care Act 1997, pp. 5, 7, 16.

74 DoHA, 'Support for Aged People from all Backgrounds'

75 DoHA, 'Partners in Culturally Appropriate Care' at www.ageing.health.gov.au.

care'.[76] In 2002, total funding for PICAC and the Ethnic Aged Services Grants Program was $1.6 million.[77]

The Review supports the continuation of existing arrangements for assistance to those older people with ethnically and culturally diverse backgrounds. There are grounds, however, for providing capital support as part of targeted capital grants or like provisions. Nevertheless no recommendation is offered on this matter because there might be some very special circumstance between now and 2008 for rebuilding or refurbishment of existing facilities.

In the provision of residential aged care for this group, the Review prefers allocations to be made within the framework of a large residential service, rather than to a facility committed to any one ethnic or cultural group.

9.9 Comment

Determining eligibility for entry into care is a complex process with many factors to be taken into consideration. Facilitating entry into care for those people with special needs requires dedicated resources and targeted program strategies to ensure that those people are able to access appropriate care. The role of ACATs is a fundamental issue for consideration in ensuring equitable access to care planned effectively and targeted to areas of the greatest need and to people with the greatest need.

[76] Ibid.

[77] DoHA, *Operation of the* Aged Care Act 1997, p. 16.

10. FUNDING FOR CARE

The Australian Government funds aged care in the form of subsidies paid to providers. Fees are also paid by individuals in the form of care fees and accommodation payments.

10.1 Expenditure on aged care

In 2002–03, recurrent expenditure was just over $4.9 billion on residential, community and flexible care services under the *Aged Care Act 1997*. Of this, $4.3 billion was spent on residential aged care, broken down as follows:

- $3.7 billion appropriated through the Health and Ageing portfolio; and
- $630 million appropriated through the Department of Veterans' Affairs portfolio.

Projections are that total income to providers of residential aged care is expected to increase from $4.2 billion in 1997–98 to over $6.1 billion in 2002–03. Providers obtain the majority of their income from subsidies (75 per cent) and the balance from care fees and accommodation charges paid by residents (25 per cent).

10.2 The Resident Classification Scale

The basic tool for funding aged care is the Resident Classification Scale—payments to providers are based on a resident's classification assessed on a scale from 1–8, with levels 1–4 being classified as high care and levels 5–8 as low care. The RCS table comprises 20 questions, which are given variable response weightings to give a points score up to 100. The level at which a resident is classified depends on the number of points scored. The RCS table and questions are reproduced at Appendix F.

10.2.1 The RCS subsidy

The subsidy for each resident is paid monthly in advance and calculated as follows:

- a basic subsidy amount determined by the resident's classification under the RCS (for respite residents by the ACAT's assessment of the resident); plus
- any primary supplements for concessional residents, transitional residents, respite, oxygen, enteral feeding payroll tax and transitional subsidy; less
- any reductions in subsidy resulting from the provision of extra services, adjusted subsidies for government (or formerly government) owned aged care homes or the receipt of a compensation payment; less
- any reduction resulting from the income-testing of residents who entered residential care on or after 1 March 1998; plus

- other supplements, including the pensioner supplement, the viability supplement and the hardship supplement (which reduces charges for residents who would otherwise experience financial hardship).

The basic subsidy amounts are shown below in Table 10–1. A full list of subsidies and supplements is set out in Appendix G.

10.2.2 Extra Service fees

Residents occupying extra service places pay an additional Extra Service daily fee, with providers able to charge accommodation bonds in high care as well as low care. The Australian Government's residential care subsidy to the provider is reduced by 25 per cent of the daily Extra Service fee in respect of each Extra Service place.

Table 10–1: The basic subsidy amounts

Classification Level	NSW	VIC	QLD	SA	WA	TAS	ACT	NT
RCS 1	$116.47	$119.51	$115.80	$115.80	$115.80	$120.26	$115.80	$117.00
RCS 2	$105.51	$108.14	$105.00	$105.00	$105.00	$108.94	$105.00	$106.01
RCS 3	$90.88	$93.10	$90.46	$90.46	$90.46	$93.96	$90.46	$91.30
RCS 4	$64.33	$65.91	$63.94	$63.94	$63.94	$66.86	$63.94	$64.60
RCS 5	$38.95	$38.95	$38.95	$38.95	$38.95	$38.95	$38.95	$38.95
RCS 6	$32.27	$32.27	$32.27	$32.27	$32.27	$32.27	$32.27	$32.27
RCS 7	$24.77	$24.77	$24.77	$24.77	$24.77	$24.77	$24.77	$24.77
Respite High*	$90.88	$93.10	$90.46	$90.46	$90.46	$93.96	$90.46	$91.30
Respite Low*	$32.27	$32.27	$32.27	$32.27	$32.27	$32.27	$32.27	$32.27

* These subsidies are only payable for the 'Maximum Number of Days' prescribed by Residential Care Subsidy Principles 1997.

10.2.3 Supplementary payments to the basic subsidy amount

The basic subsidy amount is supplemented by other payments. The primary supplementary payments are:

- supplements payable for concessional and assisted residents;
- respite supplement;
- charge exempt resident supplement;
- oxygen supplement and enteral feeding supplement;
- payroll tax supplement;
- transitional supplement.

The concessional and assisted resident supplement

Services receive supplementary funding for concessional residents to assist their access to care. A concessional resident is someone who is unable to afford to pay an

accommodation bond or charge. To be a concessional resident, a resident must, at the time they entered care:

- be receiving an income support payment (this includes a pension or benefit); and
- not have owned a home for the past 2 years or more; and
- have assets of less than 2.5 times the annual single base rate age pension, rounded to the nearest $500.

A person is also a concessional resident if a determination is in force under section 57–14 of the Act that paying an accommodation bond or charge would cause the person financial hardship.

In addition, providers receive a concessional resident supplement for assisted residents but at a lower rate. The criteria for determining assisted resident status are the same as for concessional resident status except that an assisted resident can have assets of between 2.5 and 4 times the annual single base rate age pension, rounded to the nearest $500.

An assisted resident, unlike a concessional resident, may be asked to pay an accommodation bond or charge as long as the resident is left with assets of 2.5 times the annual single pension. The maximum bond for such residents equates to $14,000.

Concessional resident supplement is only payable for residents who enter the service after the commencement of the Aged Care Act and after the service was certified. Concessional resident supplement cannot be paid for a resident who is receiving care on an extra service basis, or for one who is cared for in an uncertified facility. Respite residents are not eligible to receive the concessional resident supplement (the equivalent is included in the respite supplement) and respite residents cannot be counted towards a concessional resident quota.

The supplement is paid at two rates depending on the proportion of place days occupied by concessional residents. The lower rate of $7.70 per day is paid to facilities that have up to 40% of their new residents as concessional residents. The higher rate of $13.20 per day is paid for all concessional residents in facilities with more than 40% of their new residents as concessional residents.

The two-tier Concessional Resident Supplement is considered by providers of aged care to be unfair—providers with fewer than 40 per cent concessional residents are paid $7.70 per day compared with $13.20 per day if they have more than 40 per cent (see Table 10–2). The supplement was intended to act as an incentive to mainstream providers to provide services to homeless or financially disadvantaged residents. However, according to one provider, it severely impacts on those organisations whose clients are exclusively financially disadvantaged and who therefore have no opportunity to cross-subsidise with accommodation bonds. However, it should be noted that there is no time limit on the payment of the subsidy, whereas the retention amount from bonds ceases after 5 years.

One provider has suggested that organisations charging an industry-standard accommodation bond earn more than $20.00 a day per resident (earnings = interest + retention on a $110 000 bond), as opposed to organisations relying on the concessional resident supplement, which equates to a maximum of $13.20 a day per resident. An example given by this provider indicates that $13.20 per day would just service a debt of $27 690—considerably less than what is needed per bed to build a new service.

Table 10–2: Concessional resident supplement

% of new residents* who are concessional residents	Amount of supplement paid to the home per concessional resident per day	Annual income for the home per concessional resident
Less than or equal to 40%	$7.70	$2810.50
Greater than 40%	$13.20	$4818.00

* A new resident is a care recipient who enters the residential care service:

- if the service was certified during the period 1 October 1997—30 September 1997; or

- if the service was certified after 1 October 1997—the date the service was certified.

Recommendation 16 provides for amended concessional, transitional and assisted resident arrangements.

10.2.4 Assessment of concessional status

Concessional or assisted resident status is established at the time the resident enters care. Failure to assess a resident's concessional status correctly can mean significant financial disadvantage to a facility. The level of concessional resident supplement and the viability supplement may be affected by this assessment.

However, providers are dependent on the financial information provided to them by the resident or their family and may not therefore be in the best position to assess a resident's concessional status. Centrelink, on the other hand, has available to it the necessary information required for this assessment and the administrative mechanisms to manage the function. Recommendation 10 refers.

The respite supplement

Facilities receive a respite supplement in respect of respite residents. This supplement is aimed at offsetting the higher administration and care costs of respite care. It also includes an amount equivalent to the concessional supplement paid in lieu of an accommodation bond or accommodation charge for respite recipients. The respite payments can only be made for days on which the care provided was respite care, approved as such by an Aged Care Assessment Team.

There is a limit of 63 days per respite resident per financial year across any number of facilities. Subsidy will not be paid where the 63 day limit is exceeded unless an Aged

Care Assessment Team has approved an extension of respite following application. The extra days can be allocated depending on carer stress, the severity of resident's condition, absence of carer, or any other relevant matter.

Charge-exempt resident supplement

Charge-exempt residents are residents who were in a nursing home on 30 September 1997 and who move to another home where they would otherwise be eligible to pay an accommodation charge. This measure was implemented on 21 October 1999 and was retrospective. Service providers receive payments of charge-exempt resident supplement for the charge-exempt residents in their aged care homes, and cannot ask charge-exempt residents to pay the accommodation charge.

Oxygen and enteral feeding supplements

All residential care services can apply for a supplement for residents who are receiving oxygen treatment or enteral feeding. These treatments must be at the written direction of a medical practitioner.

To be eligible for an oxygen supplement, a resident must have an ongoing medical need for an eligible oxygen treatment (that is, the resident must require oxygen treatment on an ongoing continual basis rather than episodic or for a short term illness such as bronchitis). There is a standard supplement, where the need is met by a concentrator, and a higher supplement where medical requirements cannot be met by concentrator oxygen. A higher supplement is not available unless the costs incurred are at least 25 per cent above the standard supplement.

To be eligible for an enteral feeding supplement the resident must be receiving a complete food formula by means of nasogastric, gastrostomy or jejeunostomy tube. There are two levels of the supplement, one for bolus and another for non-bolus feeding.

A higher supplement may be approved for a resident whose enteral feeding needs cannot be met by a standard formula or dietary requirement. Before a higher supplement can be approved, medical certification is required and the costs incurred must be at least 25% above the standard supplement.

Payroll tax supplement

A payroll tax supplement is payable to providers who care for high dependency residents (categories 1 to 4) and who are liable for state-based payroll tax. The payroll tax supplement has a three-tiered rates structure in each state, apart from the Australian Capital Territory, the Northern Territory and Tasmania, which each have a single rate. The three tiers reflect the size of an eligible residential service and are 1 to 30 places, 31 to 60 places and 61 places or more.

Transitional resident supplement

Residents in nursing homes and hostels as at 1 October 1997 could not be assessed for concessional resident status and do not receive concessional resident supplement. Instead, existing residents receive a Transitional Resident Supplement. The amount of the supplement is a weighted average of the concessional and non-concessional resident rates under the new funding structure. Separate rates will apply to certified and uncertified facilities.

Residents who were in a residential care facility when the new arrangements commenced on 1 October 1997 continue to receive their current funding until they are reclassified under the Resident Classification Scale. They then receive funding under the Resident Classification Scale, plus transitional supplement at the appropriate rate.

Transitional supplement ensures that, overall, current residents are not disadvantaged, by providing funding equivalent to the total concessional resident supplement for a facility with an average number of concessional residents.

10.2.5 Other supplements

The adjusted subsidy reduction

Currently, the Government reduces the basic subsidy payable in respect of residents in some places operated, or formerly operated, by state governments by a notional return on investment component. This reduction is an historical artefact. It does not apply to all state government services and it continues to apply to services even after they are transferred to non-government operators. Recommendation 17 provides for the abolition of this subsidy reduction.

The pensioner supplement

Pensioners who occupy approved places in aged care homes are not entitled to rent assistance with their pension. Instead, the Department of Health and Ageing pays a pensioner supplement directly to the aged care home. Pensioner supplement is payable on a daily basis for residents who:

- receive an income support payment; or
- have a dependent child; or
- are respite residents, regardless of their pension status.

Recommendation 18 provides for the abolition of the pensioner supplement, to be replaced by an amended daily care fee arrangement, which will include access to the rent assistance component of the pension.

The hardship supplement

The hardship provisions came into effect on 1 October 1997. Residents who experience difficulty in paying the standard resident contribution, the income tested fee, an accommodation bond or an accommodation charge, may apply for assistance under these provisions. Where a resident is experiencing financial hardship in paying for their care, approval may be given to reduce their care fees, waive the income tested fee, or to waive an accommodation bond or charge.

A hardship supplement may be paid for specific classes of residents or for individuals who have applied for a hardship determination. A hardship supplement will not be paid in respect of periods prior to 1 October 1997.

Because each person's circumstances are unique, each application for assistance under the hardship provisions is considered on its merits. The resident fee is reduced by the amount of any hardship supplement.

The viability supplement

The Australian government recognises that there are some circumstances where the basic subsidy rates will not be sufficient to deliver quality care. A viability supplement is available to eligible residential care services in rural and remote areas to ensure their ongoing viability in circumstances which might otherwise not be viable. The supplement recognises the particular difficulties faced by such homes as a result of their isolation, small size and consequential higher cost structures.

The viability supplement ensures that people living in remote and isolated areas and people from certain special needs groups have access to care by allowing services catering to these groups to operate in circumstances that might otherwise be financially non-viable. The relevant special needs groups are Aboriginal and Torres Strait Islander people, people from a non-English speaking background, and veterans and war widows.

Three criteria, each of which contributes to a total of 100 points, determine eligibility:

- remoteness of a home's location (maximum of 60 points);
- the size of the home (maximum of 30 points); and
- whether 50 per cent or more of a home's residents are people who have special needs, excluding rural and remote considerations and those who are financially disadvantaged (maximum of 10 points).

A home needs to score at least 40 out of a possible 100 points to qualify for the supplement, with the weightiest element being remoteness. The other criteria make smaller contributions to a service's eligibility. The current viability supplement rates (per care recipient per day) are outlined in Table 10–3.

Table 10–3: Rates of viability supplement (as at December 2003)

Score	Amount of Supplement
Eligibility score of 100	$20.27
Eligibility score of 90	$12.48
Eligibility score of 80	$9.67
Eligibility score of 70	$6.87
Eligibility score of 60	$4.07
Eligibility score of 50	$1.40
Eligibility score of 40	$1.24

In 2002–03, 567 homes received total funding of $13.5 million in viability supplements.[1] The viability supplement varies from $1.24 to $20.27, largely depending on the degree of isolation.

10.2.6 Indexation of RCS subsidies

Residential care subsidies and supplements are indexed annually on 1 July each year, when the Minister determines the rates of payment for the basic subsidy and supplements. The indexation factor applied is made up as follows:

- 50 per cent of the recurrent income is indexed by a wage component based on movements in the Safety Net Adjustment (SNA), set by the Australian Industrial Relations Commission in the context of the National Wage Case and a price component, based on movements in the Consumer Price Index (CPI);
- 25 per cent of a provider's income comes from residents and grows in line with either the CPI or Male Total Average Weekly Earnings (MTAWE), whichever is the greater;
- 25 per cent of a provider's income from the Australian Government is linked to the CPI.

10.3 Limitations of the funding delivery system

The main disadvantages identified in the current funding delivery system are the administrative burden inherent in the RCS and the adequacy of the current funding arrangements to appropriately compensate for the care needs of particular groups of care recipients.

Further, a study by ABARE has highlighted the volatility of the RCS classification tool as a funding mechanism.[2] This volatility contributes to an uncertain funding stream to providers and to the potential for providers to maximise their income under the funding tool.

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1 DoHA, *Report on the Operation of the* Aged Care Act 1997, p. 25.

2 R Lindsay, G Griffiths & V Boero Rodriguez, *Aged Care Data: Statistical Analysis by ABARE (ABARE eReport 03.26)*, Report prepared for the Australian Government Department of Health and Ageing, November 2003.

Administrative burden

Providers argue that the administration, documentation and validation requirements of the RCS place an undue burden on them.

A major burden arises from care staff undertaking significant clinical documentation to justify RCS classifications in the event of being audited by Australian Government review officers. During the consultation process of this Review, reports of registered nurses (RNs) spending 20 per cent of their time on RCS documentation were common, while one claimed documentation was taking up 60 per cent of RN time. Providers also reported that the RCS validation process put care staff under a great deal of pressure and had deleterious effects on staff morale, which contributed to recruitment and retention problems.

The Resident Classification Scale Review (the 'RCS Review') was commissioned in response to increasing dissatisfaction by providers about the burden of the administration and documentation requirements of the RCS. It investigated the operation of the RCS and alternative funding and classification mechanisms. The report was released in February 2003.

The RCS Review:

- identified a number of administrative and operational difficulties with the current RCS-based system;
- noted the widespread practice across the industry whereby resident assessment is driven by the structure of the RCS;
- identified perceptions that the current RCS assurance/validation process is driven by documentation, is inconsistent across review officers, is a process that produces significant rates of change in category (42%) and results in excessive levels of documentation that reduces the capacity to provide resident care;
- suggested legitimate alternative approaches that, if pursued, would provide the opportunity to establish a sound base for the operation and funding of residential aged care for the future; and
- identified a lack of incorporation of many essential principles relevant to sound funding models.[3]

The issue of the RCS structure driving resident assessment is identified as a fundamental problem. While the RCS was designed to classify residents on the basis of care needs in order to determine levels of subsidy, the RCS Review suggested that it had become the basis upon which an assessment of care needs for the purposes of care planning is made. The RCS Review concluded that substantial revision of the RCS was required or replacement with an alternative system was recommended, particularly for the longer term.

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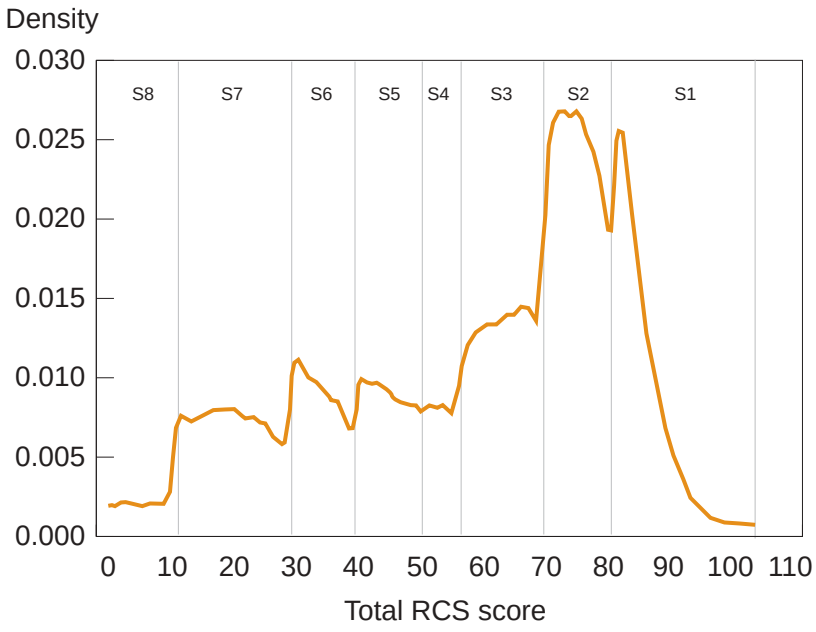
[3] RCS Review, pp. 5–6

Volatility of the RCS

The project Aged Care Data: Statistical analysis by ABARE,[4] which was commissioned by the Review, involved a range of analyses conducted on RCS scores across all admissions to permanent residential aged care between 1 October 1997 and 31 December 2002.

Figure 10–1 plots the density of RCS scores in this population against the aggregate (total) RCS score. The vertical lines indicate the boundaries between each of the RCS classification levels. As this figure shows, there is distinct patterning in the aggregate RCS scores, in that the density of scores drops just before the boundaries and rises on the other side of the boundary. This is particularly evident at the boundaries of RCS 6 and 7, RCS 5 and 6, RCS 2 and 3 and RCS 1 and 2. It can be argued that this patterning forms evidence that providers may overestimate the care needs of care recipients whose aggregate RCS scores are close to the upper boundary of an RCS category, in order for them to be classified at a higher RCS level and hence receive a larger subsidy. The fact that this patterning is not evident at the boundary of RCS 4 and 5, where an ACAT assessment is required to move across the boundary, is consistent with this argument.

Figure 10–1: Density of Resident Classification Scale score



Source: R Lindsay, G Griffiths & V Boero Rodriguez, Aged Care Data: Statistical Analysis by ABARE (ABARE eReport 03.26), 2003.

[4] R Lindsay, G Griffiths & V Boero Rodriguez, *Aged Care Data: Statistical Analysis by ABARE (ABARE eReport 03.26)*, Report prepared for the Australian Government Department of Health and Ageing, November 2003.

The ABARE report also provided evidence of the potential volatility of RCS classifications. The study examined the number of clients whose aggregate RCS score was at a level that a movement of the rating of one of the 20 RCS questions up or down a level (eg. B to C or D to C) would cause a change in RCS category. This was defined as being within reach of a category boundary. ABARE's results are reproduced in Table 10–4.

Table 10–4: Percentage of clients with ratings in reach of a category boundary

		Percentage of residents with ratings in reach of:			
Category	**Number of clients**	**only the lower boundary**	**only the upper boundary**	**both upper and lower boundaries**	**neither upper nor lower boundary**
	No.	**%**	**%**	**%**	**%**
S1	38 946	83.6	na	0.0	16.4
S2	66 891	65.5	22.9	6.2	5.3
S3	42 093	50.4	37.7	0.9	10.9
S4	10 699	5.8	9.8	84.3	0.0
S5	21 071	31.1	37.2	31.3	0.4
S6	22 475	34.6	37.0	25.8	2.6
S7	29 645	29.4	40.1	0.0	30.5
S8	3 483	na	62.7	0.0	37.3

Notes: na = not applicable

Source: Ray Lindsay, Greg Griffiths and Veronica Boero Rodriguez Aged Care Data: Statistical Analysis by ABARE (ABARE eReport 03.26), 2003.

As can be seen in the table, a significant proportion of clients at each RCS level, but particularly levels 4, 5 and 6, are within reach of at least one category boundary, and many are in reach of both the upper and lower boundaries. The implications of this sensitivity are twofold. On one hand, it indicates the potential ease with which RCS scores can be manipulated in order to classify at a higher level. On the other, it is indicative of the potential for RCS classifications to be changed in the validation process, with financial implications for affected providers.

Strategies that some providers take in order to maximise their RCS income include:

- avoiding classifying residents at certain levels (eg. RCS 4 and RCS 8);
- taking a strategy of upgrading the RCS classification of residents and accepting that some may be downgraded at review; and
- managing their resident profile by admitting new residents at the same level as the resident that left the service to maintain a consistent income over time.

It should be noted that there are clear links between the documentation burden associated with administering the RCS and provider gaming. This relationship was described in the submission provided by Shepparton Retirement Villages Inc:

> Many facilities only continue to exist because they have learned the new funding rules with the assistance of the myriad of expensive consultants born of the new legislation and in particular the new funding tool. As the Government acts to stop Treasury leakage from the documentation upskilling by changing the rules or the emphasis, the industry discovers some new system of recording that maximises more revenues. The system perpetuates the problems because to maximise the revenues significant [sic] more documentation consumes significantly more resources. The Government then retaliates either by changing the rules again or by scheduling an RCS audit, and so on.[5]

10.4 Adequacy of the arrangements in funding the care needs of particular groups

Evidence presented to the Review has indicated there may be changing expectations of what level of care can be delivered within the residential aged care context. There are expectations that residents with complex pain management, palliative care, wound management, nutritional, dialysis and tracheotomy care will stay within the nursing home to receive these types of care, rather than transferring to an acute facility.[6]

Providers question the adequacy of the subsidies payable for people with a range of specific care needs including:

- special medical needs such as palliative care, dementia care for people with challenging behaviours, stroke victims, or people with intellectual or physical disabilities
- needs of people from diverse or disadvantaged backgrounds such as homeless people, people from culturally or linguistically diverse backgrounds and indigenous Australians.

Additionally, the RCS Review recommended that additional payments be investigated for special medical activities typically of short duration. They mention intravenous therapy, major wound management, intensive pain management, tracheostomy, and for insulin-dependent residents.

10.5 Alternative approaches

The alternative approaches outlined below are presented in terms of their capacity to address the three types of weaknesses identified above, namely: the administrative burden that the classification process places on providers; the volatility of the classification tool leading to problems of income security for providers and potential for provider gaming; and the adequacy of the funding arrangements to appropriately fund the care needs of particular groups of care recipients.

[5] Shepparton Retirement Villages Inc, Submission 117, p. 2.
[6] Submission 109.

10.5.1 A streamlined payment structure

As discussed above, the current payment structure, where subsidies are paid at seven rates, is highly volatile in terms of the potential for classifications to be affected even by a one level change on a single question on the RCS.

In addition, analysis has been undertaken to examine whether 'the client population could be considered as being composed of an identifiable set of well formed clusters based on the pattern of ratings in the 20 RCS components'.[7] This may indicate the logical number of funding levels to include in a revised payment structure. However, the analysis showed that there were no well-separated clusters in the RCS scores of the resident population. This is interesting on two accounts: it indicates that the current structure with eight levels does not reflect any clear naturally occurring clusters; and that no other set of well separated clusters exists within the admissions data.[8]

While the cluster analysis did not provide any evidence of natural groupings, there was some evidence that high care and low care formed two distinct populations in aged care admissions.

There is also evidence that the spread of classifications within the high care and low care bands is changing. As Table 10–5 shows, between June 1999 and June 2002 there was a 36 per cent increase in the proportion of care recipients classified at RCS 1, while classifications at RCS 2 and 3 have dropped, and a similar pattern can be seen in low care. This 'squeezing' at the top of the bands (but within the bands) is further evidence of two distinct populations of aged care residents.

Table 10–5: Proportion of residents in each RCS category, 1999 to 2002

RCS category	Unit	June 1999	June 2000	June 2001	June 2002	Change 1999 to 2002
RCS 1	%	14.2	17.2	18.8	19.3	35.9
RCS 2	%	25.7	25.4	25.1	24.9	-3.1
RCS 3	%	16.5	15.4	14.7	14.5	-12.1
RCS 4	%	4.6	4.6	4.6	4.6	0.0
High care	**%**	**61.0**	**62.6**	**63.2**	**63.3**	**3.8**
RCS 5	%	8.8	9.8	10.5	10.5	19.3
RCS 6	%	10.2	10.5	10.8	10.8	5.9
RCS 7	%	16.9	14.9	13.9	13.8	-18.3
RCS 8	%	3.1	2.2	1.6	1.5	-51.6
Low care	**%**	**39.0**	**37.4**	**36.8**	**36.7**	**-5.9**

Source: DoHA unpublished data.

7 Lindsay et al., op. cit, p 40.
8 Lindsay et al., op. cit, p. 41.

The evidence presented above indicates that a) the current funding classifications are highly volatile and b) the eight levels within the funding system are arbitrary cut-off points rather than representing meaningful groupings of care recipients. On the basis of this evidence, it can be argued that reform of the subsidy arrangements is warranted.

One option is to abandon the eight classifications and pay subsidies on a continuous scale depending on a care recipient's aggregate RCS score. There are several advantages to a continuous funding model. First, subsidies would be more accurately pitched to individual need, and would better recompense providers for providing care to those whose RCS score is at the upper end of a classification band. Second, it would minimise the incentive for providers to manipulate RCS scores to get a care recipient 'over the line' to qualify for a higher RCS classification. However, it does not entirely remove the incentive to overestimate the care needs of a resident, as any increase in RCS score, even only a few points, would result in a higher rate of subsidy. It is therefore not clear that this option would resolve the problems of provider gaming and uncertainty of income for providers.

Another option is to reduce the number of levels within the payment structure and introduce a wider range of supplements to target funding towards care recipients with above average care needs. Reducing the number of subsidy levels in the funding structure should meet the reform goals of providing income certainty for providers and less opportunity for provider gaming. It can also be argued that a funding system with a smaller number of funding levels lends itself to a simplified assessment process and this, in turn, may deliver a reduction in the administrative burden on providers.

While the ABARE analysis provides some support for two funding levels, an alternative option is to fund basic subsidies at three levels: high care, medium care and low care. Low care would consolidate RCS levels 5 to 7, while the medium and high care categories would consolidate levels 3 and 4 and levels 1 and 2 respectively. This approach is in keeping with the findings of the ABARE analysis, in that it recognises there may be definable populations for high care and low care, but retains some differentiation of care needs in high care. Recommendation 5 proposes an amended RCS, comprising only 3 funding levels.

It could also be argued that with the considerable increase in the availability of care in the community, through Community Aged Care Packages (CACPs) and the Home and Community Care (HACC) and Extended Aged Care at Home (EACH) programs, residential aged care services should be focused more towards people whose needs cannot be met in the community. Under current arrangements, government subsidies are not payable for people assessed at the RCS 8 level. With the changing profile of aged care service delivery, consideration could be given to setting the minimum eligibility requirements for subsidised residential care at a higher level, for example paying subsidies for care recipients classified as RCS 6 and above only (or the equivalent in any new assessment process).

Recommendation 6 provides for the introduction of supplements for a range of special care needs, such as short-term medical needs, such as intravenous therapy, wound management, intensive pain management and tracheostomy (as named in the RCS Review), or for ongoing needs, in the same vein as the oxygen and enteral supplements that are already in place. Supplements could be introduced for dementia sufferers exhibiting challenging behaviours, or for residents requiring palliative care.

To ensure the integrity of the funding system, supplements should only be offered for those conditions/treatments where the condition/treatment significantly increases the cost of providing care; and where eligibility criteria can be clearly defined and 'gate kept'. It is envisaged that sign-off by a medical professional would required to claim a supplement, in the same way that operates for the oxygen and enteral supplements.

It should be noted that there are a number of issues that require consideration in introducing new supplements to a funding system:

- paying supplements for specific medical activities would require clear definition of what forms the 'baseline' of medical activities funded under basic subsidy levels;
- introducing supplements for certain medical activities or care needs may lead to criticism that other needs have been overlooked for additional funding.

It is acknowledged that reducing the number of payment levels from seven to three may increase the risk that providers cherry pick residents on the basis of their need for care (or lack thereof) since the incentive to admit older people with complex care needs is reduced. However, the inclusion of greater access to targeted funding for particular care needs (through supplements) should overcome this. Additionally, it should be noted that while this might apply in the current context of high occupancy rates and long waiting lists (eg. unmet demand), cherry picking will not be a major issue if the current constraints on bed supply are freed up.

10.5.2 Reducing the number of questions on the RCS

While noting that it is not a complete solution, reducing the number of questions on the resident classification scale could go some way towards relieving the administrative burden of the classification process. The key issue is whether the scale can be reduced without compromising its capacity to measure and rank the care needs of residents.

The ABARE analysis of admissions data[9] explored the potential for using a reduced number of questions to predict an individual's aggregate RCS score. Using a stepwise regression, ABARE found that it is possible to produce a predictor using only one variable (question 5 relating to toileting) that explains 77 per cent of the variation in

[9] Lindsay et al., op. cit, pp. 21–23.

aggregate RCS scores. Predictors based on seven and 12 questions can explain more than 95 per cent and 99 per cent of the variation respectively. For these models, their capacity to predict an individual's RCS category (rather than simply their aggregate RCS score) was assessed. The results are presented in Table 10–6.

Table 10–6: Classification performance of selected predictors

Number of components used in predictor	Percentage of appraisals where predicted and current categorisations agree	Percentage of appraisals where predictor categorisation is within one category of current	Percentage of current S1 appraisals that are predicted as S1	Percentage of S1 predictions that are currently categorised S1
1a	34	79	93	35
7	71	99	62	75
12	88	100	85	88

a Note that the 1 variable predictor is only able to place appraisals into 4 separate categories, corresponding to the A–D ratings of the Toileting component, the 4 predicted categories have been treated as S1/S3/S5/S7.

As Table 10–6 indicates, in 88 per cent of cases the predicted categorisation using the 12-component predictor matches exactly with the categorisation using the existing RCS tool, and in all cases, the categorisation is within one category of the existing categorisation.

This analysis provides clear evidence that there is scope for the number of items on the RCS tool to be reduced without significantly jeopardising the power of the tool to classify aged care recipients on the basis of their need for care.

RCS reduced questions project

Work on the development of a revised RCS has already begun in the Department; the RCS Reduced Questions project was undertaken in response to the findings of the RCS Review with the aim of simplifying the classification process. Interestingly, it also proposes a 12-question model. Rather than simply excluding some of the questions from the scale, it reduces the RCS to 12 questions by excluding some questions that make only a minor contribution through their low weighting to the funding decision and by combining other questions that measure similar needs.

The project developed three alternative funding classification systems based on the reduced RCS question set: a regression model; an item response theory model; and a branching model. The three models were tested against the current RCS funding benchmarks with the report concluding that both the regression and branching models provide viable alternatives to the current RCS approach. The project also supported funding on the basis of continuous scores rather than the current approach of setting arbitrary categories, and conducted its analyses on a continuous cost variable that was derived from the current seven funding levels.

The regression model is fundamentally the same as was used to develop the current RCS system in that the regression co-efficients on each question level (A, B, C, D) relate directly to a dollar value. Branching models are used in the health sector to relate a set of patient attributes to the cost of an episode of care; those attributes most highly related are selected for the model. Branching models partition patients into 'end point' groups or 'nodes' where the patients' clinical characteristics and cost of care are as similar as possible. In this model, the patient attributes utilised are the responses on the 12 reduced RCS questions, although only 11 were used in the branching model developed in this project.

The report recognises that reducing the number of questions in the assessment tool will not be sufficient to significantly reduce the documentation burden on providers: that will require a revised approach to the review audit processes. It proposes that review officers validate a funding claim on the basis of assessment notes only, and do not examine care plans, progress notes or exception writing. The funding review audit would therefore be limited to validating the assessment of care needed, and not the care provided. The report notes that this would require a strengthened/confirmed role for the accreditation agency to ensure that high quality care, appropriate to the individual, is being delivered.

It should be noted that this project only examines the alternative models in relation to the current RCS and does not examine the RCS in terms of its ability to measure and weight, for funding purposes, various types of care need. The report does note that the revised RCS scale could be re-calibrated in a new costing study.

The work of the reduced RCS project has shown that a 12-question assessment tool has the capacity to effectively classify care recipients into eight levels. It could be argued that if the number of subsidy levels was reduced from eight to three, there would be scope for the assessment tool to be simplified further. Indeed, Aged Care Assessment Teams already assess potential care recipient on the basis of requiring high care or low care.

The Review notes and supports the announcement by the Minister for Ageing on 20 October 2003 that the RCS would be reduced to 11 or 12 questions and that review officers will only inspect documentation relating to a resident's assessment and not that relating to the ongoing care of a resident.

10.5.3 Independent assessment of care needs

Two factors undermine income certainty for providers: that the assessment for determining the subsidy payable for a particular care recipient takes place after the care recipient has been admitted into a facility; and the potential for classifications to be changed through the validation process. Introducing assessment that takes place before a person is admitted to care would alleviate the former factor, while assessment

conducted by an independent party, rather than the provider of care, has the potential to address the latter.

Work has already started on examining the feasibility of introducing independent assessment. The Independent Assessor Trial project, also undertaken in response to the RCS Review, had two aims: 1) to develop and trial an embryonic classification assessment tool (CAT) that was suitable for use by independent assessors; and 2) to determine the inter-rater reliability of a group of independent assessors using the CAT to classify a range of residents in aged care facilities.

The design of the new tool was based around the principles that the assessment should not require excessive documentation and that the tool should be easy for the assessor to use. A 10 domain tool was developed from current RCS questions, focussing on those domains that were appropriate for direct clinical assessment. To simplify the decision making process, the ratings were condensed to three levels rather than the four that apply in the RCS.

Twenty-one facilities from a number of states and covering a range of facility types participated in the trial of inter-rater reliability. Four residents were randomly selected from each facility. The operation of the trial is described below:

> Three principal trial assessors (PTA) were selected and trained in the use of the CAT. Each PTA carried out the Assessment Interviews of residents in each facility and video-recorded the interviews for the inter-rater reliability component of the trial. Each PTA assembled and trained seven Independent Assessors (IA) including three Commonwealth Nursing Review Officers, who reviewed the video-recordings of the assessment interviews under controlled circumstances and completed a CAT for each interview. The resulting CATs were analysed to determine agreement between IAs and accuracy against the PTA assessments which were used as a benchmark.[10]

The project reports that inter-rater reliability between Independent Assessors using the CAT was high, and disagreement on ratings was low. The report recommends the further development of the CAT to produce a validated tool that can be used as a resource allocation instrument. One issue to note is that the report claims that an Independent Assessor is not in a position to make assessments on behaviours or interventions to reduce or prevent behaviours, and that 'assessment for this domain will rely on facility staff supported by documentation'.

[10] Centre for Efficiency and Productivity Analysis, *Efficiency of Aged Care Facilities in Australia*, Report commissioned for the Review, 2003.

11. THE AGED CARE WORKFORCE

The aged care sector is a major employer in the Australian economy. The residential care sector alone is the ninth largest employing industry in Australia. In June 2000, approximately 131 230 people, or 1.3 per cent of the workforce, were employed in the aged care industry as well as an estimated 32 628 volunteers.[1]

11.1 Current situation

The aged care workforce has undergone considerable adjustment over the last decade. These adjustments are in response to the growth of the industry, the changing profile of consumers of aged care services and the dynamics of the nursing workforce.

11.1.1 Recent trends

The number of employees in the residential care sector declined between 1995–96 and 1999–2000, while the number of people cared for by the sector increased. This period also saw significant restructuring of the industry's workforce (Table 11–1). Employment in the for-profit sector contracted by 25.0 per cent, both among employees providing direct care and other employees. At the same time, the not-for-profit workforce grew by 14.0 per cent, but with a much greater emphasis on employment in direct community services provision, at the expense of managerial, administrative and other support staff. In the nursing home sector, the number of employees fell by 12.3 per cent. Contributing significantly to this decline was a sharp fall of 65.3 per cent in the number of employees not providing direct care.

In contrast, in the accommodation for the aged sector (low care), there has been an overall increase in the number of employees of 33.0 per cent, with this increase occurring in the direct care area. The increase in the number of employees in the accommodation for the aged sector is attributable to the growth of the sector and the introduction of ageing in place, which has increased the average frailty of residents in former hostels, with a concomitant increased need for care staff.

The major trend apparent in all of these changes is a decline in the use of staff not involved in the direct provision of care. Part of this decline is attributable to the decline in the number of small services, as the industry has consolidated. This has enabled greater economies of scale to be realised in staffing arrangements. It is also

[1] Australian Bureau of Statistics, *Community Services, Australia, 1999–2000*, Cat. No. 8696.0. ABS, Canberra, 2001.

attributable to a greater reliance on outsourcing of some activities and to a greater use of multiskilling, with direct care staff being utilised across a greater range of duties.

Table 11–1: Employment in the residential aged care industry, by for-profit and not-for-profit providers, 1995–96 and 1999–2000

	For-profit		Not-for-profit		Totals	
	1995–96	1999–2000	1995–96	1999–2000	1995–96	1999–2000
Nursing homes						
Employees						
Direct community services provision	38 255	32 118	34 056	43 180	72 311	75 298
Contract DCS provision	na	983	na	1259	na	2 242
Other	10 419	2 255	16 165	6 966	26 585	9221
Total	48 674	35 356	50 221	51 405	98 896	86 761
Volunteers						
Direct community services provision	632	477	6 579	11 045	7 211	11 523
Other	555	61	7 811	4 168	8 367	4 229
Total	**1 187**	**538**	**14 391**	**15 213**	**15 578**	**15 552**
Accommodation for the aged						
Employees						
Direct community services provision	884	2 019	18 805	33 550	19 689	35 569
Contract DCS provision	na	330	na	1 737	na	2 067
Other	752	177	12 978	6 656	13 730	6 833
Total	1 636	2 526	31 783	41 943	33 420	44 469
Volunteers						
Direct community services provision	25	126	3 958	11 280	3 983	11 406
Other	68	30	14 633	5 441	14 701	5 471
Total	**93**	**156**	**18 591**	**16 721**	**18 683**	**16 877**
All Industry						
Employees						
Direct community services provision	39 139	34 137	52 861	76 730	92 000	110 867
Contract DCS provision	na	1 313	na	2 996	na	4 309
Other	11 171	2 432	29 143	13 622	40 314	16 054
Total	50 310	37 882	82 004	93 348	132 314	131 230
Volunteers						
Direct community services provision	657	603	10 537	22 325	11 194	22 929
Other	623	91	22 444	9 609	23 067	9 700
Total	**1 280**	**694**	**32 982**	**31 934**	**34 262**	**32 628**

Notes: DCS = direct community services; na = not available

Source: Australian Bureau of Statistics. Community Services, Australia, 1999–2000. Cat. No. 8696.0

There has also been a considerable adjustment within the direct care workforce (see Table 11–2). The share of direct care provided by registered and enrolled nurses (RNs and ENs respectively)[2] has declined in both the nursing home and accommodation for the aged industries. In contrast, the use of personal care assistants, has significantly increased. These changes reflect both the growing shortage of nursing staff and the development of more efficient workforce structures.

Table 11–2: Employment in nursing homes and accommodation for the aged, by occupation, 1996 and 2001

	Nursing homes		Accommodation for the aged	
	1996	2001	1996	2001
Registered nurses	45.0%	43.3%	35.1%	29.2%
Enrolled nurses	11.0%	7.7%	9.8%	6.1%
Personal care assistants	6.0%	17.9%	25.8%	44.6%
Nursing assistant	37.0%	30.4%	28.3%	19.2%
Physiotherapists	1.0%	0.7%	0.9%	0.9%

Source: Australian Bureau of Statistics. Census of Population and Housing, 1996 and 2001.

11.1.2 Current issues

The residential care sector faces significant workforce issues that need to be addressed in the near future if the quality of care in residential care services is to be maintained. These issues include:

- the general shortage of trained nursing staff, which is greater in the residential care sector than in other areas of the health system;
- specific barriers to recruitment, retention and re-entry to the aged care workforce;
- the ageing of the aged care sector's nursing workforce;
- differences between the states and territories in the regulatory frameworks governing training, medication management and employment conditions; and
- the changing profile of consumers of residential aged care services, with its implications for the nature and extent of the demand for future services and the composition and skills mix of the workforce.

[2] 'Registered nurse' (Registered nurse Division 1 in Victoria) refers to a nurse who is on the register maintained by the state or territory nurses board or council to practise nursing in that state or territory, and who has attained at least a 3-year Bachelor degree in nursing. An 'enrolled nurse' (Registered nurse Division 2 in Victoria) is a nurse who is on the roll maintained by the state or territory nurses board or council to practise nursing under supervision in that state or territory, and who has a specified level of training depending on the particular state or territory. Training is generally conducted in the vocational education sector at the Certificate IV or Diploma level. (Definitions paraphrased from Senate Community Affairs References Committee Report on the Inquiry into Nursing, *The patient profession: Time for action*, June 2002).

General nursing staff shortage

The shortage of nurses is a worldwide phenomenon. Between 1994 and 1999 there was a 17.8 per cent decrease in the number of nurses working in the residential aged care sector, from 33 841 in 1994 to 27 822 in 1999 (Table 11–3).

Table 11–3: Aged care nurses employed in residential aged care 1994 to 1999

	1994	1995	1996	1997	1999	% change 1994–1999
Public sector						
Enrolled nurses	8 301	5 718	5 858	6 184	6 481	-21.9%
Registered nurses	8 157	6 978	7 149	7 836	7 418	-9.1%
Total nurses	16 458	12 696	13 007	14 020	13 899	-15.5%
Private sector						
Enrolled nurses	6 234	5 837	5 429	4 902	5 000	-19.8%
Registered nurses	11 149	11 866	11 036	10 261	8 923	-20%
Total nurses	17 383	17 703	16 465	15 163	13 923	-19.9%
Total						
Enrolled nurses	14 535	11 555	11 287	11 086	11 481	-21.0%
Registered nurses	19 306	18 844	18 185	18 097	16 341	-15.4%
Total nurses	33 841	30 399	29 472	29 183	27 822	-17.8%

Source: Australian Institute of Health and Welfare, *Nursing Labour Force 2001*, AIHW Cat. No HWL 26, 2003.

This decrease is a consequence of the growing shortage of nurses in all sectors of the health system and of specific problems of recruitment and retention of nursing staff in the aged care sector.[3]

Attracting and retaining skilled aged care nurses is becoming increasingly difficult and has the potential to impact on the standards of care that aged care homes are able to deliver.

Barriers to recruitment, retention and re-entry

There are a number of factors impacting on the supply of registered and enrolled nurses in all sectors of the health system. In the aged care sector, the barriers to recruitment, retention and re-entry to the aged care workforce include the lack of wage parity with the acute care sector, poor working conditions, lack of educational

[3] Working Group on Aged Care Worker Qualifications, National Aged Care Forum, Minister for Ageing, *A Review of the Current Role of Enrolled Nurses in the Aged Care Sector: Future Directions*, Department of Health and Ageing, Canberra, 2001. La Trobe University, *Recruitment and Retention of Nurses in Residential Aged Care—Final Report, Report for the Department of Health and Ageing*, Canberra, 2002. Aged Care Enrolled Nurse Working Party, *Report to the Minister for Ageing*, Department of Health and Ageing, Canberra, 2003. Australian. Parliament. Senate Community Affairs References Committee, Inquiry into Nursing. *The Patient Profession: Time for Action*, AGPS, Canberra, 2003.

opportunities and a clear career path, the poor public image of aged care compared to acute care nursing, and other workplace issues that make recruitment and retention of skilled nursing staff in residential aged care homes even more problematic than for mainstream health services.

Wage parity

The disparity in the rates of pay for aged care nurses varies between jurisdictions with the gap for a RN ranging from 26.3 per cent in the ACT to 12.5 per cent in NSW. Differences in pay rates also exist between the state government and non-government owned aged care facilities, and between non-government facilities without Fringe Benefits Tax (FBT) advantages, and those classified as Public Benevolent Institutions (PBIs) able to utilise the provisions of the FBT legislation to offer salary packaging arrangements to their staff.

Some of the differences in labour costs as a proportion of total expenses between jurisdictions and sectors are illustrated in the data analysed in Chapter 3 and Appendix A of this Report.

Table 11–4: Disparity in pay rates RN (Year 8 or equivalent) across states and territories at September 2003

State/Territory	Public Sector EBA Rate Weekly Earnings $	Aged Care Award Rates Weekly Earnings $	% Difference
Victoria	930.10	784.20	18.6
NSW	1037.90	922.70	12.5
Queensland	986.35	808.90	21.9
WA	942.60	754.60	24.9
SA	929.60	800.20	16.2
Tasmania	881.00	755.70	16.6
NT	932.80	817.00	14.2
ACT	960.94	760.79	26.3

Source: Australian Nursing Federation. *Nurses Paycheck*, Vol. 2, No. 4, September—November 2003.

Table 11–4 shows the differences by jurisdiction between pay rates for a RN (Year 8 or equivalent top of the range) in those areas of nursing covered by the Public Sector Enterprise Bargaining Agreements (EBA) and nurses covered by aged care awards as at September 2003. While there are a growing number of nurses covered by EBAs, this is generally in the public sector and there are far fewer nurses in other sector aged care facilities covered by EBAs.

The disparity in rates of pay for aged care nurses compared to acute care nurses can act as an obstacle to recruitment and retention of skilled staff in the sector. Where EBAs are in place in aged care facilities, the wage disparity between nurses employed in these homes and those in the public sector is reduced (Table 11–5).

Table 11–5: Disparity in pay rates RN (Year 8 or equivalent) between Public Sector and Aged care EBAs in selected states and territories as at September 2003

State/Territory	Public Sector EBA Rate Weekly Earnings $	Aged Care Award Rates Weekly Earnings $	% Difference
Victoria—Anglican Aged Care Services Group and ANF Certified Agreement 2002	930.10	857.17	8.5
SA—Nurses—ANF—Flora McDonald Lodge Enterprise Agreement 2001	929.60	827.96	12.28
Tasmania—Tasmanian Aged Care Nursing Enterprise Agreement 2001	881.00	807.70	9.1
ACT—Anglican Retirement Services—Brindabella Gardens, ANF Enterprise Agreement 2002–04	960.94	793.00	21.17

Source: Australian Nursing Federation. *Nurses Paycheck*, Vol. 2, No. 4, September—November 2003.

The aged care sector has been slow to take up the option of negotiating EBAs at individual workplaces. Employers have often claimed that the current funding regime allows insufficient capacity for them to pay anything more than the award rates. This claim warrants closer examination, as the negotiation of EBAs at the workplace level allows salary packaging arrangements to be put in place, enabling many employers in the sector to greatly improve the salary outcomes for their employees at no additional cost. This option does not seem to have been taken up to its full extent.

Under the taxation legislation most religious and charitable residential aged care facilities are regarded as PBIs and, as such, are not subject to pay FBT on benefits provided to staff under salary packaging arrangements up to an FBT-free threshold limit of $30,000 of the grossed-up value of the benefit. The FBT exemption on benefits to employees of PBIs can mean significant salary advantages to staff. The recent introduction of new products, such as debit cards that allow employees to draw against a balance of funds at a nominated salary sacrifice level, means that salary sacrificing is now a more attractive option for a broader range of staff including those at lower salary levels. It should allow employers to increase the remuneration to a great many of their staff at little or no cost to themselves, and enhance their recruitment and retention capacity by becoming more competitive with employers in the acute care sector who are already offering increased pay rates to nurses and other staff under State hospital awards and public sector EBAs.

Working conditions

Poor working conditions and an unsupportive working environment have often been cited as reasons for nurses leaving aged care or not being willing to enter this area of

employment. Particular areas highlighted for attention relate to stresses caused by staff shortages and associated high workloads combined with having deal with residents with high dependency needs requiring the exercise of clinical skills as well as a high degree of managerial and leadership ability and counselling skills in providing emotional support to families and residents. Inflexible work practices and unsafe working environments were also frequently cited as making employment in aged care less attractive.[4]

Lack of education and career opportunities

A key factor in increasing the recruitment and retention of nurses in aged care lies in the development of suitable undergraduate, post-graduate and vocational courses that cater to the needs of the aged care sector. In addition there must be more attention paid to the development of suitable continuing education and professional development courses for nurses currently working in the industry or for those seeking to re-enter the workforce.

All of the reports from the above mentioned reviews, as well as the major National Review of Nursing Education 2002, have highlighted the poor identification and valuing of aged care nursing in undergraduate courses and a paucity of specialist nursing training at postgraduate level in gerontology studies. They have advocated more flexible modes of learning including distance education, use of technology and the establishment of teaching nursing homes and greater attention to refresher/re-entry courses as critical issues not only to improve the image of aged care nursing and attract new recruits, but to facilitate retention of the existing workforce, and encourage the re-entry of nurses into aged care. The reports call for greater consistency and co-operation between states in nurses training and education programmes, and better 'articulation between levels of nursing qualifications to provide clear pathways for career development and a reward system that recognises education, experience and productivity'.[5]

Poor image and lack of appreciation of skills

The Senate Inquiry into Nursing found that an important factor in the recruitment of nurses into the profession lay in the poor image that nursing now seems to hold in the community and the negative media it receives.[6] With so many more career options available to young women leaving school in professions that are better paid, and have better working conditions and career prospects, it is becoming increasingly difficult to persuade school leavers to entertain entering the nursing profession. It is even harder to

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[4] Many of these issues are more fully discussed in the publications: La Trobe University, *Recruitment and Retention of Nurses*; Senate Community Affairs References Committee, Inquiry into Nursing.

[5] A Pearson, R Nay, S Koch & C Ward, 'Australian Aged Care Nursing, A Critical Review of Education, Training, Recruitment and Retention in Residential and Community Settings' in *National Review of Nursing Education*, Literature Review, 2002, p. 16.

[6] Pearson et al., op. cit., p. 23.

attract new young nursing graduates to think of entering aged care as their area of choice as nursing in aged care has an even worse image than the profession in general. There is a common misconception that aged care nursing is more menial and less skilled involving unchallenging and unrewarding work that results in a loss of a nurse's clinical skills.

The Review into the Recruitment and Retention of Nurses in Residential Aged Care (2002) conducted by La Trobe University for the Department of Health and Ageing, identified that the 'image of aged care and of older people in a major obstacle to recruitment and retention'.[7]

The review recommended the Department of Health and Ageing in collaboration with stakeholders in the aged care sector and the media develop a strategy to improve the image of aged care in Australia. The Government agreed with this recommendation and has initiated a number of strategies to address the image problem.

The ageing of the workforce

In 1999, the average age of nurses in the aged care sector was 45.2 years, some 3.6 years older than the average age of all employed nurses. Moreover, the average age of nurses in the aged care sector had increased by 3.5 years in the five years between 1994 and 1999, while the average age of all employed nurses had increased by only 1.5 years in the same period.[8]

The ageing of the nursing workforce carries with it implications for the currency of the workforce's training and, in particular, whether it has the skills needed to meet modern care delivery standards and to deal with the increasing frailty of the users of residential care services.

Regulatory requirements

In a number of areas there are certain regulatory requirements that impact on workforce structures and practices. These regulatory requirements occur at both State level under various pieces of legislation covering nurses' registration and role, as well as medication management, federal legislation such as the *Aged Care Act 1997* and Principles, and industrial award and agreement provisions.

Some constraints on staffing arrangements relate to various state and territory regulations covering who can and cannot administer medication. In particular, there is no uniformity between states and territories in their approaches to the administration of medications by enrolled nurses. For example, enrolled nurses in South Australia can administer up to Schedule 4 medication while enrolled nurses in Victoria and the ACT

7 La Trobe University, *Recruitment and Retention of Nurses*, p. 57.
8 Australian Institute of Health and Welfare, *Nursing Labour Force, 2001*, AIHW, Canberra, 2003.

cannot. Enrolled nurses in Queensland, Tasmania and the Northern Territory are able to administer under supervision. Enrolled nurses in New South Wales and Western Australia are able to administer with stipulations.

Some states and territories have legislated specific staffing requirements for residential care services. In New South Wales, the Director of Nursing of a nursing home must be a registered nurse with administrative experience and a registered nurse must be on duty at all times. In Tasmania, the legislation requires that a manager be resident on the premises. The other states have no specific legislative requirements that impinge on workforce structures or practices other than those that are contained in awards and other industrial agreements.

> Under present arrangements, nurses working in each state or territory are registered or enrolled by the relevant regulatory authority. This raises issues of national consistency regarding professional regulation and practice.[9] This has been partly overcome through the establishment of national competency standards for registered and enrolled nurses, and mutual recognition requirements allowing nurses to move from state to state and apply for mutual recognition of qualifications for registration. Problems were recognised by the Working Group on Aged Care Worker Qualifications, and more work needs to be done in relation to enrolled nurses as:

Under these reciprocal arrangements for registration involving registered and enrolled nurses some anomalies still occur. For example, Western Australia enrolled nurses whose course is much longer and whose scope of practice is more comprehensive than that of Victoria find that their practice is restricted considerably if they move to that state. Equally, an enrolled nurse who moves from Victoria to Western Australia, or any other state or territory, would find much more is expected of them than their education and training has provided.[10]

The Senate Inquiry recommended that the state and territory governments develop nationally consistent legislation in relation to the administration of medication by enrolled nurses. Also the Australian Nursing Council (ANC), in conjunction with key stakeholders, including state regulatory bodies, the universities, professional nursing bodies and nursing unions, should develop a national curriculum framework or guidelines for undergraduate nursing courses to ensure greater consistency in the interpretation of ANC competencies, as well as a national framework for the education of enrolled nurses in relation to course structure, duration and content.[11]

Under the *Aged Care Act 1997*, approved providers are required to provide to every resident who needs it, such care and services as are specified in Schedule 1—Specified Care and Services under the Quality of Care Principles 1997. In doing so, the approved

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[9] Senate Community Affairs References Committee, Inquiry into Nursing, p. 37.

[10] Working Group on Aged Care Worker Qualifications *Review of the Current Role of Enrolled Nurses*, p. 18.

[11] Senate Community Affairs References Committee, Inquiry into Nursing, p. xix.

provider must put in place appropriate systems in their facilities to enable standards of care and residents' needs to be met. Facilities are then held accountable for the provision of care against the Residential Aged Care Standards through the accreditation process and review audits conducted by the Aged Care Standards and Accreditation Agency. While setting general standards of care and accountability framework, the Act is not prescriptive in relation to how providers should meet these standards in relation to staff numbers, structure or work practices.

Changing consumer profile and implications for care

The ageing of Australia's population and needs and requirements in relation to care are also changing. This trend has implications for the form and extent of care that may be required in future years, as well as the numbers and skills mix of care staff that may be required to meet client demands.

Apart from demographic pressures, there are other factors related to the working environment and the characteristics of the recipients of care that heighten the need for a skilled nursing workforce of sufficient numbers to meet future needs of people in residential aged care.

The continuing community preference and concomitant shift in government policy to keep older people in the community with appropriate care and support for as long as possible, has resulted in people moving into residential aged care at a stage of higher dependency and frailty.

The introduction of the structural reforms in October 1997 under the *Aged Care Act 1997*, has seen a significant expansion in the supply of community aged care packages (CACPs) aimed at providing equivalent low level residential care to people in their own homes, with the number of CACPs increasing from 6640 in June 1997, prior to the introduction of the reforms, to 10 014 in June 1998 and 17 998 in June 2000.[12]

The increasing dependency and frailty of residents at both high and low levels of residential aged care is expected to continue with the proportion of residents classified as high care rising from 61.0 per cent to 63.3 per cent in the period from June 1999 to June 2002, and the proportion of residents classified as low care falling from 39.0 per cent to 36.7 per cent. Within the high care category the most dramatic change has been at the RCS 1 level, representing those residents requiring the most care, where the increase over this period has been 36 per cent.[13]

Many of the residents entering high level care are coming directly from acute care hospitals. Older patients in acute hospitals are often regarded as more appropriately cared

[12] Len Gray, *Two Year Review of Aged Care Reforms*, Commonwealth of Australia, 2001, p. 35.

[13] Review of Pricing Arrangements in Residential Aged Care, *Background Paper No. 1: The Context of the Review*, Commonwealth of Australia, 2003, pp. 7–8.x

for in nursing homes as the pressure for hospital beds continues to increase with reductions in the number of acute care beds, and the decrease in average length of stay for patients. However the result is that residents are entering residential aged care often with complex needs requiring intensive levels of care, such as palliative or post-operative care. The development of transitional arrangements in the nature of sub-acute care being once the province of general hospitals, requires much greater attention. Pilot and experimental efforts such as are occurring in Adelaide, should be greatly increased in scope and application.

Other factors that are likely to impact on the future demand for residential care, which to some extent act as counter influences to the preference for community care, are the changing nature of health and disease patterns in the elderly, combined with the declining trend for the elderly to be cared for through informal family caring arrangements.

Life expectancy is increasing along with the overall growth in the older population. Although people may experience healthy ageing to a greater extent and not suffer any great degree of ill-health or disability until a later age, they may have more years in which their health is problematic and the kinds of diseases they experience may be different.[14]

Chronic diseases such as dementia which is strongly age-related will become more prevalent as a greater proportion of the population reaches old age. About 5 per cent of people over the aged of 65 and 20 per cent of people over the age of 80 have some form of dementia. The most significant increase in people with dementia will be among those aged 85 years and over. On current projections, the number of people with dementia could be expected to increase from 162 300 in 2002 to 242 600 in 2020 (Table 11–6).

Table 11–6: People with dementia by age, 30 June 2000 to 2020 (projected)

	2000		2005	2010		2015	2020	
Age	No.	% of pop. group (approx)	No.	No.	% of pop. group (approx)	No.	Number	% of pop. group (approx)
65–69	9 500	2%	10 500	12 600	2%	16 200	17 500	2%
70–74	17 500		17 300	19 200		23 200	29 900	
75–79	28 100	7%	29 900	29 900	8%	33 400	40 600	7%
80–84	33 400		42 400	45 500		45 900	51 900	
85+	58 400	22%	67 600	83 900	22%	96 200	102 800	22%
Total	**146 800**		**167 600**	**191 100**		**214 900**	**242 600**	

Source: Australian Institute of Health and Welfare. Older Australians at a Glance, 3rd edition, 2002.

While many older people may prefer to continue to receive the care they need in their own homes with appropriate support, changes in social structures as well as patterns of

[14] Australian Institute of Health and Welfare (AIHW). Older Australians at a Glance, 3rd edition, 2002

disease may mitigate against this and lead them to require residential aged care services. Historically, the principal sources of care for the infirm elderly has been women looking after their own family members (husbands or parents) in their own homes.

Increasing divorce and separation rates will result in more older people in future being without partners. This, together with the increasing labour participation rate by women, is likely to result in a fall in the availability of informal carers. These factors may work against consumer preference to receive care in the home for as long as possible as this often requires informal care from a spouse or other family member, usually female, with women making up over 72 percent of primary carers of older people.[15] This will be especially true of the rising numbers of older people suffering from dementia-specific conditions.

With the changing dependency needs of the resident population, and the increasing numbers of residents with complex care needs, residents are requiring expert nursing care to a greater extent now and will continue to do to even more in the future than in past days when dependency and frailty levels of residents was less, and nursing home care tended to be somewhat more in the nature of 'custodial care'.

Implications for staffing

The number and mix of staff that may be required to meet future labour demand trends for care services is shown in Figure 7–6. These estimates should be addressed with due caution because of changes which technology may bring to the circumstances of care, whether residential or domiciliary.

11.1.3 Impact

All of the factors discussed above have an impact on the workforce structures and practices in the aged care sector. It is important, therefore, to identify those factors that impact to the greatest extent on labour costs and the flexibilities available to employers in the aged care sector to optimise their workforce structures and practices to be able to operate at optimal efficiency.

Employment framework

The employment frameworks in the various states and territories impact on workforce composition, workplace practices and workforce costs in a number of ways. The awards and other industrial agreements covering employment in the aged care cover a multiplicity of factors such as wage rates, hours of work and other conditions such as leave, rosters, shift lengths, allowances and loadings, use of casual labour and so on. All of these matters have the potential to impact on workforce costs by either increasing or decreasing the flexibilities available to employers in their cost structures,

[15] AIHW, op. cit., p. 42.

the type and skills mix of staff they employ, and the particular work practices they are able to implement at the workplace level.

An analysis of the major awards and agreements covering employees in residential care services indicates their impact on workforce costs is substantial. The complexity and prescriptive nature of wage setting imposes significant costs. Some of the inflexibilities of the prevailing award-based system present difficulties for employers in the recruitment and retention of skilled staff and their ability to constitute and organise their workforce to optimise the skills mix required to meet required standards.

Awards remain the dominant form of employment agreement in the industry. Enterprise agreements potentially offer more flexibility to employers and employees in working practices, are available under all jurisdictions and are being negotiated in a significant proportion of aged care homes, albeit with variations in the take-up rate between states. However, in most cases the prevailing award still provides the basis for most enterprise agreements and represent the starting point of the parties in developing an enterprise agreement often involving trading off aspects of the award. It is useful therefore to focus on the main awards covering both nursing and non-nursing staff and to try to determine those factors that most contribute to the proportionately high cost of labour compared to other operating costs. The award-determined base wage rates, which vary from one jurisdiction to the other, form the predominant cost. However, other award determined factors also contribute significantly to overall labour costs to varying degrees depending on how prescriptive the individual relevant award is. Factors such as hours and rostering, leave provisions, loadings and allowances, as well as whether a particular award makes it more or less expensive to utilise casual labour and prescribes other work practices, all add to overall labour costs and can vary between state systems.

Because the awards define a very wide range of working conditions as well as setting the relationship between, for example, overtime and base wages, they constrain facility managers from optimising the mix of staff. Changes in workforce structure can have large and sometimes unintended impacts on overall costs because of various loadings and additions triggered. In addition, where employers choose to run more night shifts than afternoon shifts, utilise more overtime or employ more casual as opposed to permanent staff for either RN or EN levels of staff, the cost implications can be significant.[16]

[16] A more comprehensive examination of these impacts is contained in the report 'Employment Frameworks in the Residential Aged Care Sector' 2003, prepared for the Review of Pricing Arrangements for Residential Aged Care and available on the Review website at http://www.health.gov.au/acc/rescare/acprtask.htm.

Other main labour cost drivers

Workforce structures and practices

There are a number of other drivers of labour costs that impact on provider decisions about workforce composition and usage, and therefore affect the overall operational costs of aged care homes. Some of these factors are environmental, or are related to the jurisdiction, locality (capital city, other metropolitan, rural or remote), provider type (charitable, religious, private, community-based, or state government), the size of the home and, most importantly, the resident mix (that is, how many high or low care residents) and whether the facility caters for residents with dementia.

Other factors are more directly influenced by providers' own decisions at the workplace level about how they structure their workforce and the particular work practices they implement. These relate to the number of care hours devoted to each resident per day, and the categories of staff used to deliver that care, the nature of the industrial relations agreement in place under which the staff are employed, and whether the aged care home practices multi-skilling or shares staff with other facilities.

Depending on the individual circumstances of the aged care home, each of these factors has an influence on labour costs to varying degrees, and needs to be taken into consideration by the management when determining the optimal mix and employment arrangements of staff required in order to maximise labour efficiencies, while continuing to meet prescribed standards of care delivery.[17]

Labour on-costs

A major labour on-cost to employers in the aged care sector impacting to a significant extent on their operational costs relates to workers' compensation premium costs. As with all insurance costs, the cost of workers' compensation insurance has undergone substantial increases in recent years across all jurisdictions.

There are different workers' compensation arrangements under each state scheme and the costs of premiums and direct workers' compensation payouts vary for employers depending on which state or territory scheme applies, each scheme's coverage in relation to definitions of 'employees', the benefit structure and premium rating methodology used.

A large number of submissions were received dealing with workers' compensation issues, and indicating that the significant and increasing costs of premiums pose a serious threat to the viability of many homes. The two main peak body organisations

[17] A more comprehensive analysis of all the factors relating to workforce structures and practices and their impact on workforce efficiencies is contained in the report 'Efficient Workforce Structures in the Australian Aged Care Sector' 2003, prepared for the Review of Pricing Arrangements for Residential Aged Care and available on the Review website at http://www.health.gov.au/acc/rescare/acprtask.htm.

representing aged care providers, the Australian Nursing Homes and Extended Care Association Ltd (ANHECA) and the Aged and Community Services Australia (ACSA), also put forward a proposal on options for further research into establishing a special workers' compensation scheme specifically for the aged care sector.

The Australian Government has recently commissioned the Productivity Commission to conduct an inquiry into possible frameworks for establishing nationally consistent arrangements for workers' compensation and occupational health and safety. The Commission released its interim report on National Workers' Compensation and Occupational Health and Safety Frameworks on 21 October 2003. Public hearings and consideration of submissions are now underway with the final report scheduled for completion in March 2004.

In view of the wider jurisdictional policy considerations that are involved in the review by the Productivity Commission, the Pricing Review did not consider it appropriate to make recommendations on workers' compensation arrangements in relation to the aged care sector that may have pre-empted the outcomes of the wider Commission review.[18]

11.2 Comment

There are three main sets of factors influencing workforce issues in residential aged care. They are the supply of nurses and other aged care workers, the current and future demand for staff, and the overall financing arrangements for the industry which in turn influences how workforce demands can be met.

Solving workforce issues will involve implementing strategies to address factors on the demand side that will optimise workplace efficiency in terms of reducing labour costs through changes to staffing structures, employment frameworks (including enterprise bargaining arrangements at the local level) and workplace practices (including rostering, occupational health and safety procedures, supervisory arrangements, etc). On the supply side, strategies will need to be implemented to assist in the recruitment and retention of aged care workers and the re-entry of those workers who may have left the aged care workforce. New financing arrangements that provide a more sustainable funding base will serve to assist both.

The urgency of addressing workforce issues in aged care is widely acknowledged. The Budget measures the Australian Government is implementing are a step in the right direction. Innovations being put in place by providers indicate an increasing acceptance that growing the workforce is a shared responsibility and provides opportunities to reward staff in flexible ways.

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[18] A more detailed examination of the issues relating to workers' compensation in aged care including an analysis of the options put forward by industry is contained in the Issues Paper on Workers' Compensation Issues available on the Pricing Review website.

Achieving better integration of services for the aged in the future must be accompanied by better integration of the workforce providing residential care and care services in the community through improving opportunities to enhance skills and training, and by improving working conditions to aid recruitment and retention of staff. Innovative and accessible education and training opportunities, designed to develop flexible team approaches to care in aged care settings are essential.

Advances in care and the cost effectiveness of care delivery will come from the development of a better understanding of old age. Education and training frequently are more focused on what works in acute care and what works for younger adults. Building an evidence base and developing new education and training curricula are essential. The closer involvement of the industry individually and in partnership arrangements with the Government means shared responsibilities for the establishment and funding of research and development projects for future workforce planning, training and education will help ensure faster transfer into practice. As with other industries, the aged care industry and individual providers must take ownership of the need to improve their workforce.

Some providers are already taking a lead role in this direction by recognising the need to 'grow' their own staff, and to introduce innovative educational and training avenues such as the use of satellite technology. The encouragement of younger nurses and other staff to stay in aged care might best be offered by increasing permanent part-time arrangements to allow employees to better combine professional work and parenthood. Large entities might sponsor childcare centres for infants of staff members, or a number of separate entities might join in such a provision. The best practices of leading groups should serve as a benchmark for others to attain. Consultations and discussions across the country have revealed excellent leadership in education, training and support is to be found in the provinces as well as capital cities.

The work undertaken for the Review on the impact of employment frameworks and workforce structures and practices on efficiencies to be gained in the aged care sector, provide useful insights for employers in assessing the feasibility, and likely financial impact of changes in the way they employ staff.

In relation to the recruitment and retention of employees in the industry, a number of important initiatives are already underway. Nevertheless, there is scope for a greater role by industry organisations in influencing employers to adopt more innovative practices and in promoting aged care as an industry offering worthwhile employment opportunities.

All prospects are for a continuous shortage of nurses and personal health workers in the coming decades. At present the likelihood for a shortfall of nursing staff by about 5000 or a little more each year but rising to about 6,500 a decade hence. This summation rests on the basis of present policy arrangements. The sizeable gap is a

measure of the priorities needed to foster training of the two main categories of nurses as well as to reduce the regulatory barriers which hamper the effective use of the skills offered by registered nurses.

Given the inevitable greater demand for aged care services in future decades as the post-World War II Baby boomers enter in the 'twenties and 'thirties of this century, there is no prospect of a falling off in the demand for staff. The expansion of education and training of aged care staff in general must be expanded to a level well beyond anything contemplated in recent years. The expansion will not be a temporary commitment. **Recommendation 8** provides for a significant role for governments and providers to enhance education and training for all aged care workers.

12. QUALITY OF CARE AND CONSUMER PROTECTION

12.1 Regulatory arrangements

The monitoring of aged care services for compliance with their obligations under the *Aged Care Act 1997* (the Act) is a responsibility of both the Aged Care Standards and Accreditation Agency (the Agency) and the Department of Health and Ageing.

The Agency's regulatory role is focused on homes' compliance with the Accreditation Standards (as set out in the Quality of Care Principles 1997). Its functions are mainly governed by the Accreditation Grant Principles 1999 and the Accountability Principles 1998. In short, the Agency has responsibility for (and expertise in) monitoring homes against the Accreditation Standards. Consumers are encouraged to participate in the process of monitoring homes' compliance with the Standards.

The Quality of Care Principles stress that while the quality intent of the accreditation standards must apply equally to all residents, providers have room for innovation and flexibility in responding to the needs of individual residents. The Accreditation Standards:

> … are intended to provide a structured approach to the management of quality and represent clear statements of expected performance. They do not provide an instruction or recipe for satisfying expectations but, rather, opportunities to pursue quality in ways that best suit the characteristics of each individual residential care service and the needs of its residents. It is not expected that all residential care services should respond to a standard in the same way.
>
> … apply equally for the benefit of each resident of a residential care service, irrespective of the resident's financial status, applicable fees and charges, amount of residential care subsidy payable, agreements entered into, or any other matter.[1]

This places the ultimate responsibility for quality of performance in each facility on the professional staff and management.

The Department's regulatory role is focused on Approved Providers' compliance with their responsibilities under Parts 4.1, 4.2 and 4.3 of the Act, and is governed by the Act and the Aged Care Principles (the Principles), excluding the Accreditation Grant Principles 1999. In brief, the Department has responsibility for ensuring homes meet their other obligations under the Act and for actioning sanctions where Approved Providers have breached their responsibilities and/or failed to implement improvements.

These arrangements are designed to provide residents and their families with assurance that they are receiving quality care and that their user rights under the Act are respected. They are also designed to assist facilities to develop a culture of continuous improvement.

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[1] Quality of Care Principles, Part 3, Sections 18.9 and 18.12.

When consumers have concerns about any aspect of their care, these may be raised through a number of avenues, some specifically concerned with aged care and others concerned more broadly with consumer protection and professional standards. Apart from participating in the accreditation process, the main avenues are each facility's complaints resolution mechanism and the system-wide Aged Care Complaints Resolution Scheme, oversighted by the Complaints Commissioner. These mechanisms are designed to resolve individual issues at a facility, rather than monitoring overall compliance. However some complaints may indicate systemic non-compliance by a home. Departmental officers can make inquiries about systemic matters within a home and, if necessary, refer them to the Agency.

In addition to raising complaints with the Agency, the Department, or the Aged Care Complaints Resolution Scheme, consumers and their families or other representatives may take up issues through more generic consumer protection mechanisms put in place by the Australian Government or state and territory governments. Together these arrangements provide a comprehensive, regulatory framework for monitoring and consumer protection.

12.1.1 Quality assurance and consumer protection

The need for the regulation of quality and consumer protection in the aged care industry is summed up by the assurance given by the Amity Group to potential residents:

> Aged care is one of Australia's most highly regulated sectors, and for good reason, with Approved Providers vested with the heavy responsibility of caring for the frail and dependent elderly, and the industry being substantially Federal Government funded. [2]

The extent, focus and compliance burden of the regulation of quality assurance and consumer protection has been a matter of debate throughout the Review. Arguments have ranged from support for complete deregulation of all aspects of the industry and concern that certain approaches to de-regulation might threaten the privileged position of providers, to better focusing regulation on those aspects where government intervention is most justified.

Government intervention to promote the quality of residential care for the aged and the protection of consumer interests is justified for the following reasons:

- there are information asymmetries which result in parties in a transaction having unequal access to relevant information;
- clients are vulnerable and in some need of guardianship or protection;
- for social equity reasons, the government wishes to manage all or some aspects of the availability and access to services; and

[2] Amity Group http://www.amitygroup.com.au, accessed 15 October 2003.

- when a decision to accept a particular price-quality offering 'locks' the consumer into future consumption of that specific good or service. This occurs when the transaction costs incurred to alter an initial decision are high.[3]

The roles of monitoring of quality, complaints resolution and enforcement on the parts of the Agency and the Australian Government are seen as critical to protecting consumers.

12.1.2 Regulatory concerns

Submissions and evidence presented at consultations indicate broad support for accreditation. There is general acknowledgment that standards of care and accommodation across the industry have been improved substantially by accreditation.[4]

Even so, the regulatory requirements are seen by some providers as limiting efficiency, innovation and the flexibility to deliver an appropriate range of services.[5] The accreditation sanctions are regarded by a few providers as disproportionate at least where there is a lack of alternative accommodation should a facility be forced to close.[6] Others see the Agency and its accreditation processes as adversarial[7] and the notion of quality being lost in a war of words on paper, at a significant resource cost to providers.[8]

Concerns were expressed in some submissions that the potential for accreditation information to influence the industry's responsiveness to consumer needs and consumer choice is not being fulfilled and that this will not change while demand outstrips supply.[9] Similarly, accreditation, the accreditation standards, and the published assessments are not seen as placing sufficient emphasis on needs of people with diverse languages and backgrounds, or the care of people with dementia.[10]

Some providers stressed the direct link between quality of care, the quality of staff-resident interactions[11] and how these are affected when staff cannot spend enough time with residents because they are diverted to paper work or must spend more time walking between single rooms.[12] While this was seen as applying to the care of all residents, the time-intensive nature of quality care for people with dementia was

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3 The Allen Consulting Group, *Regulation of Quality in Service Industries, Report prepared for the Review of Pricing Arrangements in Residential Aged Care*, September 2003, p. 26.

4 For example, Submission 241, p. 17.

5 See for example Submissions 77, 36 and 234.

6 See Submissions 117, 10 and 227.

7 See Submissions 10, 79, 117, 120 and 299.

8 See for example Submissions 195, 34, 180, 123 and 236.

9 For example, Submissions 88, 97, 105, 120, 134 and 241, p.17.

10 See, for example, Submission 41, 93, 226 and 264.

11 See, for example, Submissions 66, 68, 77, 250, 252 and 285.

12 The additional time required to attend to residents in single rooms was raised during several of the consultation sessions as affecting care, increasing costs, and adding to staff stress. This was sometimes linked with what was seen as unreasonable certification standards and the isolating effect of single rooms. Other providers considered that the benefits to residents of single rooms far outweighed such matters.

stressed.[13] Others stressed the types of cuts they have made (or threaten to make) to the quality of care in response to constrained resources (eg. cuts to outings and menu, reduced hygiene and transport).[14]

Other issues raised concerned the apparent overlap of complaints schemes,[15] at times resulting in providers being required to respond to the same complaint several times with several agencies, federal and state.

12.2 The Aged Care Standards and Accreditation Agency

The Agency is an independent company, wholly-owned by the Australian Government, established under Corporations Law and the *Commonwealth Authorities and Companies Act 1997*. It is the 'accreditation body' for the purposes of the *Aged Care Act 1997* (Section 96–3(5)) with its delegated core functions set out in the Accreditation Grant Principles 1999.

The core functions of the Agency are to:

- manage the residential care accreditation process using the Accreditation Standards;
- promote high quality care and assist the industry to improve service quality by identifying best practice, and providing information, education and training;
- assess and strategically manage services working towards accreditation;
- liaise with the Department of Health and Ageing about services that do not comply with relevant Standards.

Accreditation audits take place at set intervals which means that the Agency's work pattern and revenues vary over a four year cycle: two years with a high volume of accreditation audits followed by two years with a significantly lower volume. Between accreditation audits, the Agency is responsible for monitoring ongoing compliance with accreditation standards and monitoring continuous improvement plans. The Agency may institute support contacts, random or targeted spot checks, or review audits (scheduled or unannounced) and the number of these contacts increases in the 'off years' for accreditation audits. At the request of the Secretary of the Department, the Agency must arrange a review audit, which assesses the quality of care against the accreditation standards, in much the same way as an accreditation audit, and may result in a decision to vary or revoke the home's accreditation status.[16]

[13] See for example Submissions 54, 92, 149, 161, 162, 166, 180, 191, 195, 226, 202, 218, 250, 253 and 296.

[14] See for example Submissions 49, 57, 68, 76, 185, 205, 309 and 321.

[15] See for example Submissions 6, 76, 77, 150, 186 and 197.

[16] A review audit may be triggered for any of the following reasons: the Agency or Department has reason to believe that the home may not be complying with the accreditation standards; there has been a change to the home such as a change of ownership or key personnel; there has been a transfer of allocated places; there has been a change in the premises of the home; the home has not complied with the arrangements made for support contacts.

In 2002–03, a period in which the renewal of most aged care homes fell due for renewal:[17]

- 1965 site audits for accreditation were conducted (compared with 205 in 2001–02);
- 1519 support contacts were conducted (1310 site contacts, 209 desk audits; compared with 3653 in 2001–02) exceeding the 1300 support contacts planned;
- 68 review audits were conducted (compared with up to 320 review audits allowed for and 86 undertaken in 2001–02) with 66 decisions made, 24 to vary the period of accreditation; 41 to not revoke accreditation, and one to revoke accreditation;
- 242 spot checks were conducted (c.f. at least 200 spot checks allowed for and 449 undertaken in 2001–02);
- 1657 decisions about applications for a further period of accreditation were made:
- 1527 to grant three years;
- 125 for less than three years;
- two homes were not accredited; and
- three homes were granted accreditation for four years recognising their consistent exceptional performance against the Accreditation Standards.

The accreditation status of homes as at 30 September 2003 is shown in Table 12–1. Of the 2418 decisions18 by 30 September 2003, 2170 (89.7 per cent) were compliant with all expected outcomes and a further 123 facilities (5.1 per cent) were compliant with all but one expected outcome.

Table 12–1: Accreditation status as at 30 September 2003

Status	Number of services
Less than 1 year	2
1 year: commencing homes	48
1 year: existing homes	24
More than 1 year and less than 2 years	12
2 years	89
More than 2 years and less than 3 years	61
3 years	2695
4 years	4
Total accredited homes	**2935**

Note: The figures in the table do not necessarily agree with the accreditation decisions made to 30 September 2003 because those decisions may not have taken effect in the period or may have been superseded.

Source: The Aged Care Standards and Accreditation Agency, 21 November 2003.

[17] The Aged Care Standards and Accreditation Agency, Annual Report 2002–2003, pp. 15, 24. The first accreditation round was undertaken in 1999–2000. Round 2 will be completed in early 2004.
18 Made as a result of an accreditation application received after 1 May 2002 with a decision by 30 September 2003.

Table 12–2 shows the top 14 expected outcomes against which accreditation assessors recorded the highest numbers of incidents.[19] By far the greatest non-compliance concern was incidents relating to medication management followed by information systems and clinical care. Continuous improvement against each of the four standards also features.

Table 12–2: Number of non-compliance incidents by expected outcome

Expected outcome	Number of incidents
2.7 Medication management	84
1.8 Information systems	57
2.4 Clinical care	47
1.1 Continuous improvement	39
2.1 Continuous improvement	33
1.6 Human resource management	32
3.1 Continuous improvement	31
3.7 Leisure interests and activities	30
4.4 Living environment	29
2.13 Behaviour management	24
2.8 Pain management	23
4.1 Continuous improvement	22
2.10 Nutrition and hydration	21
2.12 Continence management	20

Source: The Aged Care Standards and Accreditation Agency, 21 November 2003.

The magnitude of the task undertaken by the Aged Care Standards and Accreditation Agency (the Agency) since October 1997 and the importance of the Agency's risk management role is impressive. The Agency has worked to improve and refine its focus and the accreditation processes.[20] In this it has been assisted by the advice of the Working Group of the National Aged Care Forum which has identified areas for improvement relating to accreditation reporting and consumer information, the integrity of the accreditation process and quality management education.[21] In addition, the Agency has been subject to an audit by the Australian National Audit Office.[22] The Agency is moving to implement all six recommendations made in the audit report.

In a diverse industry, with a substantial proportion of vulnerable clients, a wide range of stakeholders and the Australian Government as a major purchaser of services, there

[19] From 1 to 18 incidents were recorded against each of the other expected outcomes.

[20] The Aged Care Standards and Accreditation Agency, *Annual Report 2001–2002*, and *Annual Report 2002–03*, http://www.accreditation.aust.com/index.html.

[21] Working Group of the National Aged Care Forum, *Report of the Lessons Learned from Accreditation*, September 2002.

[22] The Auditor General, *Managing Residential Aged Care Accreditation: The Aged Care Standards and Accreditation Agency Ltd*, Audit Report No. 42, 2002–03, Tabled 7 May 2003.

can be tensions between expectations about the system and about the role of the Agency in implementing the system. The Agency faces a considerable challenge in balancing the expectations of Government, providers, consumers and their families. Questions have been raised as to whether the roles of robust assessment (including the possibility of recommending sanctions that may eventually lead to the closure of a facility) are compatible with responsibility for fostering continuous improvement. Staff in facilities at times have difficulty reconciling the Agency's inspectorial and support functions.[23]

The Agency should promote better understanding of its responsibilities and of the accreditation standards and processes. The Review questions the expansion of the Agency's education role to compete in areas of staff training where there are other competent providers.[24] Consideration should also be given to the appropriateness of an agency tasked with evaluating performance also being a major source of training relating to performance. Providers need to develop skills in demonstrating how they measure up against the standards and adhere to evidence-based practice. They must be able to do this in relation to their particular clients or niche market. Continuing to look to the Agency (and hence the Government) as a main source of training must discourage initiatives by board and management of each entity offering aged care.

Standards are not designed to provide a recipe. Rather they are about opportunities to pursue quality in ways best suited to the characteristics of each residential care facility and the needs of its residents. There is strong concern across the industry at present that the Agency is in danger of imposing a set recipe, with getting the 'right words' on paper replacing the notion of quality care. There is a danger that increasing the Agency's role in general training may exacerbate this situation.

In recent years, RCS validators have to some extent abrogated responsibility for monitoring the quality of care received by individual residents. As discussed elsewhere, the Review considers that, in future, RCS validators should confine their role to validating classifications for funding purposes. The Agency, through accreditation audits and other appraisals of facilities, should have sole responsibility for monitoring whether individual residents are receiving ongoing care designed for their specific needs and in accordance with their care plan and resident's agreement.

Assessing quality where services are flexibly and responsively designed and delivered is more challenging than checking adherence to a 'recipe'. This capacity will become more necessary as the industry moves to greater flexibility in making decisions on the service mix each provider offers. At present, assessing quality in residential care is hindered by the relative lack of research on the long-term care of the aged to establish

[23] Submission 10, p. 3.

[24] For example, training in turning data into action, participating in the development of television programs, and delivering staff training on dementia care.

an evidence base to assist assessors. The Agency has worked to strengthen its quality assurance systems, consistency in assessment and decision making, and the training and selection of quality assessors.

12.2.1 The role of accreditation in supporting user choice

The potential for accreditation information to influence the industry's responsiveness to consumer needs and consumer choice is yet to be fully realised.[25] This is in part due to factors beyond the control of the Agency. These include disincentives in current arrangements for providers to be more responsive to consumers' needs and preferences, and the separate, optional, process for higher ratings.

Even so, the Agency could significantly improve its focus on supporting informed consumer choice and consumer input to monitoring standards. Better strategies for communicating directly with consumers are needed as are strategies for enabling other organisations (such as ACATs, seniors community organisations, community libraries and Centrelink) to assist in this task.

The Agency's website holds a wealth of information but much more could be done to make it more 'user friendly' for older people and their families. Well-signposted paths are needed leading directly to information on user rights, how consumers can be involved in the accreditation process, and information on the relative performance of specific homes. Information, including the relevant provisions of the Act, should be in plain English and there should be explicit provision to make the information accessible to people from culturally and linguistically diverse backgrounds. But at present it is necessary to search the Agency's and the Department's websites to get maximum information. **Recommendation 7** refers.

12.2.2 Future action

Accreditation processes and the way in which accreditation outcomes are disseminated could better assist consumers to compare facilities and provide incentives for providers to become more competitive in providing quality services. The Agency should develop a star rating system and its capacity to rate all homes against the system. The basis of the system would be the relative performance of homes against the accreditation standards. This would involve moving to a single process for assessments and ratings, covered by a single fee. **Recommendation 7** refers.

The star ratings should be displayed in such a way as to enable consumers to readily compare facilities. They should include links to any current and past sanctions relating to the facility and to comprehensive information on the approved provider including their corporate structure and any other homes operated.

[25] See, for example, Submission 35, pp. 3–4.

The star ratings for all providers should be readily accessible through the Agency's website and in other formats, including through the provision of 'on request' printouts for people without access to electronic information to ensure that they receive up-to-date information. In developing the system, it would be essential to clearly distinguish between the quality of clinical care and those elements of residential care where the standard is a matter of preference.

The current accreditation process may encourage some providers to aim only for the minimum standard required to maintain accreditation and access to Government funding. A star rating system would reinforce commitment to continuous improvement. Further, as the industry moves to more flexibility in management and pricing, consumers would have greater assurance of transparency to determine the choices available.

The next five years at least will be ones of structural adaptation and changes in ownership. This circumstance should alert the Agency to the increased need for spot checks not announced in advance or with only a day's notice. Conditions alerting the Agency would be change of ownership accompanied by changes in personnel as well as an institution's greater reliance on temporary staff. Reliance on temporary or so-called agency staff may be linked to high staff turnover. Where questions arise about possible concerns on staff morale and performance, turnover should be a solid surrogate measure.

The Agency is uniquely placed to undertake systemic and comprehensive analysis of performance yet little has been undertaken. The Agency has identified this as a priority for the coming year and is transferring accreditation audit data and other information to a comprehensive database to support analyses. The Agency holds a wealth of performance information which should be used to assist in the development of an evidence base for the care of the frail elderly. This should be a far higher priority for the Agency than conducting training for providers on matters where other suppliers are readily available.

More providers are developing 'portfolio' approaches to service provision, possibly integrating the delivery of a full spectrum of services for the elderly: CACP and or HACC services, congregate living accommodation, low and high care, and dementia-specific care across an extended campus. Analysis could also be used assess whether changes to the accreditation process are needed to ensure there are no disincentives to the further development of portfolio approaches.

12.3 Agency revenues

Agency revenues are derived from application fees paid by approved providers, grants from the Government and charges for training and other activities.

- Application fees are graduated depending on the number of places allocated to the provider and whether the application relates to a commencing or established residential care service. The levels of fees are specified in the Act (Section 2.6 to

2.8). Consequently, in the current accreditation round, fees are at the same levels as for the first round in 1999. There is no mechanism in the Act for varying the level of charges. This prohibition is absurd should be abandoned.

- Application fees relate only to accreditation audits. No fees may be charged for random or targeted spot checks, or for review audits (scheduled or unannounced) initiated by the Agency or at the request of the Department Secretary. Nor are fees charged for support contacts (on site or via teleconference).
- The Government provides an ongoing base grant of $6.5 million a year and funding in lieu of application fees from approved providers with fewer than 20 residential care places. The adequacy of the base grant has not been revisited in light of the actual scope of the Agency's functions and operational costs.
- Additional grants of $5 million per year were provided for 2001–02 and 2002–03 only to increase capacity to undertake spot checks.
- The levels of fees to be charged for manuals and other materials, seminars and conferences are also specified in the Act (Sections 6.2 and 6.3). For activities and training where cost recovery would be desirable, the opportunity to set appropriate charges is prohibited.

The costs of accreditation audits have increased due to a five per cent increase in the total number of residential aged care places, a 23 per cent increase in the number of homes with 80 beds or more and a decrease of over 12 per cent in the number of homes with less than 20 beds. At the same time, revenue from application fees is tied to rates set in 1999. Accreditation audit costs are increasingly being met from Government base funding, diminishing the Agency's capacity to, and funding for, improving the communication of accreditation results to consumers and further developing its management systems.

Recommendation 7 requires funding arrangements for the Agency to be addressed as a matter of urgency. Continuation of the current constraints will seriously affect the Agency's viability. As the contract with the Agency is due for re-negotiation, the urgency of removing the constraints cannot be over stated.

In addressing the issue, the principle of sharing costs between the Government and the industry should be adhered to. Providers (with the exception of homes with less than 20 beds) should bear the total cost of accreditation audits.

Government has a responsibility on behalf of users in a situation where asymmetry of information applies. Government should therefore bear the costs of promoting understanding of the accreditation standards among providers, ACATs, consumers and such organisations as Centrelink, for wide-dissemination of accreditation outcomes, monitoring the effectiveness of accreditation and identifying and addressing issues affecting the overall performance of the industry.

Specification of application fees in the Act should be replaced with a set of principles for graduated charging and increasing fees without a need for changes to the Act. Consideration should be given to the possibility of charging for on-site and teleconference support contacts if these involve substantial time. No fees should be charged for random or targeted spot checks, or for review audits (scheduled or unannounced) initiated by the Agency or at the request of the Department Secretary.

Base-line funding should be increased based on the robust assessment of the costs of current and projected workloads.

12.4 Consumer protection and consumer interests

The *Aged Care Act 1997* and Principles contain specific consumer protection provisions, including:

- a Charter of Resident's Rights and Responsibilities;
- resident agreements;
- complaint resolution mechanisms; and
- support from advocacy services.

As part of the User Rights Principles under the Aged Care Act, each residential aged care service must establish a complaints resolution mechanism and use it to address complaints made by, or on behalf of, care recipients of that service. They must advise the complainant and assist them in using any other mechanisms to address the complaint. Providers must allow people authorised by the Secretary to assist in resolving complaints and must also comply with any determination made by a Complaints Resolution Committee.

12.4.1 User rights

Three major issues were raised with the Review concerning the upholding of user rights:

- lack of clarity about what services must be provided without extra charges;
- security of tenure especially as bond agreements reach the end of the period for retention payments; and
- the confidence of residents to participate in the accreditation process and in internal complaints resolution mechanisms.

Payments and services

Evidence in submissions and from the consultations indicates that there is sometimes a lack of shared understanding between residents and providers about services included in standard charges. Participants in consultations in one state presented a confusing

picture of 'impoverished' residents 'imprisoned' because they are not able to pay for social outings with the income left after deducting 85 per cent of their income. Other participants were quick to assure the Review that the costs referred to are covered by standard charges in their facilities.

Section 56(1) of the Act requires providers to offer to enter into a resident agreement with each care recipient, and to enter into such an agreement if the care recipient wishes. In view of the issues identified above and recommendations elsewhere in this report that providers should take greater responsibility for decision making, there appears to be a need to strengthen some aspects of user rights.[26]

Security of tenure

Comments made by some participants in the consultations have caused the Review to feel uncertain about the commitment of providers to upholding resident's right to security of tenure, particularly in the case of those residents whose bonds are nearing the end of the period for retention payments. The Commissioner for Complaints also expressed concern that there continue to be complaints around security of tenure, particularly for residents who begin to exhibit challenging behaviours. Transfers to hospital or another facility 'often appear to be the first resort rather than the last and may occur without appropriate medical and/or behaviour assessment and care planning having been undertaken or instituted'.[27] The Commissioner stresses the importance of the resident's agreement in setting out the resident's rights in such circumstances. In the case of residents with challenging behaviours, access to support by a psycho-geriatric unit is important before any such transfer is made.

Resident's agreements could be made mandatory covering all matters to be agreed between the resident and the provider including matters relating to accommodation bonds and charges. Some residents may also wish to include advance directives for end-stage care in their agreements.

Consumer lack of confidence in accreditation processes and internal complaints mechanisms also features prominently in the report of the Commissioner for Complaints. The report notes that during the period 1999 to 2002, in 4365 records 'the word or words fear, intimidation, retribution, reprisal, harassment and victimisation' are used. While the accreditation process places much emphasis on continuous improvement, it appears that many participants in the industry are yet to adopt a 'safety and quality' approach, with complaints accepted as learning and improvement opportunities.

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[26] The NSW Aged Care Alliance regards the optional nature of resident agreements as unsatisfactory (Submission 36, p. 3).

[27] Commissioner for Complaints, *Annual Report*, p. 31.

The Review observed ways in which some boards and management tested the opinions of residents and their families by surveys. These surveys were developed frequently on a separate basis because the interests of families might differ from those of residents. A certain proportion of residents would not be in a position to respond. The results of the surveys may be made public to inform families and potential residents as well as boards and management.

The Review considered the imposition of a requirement to conduct surveys but decided that a reluctant participant would be unlikely to encourage responses. Nonetheless the Review would ask providers to consider an approach used by some of the best of their peers.

Advocacy services

Consumers have access to other mechanisms through which they may seek support and assistance in pursuing their rights under the Act. Through the National Aged Care Advocacy Program (NACAP), the Department funds Advocacy Services in each state and territory to provide independent advocacy and information services to residents, potential residents, their families or other representatives.[28] Support and education may be given in relation to care and rights matters within a facility, information, entitlements such as pensions, making complaints to the Commonwealth Complaints Resolution Scheme, legal advice and referral to other relevant organisations. A plain English booklet, It's Your Right: Living In Residential Care, sets out consumer rights and other information. In 2002–03, around 4800 clients were assisted. The five most common issues identified by NACAP were choice/decision making, fees and charges, alternate decision making, security of tenure, and access to appropriate care.[29]

12.5 Comment

Given the immaturity of the industry overall and the mid- to long-term restructuring it is likely to undergo, a period of consolidation would seem to be desirable in relation to quality assurance and consumer protection. In general, issues raised with the Review indicate the need for far greater consumer focus, some clarification and/or strengthening of roles and users' rights, and better communication with consumers and the community, rather than any major changes to the Australian Government's regulatory framework.

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[28] Expenditure for the Advocacy Program in 2002–03 was $2.2 million. See DoHA, *Report on the Operation of the* Aged Care Act 1997, pp. 41–42.

[29] Information provided by the National Aged Care Advocacy Program. While the issues are similar to those recorded by the Complaints Resolution Scheme, differences in recording methods mean they are not comparable. In addition, a further 5400 people contacted the services for information and general assistance.

13. INTERACTION BETWEEN THE AUSTRALIAN GOVERNMENT, STATES AND TERRITORIES

One of the most significant issues for consideration in the delivery of aged care is the interface between the Australian Government, state government and local government programs. State and local governments are often aged and community care providers: health care services accessed by the frail aged are a state government responsibility, as are many allied health services. The effective coordination of health and acute care services with community care, rehabilitation, palliative care and residential aged care is essential for the delivery of a quality aged care service.

There is a perceived need for convergence and better communication between the health and aged care sectors to optimise the outcomes of both sectors as opposed to optimising the current elements within the individual health and aged care 'silos'. Considerable concern has been expressed to the Review that there is currently insufficient integration with the different government agencies and inadequate communication. Stakeholders would like to see policies and strategies aimed at enhancing integration in and communication between the different government agencies.

One situation which typifies the difficulties for service recipients is that of the young disabled in nursing homes. Many young disabled people are accommodated in aged care facilities in order to access the 24 hour care required by them. The issues around this arrangement are complex and exemplify the difficulties for care recipients who need to access both Australian Government and state services.

Regulation and licensing of facilities is another significant issue and one raised often during consultations and submissions to the Review.

13.1 User needs

The aged can access a range of services offered by various levels of government, some of which are joint programs. The range of services comprises community, respite and residential care, which can be offered individually or as part of an integrated care plan. The aged who still live in their own homes and who are becoming more frail can have an ACAT assessment. That assessment can be used to advise the person on the most effective and desirable care options for them. Often the option is not residential aged care. The preferred or optimum outcome will depend on individual circumstances and the care options and support offered in the community in which the person resides.

13.1.1 Problems for care recipients

One of the major criticisms of the current system is the difficulty of negotiating the Australian Government aged care system while accessing the state health and

community care systems. There are also significant difficulties in accessing residential aged care for shorter periods—residential respite care is generally limited to 63 days per financial year. Further, the funding system makes it operationally difficult for providers to admit residents for short periods outside the respite bed allocation system.

Care recipients who enter residential care, having received community care and other allied health services, may be required to pay for those services in full, where previously they received them at little or no cost. From their perspective, all that has changed is the location in which the service is received; their needs are generally the same or greater.

Further, permanent residential aged care may not be the most desirable long-term outcome for a care recipient. They may have periods of transition, say from acute care in hospital to residential aged care to a return home with support. These transitional periods require more flexibility in the aged care and health systems than is currently possible to ensure that, once a person has regained a specified level of functionality, they can be cared for in the most suitable environment and receive the most effective care options. That may mean enhanced rehabilitation opportunities, not necessarily in an aged care facility. Again, a comprehensive program of assessment, rehabilitation and care is required to ensure the optimum outcome for the care recipient and the providers of care.

Aged care service providers often find themselves in a position of looking after residents with acute medical care needs on discharge from hospital. Many in the industry consider the care received by the elderly in the acute sector is inadequate and does not enhance chances of recovery. While residential care services are not normally in a position to offer acute care to their residents, they are sometimes forced to do so. Residential aged care service providers expressed serious concern in submissions and consultations about the care received by the elderly in the acute sector. During the many consultations and discussions, the acute sector was said to be dangerous to the health of their residents.

13.2 Disabled young people in aged care

There are a number of younger people with disabilities living in residential aged care as a result of a lack of more suitable accommodation. This situation is problematic both for the residents and for the providers. Young disabled residents may not get the services they need, they may suffer social isolation and they may be disadvantaged financially. Aged care providers are geared to the provision of care to the elderly, as is the funding system, and both may not take sufficient account of the needs of the profoundly disabled, who reside in residential aged care. Further, the demand on providers' resources required to care for young disabled residents may disadvantage frail aged residents.

Under the Aged Care Act, younger people with disabilities are able to enter aged care facilities if they are assessed as needing the intensity, type and model of care provided in such facilities, and provided no other more appropriate service is available. Currently there are over 6000 people under the age of 65 in residential aged care, the majority of which have some form of disability (Table 13–1). This figure equates to five per cent of residential care beds. The majority of younger people in residential aged care facilities receive high level care and consequently are subsidised at the RCS 1–3 level.

Table 13–1: People aged under 65 in residential aged care by jurisdiction as at August 2003

State	<50	<65
New South Wales	391	2218
Victoria	222	1461
Queensland	220	1290
Western Australia	78	489
South Australia	61	389
Tasmania	21	158
Australian Capital Territory	3	54
Northern Territory	14	72
Australia	**1010**	**6131**

Source: DoHA data

13.2.1 Appropriateness of accommodation

In assessing whether younger people with disabilities should enter residential aged care facilities, it is the Australian Government's view that residential aged care facilities that are focused on the needs of aged people rarely, if ever, enhance the quality of life for younger people with disabilities.[2] The limitations for young disabled of residential aged care include:

- inappropriate setting;
- social isolation; and
- inability to attend to special care needs.

Contemporary disability policy locates people in their communities and residential disability services are generally delivered in settings of five to eight people. However, aged care facilities often accommodate much larger numbers, lessening the opportunity for individual care and attention. Younger people in these facilities may be isolated socially and emotionally through separation from their age peers, although this depends on the numbers of disabled in aged care facilities.

The type of care required for younger people with complex disability support needs is

1 DoHA data

2 Assessment and Entry to Nursing Homes and Hostels of Young People with Disabilities; www.ageing.gov.au.

highly demanding in time and intensity. Often it will require particular sets of skills and a number of different professionals attending to an individual's needs. The skills and experience of staff in aged care facilities generally do not cater adequately to such needs.

From a provider's point of view, the accommodation of younger people in nursing homes is also problematic. It would appear that the funding arrangements, in part, contribute to the inappropriateness of the service available in aged care facilities for the younger disabled, due to the fact that the funding subsidy arrangements are applied to younger disabled people in the same way as the frail elderly.

Further, some younger disabled residents with cognitive impairment and consequential challenging behaviours can impact detrimentally on residential aged care staff, management and other residents.

13.2.2 Funding responsibility and costs to the Australian Government

Residential aged care is the funding responsibility of the Australian Government, which also funds disability support pensions.[3] However, state and territory governments are responsible for the provision of disability support services, including accommodation.

While the Aged Care Act allows for entry of people under the age of 65 into residential aged care on compassionate grounds, disability is a state matter and funded under the Commonwealth–State/Territory Disability Agreement (CSTDA).

The majority of younger residents receive RCS level 1–3 subsidies. With 7,141 people under the aged of 65 receiving an average annual RCS subsidy of $38,000 per year, the Australian Government subsidy amounts to approximately $270 million per year on servicing younger residents.[4] Those young people in nursing homes who receive the disability support pension are classed as concessional residents, entitling the provider to the concessional resident supplement.

The Commonwealth–State–Territory Disability Agreement

The Commonwealth State Territory Disability Agreement (CSTDA) is the instrument by which disability services are funded and administered in Australia. Under the CSTDA, the Australian Government is responsible for providing employment assistance for people with disabilities, and the states and territories are primarily responsible for providing accommodation support services, respite care services and community access programs such as day programs.

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3 The Disability Support Pension is a payment for people whose physical, intellectual or psychiatric impairment prevents them from working, or for people who are permanently blind. The maximum pension rate payable per fortnight for a single individual is $452.80.

4 DoHA data

Australian Government funding is allocated to the states and territories using a formula based on population share of people with disabilities.[5] Under the current agreement the Australian Government's $3.2 billion contribution to the CSTDA is allocated as follows:

- $1.31 billion for specialist disability employment services; and
- $1.93 billion to assist states and territories fund accommodation and support services.

Younger people in aged care facilities are excluded from accessing CSTDA disability services because they are accommodated in residential aged care, despite being in the CSTDA target group. The expectation by the CSTDA is that the aged care sector should provide the relevant services (e.g. equipment, therapy and attendant care) when state services are unable to do so.[6]

It may be that younger disabled people who are accommodated in Australian Government funded residential aged care facilities are missing out on financial or other funded support. Table 13–2 compares the funding support under the Aged Care Act and that under Victorian Disability Services for a person with 24-hour care needs.

Table 13–2: Comparison of funding support in the disability system versus the aged care system

Indicative person with a disability, with full service	$	Young person in a nursing home, with high care needs	$
Accommodation in community residential unit	57 000	RCS Category 1 subsidy	43 000
Day Activity program	22 000	Supplements	1 000
Transport (mobility allowance)	1 500	Day activity	unmet
Case management	2 500	Equipment	unmet
		Transport	own cost
		Therapy	unmet
Total	**82 500**	**Total**	**44 000**

Source: Victorian Young People in Nursing Homes Consortium (Submission 102).

13.2.3 Comment

The accommodation of younger disabled people in residential aged care may not be the best outcome—for the resident, for the provider or for the Australian Government. The needs of the younger disabled residents are not being met as fully as they might be if they were accommodated somewhere more suitable. Provider resources are being stretched and the Australian Government is funding residential aged care beds which are not being occupied by the target population, that is, the frail aged.

The Review notes that one of the priority areas for action in the third disability

5 www.facs.gov.au
6 Submission 102.

agreement is the intersection between the ageing and disability support systems, particularly for people with a disability who have age care-related needs, and younger people with a disability living in, or at risk of living in, residential aged care.

The Review considers that no disabled person should be disadvantaged as a result of their residential status in an aged care facility and, at a minimum, an audit of younger disabled people residing in aged care facilities is required. This audit should measure the number, characteristics, age, disability types, assessed care and support needs, and geographical location of younger people with disabilities living in residential aged care. The results of that exercise would lay the foundation for the development of the most appropriate service framework for this client group.

13.3 Interface between community and residential care

Major concerns expressed in submissions and during consultations include:

- the interface between community and residential care;
- provision of medical and other health care services in aged care facilities;
- acute care/residential care transitional care services.

A major concern for submitters was the perceived inflexible and separate provision of community and residential care. Submissions argued that the two services were interrelated and should not be provided in isolation from one another.[7] Uniting Church Homes argued that the whole industry was an inter-related mix of sectors which, in turn, related to a larger health system and various other systems.[8]

A number of submissions, particularly from larger organisations or peak bodies,[9] argued that increased residential aged care places and funding are not the only options; that there are other alternatives which can complement residential aged care and delay or prevent admission to residential aged care. Alternatives include better housing design to enable people to remain longer in their home, with or without support, reform of community care and more flexible residential aged care.

ACSA would like to see a reformed community care system which provides a seamless, flexible service to the client rather than the administratively onerous one currently in place:

> Currently there is a growing plethora of largely compatible community programs that have created separate reporting requirements and different eligibility rules. Often the same organisations provide a mix of community care programs and must complete multiple sets of essentially similar information. These different requirements are inhibiting the provision of quality care to individuals while replicating management overhead costs.

7 Submissions 74, 88, 127, 151, and 252.

8 Submission 151.

9 Particularly Aged Care Assessment Service Victoria (ACSA) and Aged Care Housing Group (ACH).

Overly prescriptive program guidelines and eligibility rules often impede an effective response to meeting people's needs. Uncoordinated planning does not help people to access the services they need.[10]

The Acute Transition Alliance Pilot Project

The ACH organisation in South Australia suggests that, while there will be a continuing demand for longer term care, recent pilot programs which focus on the provision of rehabilitation services and support through transitions in and out of hospital indicate that a higher proportion of older people in the future will require short term and episodic care, rather than long term care.[11]

The ACH organisation refers to a pilot project in which they are participating, the Acute Transition Alliance. In one 12-month period, there were 521 referrals (i.e. people awaiting discharge from hospital, of which 329 were accepted onto the pilot). The discharge outcome resulted in only 17 per cent of participants going into residential care at either low or high care levels, 20 per cent returning to hospital and the remainder going home, either with a CACP, existing community support or with family. The average age for people on the ATA was 81, with 34 per cent older than 84.

The ATA pilot project is a joint Commonwealth/State initiative, comprising a partnership between 20 hospitals and 17 aged care providers. It is one of the Australian Government's Home Rehabilitation and Support Scheme (HRSS) projects and is part of a national evaluation program.

GP Homelink

The GP Homelink program, also in South Australia, is a short-term, community-based, health crisis intervention program aimed at avoiding the admission to public hospitals of older people. The program works in conjunction with GPs, major public hospitals, particularly Royal Adelaide Hospital, to provide external assistance and support to older people who would otherwise be admitted to hospital.

The Review judges this project to be a most important pilot study to aid the elderly in distress and support medical practitioners in their search for ways to alleviate strains associated with entry into acute facilities. The scheme has much potential for helping the elderly stay in their own homes but calls for close ties between those providing residential and domiciliary care. This is another example where the commitment of ACATs to the full spectrum of aged care on a case management basis would be advantageous.

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[10] Submission 252, p. 17.
[11] Submission 246, p. 2.

13.4 Provision of medical and other health care services in aged care facilities

At present, once a person enters residential aged care, their entitlements and access to medical and allied health assistance may change. If they have been part of a community care program, services such as podiatry or physiotherapy may have been provided at heavily subsidised rates or free of charge. However, once in residential aged care those subsidies are no longer accessible. For the resident, this can mean substantially reduced access to necessary services, either through having to fund the full cost personally or the availability of such services being substantially less.

Access to GPs for residential care residents is also problematic. This issue is acknowledged by the AMA in their submission to the Review, when they state: 'The AMA is concerned at the increasing difficulties that older people in residential aged care confront in being able to access timely and appropriate health care'.[12] The AMA estimates that only 16 per cent of general practitioners currently provide services in residential aged care facilities.[13] The AMA suggests that the reasons for this low participation rate are the 'substantial disincentives and barriers that currently make it difficult for GPs, geriatricians, nurses, other health professionals, and carers to operate in the aged care sector'. The disincentives include an inequitable fee structure for doctors and inequitable wages for nurses and other care staff. For example, the Medical Benefits Schedule needs to more realistically allow for medical involvement in the comprehensive medical assessment of aged care residents' health needs. Other factors include:

- the many non-face-to-face administrative tasks and red tape expected of GPs and care staff;
- the lack of integration of medical services in the aged care system; and
- the absence in many residential facilities of consultation rooms with adequate treatment facilities and plug-in computer facilities that would facilitate access to patient records.[14]

The AMA makes a number of recommendations, including amendments to the Medical Benefits Schedule, specifically:

- funding of $20 million for a trial to enable residential aged care facilities to appoint GP Facility Advisers similar to the Visiting Medical Officer arrangements in private hospitals;
- funding of $20 million for a trial to encourage residential aged care facilities to provide consultation rooms with adequate treatment facilities and plug-in

[12] Submission 130, p. 2.
[13] Submission 130, p. 2.
[14] Submission 130, p. 2.

computer facilities that would facilitate access to patient records for doctors and other health professionals.

Transitional care

While better transitional care services are supported,[15] there are few concrete suggestions as to how this might be achieved. ACH in South Australia is undertaking pilot work in this area (as described above).

13.5 Recent initiatives

Community Care Review

It should be noted that a major community care review was initiated in March 2002, the aim of which is to devise a community care system which would:

- be easier to access by people needing help;
- improve national consistency in terms of eligibility and access; and
- make it easier for people needing help to access a range of different services appropriate to their needs;
- reduce overall duplication and unnecessary paperwork across the 17 programs.

The Community Care Review is in its final stages and it is understood that proposals will shortly be forwarded to Government.

Carelink Centres

In 2001, the Australian Government established Carelink Centres to provide a single point, nationally for people to access information about the range of services available in the community. There are 65 shopfronts and more than 90 access points throughout Australia, as well as a national 1800 telephone number. Carelink Centres have extensive regional networks and maintain comprehensive databases containing community aged care, disability and other support services. The shopfronts are operated by organisations which already provide established services within their region and who have extensive local knowledge.

Medicare Plus

The MedicarePlus package announced recently provides considerable incentives to encourage GPs to provide services to residents of aged care homes. The package is expected to overcome some of the current problems of access to GP services. Initiatives include the following activities.

[15] Submission 130.

- An additional $5 rebate on top of the Medicare rebate for bulk billed residents, many of whom are age pensioners.
- Comprehensive medical assessments for residents funded under Medicare. A rebate of around $140 will apply to these assessments. This will allow GPs to better assess exactly what a new or existing resident requires for their ongoing healthcare. The medical assessment will provide important information to assist in care planning and managing medication for residents.
- Panel arrangements for GPs whereby they will be reimbursed for providing services to residents of aged care homes who are unable to access a doctor of their own.

The panel arrangements will allow aged care service providers to enter formal arrangements with a group or panel of general practitioners. Through these panel arrangements, GPs will be reimbursed for providing services to residents of aged care homes who may not have their own doctor, or whose doctor is unavailable, including in emergencies and after hours. GPs will also be reimbursed for non-face to face work with aged care homes on quality improvement activities. GPs will be able to receive up to $8000 a year for these services. Divisions of General Practice will manage these payments and also be funded to support the development of GP panels at the local level.

An adequate supply of doctors is a key factor in ensuring that patients are able to access affordable GP services. The Government also recently announced that an additional $1 billion is being invested from now until 2006–07 to increase the size of the medical workforce.

Similarly, nursing staff and personal care workers are the primary deliverers of quality aged care. They are in short supply. Notwithstanding the shortage of nursing staff at all levels, it is understood that nursing places at universities are in short supply, as are places for Enrolled or Division II nurses to undertake TAFE-level training.

13.6 Comment

The extent of Australian Government/state duplication, overlap and inadequate coordination in the delivery of care and medical services to the aged is difficult to quantify but nonetheless apparent. Concern by users, providers and other stakeholders has been expressed to the Review. Where programs are intertwined to the extent that the health and aged care programs are, it is essential that significant effort is expended on minimising overlap and duplication, providing a single point of access for consumers and maximising coordination and communication.

The Review of Community Care will report shortly and any future action in relation to the delivery of community care will need to consider the findings of that review.

Similarly, action is required in the tertiary education sector to encourage more students to pursue nursing as a career and to undertake either TAFE-level training or nursing

training at university level. Both types of courses must include modules on care of the aged as specific units. Increasing the supply of qualified nursing staff and trained personal care workers must be a priority for all levels of government. All levels of training must include modules on care of the aged.

In order to enhance service delivery to consumers, the following broad principles are recommended:

- enhanced coordination of community care delivery with the states and territories;
- improvements to lines of communication between the states and territories;
- further development of and support for joint pilot programmes, such as the Acute Transition Alliance and flexible funding options (eg Multipurpose Services);
- further consideration and development of joint Australian Government / state government programs, where the Australian Government contributes funding to a greater or lesser extent and the state delivers the program;
- enhanced coordination of and support for training for nurses and personal care workers by both the Australian Government and the states and territories.

The Review recognises that the above principles comprise broad objectives. However, given the complexity of the issue and the many different programs and areas of Australian Government and state responsibility involved, it was considered that more detailed and prescriptive recommendations would not be appropriate.

The Review recommends that, in the context of the Bilateral Commonwealth State/Territory Disability Agreement:

- a national assessment/audit of people under the age of 65 occupying residential aged care places be undertaken, including assessment of age, disability types, assessed care, support and nursing needs, and geographical location;
- an assessment of financial outcomes for young disabled people in nursing homes be undertaken, with a view to ensuring that any young disabled resident occupying a nursing home bed receives top-up funding from the states to the extent that they would were they in receipt of state/territory support; and
- options for permanently accommodating younger disabled outside the residential aged care system be progressed.

13.7 Regulation and licensing of facilities

The *Aged Care Act 1997* sets out a comprehensive regime of regulatory requirements for residential and other forms of aged care. Background Paper No 2, The Commonwealth Legislative Framework, provides a commentary on Commonwealth regulation under the Act and in particular the accreditation and certification requirements, necessary preconditions to receipt of subsidies under the Act. It is in the areas of accreditation and certification that facilities might be most affected by duplicate or inconsistent requirements.

13.7.1 Commonwealth regulatory arrangements

The Act and Principles set out detailed regulatory requirements, covering such matters as approval of providers and their responsibilities, the allocation of places, approval of care recipients, classification of care recipients, the provision of extra service places, certification of residential care services, residential and other care subsidies, accommodation payments, the protection of personal information and accountability and sanctions.

Certification and Accreditation

Under the Act, facilities must conform to relevant state regulation in order to comply with some Commonwealth requirements. However, the Commonwealth legislation also sets out specific matters for consideration before accreditation and certification is attained.

In particular, Division 38 of the Act sets out the requirements for the certification of residential care facilities. Section 38–3 and the Certification Principles 1997 allow the Secretary to have regard to relevant matters such as whether buildings and equipment meet the requirements of or are subject to any State law or State or local government authority. For example, under Part 3 of the Certification Principles whether buildings meet the certification/licensing requirements of a state, territory or local government authority is a relevant matter for consideration.

The Accreditation Standards contained in Part 4.1, Quality of Care standards and Schedule 2, the Quality of Care Principles, include but are not limited to health and personal care of care recipients, safe systems and the physical environment in which residential care is provided and professional standards and staffing relating to the provision of care.

13.7.2 State regulation of nursing homes

Victoria has vacated the field of regulation of aged care and the ACT has never regulated aged care. South Australia and Queensland exempt from regulation those homes which are certified under the Aged Care Act. Tasmania largely leaves regulation to the Commonwealth by default and Western Australia also effectively leaves regulation to the Commonwealth. Only the Northern Territory and New South Wales continue to actively regulate aged care, with New South Wales being the most comprehensive regulator of aged care.

New South Wales

As noted above, NSW remains a regulator of nursing homes under state legislation. Its *Nursing Homes Act 1988* and regulations remain in force, while the *Youth and Community Services Act 1973* is also relevant insofar as it still regulates hostels in NSW. There has

been no updating of the definition of the term 'hostels' in NSW, thereby potentially capturing facilities which have both low care and high care residents.

Regulations made under the *Nursing Homes Act 1988* prescribe standards for or with respect to any matter relating to the safety, care or quality of life of residents at nursing homes, including the following matters:

- design and construction of premises,
- facilities and equipment,
- staffing, including qualifications of staff members, number of staff and duties,
- operational matters, including administration and support services,
- clinical records, including access by residents to, and confidentiality of, those records.

These matters are also dealt with in the *Aged Care Act 1997* and Principles.

Part 2 of the NSW Nursing Homes Act covers the licensing of nursing homes. Conditions attach to the issuing of a licence, many of which are inconsistent with or duplicate the relevant Commonwealth provisions. The definition of 'nursing home' in the act includes premises with residents who require nursing care on account of age, infirmity, chronic ill-health or other condition, but does not include premises conducted by or on behalf the State government or public hospitals and rehabilitation centres. All facilities in NSW operated under the *Aged Care Act 1997*, with the exceptions listed above, could come within this definition and therefore be subject to regulation by both the Commonwealth and the State. The added complication for what were hostels in NSW is the potential for regulation under both sets of NSW legislation as well as under the Commonwealth Aged Care Act.

One consequence of the inconsistent regulatory requirements so far as staffing is concerned relates to the increased professionalism in the management of residential aged care and the potential for the NSW legislation to mitigate against that development. Section 37 of the Nursing Homes Act requires that there be a Chief Nurse in each facility, who is a registered nurse, irrespective of the size and nature of the facility. Such a prescriptive requirement, which is not mirrored in the Commonwealth legislation, means that there will be consequential pressure for that position to manage the facility as well as provide the specialist nursing expertise. The quality of management is one of the fundamental issues confronting the residential aged care industry. The requirement that all services must appoint a Director of Nursing precludes the employment of those with specialist management skills, when the real need might be for a management expert rather than a registered nurse/Director of Nursing. Given the large number of smaller facilities, opportunities to upgrade management ability overall and to appoint specialist managers are being curtailed.

NSW Review

In 2000, NSW undertook a review of nursing home legislation[16]. Regulatory issues identified included:

- The differential reach of the two regulatory frameworks under the Commonwealth legislation and the NSW Nursing Homes Act. The Commonwealth system regulates only those services it funds, while the State system regulates all nursing homes in NSW;
- The duplication between the certification and accreditation processes under the Commonwealth scheme, and the licensing and regulation of 'inputs' approach under the Nursing Homes Act and Regulation;
- The interaction between the licensing requirements under the Nursing Homes Act, for both nursing homes proper and hostels that provide nursing care under the 'ageing in place' reforms, and compliance with the Building Code of Australia 1996 (or BCA-96). Under BCA-96, high level residential aged care must be provided in facilities of a certain classification (generally Class 9a), while low level residential aged care may be provided in facilities of a different classification (generally Class 3). A facility, including a former hostel, licensed under the Nursing Homes Act to be a nursing home, is technically required to comply with BCA-96 and satisfy the Class 9a design and construction standards;
- The possible duplication in part, but difference in coverage, of the protection of residents' rights under the Commonwealth's Aged Care Act and Principles (in particular the User Rights Principles) compared with the protection under the State's regulatory scheme, by incorporation in the Nursing Homes Regulation of the former Commonwealth's Outcome Standards;
- Differences under the two schemes on security of tenure, access to clinical records, and regulation of the use of restraints on residents with dementia;
- Differences in the regulation of staffing requirements between the two schemes;
- Differences and duplication between the Commonwealth complaint resolution and investigation scheme, and the possible sanctions for non-compliance, and the State scheme for complaint resolution, investigation and enforcement by sanctions.

The final report is still under consideration.

Northern Territory

The principal legislation is the *Private Hospitals and Nursing Homes Act 1981*, by which all forms of nursing home are licensed. All institutions providing residential aged care come within the scope of the act, which is regarded by the Northern Territory government as being complementary to the Commonwealth legislation.

[16] Review of the *Nursing Homes Act 1988*—Issues Paper—June 2000

Under the Act, there is power to make regulations dealing with:

- the minimum qualifications required of employed nursing staff;
- the duties of nursing staff;
- the ratio required of nursing staff to residents; and
- the minimum standards of accommodation required for residents.[17]

However, to date no regulations have been made under the legislation, in relation to licences or to staffing. The Act itself contains few prescriptive requirements, (employing a manager and keeping a register of residents) and those few requirements do not introduce substantial inconsistencies with the Commonwealth scheme.

The two intended processes for regulating and monitoring the conduct of residential aged care facilities appear to involve the imposition of conditions on individual licences and the annual inspection of premises. The Northern Territory Government considers the requirement for annual inspection to be an important additional accountability mechanism. The potential duplication with the Commonwealth's accreditation scheme is acknowledged by the Territory Government, but it is envisaged that, in practice, the two regulatory schemes will work in a complementary manner. However, the potential for duplication or inconsistent regulation remains.

13.7.3 Comment

Duplicate regulatory arrangements are undesirable, at times imposing inconsistent requirements on providers of aged care without any appreciable benefit to consumers. Regulatory compliance is a significant business expense to providers and the existence of superfluous regulatory requirements is in no-one's best interest. The situation in New South Wales is of most concern, although other states have some degree of actual or potential regulatory overlap.

One mechanism for ensuring that regulation impacting on aged care is considered at a high level is for the matter to be raised at a high level politically and administratively. The most appropriate forum would appear to be the relevant Ministerial Council. Commonwealth–State Ministerial Councils and fora currently facilitate consultation and cooperation between governments in specific policy areas, initiate, develop and monitor policy reform jointly in these areas, and take joint action in the resolution of issues that arise between governments.

The resolution of regulatory overlap in this area is appropriate for consideration by the Ministerial Council on Health and Community Services.

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[17] *Private Hospitals and Nursing Homes Act 1981*

13.8 Other regulation

The direct regulation of aged care under the *Aged Care Act 1997* is one matter. However, residential facilities are also required to comply with State regulation of matters such as fire safety of buildings and food preparation and storage, matters which apply to a range of public facilities including residential aged care facilities. These matters principally include:

- medication management;
- state and local government planning and building regulations;
- fire safety compliance;
- food storage and preparation;
- consumer protection.

The industry recognises that these are legitimate regulatory requirements. However, their concern is that the funding received does not recognise the costs incurred in compliance activity. For example, ACSA NSW & ACT states that:

NSW State legislation requires that facilities meet public health requirements such as the installation of mixing valves, the testing of water for legionella disease and the meeting of NSW State fire regulations. These requirements are not funded by the Commonwealth or State, but nevertheless are a very real and legitimate cost to providers and should be included in any determination of the costs of residential aged care.[18]

ACSA NSW & ACT further states that compliance with local government regulations in such areas as food handling, fire inspections and building codes is highly variable, resulting in quite different financial impacts, depending on the particular local government area in which the facility is located.

There is an additional area of regulation which providers consider adds to their compliance burden and that is in the area of consumer protection. Recipients of aged care and/or interested parties have available to them a number of avenues for the resolution of complaints, either those established under the Aged Care Act, mechanisms under the *Trade Practices Act 1974* (Cth) and the state Fair Trading Acts, the Ombudsman or even common law avenues of appeal. The Aged Care Act specifically requires services to establish complaints mechanisms, separate from and additional to other existing legal or consumer protection measures.

The detail of particular regulatory arrangements as they apply in Victoria is contained in a report prepared for the Review by Peter Hanks QC[19]. That report is available on the Review's website.[20] The Report covers the following issues:

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[18] Submission 77, p 31

[19] Peter Hanks QC and Lisa De Ferrari, *Regulation of Residential Aged Care—Selected Legislation and Regulations which an Aged Care Provider Must Comply With*, paper prepared for Review of Pricing Arrangements in Residential Aged Care, 28 October 2003, p. 68.

[20] See www.ageing.health.gov.au/rescare/acprtask.htm

- medication management
- planning and building regulation
- environmental regulation
- food storage and preparation
- consumer protection.

The Hanks' Report draws the following conclusions.

Medication management

The issue is under consideration at present in a case before the Federal Court. If, after the Federal Court decides the application and the position continues to be that Division 2 nurses cannot administer medication, then State laws will remain more prescriptive than the Aged Care Act and Principles in relation to the competency of different categories of staff to administer drugs. This restriction reduces the efficient management of aged care facilities, again without any noticeable benefit to residents.

Planning and building regulation

There is duplication between the certification requirements at the Commonwealth level and the building regulations at the State level, although there is also a level of co-ordination, in the sense that the Commonwealth regulations assume that non-compliance with the State and local government laws will be taken into account.

The duplication can be found in the certification requirements at the Commonwealth level, and the building regulations (and BCA-96, as incorporated by reference) at the State level, both of which address matters of safety and standards of the buildings being used for the provision of the residential aged care service. The impact for an approved provider consists of the carrying out of multiple inspections, by authorised building inspectors or other agents, in accordance with the two regulatory schemes, and any administrative matters required in connection with those inspections. It also can be found in any compliance costs—such as the cost of any modifications required, for example.

There may also be issues of inconsistency or uncertainty in the manner in which the Commonwealth and State provisions interact, principally because:

- At the State level, the building regulations (including the provisions of BCA-96 incorporated by reference), as in force from time to time, are applicable to buildings only when they are being built.
- At the Commonwealth level, on the other hand, certification requires compliance with the certification instrument, in the form it exists from time to time, on each occasion when the certification process is carried out.

It should also be noted that the Building Act and regulations are applicable only while building is taking place. However, the certification and accreditation requirements

under the Aged Care Act are ongoing. The ongoing nature of Commonwealth regulation ensures that residential aged care recipients are guaranteed an appropriate standard of accommodation over the life of a facility.

Adding to the complications are the uncertainties associated with the administration of building requirements. State authorities and local government authorities approve planning for new or refurbished facilities. Yet inspections often bring not just concern about meeting requirements but also demands for changes in requirements with additional costs for implementation.

It is incumbent on state authorities to take all possible practical steps to ensure local government expedites the approval system for aged care building proposals. Delays between allocation of places and the implementation of building contracts are now a serious handicap to the progress of the industry.

Fire safety regulation

For buildings constructed after 1 August 1997, BCA-96 applies in relation to fire safety systems. BCA-96 is intended to apply uniformly across Australia, and be given effect in the various jurisdictions, without modification, by State and Territory laws. However, BCA-96 also contemplates that State amendments may be made to it and as time elapses differential state requirements may appear. [21]

Food storage and preparation

The Victorian Food Act applies to residential aged care services and providers through a series of definitions and the premises from which the service operates are food premises, even if the preparation of meals for residents has been outsourced.

The safe handling of food and the preparation of meals by residential aged care services are matters also monitored under the Aged Care Act and Principles, principally in the context of accreditation, but may also be considered in the context of certification.

However, there are no problems of inconsistency between the State and Commonwealth laws. At a minimum, the annual registration and audit requirements, the fee payable for registration, and the requirements for a food safety supervisor and a food safety program, impose additional operational constraints on accredited providers.

Consumer protection

A residential care recipient's personal, civil, legal and consumer rights in any residential care service are the same as those of any other Australian. They include, but

[21] See for example Victoria Appendix 1996 to the Code, as may be amended from time to time

are not limited to, the right to personal privacy, the right to move or change the care received and the right to complain.

In summary, it would be possible to utilise all or any of the available avenues of complaint or redress in a given situation. The Trade Practices Act and the Fair Trading Act may provide statutory causes of actions in a variety of factual situations in the context of the provision of residential aged care. Common law causes of action may also be open on the same facts. The acts or omissions of a provider that would constitute the elements of these statutory and common law causes of actions could also be the subject of a complaint under the complaints resolution mechanisms provided in the Aged Care Act and Principles.

To the extent that the TPA and FTA create statutory causes of actions, they are part of the general legal fabric in which every business and individual in Australia operates, including approved providers under the Aged Care Act. They are similar, in their role as general laws regulating conduct and providing causes of actions for infringement of rights, to the constraints developed by the common law and by equity and the causes of actions arising under them.

Privacy protection

State and Commonwealth legislation separately regulates aspects of the collection, custody and treatment of information, in the pursuit of potentially contradictory objectives—transparency and personal privacy. The Aged Care Act imposes specific obligations on providers in relation to the personal information of residents in their care, while State FoI Act and Regulations require organisations to release certain information on request if that information does not fit one of the exemptions. While the State FoI legislation does not directly give rise to problems of inconsistency or duplication of regulation with the Aged Care Act and Principles, it intersects with that legislation in the sense that, in certain circumstances, it gives an enforceable right of access to certain documents, including to documents required to be kept under the Aged Care Act and Principles.

The *Privacy Act 1988* (Cth), the *Health Records Act 2001* (Vic) and *Information Privacy Act 2000* (Vic), deal with both privacy of personal information, including health information, and with access to that information consistent with the privacy requirements of those Acts. The Privacy Act, the Health Records Act and Information Privacy Act cover significantly similar obligations. At the Commonwealth level, the privacy of personal information generally, and health information that is also personal information, is covered by the Privacy Act. At the State level, the issue is dealt with by the two state Acts.

In summary, most providers of residential aged care services will be required to comply with both the Privacy Act, and the Health Records Act. Some providers may also be required to comply with the Information Privacy Act. Each of these three Acts

provides for a set of 'privacy principles', covering issues of collection, use, access, correction etc, in relation to personal information or the health information that is also personal information. Although the three sets of 'privacy principles' are intended to be congruent, there are some differences between them, and providers will need to be aware of these.

Each of the three Acts also establishes a complaints system, with a mechanism for review by the Victorian Civil and Administrative Tribunal or through enforcement by the Courts. The IP Act and the HR Act also provide, in different ways, for the application of the State FoI Act in preference to the provisions of those Acts.

The Aged Care Act deals with the responsibilities of an approved provider in relation to the protection of personal information relating to a person to whom the provider provides residential aged care services.[22] It is Hanks' view that compliance with the responsibilities outlined in s 62–1 will not guarantee compliance with all the obligations under the Privacy Act, the IP Act and the HR Act.

There is significant overlap between the obligations regarding privacy of personal and health information under the Privacy Act, the IP Act and the HR Act, and under s 62–1 of the Aged Care Act. There could be uncertainty in the manner in which the obligations under the three sets of 'privacy principles' in the Privacy Acts may interact with the responsibilities under s 62–1 of the Aged Care Act.

There is clear duplication in the possible avenues of complaint where a complaint is about a matter relating to the responsibilities of an approved provider under s 62–1 of the Aged Care Act, and also about an act or practice that may be an interference with an individual's privacy, contrary to the 'privacy principles' under the Privacy Act, the IP Act and the HR Act.

13.9 Retirement Village legislation

Most states now have retirement village legislation which potentially impacts on and may directly impose obligations on aged care providers. The legislation in those states or territories which have enacted legislation is:

- Victoria—*Retirement Villages Act 1986* (Vic)
- NSW—*Retirement Villages Act 1999* (NSW)
- Queensland—*Retirement Villages Act 1999* (Qld)
- SA—*Retirement Villages Act 1987* (SA)
- WA—*Retirement Villages Act 1992* (WA)
- Northern Territory—Retirement Villages Act as in force from 1 March 2002

[22] s 62–1 (see also s 56–1(h) of the Aged Care Act)

The ACT and Tasmania have not enacted any legislation to date, however the ACT has a Code of Practice under the Fair Trading Act on Retirement Villages.

The Hanks' report

Hanks also considered state retirement village legislation, again with specific reference to Victoria. While not directly relevant to facilities certified under the Aged Care Act, many facilities will be caught by state legislation depending on the definition of 'retirement village'. The issue has particular significance for accommodation payments and prudential arrangements.

It is likely that resident agreements and, arguably, extra service agreements are residence contracts as defined in the Victorian Act. Further, where a resident agreement includes an accommodation bond agreement, there will be an 'in-going contribution' refundable to the resident or their estate under a residence contract.

This feature of the legislation contrasts with the unsecured nature of accommodation bonds by guaranteeing residents and/or their beneficiaries some protection of the sums paid as ingoing contributions for entry into the retirement village.

The areas of the Victorian Retirement Villages Act identified by Hanks as giving rise to overlap, duplication or possible conflict with the Aged Care Act and Principles include:

- Generally, all provisions of the Retirement Villages Act dealing with residence contracts conflict with the general scheme under the Aged Care Act for resident agreements and other agreements;
- Section 16 of the Retirement Villages Act is inconsistent with the security of tenure provisions under the Aged Care Act and User Rights Principles;
- Section 17 of the Retirement Villages Act at a minimum overlaps, and may possibly conflict, with the provisions of the Aged Care Act that deal with the suitability of providers and disqualified individuals;
- Section 19 of the RV Act places a burden on a provider to give documents to the resident at least 21 days before entry, while under the Aged Care Act there is no such obligation;
- Section 24 of the Retirement Villages Act is inconsistent with the requirement under the Aged Care Act that a resident agreement must allow for termination within 14 days by the resident;
- Section 25 of the Retirement Villages Act is inconsistent with s 57-16 of the Aged Care Act, which provides that a care recipient must not be required to pay an accommodation bond before the end of the period specified in the User Rights Principles or, if no period is specified, before the end of 6 months after entry to the residential care service;

- Statutory charges under Part 5 of the Retirement Villages Act are inconsistent with the prudential requirements in respect of accommodation bonds under Part 4, Division 3A of the User Rights Principles—the former provide more protection than does Division 3A;
- Section 35 of the Retirement Villages Act is inconsistent with the complaints system under the Aged Care Act and Principles.

13.10 Comments

The extent to which duplicated or inconsistent regulatory arrangements are imposed on aged care providers is difficult to assess. There is certainly potential for inconsistency or duplication in most states, but the real difficulty is in NSW, where areas of inconsistency and duplication have a real impact on providers' operations.

It is accepted that regulatory compliance costs form part of the cost of operating a residential aged care service and different state regulatory requirements, especially in the areas of medication management and staffing profiles, can impose on facilities additional costs outside the direct costs of care. Providers argue that these costs should be taken into consideration in any funding formula.

Duplicate or inconsistent regulation increases the costs imposed by governments on the service provider. It is incumbent on government to ensure that only that regulation which is essential to achieve the objectives of the program is imposed on providers. In the first instance, therefore, governments need to ensure that only regulation which is necessary for the achievement of program objectives is imposed on providers. Duplicate and inconsistent regulation should be identified and removed, so that providers can work within a consistent regulatory regime with unnecessary cost impositions being removed.

For example, NSW legislation, duplicating and inconsistent with the Commonwealth *Aged Care Act 1997*, puts operators of aged care facilities in an invidious position, as they are required to comply with competing and sometimes conflicting regulatory requirements. The NSW Government has received a report on this matter and there is no reason for the current arrangements to persist.

The constraints imposed by the imposition by state governments of certain nursing staff requirements hampers service providers by adding to operating costs and reducing potential flexibility in arrangements. It is suggested that no good purpose is served by the imposition by state governments of regulatory requirements which are superimposed over those contained in the Aged Care Act and Principles.

Medication management in Victoria is out of step with that under the Aged Care Act and Principles. The situation in Victoria is both more prescriptive and illogical, much medication management falling to personal care workers and RNs, with ENs being denied a role.

14. FINDINGS AND RECOMMENDATIONS

14.1 Strategy for development

The 1997 reforms laid the groundwork for a new framework for aged care. However, it is now necessary to assess to what extent those reforms will underpin long-term sustainability of aged care and where reform might be needed to ensure the high quality of, and access to, care currently enjoyed by elderly Australians.

The previous reforms were successful in restructuring the funding mechanism, reducing Government capital provision and fostering quality improvement. Nevertheless, the industry remains in critical need of development; it is immature, largely characterised by small operators. This feature is apparent in the variable financial performance, as demonstrated in the financial survey data and subsequent analyses discussed earlier in the report.

The existing set of policy arrangements offers little scope for management flexibility. Residential aged care is currently a very tight relationship between the Government and the management of residential aged care services. Decisions in great detail are taken by Government on administrative grounds with little or no emphasis given to using price signals other than general adjustments of government subsidies and related payments to providers. In this setting, board and management of aged care facilities have little scope for decision-making. Prices and revenues are determined by Government. Investment proposals are subject to approval of place allocations. Initiatives for experimenting in alternative ways of offering care are almost solely dependent on support and authorisation, in many instances, by one regulatory authority or another.

Reforms in management capability are fundamental to the development of the capacity of the industry to meet future challenges. More emphasis must be placed on growing the industry to a point where it is more able to operate in a commercial world and thereby boost the sustainability of the industry. These management reforms must take place in an environment which affords management the capacity to develop skills.

Notwithstanding a more flexible working environment, the protection of residents' interests and regulation of quality standards are critical matters. The Government's intervention in aged care to promote quality and protect consumer interests is justified because providers and aged care recipients have unequal access to relevant information and the frailty of residents can make them vulnerable to exploitation. The tight supply of places, the reinforcement this constraint on supply has on providers' market power and the inability of residents to exercise choice, necessitate regulatory provisions on quality assurance and conditions on entry.

14.2 Competing pressures

Regulation of aged care is justified, principally because of the need to ensure certain policy objectives in relation to the client group, such as equity of access and quality of care, and the significant levels of taxpayer funding provided. However, the degree of regulation and control exercised must be balanced with the need to encourage an efficient and innovative service sector. Features of regulation were mentioned previously.

Only with more flexibility in arrangements can improved strategies be pursued. This will require government to withdraw from detailed specification of activities in residential and other aged care, thereby allowing providers to make independent decisions about pricing and investment and thereby contributing to the maturing of the industry.

The 1997 reforms commenced the process of making providers more independent of government. Further changes to the relationship between government and providers are require to ensure that the latter take more responsibility for business decisions, focus more sharply on resident needs, and respond more flexibly to residents and their families. In making changes, account must be taken of the need for trade-offs between recovering all the inefficiency in the industry and the risk of compromising policy objectives concerning equitable access for concessional residents and people in rural and remote areas. Moreover, funding arrangements need to properly account for these trade-offs in order to ensure that, in a competitive market, providers will be willing to provide services for such residents.

While it is necessary to give providers more responsibility for making fundamental decisions about their aged care operations, clear expectations must be placed on them to ensure that the care they provide for older Australians and the use they make of residents' and taxpayers' money meets accreditation and business accountability standards.

At base, financing revolves around the sharing of the total cost of services between the residents and taxpayers. Care providers also have a responsibility to help contain costs through the efficient use of residents' and taxpayers' contributions. The challenge is to balance cost sharing between Government and care recipients with equity of access, while simultaneously upgrading quality of care and increasing the efficiency of the industry.

Quality assurance and consumer protection

Scrutinising quality of care is fundamental to maintenance and enhancement of care standards in residential aged care facilities and to consumer protection. More flexibility in financial arrangements and management options for residential aged care is only appropriate where quality is maintained and enhanced and where residents are protected.

Further, the Review endorses the philosophy of the Quality of Care Principles in setting out a structured approach to managing quality, but one designed to enable flexibility in pursuing 'quality in ways that best suit the characteristics of each individual residential care service and the needs of its residents'.

Australian Government/state interaction

The Review agrees that one of the most significant issues for consideration in the delivery of aged care is the interface between the Australian Government, state government and local government programs. The effective coordination of health and acute care services with community care, rehabilitation, palliative care and residential aged care is essential for the delivery of a quality aged care service.

The extent of duplication, overlap and inadequate coordination in the delivery of care and medical services to the aged is difficult to quantify but nonetheless apparent. Concern by residents, providers and other stakeholders has been expressed to the Review. Where programs are interlinked to the extent that the health and aged care programs are, it is essential that significant effort is expended on minimising overlap and duplication, providing seamless access to residents and maximising coordination and communication.

In order to enhance service delivery to aged care recipients, the Review considers that the broad principles of enhanced coordination of community care delivery with the states and territories and improvements to lines of communication between the states and territories are fundamental to seamless delivery of aged care and related programs.

Movement towards a more mature industry

The ability of the aged care industry to access commercial finance will be necessary if the required infrastructure investment is to take place. That access will be influenced by the extent to which the industry matures and places itself on a more professional footing. The quality and composition of boards and management will be fundamental to future operations.

Within the industry there is a growing number of innovative, high performing facilities of all sizes, in all geographic regions and with a strong consumer focus. More industry participants are eager to see a mature industry achieved more quickly to benefit residents, providers and the industry as a whole. Relieving immediate pressures will result in some short term improvements. But it will do little to hasten industry maturity if no other action is taken; rather it will perpetuate an industry focusing on its relationship with the Government to the detriment of the care provided to residents.

It is reasonable to place some responsibility squarely on providers to continue to make productivity and efficiency gains and to expect that these be reflected in lower care costs per person, and lower costs to the taxpayer per care recipient.

Briefly, the timing of the strategic shift in policy arrangements may be divided into two phases associated with the commitment to new building standards to be in place during 2008. The years from now until 2008 are a transition phase. During this initial phase the immediate and medium term recommendations would best be put in place.

The phase after 2008 is viewed as the long term. By that time pricing flexibility, concomitant with fully funding concessional and assisted residents, should be in place. Then further decisions could be taken about the future relationship of the administrative functions of government with the industry.

14.3 Recommendations for immediate change

While further flexibility in the aged care industry is desirable in the longer term, it is necessary to make some changes in the short term by strengthening the aged care framework around the issues of quality, equity, efficiency and sustainability. The Government should therefore consider the following recommendations in the short term.

14.3.1 Improving equity and access

Currently, both the demand for, and the supply of, subsidised aged care services is constrained. In the case of residential care and community care packages this constraint is applied through the needs-based planning arrangements and the gatekeeping role of ACATs.

The needs-based planning arrangements

The supply of residential care places is currently limited by the Government's provision ratio and associated needs-based planning arrangements. In the longer term, the constraint on supply implicit in these planning arrangements will lead to inefficiency and a stifling of innovation in service delivery. The Government needs to give serious consideration to replacing the needs-based planning arrangements with more market based solutions. Such solutions will allow provision to be more responsive to demand, without necessarily increasing the cost to the taxpayer. In the short to medium term, however, the constraint is necessary in order to ensure that aged care funding is equitably distributed. However, even allowing that supply must continue to be constrained for the immediate future, it is important to ensure that the constraint is tuned so as to support the objectives of quality, equity, efficiency and sustainability.

From 1985 to 2001, the planning arrangements provided, with minor modifications, for 40 high-care residential places, 50 low-care residential places and 10 community care packages for every 1000 people aged at least 70. By 2001, the Government recognised there was increasing evidence that the quantum of services provided by the planning arrangements was no longer keeping pace with the increasing demand for aged care services and therefore increased the overall level of provision to 108 operational places, including 18 community care packages, for every 1000 people aged at least 70 by 2006. The Review's modelling indicates that this expanded provision is sufficient to meet overall demand for aged care services in the medium term although there may be some delays in allocated places becoming operational.

However, the allocation mixes between residential care and community care, and between high care and low care, need to be adjusted to accommodate the increasing significance of community care provision and like programs. In the short term, it may be sufficient to increase the number of places allocated within the current planning arrangements and adjust the mix to ensure that community care provision is expanded as a proportion of total allocated places.

There is also evidence that the current arrangements do not adequately ensure equity of access for people with special needs. Currently, places are equitably distributed across Australia with respect to an estimate of the demand population, which includes all Indigenous people aged at least 50 and all non-Indigenous people aged at least 70. The special needs of older Indigenous people, older people in rural and remote areas, older people from culturally and linguistically diverse backgrounds, older people with disabilities, older people with dementia, older people who are homeless and veterans also need to be taken into account in the planning arrangements.

The arrangements also need to take greater account of the impact of ageing in place. Since 1997, low care residents have been able to move to high-level care subsidy rates as their care needs increase without moving to a new service (as they would have under the old hostel/nursing home arrangement). Currently, around a quarter of the capacity of low-level residential care services are occupied by people receiving high-level care subsidies. Given this fact, it is important to continue to maintain conditions of approval on low-level residential care places to ensure access for people needing these services, and to take current usage into account in planning the future release of places. It is also important to report provision on both an allocated and utilised basis in order to provide a fuller picture of the current arrangements.

In the main, the current planning arrangements for the release of new aged care places are not able to respond as flexibly as is desirable for the development of new care approaches or to encourage innovation in service delivery. This has been addressed to an extent by the introduction of the Innovative Pool of flexible care places, which has trialled services linked to the acute care-aged care interface, the disability-aged care interface and dementia care. These opportunities should be enhanced.

Recommendation 1 The planning arrangements

The Government's 2001 commitment to provide 108 places for every 1000 people aged at least 70 should be confirmed as ongoing.

The Review also considers that the planning arrangements should be more flexible so that they can:

a) adjust responsively to the development of new care approaches;

b) encourage innovation in service delivery;

c) *take account of current utilisation in high care and low care;*

d) *take account of the needs of older people with special needs, including those of Indigenous people, older people in rural and remote areas, older people from culturally and linguistically diverse backgrounds, older people with disabilities, older people with dementia, homeless older people and veterans.*

There should be a review of the Government's needs-based planning arrangements after 2008.

Given the extent of restructuring that can be expected in the industry in the short and medium term, until 2008, there may be times when the Government will need to urgently allocate places. For example, the Government may wish to secure the rapid implementation of projects so as to diminish the gap between allocation provisions and operational status, and to meet structural and regional distortions, especially in the transition to 2008. There is also the possibility of the aged care model being slightly conservative in its outcomes. The Government should therefore create a strategic pool of places in each year's allocation of places to meet these unexpected occurrences. The planning arrangements by themselves can do little to address implementation. The Government's recent moves to give priority to providers, who can bring residential care places into operation within a short time frame, are a considerable improvement over the previous arrangements. Consideration should also be given to developing a register of providers who have plans and approvals already in place to start within three months of allocation (a 'Ready List'). Those providers on the list would get priority for any general offer about bed allocation but its main purpose would be for immediate response to any special allocations by the Minister for Ageing. Failure to deliver places will mean loss of any standing for allocation of places until the specific Ready List project is completed.

Recommendation 2 Greater flexibility in allocations

The Government should create a strategic pool of up to 3000 additional places each year for the next four years to meet structural and regional distortions, especially in the transition period up to the end of 2008.

The places should be able to be used flexibly for any form of care—residential or community care or for such allocations as multi-purpose services and allocations to support innovative care models.

The Government should establish a 'Ready List' of providers with plans and approvals to start within three months of allocation of places to secure the rapid implementation of projects so as to diminish the gap between allocation and implementation. Those on the list should be accorded priority for any general offer about bed allocation. Failure to perform as required by status on the Ready List will mean loss of any standing for allocation of places until the specific Ready List project is completed.

Supporting Aged Care Assessment Teams

Given the high degree of subsidisation of aged care services, the many competing priorities faced by governments and the natural reluctance of taxpayers to make a greater than necessary contribution to Government revenues, some degree of control over the demand for subsidised aged care services is necessary. The gatekeeping role of ACATs is therefore essential in this regard. ACATs underpin the second of the principles for aged care regulation outlined above, namely they facilitate and encourage equity by ensuring that access to subsidised aged care is based upon an objective determination of care needs.

In light of ACATs' current responsibilities under the Aged Care Act and the increased importance of the role envisaged by the Review, their capacity must be strengthened. ACATs need to be adequately resourced to undertake their responsibilities effectively. Adequate resourcing will ensure eligibility assessments take place in a timely fashion and ACATs are able to assist residents to make informed choices. In 2003–04, the Government provided $47.2 million for the Aged Care Assessment Program. This included an additional one-off funding increase of $2.5 million pending the outcomes of the current Review. This funding should be confirmed as ongoing.

ACATs can also help address the difficulties residents and potential residents may have in obtaining information. A single assessment service for community care and residential care significantly improves choice and can smooth access to more integrated care. The integration of assessment for community and residential care can be further enhanced by:

- more focused definition of eligibility criteria across the range of services and consistent application of the criteria;
- increased emphasis on enabling the aged to make informed care and support choices;
- increased emphasis on support services to maintain and enhance functioning including (but not limited to) rehabilitation following acute episodes;
- progressive assessments to ensure services keep pace with needs as clients become more frail and do not enter residential care unnecessarily; and
- stronger case management, supported by appropriate information systems.

Given the significance of the role of ACATs as gatekeepers of the aged care system, expenditure on their activities is modest in relation to the costs of care.

Recommendation 3 Increased support for aged care assessment

The additional funding provided in the 2003–04 Budget for the Aged Care Assessment Program should be confirmed as ongoing and indexed each year in line with the base funding for the Program.

The Review would also endorse the Australian Government funding an expanded role for Aged Care Assessment Teams to provide a single assessment service for community and residential care services with a stronger focus on supporting consumers in making informed care choices.

Role of ACATs

The Review was asked to consider whether the requirement for an ACAT assessment before moving a resident from low to high care should be replaced by administrative rules. The delays in obtaining an ACAT assessment have financially disadvantaged providers in the past.

The Review considers that the arrangements could be streamlined. Providers should have discretion to apply for an increased subsidy for higher care needs, knowing that any such shift could be a trigger for a validation visit. If the Resident Classification Scale (RCS) validator considers that a shift to a higher level of care was not warranted, the provider should repay all the higher rate of subsidy received.

Consideration has also been given to whether an ACAT assessment may still be desirable for a resident to move from a stand-alone low care facility to a high care facility operated by another approved provider (eg. a move to a dementia specific facility) or to another facility operated by the same approved provider in another location. The Review considers there is no reason to change the current system.

Recommendation 4 ACAT role in reassessment of existing residents

Aged Care Assessment Teams should no longer be required to assess residents whose care needs have increased to a higher Resident Classification Scale category. However, Aged Care Assessment Teams must still be required to undertake an assessment where a resident moves to another facility as a result of increased care needs.

14.3.2 Improving efficiency

Streamlining administration

The care costs of residents are subsidised according to their care needs as assessed under the RCS. This basic subsidy is augmented by various supplements. In structuring a subsidy arrangement, the efficacy of the mechanism in accurately targeting funding to need and the practicalities of administering the arrangement are both important

considerations. A subsidy arrangement with highly detailed and intensive assessment processes and subsidies tailored to the individual is likely to be time consuming and expensive to administer, both for providers and for the Government. On the other hand a subsidy arrangement where one level of subsidy is paid in respect of all care recipients may be simple to administer, but may not adequately recompense providers for the cost of providing the care required by individuals.

Under the current arrangements, there are seven levels of basic subsidy and a range of supplementary payments which provide a way of accounting for variations in cost that are not captured by the RCS and of compensating the provider where a resident has a limited capacity to contribute to the cost of care. Reductions in subsidy also apply in a number of circumstances.

Analysis conducted for the Review has highlighted the sensitivity of the RCS classification process. A significant proportion of residents at each RCS level, but particularly levels 4, 5 and 6, are within reach of at least one category boundary, and many are in reach of both the upper and lower boundaries.[1] The implications of this sensitivity are twofold. On one hand, it indicates the potential ease with which RCS scores can be manipulated in order to classify at a higher level. On the other, it is indicative of the potential for RCS classifications to be changed in the validation process, with financial implications for affected providers. There is need for further applied policy research to explore the means for selection of the most effective questions on the RCS determination.

This high level of volatility is problematic for both providers and the Government. For providers, it leads to a lack of income security as there is a chance that a funding classification may be downgraded if audited. For the Government, it creates the potential for providers to manage the system by adjusting a resident's RCS score to get them over the line for a higher rate of subsidy, increasing expenditure on subsidies and creating the need for stringent auditing processes.

Providers are critical of the current RCS arrangements, arguing that the administration, documentation and validation requirements of the RCS place an undue burden on them. It is also questionable whether the arrangements are adequate to appropriately fund the care needs of particular residents. The Review was advised that the intensity of care required by dementia sufferers exhibiting challenging behaviours is inadequately funded under the basic subsidy levels. Similar criticisms were made of the RCS in relation to the needs of those residents who require complex palliative care services.

[1] A resident is said to be within reaching a category boundary if a change in the answer to one RCS question by one level would move the resident's classification across that boundary.

Recommendation 5 Resident Classification Scale

Basic subsidies should be paid at three levels: high care, medium care and low care, replacing the existing Resident Classification Scale (RCS) categories in the following way:

a) Low care to consolidate current RCS levels 5 to 7;

b) Medium care to replace RCS levels 3 and 4; and

c) High care to replace RCS levels 1 and 2.

Funding supplements

The Review supports the approach for basic subsidies to be determined on level of need for care, supplemented by additional payments for extraordinary care needs that add significantly to the cost of care. Eligibility for each supplement should be based upon a medical determination, where appropriate. Reducing the number of categories within the payment structure will reduce the effects caused by the volatility of the funding tool. It is imperative that subsidy rates are pitched at a level that will be sufficient to cover resident care needs. By consolidating within the existing low care and high care bands it is considered that implications for other forms of funding such as community care will be minimised.

The Review does not underestimate the severe challenges posed by the proposals for supplements. For example, the most urgent need arising with residents exhibiting challenging behaviours on several or many occasions during the course of a day, will impose differential costs depending upon the general RCS classifications. In contrast, palliative supplement costs are not subject to such potential variability.

Recommendation 6 Funding Supplements

The arrangements through which supplements are paid for the provision of oxygen and enteral feeding should be extended to other specific care needs or medical conditions.

These specific care needs could include:

a) short-term medical needs, such as IV therapy, wound management, intensive pain management and tracheostomy;

b) specific care needs, such as for dementia sufferers exhibiting challenging behaviours or for residents requiring palliative care; and

c) care needs of people from diverse or disadvantaged backgrounds such as the homeless elderly and Indigenous Australians.

The rate of payment for any new supplements should reflect the incremental increase in the cost of providing the appropriate treatment and/or level of care.

The simplification of the basic subsidy arrangements and the greater surety available to providers will also allow the current payment arrangements, where providers are paid in advance with a costly reconciliation process, to be streamlined.

14.3.3 Improving quality

Ultimately, providers of aged care services must bear responsibility for the care they provide. However, given the immaturity of the aged care sector overall and the mid- to long-term restructuring it is likely to undergo, the Government will continue to play an important role in the sector's quality assurance and consumer protection. There is a need for greater consumer focus, some clarification and strengthening of roles, and better communication with aged care recipients and the community. In the longer term, the provision of quality ratings for aged care services may empower aged care recipients and place market pressure on providers.

The Government, because of its role in education and training, also has an important part to play in ensuring that aged care providers are able to obtain the skilled workforce they need to provide high quality care.

Improving the quality assurance arrangements

An essential ingredient in ensuring that aged care services continue to be of the highest quality is the role played by the Aged Care Standards and Accreditation Agency (the Agency). There is broad industry support for accreditation and a general acknowledgment that it has substantially improved standards of care and accommodation across the industry. In the broader community the Agency's role in monitoring quality, and the Complaints Resolution Scheme are seen as critical to protecting residents, although some regard must also be directed to governance and risk management issues to underpin the accreditation standards as they are currently expressed.

In view of the immaturity of the industry overall, the Review considers there is no good reason at this time to change the role of the Agency as the sole accreditation body for the purposes of the Aged Care Act.

The Agency has worked to improve and refine its focus and the accreditation processes, but can further improve its focus on supporting informed consumer choice and consumer input to monitoring standards. At present it is difficult for consumers to compare the performance of services. Nor does the information provided by the Agency act as an incentive for providers to become more competitive in providing quality services. The Agency should develop a star rating system and its capacity to rate all homes against the system. The basis of the system would be the relative performance of services against the accreditation standards. This would involve moving to a single process for assessments and ratings.

Agency revenues are currently derived from application fees paid by approved providers for accreditation audits, grants from the Government in the order of $6.5 million a year, Government funding in lieu of application fees from approved providers with fewer than 20 residential care places, and charges for training and other activities. Currently, the fees paid by providers are set by the Government. Allowing the Agency, in consultation with the industry, control over its fees and pricing structure will assist adequate resourcing for the Agency, and give to providers a greater interest in the role and functioning of the Agency. The Review considers that Government should continue to bear the costs of promoting understanding of the accreditation standards and process and monitoring the effectiveness of accreditation and increase baseline funding to make greater use of the Agency's expertise to enhance consumer access to information and industry efficiency.

Recommendation 7 Aged Care Standards and Accreditation Agency

The role of the Aged Care Standards and Accreditation Agency should be directed mainly to the accreditation of services and the dissemination of accreditation results.

The Agency should significantly improve its focus on supporting informed consumer choice and consumer input to monitoring standards by:

a) improving direct communication with consumers, including those with special needs, and by better informing other organisations of the level of quality provided by specific services; and

b) exploring, with consumers and the industry, a star rating system to assist consumers to more readily compare services and to provide incentives for providers to become more competitive in providing quality services.

The costs of accreditation should continue to be shared by Government and providers.

a) Providers should bear the total cost of accreditation audits after 2008; and

b) Government funding for the Agency should be increased, based on the robust assessment of the costs of current and projected workload. This funding should be governed by an agreement with the Department of Health and Ageing, which specifies the services required of the Agency and their unit costs.

14.3.4 Ensuring an adequate highly trained workforce

An adequate and professionally trained workforce is critical to improving quality and level of service now, and to lay the groundwork to meet increasing demand in the future. Strategies are needed to assist in the recruitment and retention of aged care workers and the re-entry of those workers who may have left the aged care workforce. Over the next decade, the number of nurses required by the Australian health care sector as a whole will increase by around 7.1 per cent each year. This includes employment growth of 1.7 per cent a year, retirements of 2.6 per cent a year and

industry departures of 2.8 per cent a year. As a consequence, the Australian health care sector will require over 13 000 new registered nurses each year over the next decade. In 2002–03, on the other hand, only 8500 students commenced registered nurse training and only 4500 students completed training. With respect to aged care alone, the Review estimates that the annual shortfall in commencing registered nurses over the next decade will be over 750.

Measures already implemented by the Government in the 2002–03 Budget are a step in the right direction, but require expansion and revision. In particular, the emphasis in the 2002–03 More Aged Care Nurses measure on scholarships should be replaced by the purchase of additional training places for aged care nurses, given that applications for nursing places currently far exceed the supply of places. Closer links need to be built between the aged care and university sectors, to ensure that nurses will enter and remain in aged care after graduation. The Government as the major purchaser of aged care should actively influence the development of nursing curricula more suited to the needs of a workforce providing care in aged care settings.

Vocational education and training also has an important role to play in meeting the workforce requirement of the aged care sector. The aged care workforce has already undergone considerable adjustment over the last decade. These adjustments were in response to the growth of the industry, the changing profile of residents of aged care services and the dynamics of the nursing workforce. The major trend apparent in all of these changes is a decline in the use of staff not involved in the direct provision of care. Part of this decline is attributable to a greater use of multiskilling, with direct care staff being utilised across a greater range of duties. There has also been a considerable adjustment within the direct care workforce. The share of direct care provided by registered and enrolled nurses has declined in both the nursing home and accommodation for the aged industries. The use of personal care assistants, by contrast, has significantly increased. These changes reflect both the growing shortage of nursing staff and the development of more efficient workforce structures. With this greater reliance on personal care assistants comes a need to improve the skills of those workers.

Meeting this need is a shared responsibility. The Government's More Aged Care Training 2002–03 Budget measure has gone some way to address this issue. State and territory governments also have a role to play, by increasing the number of places available for Enrolled Nurse and Aged Care Worker training in the Vocational Education and Training Sector. Some providers have already recognised the need to 'grow' their own staff, and to introduce innovative educational and training avenues such as the use of satellite technology.

Three areas of vocational education require expansion. First, the improved efficiency offered by the expansion of the scope of practice of enrolled nurses that has occurred in most states and territories will only be achieved if they receive further training in

medication management. Second, more aged care services will require staff to have minimal Certificate Level III qualifications. Third, in order to allow staff to be trained to Certificate Level III standard, services will need to have some staff with Certificate Level IV qualifications.

Recommendation 8 Aged care workforce

The Government should refocus and expand its support for the education and training of aged care nurses and care workers.

The Government should increase the number of registered nurse places at Australian universities by 2700 over the next three years, with 1000 first-year places commencing in the 2005 academic year. These additional places should only be available to universities that offer specialist training for aged care nurses, including preceptor[2] *programs for newly graduated nurses and aged care placements for students.*

The Government should support aged care providers to assist at least 12 000 enrolled nurses to complete medication management training, 6000 aged care workers to complete a Certificate Level IV qualification and 24 000 aged care workers to complete a Certificate Level III qualification by 2007–08. This training support should only be available to providers who are compliant with the education and staff development accreditation requirements, maintain their training expenditure at a minimum of their 2003–04 level and provide in addition at least half of the cost of the additional training supported by this measure.

The Government should work with state and territory governments to expand the number of aged care training places available in the Vocational Education and Training Sector.

14.3.5 Improving sustainability

Prudential arrangements

Bonds amounting to about $2.8 billion are now held by approved providers as a result of loans from residents in the form of accommodation bonds. The Aged Care Act specifies that at all times accommodation bonds must be regarded as a debt to be repaid to the resident, less any legitimate retention amounts drawn down. There are no restrictions on where bonds can be held but approved providers must comply with the prudential requirements covering repayment, annual reporting and insurance against events that might render them incapable of paying back a bond.

[2] Strictly mentor, but a generally accepted term in nurse education.

There is some doubt about the status of accommodation bond balances owed to residents. These sums do not appear to qualify as preferential debts under the Corporations Act *2001*. Nor is there any provision in the Aged Care Act giving them priority status. Consequently, residents owed bond balances rank as unsecured creditors without priority in the event that an approved provider goes into liquidation. The prudential arrangements around accommodation bonds and the possible exposure of the Government are a source of concern to the Review. The Review therefore would like to see a strengthening of the prudential arrangements pertaining to accommodation bonds.

Recommendation 9 Guarantee Fund

The Government should establish a guarantee fund:

a) managed by an Authority established for the purpose;

b) funded by an industry levy, the amount of which is determined on actuarial advice; and

c) in the event of a defined 'default event', people with entitlements are able to recover accommodation bond amounts from the Fund.

A default event in relation to an approved provider, happens when:

a) the approved provider becomes bankrupt or insolvent;

b) the approved provider if it is a corporation, is being wound up or ceases to exist and there are insufficient funds to repay the accommodation bond entitlements; or

c) the approved provider is otherwise unable to meet the approved provider's liabilities under the enabling legislation.

As well as management of the Fund, the Fund Authority is to have prudential oversighting authority of approved providers. The powers of the Authority should include but not be limited to:

a) the ability to examine the financial affairs of an approved provider, by means of inspection and analysis of the records, books and accounts;

b) the ability to review, the value of the assets of each approved provider's corporate entity;

c) the ability to appoint an administrator of the corporate entity;

d) the ability to apply to court for the winding up of insolvent approved providers;

e) the ability to require an approved provider to enter into negotiations for the disposal of assets and if that fails, to secure an outcome to avoid where possible a claim on the Fund.

Financial assessment of residents

Currently, on entry into care, aged care providers are required to make an assessment about a resident's concessional status. Providers are dependent on the financial information provided to them by the resident or their family. Providers are not in the best position to assess a resident's concessional status. It is considered that Centrelink is in the best position to advise a provider on the income and assets status of a resident.

Recommendation 10 Financial assessment on entry

Assessment of residents' or prospective residents' income and assets should be the responsibility of the Australian Government and carried out by Centrelink and not the aged care provider, preferably prior to entry into care.

Rural and remote facilities

Facilities in rural and remote areas do not have the same capacity as metropolitan facilities to attract large numbers of accommodation bonds and/or bonds of any appreciative size. Across Australia, the average amount of each new bond was $98 775 in 2002–03 and $82 989 in 2001–02. Bonds as low as $14 200 were quoted by rural providers for 2001–02. Aged care recipients in rural and remote areas are often concessional or assisted residents, with limited capacity to make accommodation payments. The higher proportion of concessional residents with a low asset base limits a provider's ability to make provision for capital expenditures.

Supplements such as the viability supplement ensure that people living in remote and isolated areas and people from certain special needs groups have access to care by allowing services catering to these groups to operate in circumstances that might otherwise be financially non-viable. Eligibility criteria take into consideration the remoteness of a facility, the size of the facility and the number of residents with special needs or concessional residents in the facility.

In 2002–03, 567 homes received total funding of $13.5 million in viability supplements. The viability supplement varies from $1.24 to $20.27 per person per day, largely depending on the degree of isolation of the aged care service, but also on the size of the service.

Recommendation 11 Viability Supplement

The Government should increase the total amount available for the viability supplement for rural and remote services.

The Government should also review the viability supplement's rates and eligibility requirements to ensure that they do not create perverse incentives against consolidation. At the very least the eligibility requirement should be raised to include facilities with 30 beds or fewer.

Targeted capital assistance

The Government continues to provide a small targeted capital assistance program to assist those services, primarily rural and remote, facing extraordinary capital costs. While considerable misgivings are held about the provision of capital funding, the Review recognises there may be grounds for assistance to special needs groups. It notes the provision in 2002–03 of $35.7 million in targeted capital assistance, 89 per cent of which was allocated to assist providers of aged care services in rural and remote areas. Of this, $10.6 million was allocated as Residential Care Grants and $25.1 million was provided through the Regional and Rural Building Fund. An additional $3 million was allocated to Aboriginal and Torres Strait Islander flexible care services in rural areas to address urgent upgrading needs.

Recommendation 12 Targeted capital assistance

The Australian Government should maintain a small targeted capital assistance program to assist those services experiencing exceptional circumstances.

14.3.6 Encouraging efficiency

All the work on the aged care industry supported and funded by the Review points to the large potential gains in efficiency and productivity to be secured by changes in policy towards some regulatory features bearing on providers. Hence the continued financial support provided by the Government should reflect the necessary support to stimulate realisation of gains in efficiency.

Recommendation 13 Conditional Incentive Supplement

The Government should introduce an incentive supplement, payable in addition to all existing subsidies and supplements, with the value of the supplement for each resident to be set at 1.75 per cent on an annual basis. The need for, and value of the supplement, should be reviewed in 2007–08. Continued eligibility of providers for the supplement should be linked to gains in efficiency, productivity and workforce training.

An essential ingredient in improving the efficiency of the sector is an improvement in the current aged care information infrastructure to support both cyclical and periodic policy review and development work. While the Australian Institute of Health and Welfare (AIHW) currently undertakes routine national reporting for residential and community aged care services, and a number of ad hoc projects, the resources currently available severely constrain output from that organisation. Moreover, current reporting is mainly concerned with the demand for aged care. The work of the AIHW needs to be extended to quality and financial performance data.

Recommendation 14 Comprehensive data repository

As a complement to Recommendation 13, the existing aged care information infrastructure should be substantially expanded, building on the existing expertise within the Australian Institute of Health and Welfare and should include quality and financial performance data.

Improving Departmental information

The existing legislation and practices provide for the Department of Health and Ageing to authorise changes of key personnel in any residential aged care service. The purpose was to ensure the quality and integrity of those responsible for the care of residents. The effect was to control the transfer of places from one owner to another in the secondary market for place allocations. This provision has been circumvented by the recent practice of selling the entity owning places rather than the places themselves.

It has also come to the notice of the Review that the Department of Health and Ageing lacks any knowledge of the entities and their owners with place allocations. This failure diminishes the capacity of the Department to scrutinise and act in the interests of the residents.

No less important is the need for the Department of Health and Ageing to support the quest for a more efficient industry.

Recommendation 15 Corporate information

The names of entities and major shareholders of the companies and associate companies having ownership or part ownership of residential aged care services should be required by the Department of Health and Ageing.

The monitoring and authorisation of transfers should be extended beyond key personnel to personnel of entities owning providers, subject to review after 2008.

In the contribution to efficiency improvements the Department of Health and Ageing implement immediately provisions for electronic funding and information transfers for all accounting, financial and supervisory requirements relating to providers.

14.4 Medium term recommendations for a sustainable industry

The Review considers that there are a number of proposals that the Government should consider to assist in developing a more mature and independent industry. These proposals should be seen as medium term options that could be progressively implemented in the period up until 2008.

The maturity in the industry must be achieved to bring about provider business independence and managerial development. The relaxation of regulatory requirements necessary to achieve this will be aimed at the financial and economic parts of the industry, in recognition of the necessity to continue to regulate for quality and equity of access for those who need it.

14.4.1 Ensuring an adequate return on investment

Given the immaturity of the industry and the degree of Government control, some operators have difficulty raising the capital they need in the capital markets. Equity investors are, not surprisingly, wary of an industry that has little scope to control its operations and that lacks a culture of financial reporting and accountability. This situation has been alleviated, in low care, by accommodation bonds. However, accommodation bonds bring their own difficulties, including the need for strong prudential protections. Bonds also contribute to the immaturity, or at least militate against the maturing of the industry, by providing access to unregulated debt. Moreover accommodation bonds (or their equivalent) are not available generally in high care, exacerbating the capital problem in that sector. The current capital funding arrangements for concessional residents are also inadequate.

The concessional resident supplement should be clearly identified as a contribution to the accommodation stream made by the Government (on behalf of residents who cannot afford to make the contribution themselves) to ensure that the capital requirements of the industry are adequate. The accommodation stream requires private capital investment and therefore a clear capacity to provide a return on investment and return of investment.

A consistent claim from the industry is that the rate of concessional supplement is not adequate. While some services may be able to earn sufficient capital income through accommodation bonds to overcome the inadequacy of the concessional supplement, the problem for high care services is likely to be more severe due to the capped nature of accommodation charges.

Currently, the concessional supplement is paid at two rates: for services where more than 40 per cent of total residents are concessional or assisted, the daily supplement paid is $13.49; for services with 40 per cent or less concessional or assisted residents, it is $7.87. This translates to $4909 or $2873 per annum respectively. The requirement to have more than 40 per cent of concessional (or assisted) residents in a service to be able to claim the higher rate of supplement has the potential to create distortions in the way providers approach these residents. It may encourage ‘cherry picking’ of entrants eligible for the concessional supplement, as the failure to reach the 40 per cent threshold results in a significant decrease in revenue. This situation may result in inequitable access to care for those who are not eligible for the supplement, particularly in high care where the daily rate of accommodation payment is very similar to that of the concessional supplement.

An essential step towards ensuring that the concessional supplement is an adequate substitute for an accommodation payment is to abolish the 40 per cent threshold and pay the higher rate of supplement in respect of all concessional residents. In addition to the disincentives generated by the current system, paying two rates undermines the position of the supplement as a substitute accommodation payment. Put another way, the Government is paying differential subsidies on behalf of residents depending on the facility they occupy and not on the service received.

The Government pays only $3.93 for each assisted aged care resident even though these residents cannot themselves pay a sufficient accommodation payment to allow the total public and private payment to equal the maximum concessional payment. Moreover, the maximum level of the Government's concessional payment is itself insufficient to allow an adequate return on investment, since the return required by investors is about $25.00 per place per day (noting that $6.00 a day will be paid through the rent assistance component of the basic daily care fee or through the pensioner supplement).

The following proposal removes the disincentives in the current arrangements. It also extends the assisted consumer protection to residents with less than 10 times the pension in assets, that is, to all residents who cannot afford to make an accommodation payment sufficiently large to provide an adequate return on the operator's investment. The proposal therefore ensures that operators can receive an adequate return on their investment when they care for concessional and assisted residents. This ensures that these residents would not be priced out of the market when the price constraints are loosened. The proposal also ensures that operators can receive an adequate return on investment in respect of the remaining pre-1997 residents, thereby ensuring that they will similarly not be priced out of the market.

Recommendation 16 Concessional, transitional and assisted residents

The Government should consider modifying the concessional resident supplement arrangements by:

a) increasing the maximum rate of the concessional resident supplement to $19.00 a day, indexed annually;

b) abolishing the 40 per cent threshold;

c) introducing a sliding assisted resident supplement for residents with assets between 2.5 times and ten times the pension to ensure that the assisted resident supplement plus the maximum accommodation charge payable by each resident is equal to the maximum rate of the concessional resident supplement; and

d) extending the concessional resident arrangements to all transitional residents remaining in the system.

Adjusted subsidy reduction

Currently, the Government reduces the basic subsidy payable in respect of residents in some places operated, or formerly operated, by state governments by a notional return on investment component. This reduction is an historical artefact. It does not apply to all state government services and it continues to apply to services even after they are transferred to non-government operators.

Recommendation 17 Adjusted subsidy reduction

The Government should abolish the adjusted subsidy reduction so that all providers receive the same level of subsidy.

Simplifying resident fees

Residents of residential care services contribute to the cost of their care through income tested daily care fees and asset tested accommodation payments. Apart from extra service fees, the levels of these fees and payments are the subject of regulatory constraint. It is appropriate that residents make a contribution to the cost of their care based on their capacity to pay.

Currently, pensioner and non-pensioner residents are governed by different rules regarding the maximum basic daily care fee that they can be asked to pay. In essence, the maximum basic daily care fee payable by non-pensioner residents should equal the maximum basic daily care fee payable by pensioner residents plus the pensioner supplement. However, the different indexation regimes that apply to the age pension and the pensioner supplement have resulted in differential incomes to providers from pensioner and non-pensioner residents. An alternative approach would be for eligible pensioners in residential care to access the pensioner rental assistance payment, to abolish the pensioner supplement of $5.96 per day and to set the maximum daily care fee at 85 per cent of the pension plus the full amount of rent assistance for all residents, regardless of their financial status.

This proposal would provide a greater degree of consistency and transparency between the arrangements for pensioner and non-pensioner residents. It would also facilitate movement between community care and residential care, with pensioners not losing rent assistance because of such a move.

Recommendation 18 Pensioner supplement

Eligible pensioners should be able to gain the benefit of the rent assistance payment and the pensioner supplement should be abolished.

The maximum basic daily care fee for all residents should be set at 85 per cent of the value of the maximum rate of the basic single pension plus the full value of the maximum rate of rent assistance.

This is a medium term proposal the full implications of which require the most careful scrutiny. All distributional impacts across classes of pensioners and other residents should be investigated.

Accommodation payments

Differentiated accommodation payment arrangements exist in low care, extra service and high care, presenting providers and residents with unnecessary complications and uncertainties. Accommodation bonds are payable by residents in low care and extra service high care. However, as a result of the ageing in place policy, where a bond has been paid on entry by a low care resident, that bond may be retained by the facility, notwithstanding the fact that the resident has become high care.

Daily accommodation charges apply in high care. On average, the level of the maximum daily accommodation charge for high care residents is insufficient to allow an adequate return on investment. This is evident from the analysis of financial statements.

There is no issue in principle against the provision of bonds in high care. Extra service high care arrangements were introduced as a means of stimulating investment in high care facilities.

All residents, regardless of the classification level, should have a consistent range of options available to them on entry into care. Residents in high care remain for longer periods than was the case eight years ago. It is therefore appropriate that, on entry to a facility, a resident has available to them the option of paying an accommodation bond or a daily rental payment. This flexibility will be of particular advantage to short-term residents, such as those entering primarily for palliative care. Similarly for providers, consistent financial arrangements will apply irrespective of the care level on entry of the resident.

Potential residents must be advised prior to entry about their ability to choose between an accommodation bond and a daily charge. It is up to them to make that choice.

Where a resident chooses to pay an accommodation bond, such bonds should be fully refundable and free of retention payments. This is a break from the existing arrangements which provide for a retention amount from the accommodation bond, being a fee deducted from the initial bond value each year for up to five years. Introducing a daily rental payment would provide an alternative earnings stream clearly separate from the corporate debt generated by accommodation bonds and treated in a manner similar to any other fees no matter how they are derived. To ensure that providers continue to receive comparable contributions, the rental payments would be premised on a similar basis to the existing periodic payment and would be adjustable to match returns on accommodation bonds.

Recommendation 19 Accommodation payments

Accommodation payments for non-concessional permanent residents entering care should be as follows:

a) Options for making capital contributions should be consistent between low care and high care, not least to remove disincentives to ageing in place;

b) The notion of a 'bond' that is both a form of corporate debt (a no interest loan) and a source of fees through retention payments is confusing and should cease. Corporate debt and fees (no matter how derived) should be clearly separated;

c) Subject to retaining at least the statutory level of assets, new residents to have the option of paying:

i) a fully refundable lump sum bond (not subject to retention amounts) to be held for the period of the resident's stay; or

ii) a daily rental charge, applicable for the duration of the resident's stay;

The accommodation bond should be payable on entry to the service and should be repayable within a reasonable period of the resident's departure from the service, with interest being payable from the date of the resident's departure from the facility to ensure that the bond is repaid in a timely manner;

Existing residents should continue to be covered by the current accommodation payment arrangements including the five year limit on charges and retentions from bonds.

Research capability

More accurate prevalence and incidence data for age and dementia related or neuro-degenerative diseases is essential for establishing future demand for services and to provide a baseline for assessing future prevention strategies.

Dementia is an issue of increasing importance to the Australian aged care system, health system and population as a whole. It is the fourth leading cause of death in those aged 65 years and over and an issue of increasing concern to aged care providers and to the Government. The Government is giving increased priority to dementia-related research. In 2002, The National Health and Medical Research Council (NHMRC) allocated over $5 million for 46 projects. However, more accurate prevalence and incidence data is essential for establishing future demand for services and to provide a baseline for assessing future prevention strategies.

Recommendation 20 Research into neuro-degenerative diseases

Attention should be given to research into neuro-degenerative diseases, with funding provided for:

a) comprehensive prevalence studies; and

b) further data matching studies to enable a better understanding of neuro-degenerative disease pathways and the services accessed along pathways.

The National Health and Medical Research Council should continue to give priority to research into the prevention of dementia and dementia related illnesses and to encourage multi-disciplinary research into the care of people with such illnesses.

14.5 Options for further consideration

What follows are options mostly bearing upon longer term goals following the introduction of the main recommendations described above, that is, for the period after 2008. This is not an exhaustive list and it may be that, after careful consideration, some options or parts thereof may prove impracticable.

Choices for Consumers

The existing system is dominated by the relationships between government and provider. There is little scope for the exercise of choice by consumers of services owing to the high utilisation rate of bed capacity and the fixed price regimes determined by Government. The main recommendations are directed towards enhancing the strength of choice of consumers through freeing up the number of places and increasing the availability of information.

One proposal enjoying widespread discussion during the course of the Review was for placing the choice of provider in the hands of the resident or the resident's family. This would mean granting the prospective resident an authority to spend aged care monies on care and accommodation. The approval for entry into residential or domiciliary arrangements would still rest with an ACAT assessment. The funds would flow to the provider via the decision of a person to accept a place in that provider's RACS. Under present circumstances where the capacity utilisation of facilities is about 96 per cent, the scope for a resident or the family to negotiate the price of their care is not great. However, with the gradual extension of flexibility to institutional arrangements and a greater co-ordination of the work of ACATs including training, it should be possible to relax the constraints on bed availability by either enhanced allocations under existing allocation procedures or something akin to them or by gradually abandoning controls on bed numbers leaving the investment decisions to providers. Any approach to exploring the ways this 'voucher' system could be implemented must await the commitment to superior information flows.

The second reservation is the one where genuine misgivings do apply. This is about the scope for individuals to make their own decisions. Two groups may be readily identified; the very elderly not having support of relatives and people with dementia. With the latter group not all are lacking capacity to determine their residency in early stages. However, for most at that stage of onset of dementia the likelihood is for domiciliary care to be the order of arrangements.

Selection of location and exercise of right of choice under this system for the two categories of people referred to would require intervention by ACAT members and others in circumstances similar to those now applying to those now requiring some form of guardianship supervision.

Thus the recommendation for this approach to be seriously considered for implementation is a long-term issue for reasons spelt out about the need for major improvements in the flow of information to consumers and family members and others who may hold some legal authority such as power of attorney. Satisfying this requirement will take a few years to implement fully.

Option 1 Vouchers

In the longer term, consideration should be given to placing the choice of provider in the hands of the prospective resident or the resident's family, that is a system whereby the prospective resident is granted an authority to spend aged care monies on care and accommodation should be considered.

Selection of location and exercise of right of choice under this system for those people with dementia or who have no support available from relatives or other carers would require intervention by ACAT members and geriatricians or state guardianship bodies as appropriate. A preference would be for geriatricians independent of the hospital system with no connection to any residential aged care facility. The ACAT teams would be called upon to maintain monitoring of the condition of these residents on a case management basis.

On behalf of consumers and Government—a contracting agency

Preservation of the existing set of institutional arrangements while putting in place a set of pricing and regulatory changes for greater flexibility in decision-making by providers risks a delayed transition towards a more open and competitive regime some years hence. This proposal is designed to put in place an agency to act on behalf of government and consumers in negotiations with providers on price and funding provisions.

The proposal is to establish a contracting agency which will act on behalf of the Government to negotiate the prices and conditions for residents in facilities operated by provider entities. The contract would reflect a set of specified residents classified by

some revised version of the RCS with a margin allowing for the inevitable swings in residents' condition as specified by an adapted RCS schedule. However, the contracting agency need not confine its efforts to these features alone but should include provisions about pricing and maximum and minimum values for accommodation bonds for those entities seeking accommodation bonds.

This approach reflects actions to enhance the scope for consumers of services to negotiate with providers on their behalf. The contracting agency would act to secure the most effective prices and arrangements to benefit the taxpayers. The contracting agency would be in a position to establish benchmark conditions with the most efficient producers so as to secure gains from productivity to benefit taxpayers and residents. Experience with negotiations would establish norms for different categories of residents thus allowing an increasing scope for determining which arrangements and sets of conditions were most rewarding to providers. In this way, unlike present conditions where 'cherry-picking' of types of residents is rife, those categories of residents requiring more financial support would be detected and contractual provisioning much better informed than at present.

Yet another advantage would lie with the ways in which the less efficient amongst providers would be exposed to the contracting agency and subject to pricing and revenue pressures to enhance performance. At the same time any provider in that situation might experience testing queries on the purpose of accommodation bonds where they accepted them. Government would be in a position to determine the appropriate timing of a switch to a contracting agency approach in place of other proposals based upon existing structures.

Option 2 Contracting Agency

In the longer term, the Government may wish to consider the establishment of a contracting agency to act on behalf of the Government to negotiate prices and conditions for residents in facilities operated by board and management of provider entities. The contract would reflect a set of specified residents classified by some revised version of the Resident Classification Scale with a margin allowing for the inevitable swings in residents' condition as specified by an adapted Resident Classification Scale schedule. However, the contracting agency need not confine its efforts to these features alone but should include provisions about pricing and maximum and minimum values for accommodation bonds for those entities seeking accommodation bonds.

Resident contributions

The Review also examined current means testing arrangements to consider whether they could be strengthened or made to deliver better outcomes for residents and Government.

Historically, Australian Governments have not imposed means tests on eligibility for subsidies for recipients of aged care. Attention is drawn to this feature because it bears upon the cost to the taxpayer of aged care benefits. A means test as applied for the age pension may offer some scope to improve the sustainability of commitments. This suggestion should be seen in the light of the necessity for gains in efficiency and productivity and looms as the largest potential source of benefit to taxpayers, residents, workforce and owners.

Option 3 Means testing

In the longer term, the aged care means testing arrangements should be brought into line with those that obtain for the age pension.

Moreover, in determining an individual's income and assets the same gifting and deeming rules as obtain for the age pension should apply.

Irrespective of the means testing arrangements, the issue of the differential treatment of aged care residents in terms of the assets transfer period is anomalous.

Option 4 Asset transfer period

In the longer term, the Government to review arrangements to extend the period in which asset transfers by individuals to other persons and entities not under their control are deemed to be a part of that person's wealth at the time when a valuation for aged care purposes is required.

Application of assets test and domiciliary care

The value of the family home is currently exempt from valuation of a resident's assets, subject to some specific conditions. This exemption has the effect of encouraging the potential resident to retain possession of a large and possibly valuable home rather than shift to a more suitable residence for their contemporary needs and cash in their assets to provide a supplement to their income. This issue is of growing importance owing to the increasing longevity of the population and the apparent wish for a greater reliance on domiciliary rather than residential care. The results of much analysis and thought within the Review as well as discussions with members of the aged care industry reveal the ways in which residential and domiciliary aged care are linked but ties to housing are also important. Provision should be made for older people to shift into housing with physical arrangements suited to domiciliary care. This means wheeled access and no steps, wider doors to allow use of lifting equipment in bedrooms, bathrooms and toilets and layout designs in all these rooms.

The exclusion of the family residence from asset valuation handicaps the flexibility called for to meet the potentially changing needs of the elderly. This feature is not

independent of expectations of inheritance held by members of the family of the aged care recipient. Therefore a mechanism should be considered to relieve this impediment.

Option 5 Revised assets test arrangements

In the longer term, consideration be given to exempt the proceeds of sale of the family home from a tax imposition or inclusion in an asset valuation assessment by:

a) allowing the funds from any sale to be deposited with a government agency;

b) paying the CPI increase on a quarterly basis as a return or income on the value of the deposit;

c) allowing some part of the deposit to buy a suitably designed residence incorporating aged care features;

d) exempting the value of the deposit and any subsequent purchase of appropriate aged care housing from taxation or assessed valuations for residential aged care participation until the resident no longer requires care; and

e) applying these provisions equally to aged care support offered in domiciliary situations.

Auction of places

There is a steady secondary market in places across the aged care market. This is indicative of the value attached to the intangible asset allocated by the Government at no cost to those awarded the places. The future income stream expected from those bed approvals is discounted to give a net present value and that value appears on the balance sheet of the provider against which borrowings may be generated. The present low interest rate conditions in Australia make those income-earning intangible assets most valuable. The outcome is for public intangible assets created at no cost but with a contingent liability to the Government for future aged care subsidy payments, to generate private accumulation. The result is the stimulation of investment in increased capacity. The high rate of investment now taking place in residential aged care facilities is explained in part by this phenomenon.

The argument against the auctioning of places by the Government is the impact this would have on the likely returns to be earned. The bid price should reflect only the 'above normal' return to be expected from investment in an aged care facility. Undoubtedly some bids will reflect the gains from attaining an efficient economic size, meaning effectively a facility with more than 30 beds. Thus an array of bids may be expected. This will reflect the different interests of the various providers including expectations of earnings.

The existing procedures for the allocation of places may be questioned as is the case elsewhere in this Report. The strategic aim is to bring market influences more strongly into play intending to ensure greater flexibility in decision-making to the boards and management of entities being providers. This brings an opportunity to gradually shift the focus of bed allocation to a market-oriented and competitive system.

Option 6 Place allocation auction

In the longer term the Government should consider an auction system for place allocations.

APPENDICES

APPENDIX A:
ANALYSIS OF THE KPMG FINANCIAL DATA

The Review's financial data submission process

In January 2003, the Review of Pricing Arrangements in Residential Aged Care appointed KPMG to conduct the financial data submission process and undertake initial top line analysis on its behalf. Under these arrangements KPMG was contracted to:

- develop the financial data submission template and associated instructions;
- communicate with approved providers and inform them about the Review's financial data submission process;
- distribute the financial data submission template to all providers who had expressed an interest in completing it;
- answer questions and address any concerns and issues raised about the financial data submission process;
- undertake presentations to peak bodies and approved providers on the financial data submission process in the State capitals;
- provide a telephone conference to answer the questions and address the concerns of providers in remote and rural areas;
- provide assistance to individual providers on the completion of the financial data submission form;
- store and de-identify the financial data submission data received from aged care providers;
- follow up providers who had provided incomplete or unclear financial information;
- follow up approved providers who had not submitted a financial data submission;
- process the de-identified financial data and transmit it to the Review; and
- undertake a topline compilation and analysis of the financial data.

The financial data submission form

The financial data submission form developed by KPMG requested information from providers at a Residential Aged Care Service (RACS) level on the following areas:

- corporate ownership;
- statement of financial performance (profit and loss statement);
- statement of financial position (balance sheet);
- accommodation bond and charges;

- financial reporting structures;
- co-located activities and staff sharing arrangements;
- human resource information;
- contracting and outsourcing arrangements;
- physical infrastructure; and
- taxation and concessional information.

The confidentiality of the financial data submitted has been critical to the whole financial data submission process and at no time has the Review, the Department or any third party had access to the original information identifying providers at the RACS or approved provider level. All original information collected has been destroyed by KPMG including all correspondence relevant to the submissions.

The Review's financial data submission form was examined by the accounting firm, PricewaterhouseCoopers, being independent of the Review and KPMG, who found that all relevant items and associated instructions in the submission form complied with standard accounting practice and standards.

As indicated in Table A-1, KPMG received 912 financial data submissions from providers across Australia giving an overall response rate of 31 per cent with the Northern Territory, Australian Capital Territory, Victoria, South Australia and Western Australia having response rates higher than this average. In contrast, the response rates from Queensland and Tasmania were lower than the overall average at 16 per cent and 21 per cent respectively.

The stratification in Table A-1 also indicates that the response rate for the charitable sector was the highest at 44 per cent while providers from the private sector had the lowest response rate at 19 per cent.

The data

The financial data submitted to KPMG was processed before being provided to the Review as de-identified information and as summarised data for top-line analysis that covered revenues, expenses, labour costs, earnings and margins. This data is summarised in Table A-1 to Table A-34 below.

It is important to note that 125 of the 912 providers submitted financial data that did not just relate to the activities of their RACS. This data included financial information on co-located and other activities. In order to provide a valid and consistent comparison it was decided to remove these providers from the data analysis. This left data for 787 RACS.

Additionally, some providers did not complete the whole financial data submission form. This meant there was not any data from some providers for various data sets. This explains why some of the sample sizes differ across data sets.

In a small number of instances, in which the data submitted or processed has clearly been identified as an outlier or an unreasonable figure, it has been eliminated from the analysis, because of uncertainty about meaning and credibility.

Table A–1: Stratification by state, sector and locality

	Total population of RACS	Total responses	Responses as a % of total RACS
State stratification			
ACT	23	9	39%
NSW	935	269	29%
NT	14	9	64%
QLD	503	81	16%
SA	295	110	37%
TAS	94	20	21%
VIC	814	319	39%
WA	260	95	37%
TOTAL	**2938**	**912**	**31%**
Sector stratification			
Charitable	252	110	44%
Community-based	578	196	34%
Local Government	83	27	33%
Private	701	132	19%
Religious	1051	350	33%
State Government	273	97	36%
TOTAL	**2938**	**912**	**31%**
Locality stratification			
Capital	1669	538	32%
Other Metro	217	60	28%
Remote	74	13	18%
Rural	978	301	31%
TOTAL	**2938**	**912**	**31%**

Table A–2: All services—Labour costs as a percentage of total expenses, by state and locality

State	Category	Locality				
		Capital	Other Metro	Remote	Rural	Grand Total
NSW	Average % total expenses being labour costs, on-costs	66.21	69.30		69.62	67.73
	Number of services	143	39		77	261
	Standard deviation of observations	9.75	9.45		11.73	10.40
QLD	Average % total expenses being labour costs, on-costs	68.30	69.09		65.77	66.97
	Number of services	16	7		30	53
	Standard deviation of observations	9.65	6.79		10.17	9.59
SA	Average % total expenses being labour costs, on-costs	68.35		72.43	71.79	69.42
	Number of services	63		5	22	90
	Standard deviation of observations	9.05		5.59	9.01	8.96
TAS	Average % total expenses being labour costs, on-costs				75.95	75.25
	Number of services				11	14
	Standard deviation of observations				5.17	5.66
VIC	Average % total expenses being labour costs, on-costs	62.81	67.03		72.08	66.72
	Number of services	154	9		112	275
	Standard deviation of observations	10.45	7.59		9.41	10.90
WA	Average % total expenses being labour costs, on-costs	58.57		64.41	61.67	59.26
	Number of services	75		4	13	92
	Standard deviation of observations	9.47		14.21	12.14	10.07
Total Average % total expenses being labour costs, on-costs		64.21	68.90	69.57	70.28	66.66
Number of services		454	55	11	265	785
Standard deviation of observations		10.32	8.79	9.65	10.55	10.67

Note: Some observations are included in total figures but not reported separately due to the confidentiality commitments on disclosure.

Table A–3: All services—Labour costs as a percentage of total expenses, by sector and locality

Sector	Category	Locality				
		Capital	Other Metro	Remote	Rural	Grand Total
Charitable	Average % total expenses being labour costs, on-costs	64.33			70.58	65.19
	Number of services	69			11	80
	Standard deviation of observations	7.91			5.39	7.88
Community -based	Average % total expenses being labour costs, on-costs	66.73	68.69		69.77	68.60
	Number of services	56	11		96	166
	Standard deviation of observations	9.65	10.56		9.76	9.92
Local Govt	Average % total expenses being labour costs, on-costs	62.58			61.25	62.06
	Number of services	14			9	23
	Standard deviation of observations	7.28			21.61	14.20
Private	Average % total expenses being labour costs, on-costs	64.39	67.83		63.96	64.51
	Number of services	101	5		9	115
	Standard deviation of observations	12.11	12.28		13.13	12.11
Religious	Average % total expenses being labour costs, on-costs	63.21	68.05	71.05	68.15	64.98
	Number of services	202	35	8	63	308
	Standard deviation of observations	10.48	7.48	6.08	8.43	9.97
State Govt	Average % total expenses being labour costs, on-costs	68.75	78.29		74.40	73.84
	Number of services	12	4		77	93
	Standard deviation of observations	7.29	7.50		10.14	9.88
Total Average % total expenses being labour costs, on-costs		64.21	68.90	69.57	.70.28	66.66
Number of services		454	55	11	265	785
Standard deviation of observations		10.32	8.79	9.65	10.55	10.67

Note: Some observations are included in total figures but not reported separately due to the confidentiality commitments on disclosure.

Table A–4: All services—Labour costs as a percentage of total expenses, by resident mix and state

Resident mix	Categories	NSW	QLD	SA	State TAS	VIC	WA	Grand Total
High care*	Average % total expenses being labour costs, on-costs	73.79	73.34	73.31	79.35	71.94	60.74	71.67
	Number of services	123	22	53	6	115	42	361
	Standard deviation of observations	7.18	6.16	6.27	1.29	8.67	9.65	8.76
Low care*	Average % total expenses being labour costs, on-costs	61.11	62.23	61.67	70.49	61.18	58.15	61.07
	Number of services	97	19	23	5	115	34	293
	Standard deviation of observations	10.72	9.08	9.01	6.88	10.89	9.66	10.45
Mixed care	Average % total expenses being labour costs, on-costs	64.58	62.82	67.40		68.08	58.42	65.51
	Number of services	39	12	14		44	14	126
	Standard deviation of observations	6.05	9.38	9.12		8.66	11.29	8.84
Total Average % of total expenses that are labour costs, on-costs		67.73	66.97	69.42	75.25	66.72	59.26	66.66
Number of services		261	53	90	14	275	92	785
Standard deviation of observations		10.40	9.59	8.96	5.66	10.90	10.07	10.67

* 'High care' and 'low care' categories refer to services that deliver predominantly high care or low care respectively. 'Mixed care' refers to services where there are 30 per cent or more of residents in both high care and low care.

Note: Some observations are included in total figures but not reported separately due to the confidentiality commitments on disclosure.

Table A–5: All services—Labour costs as a percentage of total expenses, by resident mix and sector

Resident mix	Categories	Sector						
		Charitable	Community-based	Local Govt	Private	Religious	State Govt	Grand Total
High care	Average % total expenses being labour costs, on-costs	69.69	74.99	71.45	67.86	70.82	77.23	71.67
	Number of services	40	50	7	89	112	63	361
	Standard deviation of observations	6.04	7.88	7.01	10.36	7.49	7.18	8.76
Low care	Average % total expenses being labour costs, on-costs	60.20	64.84	56.60	48.84	59.92	63.73	61.07
	Number of services	24	86	14	12	134	23	293
	Standard deviation of observations	6.60	9.05	15.30	8.90	10.27	10.22	10.45
Mixed care	Average % total expenses being labour costs, on-costs	61.42	68.20	67.44	58.42	65.26	76.53	65.51
	Number of services	16	29	2	11	61	7	126
	Standard deviation of observations	7.54	9.92	2.51	9.60	7.05	7.65	8.84
Total Average % total expenses being labour costs, on-costs		65.19	68.60	62.06	64.51	64.98	73.84	66.66
Number of services		80	166	23	115	308	93	785
Standard deviation of observations		7.88	9.92	14.20	12.11	9.97	9.88	10.67

* 'High care' and 'low care' categories refer to services that deliver predominantly high care or low care respectively. 'Mixed care' refers to services where there are 30 per cent or more of residents in both high care and low care.

Table A–6: All services—EBITDA per bed year, by state and locality

State	Category	Capital	Other Metro	Locality Remote	Rural	Grand Total
NSW	Average EBITDA per bed year ($)	3 354	3 658		3 725	3 467
	Number of services	142	39		77	260
	Standard deviation of observations	8 568	5 359		6 412	7 518
QLD	Average EBITDA per b0ed year ($)	1 237	6 318		3 468	3 171
	Number of services	16	7		30	53
	Standard deviation of observations	5 970	1 190		4 739	5 050
SA	Average EBITDA per bed year ($)	3 401		-9 520	4 432	2 935
	Number of services	63		5	22	90
	Standard deviation of observations	3 874		13 920	4 241	5 730
TAS	Average EBITDA per bed year ($)				6 120	4 362
	Number of services				10	13
	Standard deviation of observations				9 341	9 012
VIC	Average EBITDA per bed year ($)	258	2 618		195	310
	Number of services	154	9		112	275
	Standard deviation of observations	6 036	1 547		10 522	8 090
WA	Average EBITDA per bed year ($)	797		2 339	1 559	967
	Number of services	74		4	12	90
	Standard deviation of observations	3 714		7 378	3 887	3 895
Total average EBITDA per bed year ($)		1 780	3 827	-3 860	2 244	2 001
Number of services		452	55	11	263	781
Standard deviation of observations		6 565	4 668	11 221	8 367	7 233

Note: Some observations are included in total figures but not reported separately due to the confidentiality commitments on disclosure.

Table A–7: All services—EBITDA per bed year, by state and sector

State	Categories	Sector						
		Charitable	Community-based	Local Govt	Private	Religious	State Govt	Grand Total
NSW	Average EBITDA per bed year ($)	6 419	3 534	9 925	3 078	3 662	-4 472	3 467
	Number of services	11	58	6	37	137	11	260
	Standard deviation of observations	2 589	3 342	7 261	3 703	8 936	11 267	7 518
QLD	Average EBITDA per bed year ($)		3 886		1 940	2 916		3 171
	Number of services		24		10	19		53
	Standard deviation of observations		4 937		4 444	5 574		5 050
SA	Average EBITDA per bed year ($)	3 899	3 622	3 116	5 510`	277	5 111	2 935
	Number of services	24	16	6	11	28	5	90
	Standard deviation of observations	3 350	4 532	4 426	3 892	8 008	3 547	5 730
TAS	Average EBITDA per bed year ($)		6 946			2 147		4 362
	Number of services		6			7		13
	Standard deviation of observations		12 056			5 376		9 012
VIC	Average EBITDA per bed year ($)	349	4 455	728	3 483	-330	-2 857	310
	Number of services	22	49	10	29	88	77	275
	Standard deviation of observations	7 044	9 313	4 145	3 522	6 199	9 555	8 090
WA	Average EBITDA per bed year ($)	1 097	3 782		-4	320		967
	Number of services	23	14		25	28		90
	Standard deviation of observations	2 591	4 203		3 321	4 561		3 895
Total average EBITDA per bed year ($)		2 464	4 007	3 887	2 632	1 823	-2 620	2 001
Number of services		80	167	22	112	307	93	781
Standard deviation of observations		4 876	6 354	6 318	3 951	7 723	9 668	7 233

Table A–8: All Services—EBITDA per bed year, by state and resident mix

Resident mix	Observations	State NSW	QLD	SA	TAS	VIC	WA	Total
High care	Average EBITDA per bed year ($)	2 120	3 604	2 914	8 911	-1 408	-781	956
	Number of services	123	22	53	5	115	42	360
	Standard deviation of observations	7 020	6 125	4 569	13 020	8 833	4 106	7 419
Low care	Average EBITDA per bed year ($)	4 512	2 695	4 242	626	1 397	2 275	2 824
	Number of services	97	19	23	5	115	34	293
	Standard deviation of observations	8 614	4 707	4 230	4 148	7 237	2 695	7 116
Mixed care	Average EBITDA per bed year ($)	5 095	3 132	870	3 009	1 923	3 033	3 043
	Number of services	39	12	14	3	45	14	127
	Standard deviation of observations	5 306	3 454	10 166	4 943	7 503	3 649	6 625
Total Average EBITDA per bed year ($)		3 467	3 171	2 935	4 362	310	967	2 001
Total Number of services		260	53	90	13	275	90	781
Total Standard deviationof observations		7 518	5 050	5 730	9 012	8 090	3 895	7 233

Note: One observation not categorised by resident mix included in total figures.

Table A–9: All services—EBITDA per bed year, by state and size

State	Categories	Size 0–30	31–60	61–90	91+	Grand Total
NSW	Average EBITDA per bed year ($)	2 884	3 147	5 323	1 708	3 467
	Number of services	51	123	61	25	260
	Standard deviation of observations	7 013	6 805	9 807	4 296	7 518
QLD	Average EBITDA per bed year ($)	3 505	3 245	4 766	837	3 171
	Number of services	18	20	7	8	53
	Standard deviation of observations	4 678	6 200	3 164	4 367	5 050
SA	Average EBITDA per bed year ($)	805	3 124	3 510	4 897	2 935
	Number of services	15	54	14	7	90
	Standard deviation of observations	11 348	4 234	1 196	2 855	5 730
TAS	Average EBITDA per bed year ($)		6 801			4 362
	Number of services		7			13
	Standard deviation of observations		11 251			9 012
VIC	Average EBITDA per bed year ($)	-2 042	1 889	1 492	-561	310
	Number of services	96	139	20	20	275
	Standard deviation of observations	10 313	5 837	7 371	7 859	8 090
WA	Average EBITDA per bed year ($)	245	1 330	1 326	-2 476	967
	Number of services	16	54	16	4	90
	Standard deviation of observations	3 979	3 609	4 031	6 158	3 895
Total average EBITDA per bed year ($)		152	2 526	3 862	977	2 001
Number of services		199	397	121	64	781
Standard deviation of observations		9 093	5 840	7 921	5 813	7 233

Note: Some observations are included in total figures but not reported separately due to the confidentiality commitments on disclosure.

Table A–10: All services—EBITDA per bed year, by sector and size

Sector	Categories	Size 0–30	31–60	61–90	91+	Grand Total
Charitable	Average EBITDA per bed year ($)	57	2 885	2 524	2 176	2 464
	Number of services	9	52	15	4	80
	Standard deviation of observations	3 151	5 514	3 253	3 548	4 875
Community -based	Average EBITDA per bed year ($)	4 319	3 752	3 835	4 859	4 007
	Number of services	56	80	23	8	167
	Standard deviation of observations	8 330	5 632	3 621	3 263	6 354
Local Govt	Average EBITDA per bed year ($)	9 268	1 593			3 887
	Number of services	6	13			22
	Standard deviation of observations	8 115	4 511			6 318
Private	Average EBITDA per bed year ($)	3 802	2 773	1 549	2 265	2 632
	Number of services	15	61	18	18	112
	Standard deviation of observations	4 379	4 009	4 387	2 742	3 951
Religious	Average EBITDA per bed year ($)	-931	2 199	4 613	-716	1 823
	Number of services	58	162	60	27	307
	Standard deviation of observations	8 226	6 150	9 961	7 203	7 723
State Govt	Average EBITDA per bed year ($)	-4 924	219		-982	-2 620
	Number of services	55	29		6	93
	Standard deviation of observations	9 491	8 104		7 492	9 668
Total average EBITDA per bed year ($)		152	2 526	3 862	977	2 001
Number of services		199	397	121	64	781
Standard deviation of observations		9 093	5 840	7 921	5 813	7 233

Note: Some observations are included in total figures but not reported separately due to the confidentiality commitments on disclosure.

Table A–11: All services—positive EBITDAs only per bed year, by state and locality

State	Category	Capital	Other Metro	Locality Remote	Rural	Grand Total
NSW	Average EBITDA per bed year ($)	5 360	5 066		5 595	5 383
	Number of services	113	34		63	210
	Standard deviation of observations	7 225	3 877		4 181	5 963
QLD	Average EBITDA per bed year ($)	5 183	6 318		5 074	5 316
	Number of services	9	7		24	40
	Standard deviation of observations	4 552	1 190		3 509	3 457
SA	Average EBITDA per bed year ($)	4 504			4 915	4 530
	Number of services	54			20	76
	Standard deviation of observations	2 890			4 145	3 252
TAS	Average EBITDA per bed year ($)				7 063	6 761
	Number of services				9	10
	Standard deviation of observations				9 389	8 903
VIC	Average EBITDA per bed year ($)	3 615	3 023		7 131	4 794
	Number of services	97	8		55	160
	Standard deviation of observations	2 545	1 021		8 884	5 802
WA	Average EBITDA per bed year ($)	2 766			3 599	3 029
	Number of services	50			8	60
	Standard deviation of observations	1 884			2 373	2 311
Total Average EBITDA per bed year ($)		4 286	4 912	4 337	5 906	4 863
Number of services		324	49	4	179	556
Standard deviation of observations		4 834	3 401	5 639	6 217	5 265

Note: Some observations are included in total figures but not reported separately due to the confidentiality commitments on disclosure.

Table A–12: All services—positive EBITDAs only, by state and sector

State	Categories	Sector						
		Charitable	Community-based	Local Govt	Private	Religious	State Govt	Grand Total
NSW	Average EBITDA per bed year ($)	6 419	4 723	9 925	3 766	5 829	4 660	5 383
	Number of services	11	47	6	33	109	4	210
	Standard deviation of observations	2 589	2 415	7 261	3 108	7 556	5 538	5 963
QLD	Average EBITDA per bed year ($)		5 639		4 615	5 189		5 316
	Number of services		19		6	15		40
	Standard deviation of observations		3 565		3 458	3 509		3 457
SA	Average EBITDA per bed year ($)	4 242	3 898	4 423	6 145	4 149	6 459	4 530
	Number of services	23	15	5	10	19	4	76
	Standard deviation of observations	2 963	4 550	3 418	3 452	2 242	2 158	3 252
TAS	Average EBITDA per bed year ($)		8 755			4 766		6 761
	Number of services		5			5		10
	Standard deviation of observations		12 535			3 359		8 903
VIC	Average EBITDA per bed year ($)	3 565	6 635	3 274	4 751	3 542	5 625	4 794
	Number of services	14	38	6	23	52	27	160
	Standard deviation of observations	2 920	9 436	2 248	2 717	2 590	6 658	5 802
WA	Average EBITDA per bed year ($)	2 417	4 868		2 786	2 560		3 029
	Number of services	16	12		12	20		60
	Standard deviation of observations	1 604	3 382		2 031	1 681		2 311
Total Average EBITDA per bed year ($)		4 012	5 455	5 959	4 239	4 779	5 610	4 863
Number of services		64	136	17	84	220	35	556
Standard deviation of observations		2 868	6 092	5 506	3 026	5 725	6 100	5 265

Table A–13: All services—positive EBITDAS only, by state and size

State	Categories	Size 0–30	31–60	61–90	91+	Grand Total
NSW	Average EBITDA per bed year ($)	5 716	4 985	6 857	3 183	5 383
	Number of services	38	101	50	21	210
	Standard deviation of observations	4 305	3 696	10 168	2 049	5 963
QLD	Average EBITDA per bed year ($)	5 703	5 455	5 616	3 461	5 316
	Number of services	14	15	6	5	40
	Standard deviation of observations	4 874	2 355	2 439	2 727	3 457
SA	Average EBITDA per bed year ($)	5 748	4 491	3 510	4 897	4 530
	Number of services	11	44	14	7	76
	Standard deviation of observations	4 740	3 303	1 196	2 855	3 252
TAS	Average EBITDA per bed year ($)		8 285			6 761
	Number of services		6			10
	Standard deviation of observations		11 551			8 903
VIC	Average EBITDA per bed year ($)	5 852	4 398	4 825	4 321	4 794
	Number of services	41	96	11	12	160
	Standard deviation of observations	8 386	4 219	8 416	2 628	5 802
WA	Average EBITDA per bed year ($)	3 169	2 900	3 383		3 029
	Number of services	8	41	10		60
	Standard deviation of observations	1 694	2 099	3 596		2 311
Total Average EBITDA per bed year ($)		5 544	4 534	5 634	3 781	4 863
Number of services		114	303	93	46	556
Standard deviation of observations		6 034	3 935	8 170	2 399	5 265

Note: Some observations are included in total figures but not reported separately due to the confidentiality commitments on disclosure.

Table A–14: All services—positive EBITDAs only, by sector and size

Sector	Categories	Size 0–30	31–60	61–90	91+	Grand Total
Charitable	Average EBITDA per bed year ($)	2 171	4 321	3 742		4 012
	Number of services	5	44	12		64
	Standard deviation of observations	1 801	3 130	2 116		2 868
Community -based	Average EBITDA per bed year ($)	6 142	5 183	4 687	5 720	5 455
	Number of services	45	64	20	7	136
	Standard deviation of observations	8 226	5 330	3 001	2 346	6 092
Local Government	Average EBITDA per bed year ($)	11 158	3 574			5 959
	Number of services	5	10			17
	Standard deviation of observations	7 452	2 744			5 506
Private	Average EBITDA per bed year ($)	5 482	4 160	4 452	3 297	4 239
	Number of services	12	48	10	14	84
	Standard deviation of observations	2 885	3 222	3 156	2 131	3 026
Religious	Average EBITDA per bed year ($)	4 807	4 388	6 269	3 468	4 779
	Number of services	29	125	48	18	220
	Standard deviation of observations	3 362	3 447	10 451	2 401	5 725
State Government	Average EBITDA per bed year ($)	4 659	5 663		3 601	5 610
	Number of services	18	12		4	35
	Standard deviation of observations	3 700	5 826		2 893	6 100
Total Average EBITDA per bed year ($)		5 544	4 534	5 634	3 781	4 863
Number of services		114	303	93	46	556
Standard deviation of observations		6 034	3 935	8 170	2 399	5 265

Note: Some observations are included in total figures but not reported separately due to the confidentiality commitments on disclosure.

Table A–15: All services—negative EBITDAs only, by state and locality

State	Category	Capital	Other Metro	Locality Remote	Rural	Grand Total
NSW	Average EBITDA per bed year ($)	-4 464	-5 914		-4 688	-4 578
	Number of services	29	5		14	50
	Standard deviation of observations	9 023	4 172		7 990	8 083
QLD	Average EBITDA per bed year ($)	-3 838			-2 955	-3 430
	Number of services	7			6	13
	Standard deviation of observations	2 839			3 424	3 021
SA	Average EBITDA per bed year ($)	-3 220				-5 721
	Number of services	9				14
	Standard deviation of observations	1 857				8 258
TAS	Average EBITDA per bed year ($)					-3 633
	Number of services					3
	Standard deviation of observations					2 428
VIC	Average EBITDA per bed year ($)	-5 453			-6 498	-5 929
	Number of services	57			57	115
	Standard deviation of observations	5 978			7 106	6 548
WA	Average EBITDA per bed year ($)	-3 306			-2 521	-3 157
	Number of services	24			4	30
	Standard deviation of observations	3 197			2 992	3 051
Total Average EBITDA per bed year ($)		-4 563	-5 033	-8 544	-5 559	-5 071
Number of services		128	6	7	84	225
Standard deviation of observations		6 086	4 311	11 116	6 894	6 554

Note: Some observations are included in total figures but not reported separately due to the confidentiality commitments on disclosure.

Table A–16: Top 10 per cent of services—EBITDA per bed year, by state and sector

State	Categories	Sector						
		Charitable	Community-based	Local Govt	Private	Religious	State Govt	Grand Total
NSW	Average EBITDA per bed year ($)	9 225	8 731	12 945	10 952	15 270		13 261
	Number of services	3	4	4	3	20		35
	Standard deviation of observations	881	748	7 162	2 973	13 777		10 863
QLD	Average EBITDA per bed year ($)		11 417			11 659		11 289
	Number of services		3			2		6
	Standard deviation of observations		5 154			5 261		4 059
SA	Average EBITDA per bed year ($)	11 594	13 835		9 488			10 384
	Number of services	2	2		4			11
	Standard deviation of observations	4 781	6 106		1 311			3 261
TAS	Average EBITDA per bed year ($)							20 074
	Number of services							2
	Standard deviation of observations							15 607
VIC	Average EBITDA per bed year ($)		18 790		9 687	9 305	19 614	15 184
	Number of services		9		3	5	4	22
	Standard deviation of observations		13 444		1 905	1 043	7 101	9 967
WA	Average EBITDA per bed year ($)		10 501					10 501
	Number of services		2					2
	Standard deviation of observations		3 174					3 174
Total Average EBITDA per bed year ($)		10 292	15 146	12 043	10 003	13 537	16 444	13 350
Total Number of services		6	21	5	11	29	6	78
Total Standard deviation of observations		2 513	10 429	6 522	1 849	11 715	7 426	9 428

Note: Some observations are included in total figures but not reported separately due to the confidentiality commitments on disclosure.

Table A–17: Top 10 per cent of services—EBITDA per bed year, by state and resident mix

Resident mix	Observations	State NSW	QLD	SA	TAS	VIC	WA	Total
High care	Average EBITDA per bed year ($)	10 459	14 293	10 164		15 520		12 402
	Number of services	14	3	7		7		33
	Standard deviation of observations	2 939	3 706	2 333		8 264		5 890
Low care	Average EBITDA per bed year ($)	14 762	8 459	11 620		17 687		14 591
	Number of services	16	2	3		8		30
	Standard deviation of observations	15 374	786	5 658		14 134		13 426
Mixed care	Average EBITDA per bed year ($)	16 305				11 986		12 955
	Number of services	5				7		15
	Standard deviation of observations	6 370				5 090		5 530
Total Average EBITDA per bed year ($)		13 261	11 289	10 384	20 074	15 184	10 501	13 350
Total Number of services		35	6	11	2	22	2	78
Total Standard deviation of observations		10 863	4 059	3 261	15 607	9 967	3 174	9 428

Note: Some observations are included in total figures but not reported separately due to the confidentiality commitments on disclosure.

Table A–18: Top 10 per cent of services—EBITDA per bed year, by state and locality

State	Category	Locality				
		Capital	Other Metro	Remote	Rural	Grand Total
NSW	Average EBITDA per bed year ($)	14 489	11 549		12 133	13 261
	Number of services	18	5		12	35
	Standard deviation of observations	14 623	4 486		4 667	10 863
QLD	Average EBITDA per bed year ($)	11 642			12 171	11 289
	Number of services	2			3	6
	Standard deviation of observations	5 287			4 508	4 059
SA	Average EBITDA per bed year ($)	9 948			11 147	10 384
	Number of services	7			4	11
	Standard deviation of observations	2 462			4 701	3 261
TAS	Average EBITDA per bed year ($)					20 074
	Number of services					2
	Standard deviation of observations					15 607
VIC	Average EBITDA per bed year ($)	9 449			18 461	15 184
	Number of services	8			14	22
	Standard deviation of observations	1 303			11303	9967
WA	Average EBITDA per bed year ($)					10 501
	Number of services					2
	Standard deviation of observations					3174
Total Average EBITDA per bed year ($)		12 266	10 947		14 821	13 350
Total Number of services		35	6		36	78
Total Standard deviation of observations		10 713	4 275		8 777	9 428

Note: Some observations are included in total figures but not reported separately due to the confidentiality commitments on disclosure.

Table A–19: Top 10 per cent of services—EBITDA per bed year, by sector and locality

Sector	Observations	Locality				
		Capital	Other Metro	Remote	Rural	Grand Total
Charitable	Average EBITDA per bed year ($)	11 600			9 637	10 292
	Number of services	2			4	6
	Standard deviation of observations	4 772			1 105	2 513
Community -based	Average EBITDA per bed year ($)	8 421			16 977	15 146
	Number of services	4			16	21
	Standard deviation of observations	777			11 352	10 429
Local Govt	Average EBITDA per bed year ($)				12 945	12 043
	Number of services				4	5
	Standard deviation of observations				7 162	6 522
Private	Average EBITDA per bed year ($)	9 987				10 003
	Number of services	10				11
	Standard deviation of observations	1 948				1 849
Religious	Average EBITDA per bed year ($)	14 674	10 835		12 377	13 537
	Number of services	18	5		6	29
	Standard deviation of observations	14 577	4 769		3 786	11 715
State Govt	Average EBITDA per bed year ($)				17 432	16 444
	Number of services				5	6
	Standard deviation of observations				7 850	7 426
Total Average EBITDA per bed year ($)		12 266	10 947		14 821	13 350
Total Number of services		35	6		36	78
Total Standard deviation of observations		10 713	4 275		8 777	9 428

Note: Some observations are included in total figures but not reported separately due to the confidentiality commitments on disclosure.

Table A–20: Top quartile of services—EBITDA per bed year, by state and locality

State	Observations	Locality				
		Capital	Other Metro	Remote	Rural	Grand Total
NSW	Average EBITDA per bed year ($)	9 649	7 921		8 536	8 962
	Number of services	45	17		31	93
	Standard deviation of observations	9 946	3 343		4 081	7 428
QLD	Average EBITDA per bed year ($)	9 932	6 923		7 636	7 811
	Number of services	3	5		11	19
	Standard deviation of observations	4 769	725		3 577	3 277
SA	Average EBITDA per bed year ($)	7 507			8 648	7 845
	Number of services	19			8	27
	Standard deviation of observations	2 451			4 134	3 007
TAS	Average EBITDA per bed year ($)				15 835	15 835
	Number of services				3	3
	Standard deviation of observations				13 255	13 255
VIC	Average EBITDA per bed year ($)	7 507			13 678	10 733
	Number of services	21			23	44
	Standard deviation of observations	1 868			10 632	8 318
WA	Average EBITDA per bed year ($)	6 161				7 126
	Number of services	7				9
	Standard deviation of observations	803				2 325
Total Average EBITDA per bed year ($)		8 499	7 694		10 236	9 116
Total Number of services		95	22		77	195
Total Standard deviation of observations		7 088	2 966		7 381	6 901

Note: Some observations are included in total figures but not reported separately due to the confidentiality commitments on disclosure.

Table A–21: Top quartile of services—EBITDA per bed year, by state and resident mix

Resident mix	Observations	State NSW	QLD	SA	TAS	VIC	WA	Total
High care	Average EBITDA per bed year ($)	7 928	9 006	7 806		10 153	6 111	8 726
	Number of services	37	9	16		17	2	83
	Standard deviation of observations	2 719	4 398	2 647		6 897	759	4 782
Low care	Average EBITDA per bed year ($)	9 571	6 761	8 244		12 172	6 737	9 500
	Number of services	42	7	8		15	5	77
	Standard deviation of observations	10 190	1 331	4 161		11 715	1 178	9 267
Mixed care	Average EBITDA per bed year ($)	9 871	6 678	6 984		9 754	9 112	9 194
	Number of services	14	3	3		12	2	35
	Standard deviation of observations	6 115	1 329	1 629		4 712	5 138	4 889
Total Average EBITDA per bed year ($)		8 962	7 811	7 845	15 835	10 733	7 126	9 116
Total Number of services		93	19	27	3	44	9	195
Total Standard deviation of observations		7 428	3 277	3 007	13 255	8 318	2 325	6 901

Note: Some observations are included in total figures but not reported separately due to the confidentiality commitments on disclosure.

Table A–22: Top quartile of services—EBITDA per bed year, by sector and locality

Sector	Observations	Locality				
		Capital	Other Metro	Remote	Rural	Grand Total
Charitable	Average EBITDA per bed year ($)	6 993			8 576	7 521
	Number of services	12			6	18
	Standard deviation of observations	2 683			1 890	2 510
Community -based	Average EBITDA per bed year ($)	6 975	6 454		10 839	9 477
	Number of services	13	7		37	58
	Standard deviation of observations	1 283	702		9 140	7 557
Local Govt	Average EBITDA per bed year ($)	6 774			12 945	10 300
	Number of services	3			4	7
	Standard deviation of observations	1 497			7 162	6 105
Private	Average EBITDA per bed year ($)	7 905				7 992
	Number of services	25				26
	Standard deviation of observations	2 189				2 190
Religious	Average EBITDA per bed year ($)	9 953	8 042		8 229	9 149
	Number of services	41	14		19	74
	Standard deviation of observations	10 416	3 451		3 560	8 094
State Govt	Average EBITDA per bed year ($)				11 734	11 305
	Number of services				10	12
	Standard deviation of observations				7 988	7 363
Total Average EBITDA per bed year ($)		8 499	7 694		10 236	9 116
Total Number of services		95	22		77	195
Total Standard deviation of observations		7 088	2 966		7 381	6 901

Note: Some observations are included in total figures but not reported separately due to the confidentiality commitments on disclosure.

Table A–23: Top quartile of services—EBITDA per bed year, by state and sector

State	Categories	Sector						
		Charitable	Community-based	Local Govt	Private	Religious	State Govt	Grand Total
NSW	Average EBITDA per bed year ($)	7 400	6 761	12 945	7 876	10 303	9 160	8 962
	Number of services	9	24	4	9	45	2	93
	Standard deviation of observations	1 557	1 138	7 162	2 834	10 118	3 318	7 428
QLD	Average EBITDA per bed year ($)		7 547		8 338	8 120		7 811
	Number of services		11		2	6		19
	Standard deviation of observations		3 452		2 582	3 623		3 277
SA	Average EBITDA per bed year ($)	7 943	10 936	6 774	8 526	6 538	7 348	7 845
	Number of services	5	3	3	6	7	3	27
	Standard deviation of observations	4 104	6 623	1 497	1 871	991	1 500	3 007
TAS	Average EBITDA per bed year ($)							15 835
	Number of services							3
	Standard deviation of observations							13 255
VIC	Average EBITDA per bed year ($)	7 264	14 313		8 122	7 554	13 614	10 733
	Number of services	4	14		7	12	7	44
	Standard deviation of observations	2 518	12 261		1 900	1 854	9 013	8 318
WA	Average EBITDA per bed year ($)		8 017		6 111	5 913		7 126
	Number of services		5		2	2		9
	Standard deviation of observations		2 897		759	341		2 325
Total Average EBITDA per bed year ($)		7 521	9 477	10 300	7 992	9 149	11 305	9 116
Total Number of services		18	58	7	26	74	12	195
Total Standard deviation of observations		2 510	7 557	6 105	2 190	8 094	7 363	6 901

Note: Some observations are included in total figures but not reported separately due to the confidentiality commitments on disclosure.

Table A–24: Second quartile of services—EBITDA per bed year, by state and locality

State	Observations	Locality			
		Capital	Other Metro	Rural	Total
NSW	Average EBITDA per bed year ($)	3 577	3 648	3 669	3 614
	Number of services	36	8	19	63
	Standard deviation of observations	686	816	756	713
QLD	Average EBITDA per bed year ($)	4 431	4 806	3 554	3 921
	Number of services	3	2	9	14
	Standard deviation of observations	743	37	927	942
SA	Average EBITDA per bed year ($)	3 793		3 525	3 735
	Number of services	22		6	28
	Standard deviation of observations	838		724	809
TAS	Average EBITDA per bed year ($)			3 435	3 556
	Number of services			4	5
	Standard deviation of observations			346	403
VIC	Average EBITDA per bed year ($)	3 574	3 490	3 810	3 626
	Number of services	41	6	16	63
	Standard deviation of observations	923	633	910	891
WA	Average EBITDA per bed year ($)	3 579		3 687	3 604
	Number of services	17		5	22
	Standard deviation of observations	793		902	798
Total Average EBITDA per bed year ($)		3 641	3 734	3 661	3 655
Total Number of services		120	16	59	195
Total Standard deviation of observations		817	791	794	804

Note: One observation is included in total figures but not reported separately due to the confidentiality commitments on disclosure.

Table A–25: Second quartile of services—EBITDA per bed year, by state and resident mix

Resident mix	Observations	State NSW	QLD	SA	TAS	VIC	WA	Total
High care	Average EBITDA per bed year ($)	3 506	3 649	3 504		3 889	3 486	3 603
	Number of services	31	4	14		20	7	78
	Standard deviation of observations	698	1 345	724		847	771	777
Low care	Average EBITDA per bed year ($)	3 525	3 912	4 114		3 546	3 586	3 627
	Number of services	19	5	7		31	9	73
	Standard deviation of observations	751	1 005	1 027		899	791	853
Mixed care	Average EBITDA per bed year ($)	3 965	4 147	3 820		3 396	3 768	3 778
	Number of services	12	5	7		12	6	43
	Standard deviation of observations	610	616	677		914	951	772
Total Average EBITDA per bed year ($)		3 614	3 921	3 735	3 556	3 626	3 604	3 655
Total Number of services		63	14	28	5	63	22	195
Total Standard deviation of observations		713	942	809	403	891	798	804

Note: Some observations are included in total figures but not reported separately due to the confidentiality commitments on disclosure.

Table A–26: Second quartile of services—EBITDA per bed year, by state and sector

State	Categories	Sector						
		Charitable	Community-based	Local Govt	Private	Religious	State Govt	Grand Total
NSW	Average EBITDA per bed year ($)		3 418	3 885	3 400	3 740		3 614
	Number of services		14	2	11	36		63
	Standard deviation of observations		706	522	601	745		713
QLD	Average EBITDA per bed year ($)		3 790		3 615	4 182		3 921
	Number of services		5		3	6		14
	Standard deviation of observations		1 087		1 146	826		942
SA	Average EBITDA per bed year ($)	3 852	3 324		3 580	3 772		3 735
	Number of services	14	4		2	7		28
	Standard deviation of observations	933	817		688	702		809
TAS	Average EBITDA per bed year ($)							3 556
	Number of services							5
	Standard deviation of observations							403
VIC	Average EBITDA per bed year ($)	3 442	3 341	4 715	3 753	3 246	3 997	3 626
	Number of services	4	10	4	13	19	13	63
	Standard deviation of observations	440	641	239	890	923	891	891
WA	Average EBITDA per bed year ($)	3 749	3 276		3 516	3 688		3 604
	Number of services	8	4		4	6		22
	Standard deviation of observations	891	875		724	809		798
Total Average EBITDA per bed year ($)		3 757	3 443	4 438	3 584	3 640	3 983	3 655
Total Number of services		26	40	6	33	76	14	195
Total Standard deviation of observations		848	730	522	761	815	858	804

Note: Some observations are included in total figures but not reported separately due to the confidentiality commitments on disclosure.

Table A–27: Second quartile of services—EBITDA per bed year, by sector and locality

Sector	Observations	Locality			
		Capital	Other Metro	Rural	Total
Charitable	Average EBITDA per bed year ($)	3 745		3 850	3 757
	Number of services	23		3	26
	Standard deviation of observations	864		872	848
Community -based	Average EBITDA per bed year ($)	3 425	3 678	3 433	3 443
	Number of services	14	2	24	40
	Standard deviation of observations	673	172	801	730
Local Govt	Average EBITDA per bed year ($)	4 715		3 885	4 438
	Number of services	4		2	6
	Standard deviation of observations	239		522	522
Private	Average EBITDA per bed year ($)	3 533	3 939	3 560	3 584
	Number of services	27	4	2	33
	Standard deviation of observations	713	906	1 515	761
Religious	Average EBITDA per bed year ($)	3 610	3 663	3 696	3 640
	Number of services	46	10	20	76
	Standard deviation of observations	853	860	736	815
State Govt	Average EBITDA per bed year ($)	3 756		4 153	3 983
	Number of services	6		8	14
	Standard deviation of observations	999		758	858
Total Average EBITDA per bed year ($)		3 641	3 734	3 661	3 655
Total Number of services		120	16	59	195
Total Standard deviation of observations		817	791	794	804

Table A–28: Third quartile of services—EBITDA per bed year by state and locality

State	Observations	Locality				
		Capital	Other Metro	Remote	Rural	Grand Total
NSW	Average EBITDA per bed year ($)	1 004	934		1 158	1 030
	Number of services	40	9		15	64
	Standard deviation of observations	931	723		915	891
QLD	Average EBITDA per bed year ($)	1 186			906	999
	Number of services	3			6	9
	Standard deviation of observations	980			1 135	1 032
SA	Average EBITDA per bed year ($)	1 195		1 361	898	1 110
	Number of services	14		2	8	24
	Standard deviation of observations	806		977	1 101	896
TAS	Average EBITDA per bed year ($)					1 163
	Number of services					2
	Standard deviation of observations					582
VIC	Average EBITDA per bed year ($)	1 071	1 623		742	980
	Number of services	41	2		21	64
	Standard deviation of observations	895	248		827	874
WA	Average EBITDA per bed year ($)	1 191			570	1 154
	Number of services	28			3	32
	Standard deviation of observations	858			1 185	885
Total Average EBITDA per bed year ($)		1 093	1 059	1 535	902	1 044
Total Number of services		126	11	3	55	195
Total Standard deviation of observations		880	709	754	917	881

Note: Some observations are included in total figures but not reported separately due to the confidentiality commitments on disclosure.

Table A–29: Third quartile of services—EBITDA per bed year, by state and resident mix

Resident mix	Observations	State NSW	QLD	SA	TAS	VIC	WA	Total
High care	Average EBITDA per bed year ($)	865	1 278	1 252		728	987	943
	Number of services	31	4	15		19	12	81
	Standard deviation of observations	853	1 026	837		909	846	870
Low care	Average EBITDA per bed year ($)	960	1 184	825		1 021	1 339	1 052
	Number of services	23	2	7		34	15	83
	Standard deviation of observations	932	1 722	846		862	938	893
Mixed care	Average EBITDA per bed year ($)	1 702	504	1 038		1 292	1 003	1 285
	Number of services	10	3	2		11	5	31
	Standard deviation of observations	638	801	1 866		802	881	857
Total Average EBITDA per bed year ($)		1 030	999	1 110	1 163	980	1 154	1 044
Total Number of services		64	9	24	2	64	32	195
Total Standard deviation of observations		891	1 032	896	582	874	885	881

Note: Some observations are included in total figures but not reported separately due to the confidentiality commitments on disclosure.

Table A–30: Third quartile of services—EBITDA per bed year, by state and sector

State	Categories	Sector						
		Charitable	Community-based	Local Govt	Private	Religious	State Govt	Grand Total
NSW	Average EBITDA per bed year ($)	2 006	897		1 102	1 080	22	1 030
	Number of services	2	12		14	33	3	64
	Standard deviation of observations	128	968		743	921	243	891
QLD	Average EBITDA per bed year ($)		1 284		-81	1 340		999
	Number of services		4		2	3		9
	Standard deviation of observations		1 169		352	803		1 032
SA	Average EBITDA per bed year ($)	981	1 317	896	1 564	1 036		1 110
	Number of services	4	9	2	2	6		24
	Standard deviation of observations	659	1 102	892	387	847		896
TAS	Average EBITDA per bed year ($)							1 163
	Number of services							2
	Standard deviation of observations							582
VIC	Average EBITDA per bed year ($)	959	1 111	7	568	1 425	404	980
	Number of services	7	16	4	5	22	10	64
	Standard deviation of observations	859	813	538	1 022	770	642	874
WA	Average EBITDA per bed year ($)	916	1 743		945	1 297		1 154
	Number of services	9	3		7	13		32
	Standard deviation of observations	921	673		1 025	824		885
Total Average EBITDA per bed year ($)		1 040	1 163	303	928	1 216	273	1 044
Total Number of services		22	45	6	30	78	14	195
Total Standard deviation of observations		834	920	737	868	843	588	881

Note: Some observations are included in total figures but not reported separately due to the confidentiality commitments on disclosure.

Table A–31: Third quartile of services—EBITDA per bed year, by sector and locality

Sector	Observations	Locality				
		Capital	Other Metro	Remote	Rural	Total
Charitable	Average EBITDA per bed year ($)	999				1 040
	Number of services	21				22
	Standard deviation of observations	830				834
Community -based	Average EBITDA per bed year ($)	1 220	1 000		1 131	1 163
	Number of services	19	2		24	45
	Standard deviation of observations	938	315		960	920
Local Govt	Average EBITDA per bed year ($)	7			896	303
	Number of services	4			2	6
	Standard deviation of observations	538			892	737
Private	Average EBITDA per bed year ($)	1 068			163	928
	Number of services	25			4	30
	Standard deviation of observations	845			757	868
Religious	Average EBITDA per bed year ($)	1 172	1 290	1 535	1 308	1 216
	Number of services	57	7	3	11	78
	Standard deviation of observations	883	748	754	775	843
State Govt	Average EBITDA per bed year ($)				285	273
	Number of services				13	14
	Standard deviation of observations				611	588
Total Average EBITDA per bed year ($)		1 093	1 059	1 535	902	1 044
Total Number of services		126	11	3	55	195
Total Standard deviation of observations		880	709	754	917	881

Note: Some observations are included in total figures but not reported separately due to the confidentiality commitments on disclosure.

Table A–32: Fourth quartile of services—EBITDA per bed year, by state and locality

State	Observations	Locality				
		Capital	Other Metro	Remote	Rural	Total
NSW	Average EBITDA per bed year ($)	-6 044	-5 914		-5 405	-5 639
	Number of services	21	5		12	40
	Standard deviation of observations	10 220	4 172		8 457	8 735
QLD	Average EBITDA per bed year ($)	-3 838			-4 341	-4 021
	Number of services	7			4	11
	Standard deviation of observations	2 839			3 441	2 907
SA	Average EBITDA per bed year ($)	-3 567				-7 169
	Number of services	8				11
	Standard deviation of observations	1 643				8 826
TAS	Average EBITDA per bed year ($)	-4 266				-3 633
	Number of services	2				3
	Standard deviation of observations	3 064				2 428
VIC	Average EBITDA per bed year ($)	-6 045			-7 102	-6 521
	Number of services	51			52	104
	Standard deviation of observations	6 051			7 155	6 614
WA	Average EBITDA per bed year ($)	-3 562			-3 232	-3 457
	Number of services	22			3	27
	Standard deviation of observations	3 220			3 225	3 074
Total Average EBITDA per bed year ($)		-5 203	-5 033	-8 544	-6 439	-5 771
Total Number of services		111	6	7	72	196
Total Standard deviation of observations		6 297	4 311	11 116	7 076	6 747

Note: Some observations are included in total figures but not reported separately due to the confidentiality commitments on disclosure.

Table A–33: Fourth quartile of services—EBITDA per bed year, by state and resident mix

Resident mix	Observations	State NSW	QLD	SA	TAS	VIC	WA	Total
High care	Average EBITDA per bed year ($)	-7 005	-4 296	-4 790		-7 223	-3 869	-6 249
	Number of services	24	5	8		59	21	118
	Standard deviation of observations	10 120	2 655	2 929		7 415	3 310	7 217
Low care	Average EBITDA per bed year ($)	-4 104	-3 610			-4 760	-1 737	-4 268
	Number of services	13	5			35	5	60
	Standard deviation of observations	6 384	3 696			4 801	1 433	4 845
Mixed care	Average EBITDA per bed year ($)	-1 361		-18 792		-8 547		-7 644
	Number of services	3		2		10		18
	Standard deviation of observations	691		19 638		6 279		8 300
Total Average EBITDA per bed year ($)		-5 639	-4 021	-7 169	-3 633	-6 521	-3 457	-5 771
Total Number of services		40	11	11	3	104	27	196
Total Standard deviation of observations		8 735	2 907	8 826	2 428	6 614	3 074	6 747

Note: Some observations are included in total figures but not reported separately due to the confidentiality commitments on disclosure.

Table A–34: Fourth quartile of services—EBITDA per bed year, by sector and locality

Sector	Observations	Capital	Other Metro	Locality Remote	Rural	Total
Charitable	Average EBITDA per bed year ($)	-4 443				-4 204
	Number of services	13				14
	Standard deviation of observations	6 813				6 607
Community -based	Average EBITDA per bed year ($)	-2 144			-3 750	-2 941
	Number of services	11			11	24
	Standard deviation of observations	2 082			2 395	2 272
Local Government	Average EBITDA per bed year ($)	-5 010				-5 010
	Number of services	3				3
	Standard deviation of observations	1 783				1 783
Private	Average EBITDA per bed year ($)	-2 472				-2 569
	Number of services	22				23
	Standard deviation of observations	1 971				1 981
Religious	Average EBITDA per bed year ($)	-6 697	-2 475	-10 808	-3 307	-6 186
	Number of services	57	4	5	13	79
	Standard deviation of observations	7 331	1 911	12 726	2 817	7 204
State Government	Average EBITDA per bed year ($)	-9 003			-8 121	-8 281
	Number of services	5			46	53
	Standard deviation of observations	6 879			8 211	7 890
Total Average EBITDA per bed year ($)		-5 203	-5 033	-8 544	-6 439	-5 771
Total Number of services		111	6	7	72	196
Total Standard deviation of observations		6 297	4 311	11 116	7 076	6 747

Note: Some observations are included in total figures but not reported separately due to the confidentiality commitments on disclosure.

Table A–35: Fourth quartile of services—EBITDA per bed year, by state and sector

State	Categories	Sector						
		Charitable	Community-based	Local Govt	Private	Religious	State Govt	Grand Total
NSW	Average EBITDA per bed year ($)		-1 991		-3 274	-5 750	-11 262	-5 639
	Number of services		8		3	23	6	40
	Standard deviation of observations		1 321		4 152	9 691	10 484	8 735
QLD	Average EBITDA per bed year ($)		-3 459		-2 652	-5 609		-4 021
	Number of services		4		3	4		11
	Standard deviation of observations		3 757		1 815	2 490		2 907
SA	Average EBITDA per bed year ($)					-8 827		-7 169
	Number of services					8		11
	Standard deviation of observations					9 947		8 826
TAS	Average EBITDA per bed year ($)							-3 633
	Number of services							3
	Standard deviation of observations							2 428
VIC	Average EBITDA per bed year ($)	-5 979	-3 696	-5 805	-1 873	-6 078	-7 900	-6 521
	Number of services	7	9	2	4	35	47	104
	Standard deviation of observations	9 179	2 379	1 599	1 024	5 596	7 558	6 614
WA	Average EBITDA per bed year ($)	-2 167	-2 737		-2 749	-5 980		-3 457
	Number of services	6	2		12	7		27
	Standard deviation of observations	1 724	2 163		1 790	4 642		3 074
Total Average EBITDA per bed year ($)		-4 204	-2 941	-5 010	-2 569	-6 186	-8 281	-5 771
Total Number of services		14	24	3	23	79	53	196
Total Standard deviation of observations		6 607	2 272	1 783	1 981	7 204	7 890	6 747

Note: Some observations are included in total figures but not reported separately due to the confidentiality commitments on disclosure.

APPENDIX B:
MEMBERSHIP OF CONSULTATION GROUPS

Industry and Consumer Reference Group

Mr David Angell
Uniting Care Ageing and Disability Services, NSW

Mr Peter Bowman
General Manager, Corporate Services
ANHECA (NSW)

Ms Sharon Davis
General Manager,
Uniting Church Frontier Services, NT

Mr David Deans
Chief Executive,
National Seniors Association & Council on the Ageing

Mr Brian Dooley
General Manager,
Our Lady of Consolation Aged Care Service, NSW

Ms Sally Garratt
Royal College of Nursing

Ms Irene Gibbons
Chief Executive Officer, Carers Australia

Mr Rodney Greene
Manager, Emerton Park Hostel, Tas

Mr Ian Hardy
Chief Executive Officer, Helping Hand, SA

Ms Joan Heard
Association of Independent Retirees

Ms June Heinrich
Chief Executive Officer,
Baptist Community Services, NSW

Ms Nancy Hogan
Former Chief Executive Officer Jewish Care, Vic

Ms Jill Iliffe
Federal Secretary, Australian Nursing Federation

Ms Betty Johnson
Consumer Representative

Dr Stephen Judd
Chief Executive Officer, Hammond Care, NSW

Dr John Leaper
Chairman, TLC Aged Care, Vic

Mr Bryan Lipmann
Chief Executive Officer, Wintringham, Vic

Mr Kevin Moss
Managing Director, Omega Australia Pty Ltd

Mr Greg Mundy
Chief Executive Officer,
Aged and Community Services Australia

Mr Chris Puckey
Manager, Aged Care Policy & Analysis,
Dept of Human Services, Vic

Mr Glenn Rees
National Executive Director,
Alzheimers Association Australia

Ms Patricia Reeve
Director, National Policy Secretariat,
Council on the Ageing

Dr Sam Scherer
General Manager Medical Services,
Royal Freemasons' Homes of Victoria

Mr Ron Thompson
Chief Executive Officer,
RSL Veterans Retirement Village, NSW

Mr Craig Thomson
National Secretary,
Health Services Union of Australia

Mr Jim Toohey
Chief Executive Officer,
Tricare Limited, Qld

Mr David Vaux
Managing Director, DCA Group Ltd;
Chairman, Amity Group Pty Ltd

Mr Paul Wilmot
Former Chief Executive Officer, Anglican Homes Inc, WA [until mid 2003]

Mr Rod Young
Chief Executive Officer, ANHECA

Expert and Technical Advisory Group

Mr Alan Bansemer
Consultant

Dr Ian Dover
Director, Alitek Pty Ltd

Dr Michael Fine
Senior Lecturer, Department of Sociology,
Macquarie University

Dr Diane Gibson
Head of the Welfare Division,
Australian Institute of Health and Welfare

Mr Richard Gray
Director, Aged Care Services,
Catholic Health Australia

Professor Hal Kendig
Dean, Faculty of Health Sciences,
University of Sydney

Mr Robert Livy
Management Accountant,
Lee & Partners

The Hon Jim Longley
Head of Government Finance,
Commonwealth Bank of Australia

Professor John McCallum
Dean, College of Social and Health Sciences,
University of Western Sydney

Mr Nick Morris
Chief Executive, ACIL Tasman Pty Ltd

Mr Hugh Sarjeant
Director, Cumpston Sarjeant Truslove Pty Ltd

Mr James Underwood
Director, James Underwood and Associates

Mr Peter Vaughan
Chief Executive Officer,
South Australian Employers' Chamber of
Commerce & Industry Inc

APPENDIX C: SUBMISSIONS

Sub Number	State	Organisation
1 C	WA	Confidential
2	WA	The RSL (WA) Retirement & Aged Care Assoc. (Inc)
3	VIC	Victorian Association of Health & Extended Care
4 C	NSW	Confidential
5	QLD	Confidential
6	NSW	Warrigal Care
7	NSW	Churches of Christ Property Trust
8	ACT	Catholic Health Australia
9	NSW	Forbes Jemalong Retirement Village
10	VIC	Carnsworth Nursing Home
11 C	VIC	Confidential
12	NSW	Mr W R Wade
13	WA	Mr Colin Scott
14	QLD	Ms Jennifer McPhee
15	WA	Ms Rosemary Blackham
16	WA	Mrs Judith Croft
17	SA	Ms Suusan Thanawathik
18	WA	Churches of Christ Homes & Community Service Incorporated
19 C	NSW	Confidential
20 C	NSW	Confidential
21	VIC	Royal Freemasons' Homes of Victoria Ltd Coppin Community Hostel
22 C	WA	Confidential
23	VIC	Ms Jean Downing
24	NSW	Mercy Health Service - Albury Limited
25	NSW	Maranatha Lodge Incorporated
26 C	QLD	Confidential
27	QLD	The Travel Doctor
28	WA	Mrs A Brooks
29	NSW	Mrs Ann Clark
30	NSW	Harbourside Haven Villages
31 C	ACT	Confidential
32 C	QLD	Confidential
33	NSW	Ms Elsa Robinson
34	NSW	Mr Don Howe
35	VIC	Burns Bridge Transactions
36	NSW	NSW Aged Care Alliance
37	VIC	Bethlehem Home for the Aged
38	QLD	Torbay Aged Care & Retirement Village
39	NSW	Wallace Mackinnon & Associates Pty Ltd
40	VIC	Knox City Council
41	NSW	Ethnic Communities' Council of NSW
42	VIC	Western District Health Service
43	WA	Aegis Health Care Group Pty Ltd

Sub Number	State	Organisation
44 C	QLD	Confidential
45	VIC	Woorayl Lodge Inc
46	NSW	Ms Karen Toft & Sarah Charman
47	WA	Esperance Aged Care Facility
48	VIC	Lewis Court Home for the Aged Inc
49	VIC	Alawara Retirement Village
50	VIC	Neerim District Soldiers' Memorial Hospital
51	VIC	Allambi Elderly Peoples Home Inc
52	TAS	Ms Aniela Alexander
53 C	TAS	Confidential
54	VIC	Murchison Community Care Inc
55 C	ACT	Confidential
56	VIC	Churches of Christ Community Care
57	VIC	St Laurence Court Inc
58	VIC	Inglewood & Districts Health Service
59	VIC	Ararat Retirement Village
60	QLD	The Good Shepherd Home
61	NSW	Tinonee Gardens
62	NSW	St Luke's Hospital Complex
63	VIC	Royal District Nursing Service
64	NSW	Harbison Care
65 C	NSW	Confidential
66	SA	Elderly Citizens Homes of SA Inc
67	NSW	Baptist Community Services
68	SA	Italian Benevolent Foundation SA Inc
69	NSW	Baptist Care Australia Ltd
70	VIC	The Kalkee Community
71	VIC	Mirboo North Aged Care Inc
72	SA	Life Care Inc
73 C	VIC	Confidential
74	NSW	Presbyterian Church (NSW) Property Trust
75	NSW	Shoalhaven Ageing & Disability Service
76	NSW	Banksia Village
77	NSW	Aged & Community Services
78	QLD	St James Park Care Centre
79	VIC	Royal Freemasons' Homes of Victoria Ltd
80	VIC	Sunnyside Lutheran Retirement Village
81	VIC	Association of Supportive Care Homes Inc
82	NSW	Hawkins Masonic Village
83	SA	Alwyndor Aged Care
84	SA	Boandik Lodge Incorporated
85	VIC	Uniting Care Strath-Haven
86	VIC	Koroit & District Memorial Health Services Inc
87	VIC	Bellarine Peninsula Community Health Service Inc
88	WA	Anglican Homes Inc
89	VIC	Victorian Carer Services Network

Sub Number	State	Organisation
90	NSW	Estonian Relief Committee Ltd
91	QLD	Mr Dean D'Alessandro
92	NSW	United Protestant Association of NSW Ltd
93	VIC	Pentridge Piazza Pty Ltd
94	NSW	Mercy Family Centre
95	SA	Ms Helen T Taylor
96 C	QLD	Confidential
97	VIC	St Vincent's Health
98	VIC	Havilah Hostel
99	VIC	Ms June M Anderson
100 C	VIC	Confidential
101 C	QLD	Confidential
102	VIC	Victorian Young People in Nursing Homes Consortium
103 C	WA	Confidential
104 C	SA	Confidential
105	VIC	Mercy Health & Aged Care Group
106	SA	Resthaven Incorporated
107	NSW	Mercy Care Centre, Young
108	VIC	Dimboola Campus (Wimmera Health Care Group)
109	WA	Western Health Care Group
110	VIC	West Wimmera Health Service
111	SA	Australian Nursing Homes &
112	VIC	Northeast Health Wangaratta
113	NSW	Mr Noel B Chapman
114 C	NSW	Confidential
115	NSW	Ms Dawn Linklater
116	TAS	Corumbene Nursing Home for the Aged Inc
117	VIC	Shepparton Retirement Villages Inc
118 C	NSW	Confidential
119	WA	Silver Chain
120	VIC	Vasey Housing Limited
121	NSW	The Benevolent Society Centre on Ageing
122	VIC	Residential Care Rights Inc
123	NSW	Ms Sue Cechner
124	VIC	Mr John Henwood
125	NSW	Ms Sue Hearn
126	VIC	Australian Physiotherapy Association
127	ACT	National Aged Care Alliance
128	SA	Wesley Uniting Mission Incorporated
129	NSW	Sisters of the Holy Family of Nazareth
130	ACT	Australian Medical Association Limited
131	NSW	The Salvation Army
132	NSW	Our Lady of Consolation Aged Care Services
133	TAS	Department of Health & Human Services
134	NSW	Illawarra Retirement Trust
135	NT	Frontier Services

Sub Number	State	Organisation
136 C	WA	Confidential
137	VIC	Moreland City Council
138	VIC	Eastern Health
139	TAS	Huon Elder Care
140	NSW	Amity Group Pty Ltd
141	NSW	Combined Pensioners & Superannuants Assoc of NSW
142	NSW	Autumn Lodge Village Inc
143	VIC	Baptist Village Baxter Ltd
144	NSW	College of Law & Business
145 C	QLD	Confidential
146	QLD	Aloaka Lodge
147	NSW	Public Service Association of NSW (Retired Associates Branch)
148	VIC	Numurkah District Health Service
149	NSW	Feros Village Byron Bay
150	NSW	H.N. McLean Memorial Retirement Village
151	WA	Uniting Church Homes
152	WA	P Quatermaine
153	SA	Whyalla Aged Care Inc
154	NSW	The Haven (2WG Homes Incorporated)
155 C	WA	Confidential
156	NSW	Bankstown City Aged Care Limited
157	VIC	Moyola Cottages & Lodge Inc
158	WA	St John of God Villa
159	SA	Restvale Lobethal & District Aged Homes Inc
160 C	WA	Confidential
161	NSW	Hornsby Ku-ring-gai Care Association
162	NSW	Anglican Care
163	SA	Alzheimer's Australia
164 C	TAS	Confidential
165	QLD	Lower Burdekin Home for the Aged Society
166	VIC	Pakenham Aged Care
167 C	QLD	Confidential
168 C	NSW	Confidential
169	QLD	Village Life Ltd
170	VIC	The Abbeyfield Society (Mortlake) Inc
171	WA	Ms Margaret Little
172	WA	Baptistcare
173	QLD	Adventist Aged Care Services
174	NSW	Gosford RSL Leisure Living Limited
175 C	VIC	Confidential
176	SA	Mr Enid Grabia
177	TAS	Melaleuca Home for the Aged Inc
178 C	NSW	Confidential
179	NSW	Anglican Retirement Villages
180	NSW	Ms Sheila Gibson
181	QLD	Mr Steve Watts

Sub Number	State	Organisation
182	VIC	Echuca Community for the Aged
183	NSW	Garden Village Port Macquarie
184	WA	Mandurah Retirement Village Inc
185	WA	Amaroo Village
186	SA	Masonic Homes Inc
187	VIC	West Gippsland Healthcare Group
188	WA	Mrs M Payne
189	TAS	Orana Respite Care Inc
190	VIC	St Laurence Community Services (Barwon) Inc
191	VIC	Brotherhood of St Laurence
192 C	NSW	Confidential
193	SA	Aged & Community Services SA & NT Inc
194 C	NSW	Confidential
195	VIC	Cobden District Health Service Inc.
196 C	QLD	Confidential
197	NSW	Innovative Business Improvement Systems Pty Ltd
198	VIC	The Kilmore & District Hospital
199	SA	Jamestown & District Homes for the Aged Inc
200	NSW	Nambucca Valley Care Limited
201	QLD	Moura Retirement Village Inc
202	NSW	Marianella Nursing Home Limited
203	SA	The Society of Saint Hilarion Inc
204	WA	Shire of Wanneroo Aged Persons Homes Trust Inc - Jacaranda Lodge
205	WA	Shire of Wanneroo Aged Persons Homes Trust Inc - Barridale Lodge
206	VIC	Carers Australia; Alzheimer's Australia; COTA National Seniors
207	VIC	Barwon Regional VAHECC Group
208	VIC	"Yallambee" Traralgon Village for the Aged Inc
209	VIC	Macedon Ranges Health Services
210	VIC	St John's Village Inc
211	VIC	Cohuna District Hospital
212	VIC	Baptist Village Baxter
213	VIC	Multicultural Aged Care Services Geelong
214	VIC	Eventide Homes Stawell Inc
215	WA	Shire of Wanneroo Aged Persons Homes Trust (Inc) Wanneroo Community Nursing Home
216	TAS	Emmerton Park Incorporated
217	QLD	PresCare
218	NSW	Elouera Gardens
219	VIC	Yackandandah Bush Nursing Hospital
220	SA	Port Adelaide Central Mission Inc
221	VIC	Cooinda Village
222	VIC	Red Cliffs & Community Aged Care Services Inc
223	VIC	Tongala & District Memorial Aged Care Service Inc.
224 C	NSW	Confidential

Sub Number	State	Organisation
225	WA	Aged & Community Services WA Inc
226	VIC	Victorian Association of Health & Extended Care
227	WA	Department of Health WA
228	WA	Chamber of Commerce and Industry, WA
229	WA	Ms Mary Ann Rath
230	WA	Midland Nursing Home & Carinya of Bicton Nursing Home
231	NSW	Society of St Vincent De Paul NSW
232 C	QLD	Confidential
233 C	QLD	Confidential
234	NSW	Mountains Community Transport Inc
235	NSW	Manning Valley Senior Citizens' Homes Ltd
236	NSW	Mercy Nursing Home
237	NSW	Aruma Lodge Inc
238	SA	Southern Yorke Peninsula Health Service
239	NSW	General Practice Partnership Advisory Council
240	QLD	TriCare Limited
241	VIC	Regis Group
242	VIC	Department of Human Services, VIC
243 C	NSW	Confidential
244	NSW	Catholic Health Care Services (Central West Region)
245 C		Confidential
246	SA	Aged Care Housing Group, SA
247 C	WA	Confidential
248 C	NSW	Confidential
249	VIC	Napier Street Aged Care Services
250	NSW	Uniting Care Australia
251 C	NSW	Confidential
252	VIC	Aged & Community Services Australia
253	WA	Southern Cross Care WA Inc
254	VIC	Melbourne Citymission
255	QLD	Churches of Christ in Queensland for Churches of Christ Care
256	NSW	Advisory Committee for Severe & Persistent Challenging Behaviours in NSW Aged Care Facilities RANZCP
257	WA	Mr Ian McAlpine
258	VIC	Aged Services Network Western Region
259	TAS	Aged & Community Services Tasmania
260	NSW	Westpac Business Banking
261	ACT	Uniting Care Mirinjani Village
262	VIC	Blue Cross Community Care Services Group
263	VIC	Southern Health, Victoria
264	VIC	DutchCare Ltd
265	SA	Mid North ACAT, South Australia
266	ACT	Australian Nursing Federation
267	TAS	Sandown Apartments
268 C	NSW	Confidential
269		Mr George T Weinberger

Sub Number	State	Organisation
270	NSW	Koorabri Pty Ltd
271 C	QLD	Confidential
272 C		Confidential
273	NSW	Our Lady of the Way Retirement Court
274 C	SA	Confidential
275	NSW	Australian Society for Geriatric Medicine
276	VIC	Cohuna Retirement Village Inc
277 C	QLD	Confidential
278	QLD	Aged Care Queensland
279	QLD	TriCare
280	NSW	Wentworth District Hostel Society Incorporated
281	VIC	Wintringham
282 C	VIC	Confidential
283	WA	Broome Aged and Disabled Services
284	VIC	Fernhill Hostel for the Aged
285	VIC	Minister for Aged Care
286 C	TAS	Confidential
287	VIC	Southern Cross Care (VIC)
288	WA	Kimberley Hostels
289	WA	Brightwater Care Group
290 C	NSW	Confidential
291	NSW	Ms Judith Nicholas
292 C	QLD	Confidential
293	ACT	Australian Nursing Homes & Extended Care Association
294	VIC	Jewish Care (Victoria) Inc
295	WA	Ms Janet Ryan
296	NSW	Aged & Community Services Association of NSW & ACT
297	NSW	Anglicare
298	VIC	Ellfam Nominees Pty Ltd
299 C	WA	Confidential
300 C	VIC	Confidential
301	ACT	Alzheimers Australia
302	VIC	Rotary Club of Melbourne
303	VIC	Royal Freemasons' Homes of Victoria Ltd
304	VIC	Regis Group
305	ACT	Productivity Commission
306 C	ACT	Confidential
307		Ms Cathy Welfare
308	QLD	PresCare
309	ACT	Catholic Health Australia
310	QLD	Queensland Health, Health Funding and Systems Development Unit
311 C	SA	Confidential
312	VIC	Department of Human Services, VIC
313	NSW	Vaucluse Nursing Home Pty Ltd
314 C	ACT	Confidential
315 C	VIC	Confidential

Sub Number	State	Organisation
316	VIC	Woorayl Lodge Inc
317	VIC	Aged Care Association of Victoria Ltd
318 C	WA	Confidential
319	VIC	Regis Group
320 C	VIC	Confidential
321	VIC	South Port Community Residential Home Inc
322	NSW	Vaucluse Nursing Home Pty Ltd
323	ACT	Catholic Health Australia
324 C	QLD	Confidential
325	SA	Matthew Flinders Home Inc
326	NSW	Elouera Gardens
327 C	SA	Confidential
328	NSW	Vaucluse Nursing Home Pty Ltd
329	VIC	Victorian Carer Services Network
330	WA	Mercy Aged Care (Wembley WA)
331	NSW	Vaucluse Nursing Home Pty Ltd
332	QLD	ATSI Aged Care Queensland
333 C		Confidential
334	VIC	Kellock Lodge Alexandra Inc
335 C	NSW	Confidential
336	ACT	Catholic Health Australia
337	VIC	Homeshare Victoria
338 C	NSW	Confidential
339	NSW	Aged & Community Services
340	NSW	NSW Ministerial Advisory Committee on Ageing
341	NSW	Aged & Community Services
342	NSW	Mana House Nursing Home
343	VIC	St. Arnaud Elderly Persons Hostel Inc
344	NSW	New South Wales Government
345 C	WA	Confidential
346	NSW	Abena-Sanicare
347	NSW	Mr John McAuley
348	NSW	Catholic Healthcare Services
349	VIC	Woorayl Lodge Inc

APPENDIX D: CONSULTATIONS

The Reviewer, Professor Hogan, accompanied by members of the Pricing Review Taskforce, conducted formal consultations in States and Territories between May and October 2003. Professor Hogan and members of the Taskforce also engaged in many supplementary discussions with peak bodies, government agencies and other stakeholders, and visited a number of aged care services. Professor Hogan participated in a range of seminars and conferences during the course of the Review.

Formal consultations

WESTERN AUSTRALIA
Perth, 21–23 May 2003

Aegis Health Group
- Mr Geoff Taylor, Director
- Mr George Pampacos

Amaroo Village
- Mr David Fenwick, CEO
- Ms Nicole Dawson
- Ms Margaret Addison
- Ms Robyn Law

Braemar Presbyterian Homes
- Mr Glen Muskett, CEO
- Brightwater Group
- Dr Penny Flett, CEO
- Mr Kenneth Annand, Director, Corporate Services
- Ms Angela Brooks

Churches of Christ & Community Services Inc
- Mr Stephen Becsi

Civilian Maimed & Limbless Association
- Mr Shane Yensch

Esperance Aged Care Facility
- Mr Bruce Kelman CEO

Hall & Prior Residential Health & Aged Care Organisation
- Mr Graeme Prior, CEO
- Ms Jennie Grieve
- Ms Debbie Hegarty
- Mr Guy Tuxworth

Shire of Wanneroo Aged Persons Homes Trust & Jacaranda Homes
- Mr David Spinks, CEO

Silver Chain
- Mr Michael Bowd, Acting CEO
- Mr Wee Lee Ong

Southern Cross Care WA
- Mr Kevin Bown General Manager

Swan Village of Care
- Mr William Marshall, CEO

Uniting Church Homes
- Ms Di Russell-Taylor, Executive Manager, Corporate Services
- Mr Vaughan Harding, CEO
- Ms Deb Patterson

Midland Nursing Home
- Ms EA Manley, CEO

Miscellaneous Workers Union
- Ms Helen Creed, State Secretary
- Ms Alison Bunting

TASMANIA
Hobart, 2–3 June 2003

Aged & Community Services Tasmania
- Mr Stephen Richards
- Ms Anne McGuinness

Corumbene Nursing Home
- Mr Andrew Power, CEO
- Ms Sandra Carmichael, Director of Nursing

Eastside Care
- Ms Helen Rimmer, Director of Care

Huon Eldercare
- Mr David Beck, CEO

Tasmanian Department of Health and Human Services
- Ms Mary Bent, Deputy Secretary
- Dr Anne Brand, Deputy Secretary
- Mr Kevin O'Loughlin, Aged Care Adviser
- Dr Elizabeth Shannon
- Ms Pip Leedham, Deputy Director, Primary Health

Devonport, 4 June 2003

Emmerton Park Inc
- Mr Rodney Greene, Executive Officer

Karingal Home for the Aged
- Mr Dallas Cowan, Chairman
- Ms Pam Pattison, CEO
- Mr Paul Stephenson

SOUTH AUSTRALIA
Adelaide, 12–13 June 2003; 13–14 August 2003

Aged & Community Services SA & NT Inc
- Mr Trevor Goldstone, CEO

Aged Care Housing Group SA
- Mr Mike Rungie
- Mr Anthony Mazzone
- Ms Joan Mussarde

Alzheimer's Australia SA
Mr Alan Nankivell, Executive Director
Ms Sue Jarrad, Director of Policy Development

Australian Nursing Homes and Extended Care Association, South Australia Inc
Mr Paul Varcoe
Ms Michelle Lensink

Elderly Citizens Homes of SA Inc
Mr Rob Hankins, Chief Executive
Mr Adrian Ware, Manager Finance
Mr Anthony Moore, Manager Property Services
Ms Mary Dunn, Manager Residential Care

Helping Hand
Mr Ian Hardy, Chief Executive
Ms Megan Corlis

Holdfast Bay City Council (Alwyndor Aged Care)
Mr Dennis Chamberlain, General Manager, Corporate and Community

Italian Benevolent Foundation of SA Inc
Ms Marcia Fisher, CEO
MrGildo Marveggio

James Brown Memorial Trust
Mr Richard Hancock, CEO
Mr Peter Wright, General Manager, Operations

Life Care Inc
Mr Mark Criddle, CEO
Mr Andrew Harris

Masonic Homes Inc
Mr John Birkill, CEO

Mid North Aged Care Assessment Team SA
Ms Pam Ayliffe

Padman Health Care
Mr Viv Padman

Port Adelaide Central Mission
Mr Ray Neal, Senior Manager, Financial Services
Mr Mark Heffernan

Resthaven Inc
Mr Richard Hearn, CEO

South Australian Department of Human Services
Mr Chris Overland
Mr Peter Clark

Southern Yorke Peninsula Health Service
Ms Jillian Ashby, Executive Officer/Director of Nursing

Wesley Uniting Mission Inc
Mr Kelvin Dickens, Director of Aged Care Services
Ms Amanda Birkin

VICTORIA
Melbourne, 24–25 June 2003; 22–24 July 2003

Aged and Community Services Australia
Mr Greg Mundy, CEO

Aged Care Association of Victoria
Mr Bryan Dorman, President
Ms Meigan Lefebure, Chief Executive Officer
Mr Lino Guglielmino

Aged Services Network Western Region & Council of the Ageing Victoria
Ms Sharon Staines, Project Manager, COTA VIC
Ms Viv Shepherdson, Aged Services Planner, Hobsons Bay City Council
Ms Michele Braid, Executive Officer, ASNWR

Association of Supportive Care Homes Inc
Mr Colin Storer, President
Mr Peter Tyler, Director

Brotherhood of St Laurence
Ms Sandra Hills, General Manager, Aged & Community Care
Mr Alan Gruner, Manager, Day Programs & Residential Aged Care
Mr Steve Poole, Property Manager
Ms Anna Bubb, Project Accountant

Burns Bridge Transactions
Mr Jonathon Wright, Principal

Jewish Care (Victoria) Inc
Ms Nancy Hogan, CEO
Mr Bruce Salvin, Director, Residential Services
Mr Colin Singh, Director, Finance & Administration
Ms Tracey Devereux, Director, Community Services

The Kalkee Community - Uniting Care
Mr Austin Paterson, CEO

Knox City Council
Ms Lorna Roach
Ms Kerrie Lavery

Melbourne Citymission
Ms Michele Lewis, General Manager, Aged Services
Dr Mary-Ann Robinson, Social Policy Officer

Mercy Health & Aged Care Group
Dr Maureen Corrigan, Director, Community & Aged Care Services
Mr David Stephenson

Moreland City Council
Ms Derryn Wilson, Manager, Community Services
Ms Iris Silvia Brito, Policy coordinator, Aged and Disability Services

Neerim District Soldiers' Memorial Hospital
Mr Craig Stuchbery, CEO

Pentridge Piazza
Mr Harry Barbon, Director
Mr Reg Macey
Mr Frank Kopciewicz
Mr Thomas Hogg

Regis Group
Mr Lindsay Bender, General Manager
Mr Ray Noble, Group Financial Controller
Mr Simon Humble-Crofts, Group Manager - Treasury & Business Performance

Royal District Nursing Service
Mr Dan Romanis, CEO
Ms Lyndie Spurr, Executive General Manager, Client Services
Mr Stelvio Vido, Executive General Manager, Strategic & Support Services

Royal Freemasons' Homes of Victoria
Mr Graham Shotter, Managing Director

Southern Cross Care (VIC)
Ms Carolyn McColl, General Manager, Residential Services
Mr Michael Dillon, General Manager, Corporate Services

St Laurence Community Services (Barwon) Inc
Ms Michelle Plane, CEO
Mr John Temple, Head of Division Residential Services
Mr John James

St Laurence Court
Mr Robert Layton, Executive Director

St Vincent's Health
Ms Neth Hinton, Director, Aged and Continuing Care
Ms Rosemary Hogan, Group Manager, Residential Care/Director of Nursing Services
Ms Rebecca Power, Chief Social Worker

Victoria Carer Services Network
Ms Rose Miles
Ms Deb Burns
Ms Judy Sharp

Victorian Department of Human Services
Mr Chris Puckey, Manager Aged Care Policy and Analysis
Dr Andrew Hollows
Ms Jane Herington, Director Aged Care

Victorian Young People in Nursing Homes
Mr Alan Blackwood
Ms Bronwyn Morkham

Yallambee Traralgon Village for the Aged
Mr Anthony Boulton, CEO

Bendigo, 26 June 2003

Alawara Retirement Village
Ms Ruth Welling, CEO

Havilah Hostel
Ms Barbara Duffin, CEO

Inglewood and Districts Health Service
Mr Stephen Hando, CEO
Ms Mary Evans, Director of Nursing
Ms Elizabeth Morley, Unit Supervisor
Ms Leanne Muns

Uniting Care Strath-Haven
Ms Judith Doughty, CEO
Mr Murray Poustie, Deputy Chairman, Board of Governance

QUEENSLAND

Brisbane, 1–2 July 2003

Aloaka Lodge
Mr Paul Alcorn, Vice President

Churches of Christ Care
Mr Graham Reed, Director, Aged Care
Mr Rob Warwick, Western Region Health Manager

Gardens on Lindfield
Mrs Carmel Cleary

Prescare
Mr Ray Tuttle, CEO
Mr Greg Skelton, Financial Manager

Queensland Health
Ms Jo Root, Manager, Aged and Community Care Reform Unit
Mr Ian Reed, Principal Policy Officer

RSL (QLD) War Veterans' Homes Limited
Mr Ross Smith, CEO
Mr Kerry Roche

St James Park Care Centre
Ms Ann-Marie Robilotta, Director of Nursing
Mr Michael Isaacs, CEO Aged Care Queensland

Sundale Garden Village
Mr Glenn Bunney, CEO

TriCare
Mr Jim Toohey, CEO

Village Life Ltd
Mr Tony Roberts, Director

NORTHERN TERRITORY

Darwin, 3 July 2003

Broome Aged and Disabled Services—Germanus Kent Hostel
Ms Jean Beard, Manager

Frontier Services
Ms Sharon Davis, Regional Manager
Ms Caroline Phillips
Ms Rosemary Jeffery

Kimberley Hostels, WA
Mr Graeme Cooper
Northern Territory Department of Health & Community Services
Mr Damien Conley, Director, Aged and Disabilities

NEW SOUTH WALES

Sydney, 6–8 and 11–12 August 2003

Advisory Committee for Severe and Persistent Challenging Behaviours in NSW Aged Care Facilities
Ms Meredith Gresham, Project Officer
Dr Doug Subau

Amity Group Pty Ltd
Mr David Farrugia

Anglican Care (Lake Macquarie/Newcastle)
Mr Denis Byron, General Manager

Anglican Retirement Villages
Mr Ken Barber, CEO
Mr Graham Towle, General Manager, Residential Care

Anglicare
Carol Allen, General Manager, Aged Services
Ms Sue King, Senior Researcher
Mr Terry O'Mara, General Manager, Diocesan Services

Australian Nursing Homes and Extended Care Association NSW
Ms Sue Macri, Executive Director
Mr Peter Bowman, Manager, Corporate Services
Mr George Toemoe, NSW Director
Mr Michael Mooney, NSW Director

Bankstown City Aged Care
Mr Terry Madden, CEO

Baptist Care Australia Ltd
Ms June Heinrich, CEO

Baptist Community Services
Mr John Church, Chairman

The Benevolent Society Centre on Ageing
Ms Barbara Squires, Director

Catholic Health Care Services Ltd
Mr Chris Rigby, Managing Director
Mr David Bergman, Executive Director, Financial Services

Elouera Gardens
Mr Peter Mackie, General Manager

Ethnic Communities Council of NSW
Mr Patrick Harris, Aged and Disability Officer

Hawkins Masonic Village
- Mr D Hopkins, Village Manager
- Mr David Smith, Maintenance Manager
- Sister Denise Lynch, Care Services Manager

Innovative Business Improvement Systems (IBIS)
- Mr Arthur Brotherhood, Director
- Ms Natasha Chadwick, Director

Mercy Family Centre
- Mr Stephen Teulan, CEO
- Ms Kay Kavanagh
- Ms Pauline Armour
- Ms Heather Nicholls

NSW Aged Care Alliance
- Mr Dinesh Wadiwel, Senior Policy Officer, The Council of Social Service of NSW
- Mr David Skidmore, Combined Pensioners & Superannuants Association of NSW
- Ms Betty Scott

Our Lady of Consolation Aged Care Services Ltd
- Mr Brian Dooley, General Manager

Perigon Consulting P/L
- Mr John Creelman, Director

Presbyterian Aged Care (NSW and ACT)
- Mr Elwyn Townsend, CEO
- Mr Steve Smith, Chief Accountant

Salvation Army
- Major Brad Halse, Aged Care Director
- Major John Vale
- Major Kerry Haggar
- Major Cecil Woodward

Sisters of the Holy Family of Nazareth
- Mr Kevin Rocks, CEO

Society of St Vincent De Paul NSW
- Mr Graeme Fear, Group coordinator, Aged Care and Disability Services
- Ms Rosemary Baxter, Accreditation Officer

St Luke's Hospital Complex
- Mr George Toemoe, CEO
- Ms Lorraine Poulos, Director of Nursing Aged Care/ Community Care
- Mr Peter Tanner

United Protestant Association of NSW Ltd
- Mr Steve Walkerden, General Manager
- Ms Sandra Menzies, District Manager, Sydney West

Vaucluse Nursing Home Pty Ltd
- Mr Ralph Levy, Proprietor and CEO
- Mr Bill Bourne

Wallace Mackinnon and Associates Pty Ltd
- Mr David Wallace, Director
- Mr Peter Mackinnon, Director

Wollongong, 30–31 July 2003

Estonian Relief Committee Ltd
- Mr Ted Maidla, Deputy Chairman
- Mr Jo Ilk, Manager

Harbison Memorial Retirement Village
- Mr Noel Andrews, CEO

Shoalhaven Ageing and Disability Service
- Mr Bruce Davis, Treasurer
- Mr Kevin Venness
- Ms N Kingston

Warrigal Care
- Mr Ian Wilson, CEO
- Mr Mark Sewell, Operations Manager

Albury, 1 October 2003

Berriquin Nursing Home
- Mr Phillip Davis, CEO
- Ms Vivian Muirhead, Director of Nursing

Cooinda Village
- Mr Bill Gent, Manager

The Haven
- Mr Shane McMullen, CEO
- Ms Anne Evans, Director of Nursing
- Mr Jenny Cummins, Hostel Manager

Hume Shire Aged Care (Hume City Council)
- Mrs Judy Fishlock, Manager, Aged and Community Services

Marianella Nursing Home Ltd
- Sister Catherine Hughes, Board Member
- Ms Joan Dick
- Mr Richard Parkinson
- Ms Dianne Groch
- Mr Geoff Smith

Moyola Cottages Inc
- Ms Shirley Campbell, Manager
- Mr Sharon Felsbourg

Murchison Community Care
- Ms Margaret McMaster, Chair, Committee of Management
- Mr Bruce Brisbane, Administrator

Navorina Nursing Home
- Mr Geoff Riley, Chairman
- Mr Charles Morrissey, CEO
- Mr Trevor David, Treasurer
- Mr Peter Connell, Office Manager

Northeast Health, Wangaratta
- Ms Michele Sheehan
- Mr Jason O'Keeffe, Operations Manager

Shepparton Retirement Villages
- Mr David McKenzie, Director
- Mr Jack McLean, Director
- Mr Kevin Bertram, Chief Executive
- Mr Murray Burl, Finance Manager
- Ms Jeanette Ryan, Executive Manager/Director of Nursing

St John's Village Inc
- Mr Joe Caruso, CEO
- Mr David Evans, Board Chairman
- Ms Melva Scott, Executive Manager

Tongala & District Memorial Aged Care Service Inc
- Mr Murray McGill, President
- Ms Jean Courtney, Director of Nursing
- Ms Sarah Tee, Deputy Director of Nursing

Yackandandah Bush Nursing Hospital
- Ms Pam Crosthwaite, Director of Nursing
- Ms Robyn Ward, Deputy Director of Nursing
- Mr Steven Hooppell, General Manager

Supplementary discussions

Aged & Community Services Association of NSW & ACT
Aged & Community Services Australia
Aged Care Association of Victoria
Aged Care Queensland
Aged Care Standards and Accreditation Agency
Australian Institute of Health and Welfare
Australian Medical Association
Australian Nursing Federation
Australian Nursing Homes and Extended Care Association
Australian Prudential Regulation Authority
Australian Securities and Investments Commission
Catholic Health Australia
Mr David Deans, National Seniors
Department of Health and Ageing
Hammond Care
Myer Foundation
Omega Australia
Perennial Investments
Productivity Commission
Professor Geoffrey Donnan, Chairman, Austin Biomedical Alliance
Professor Leon Flicker, President, Australian Society for Geriatric Medicine
Royal College of Nursing Australia
Dr John Tooth, Director of Clinical Services, ADARDS Nursing Home
Western Australian Chamber of Commerce and Industry
Westpac Institutional Bank

Conferences, seminars and other fora

Conference speeches delivered by Professor Hogan

'Six Nations', Meeting of Commonwealth State and Territory Aged Care Officials, 20 May 2003, Melbourne

'Pricing Review', Catholic Health Australia National Conference, 2 June 2003, Hobart

'Setting the scene', New England Regional Committee Workshop of the Aged and Community Services Association of NSW and ACT, 8 July 2003, Tamworth

'The way forward', AIHW National Symposium on Ageing Research, 25 September 2003, Canberra

'Sustainability: What choices, futures directions', 22nd Annual Congress of the Australian Nursing Home and Extended Care Association, 27 October 2003, Melbourne

Seminars and other fora

Australian Health Policy Institute
CEOs of Victorian Government aged care facilities
Eastern Suburbs Aged Care Forum (Sydney)
Religious Aged Care CEOs Forum (Sydney)
Victorian Association of Health & Extended Care Issues and Challenges Group

Services visited during the course of the Review

ADARDS Nursing Home, Hobart TAS
Alwyndor Aged Care (Holdfast Bay City Council), Hove SA
Blue Care Nazarene Aged Care Home, Rothwell QLD
Braidwood Multipurpose Service, Braidwood NSW
Denmora Nursing Home, Bowen Hills QLD
Ella Williams House (Uniting Church Homes, Noranda WA
Five Islands Court (Illawarra Retirement Trust), Port Kembla NSW
Holy Spirit Home, Carseldine QLD
Lourdes Valley Complex (Southern Cross Care SA), Myrtle Bank SA
Marina Residential Aged Care (TLC Aged Care), Altona VIC
McDougall Park Aged Care Facility (Hall & Prior Aged Care Organisation), Como WA
Montefiore Homes for the Aged (Jewish Care Victoria), Melbourne VIC
Mount Gravatt Nursing Centre (Tricare), Mount Gravatt QLD
Mount Gravatt Private Hostel (Tricare), Mount Gravatt QLD
Mount Gravatt Retirement Village (Tricare), Mount Gravatt QLD
Orana Respite Care Centre, East Devonport TAS
Resthaven Malvern, Malvern SA
Skyline Residential Care (Padman Health Care), Flagstaff Hill SA
St Lukes Aged Care Facility (Hall & Prior Aged Care Organisation), Subiaco WA
Tiwi Gardens Village (Masonic Homes Inc), Tiwi NT
Towradgi Park Village (Illawarra Retirement Trust), Towradgi NSW
Unitingcare Mirinjani Village, Weston ACT
Wintringham Hostels, Port Melbourne and Williamstown VIC

APPENDIX E: BACKGROUND PAPERS AND CONSULTANCIES

Background papers

1 The Context of the Review

2 The Commonwealth Legislative Framework

3 Long Term Aged Care: International Perspectives

4 Historical Perspectives: The evolution of the Australian Government's involvement in supporting the needs of older people

Consultancies

Economic and Statistical Analysis, Modelling and Efficiency

1 *The Aged Care Dynamic Cohort Model*, Access Economics

2 *Older Australians: Incomes, assets, regional variations and residential aged care*, National Centre for Social and Economic Modelling (NATSEM)

3 *Efficiency of Aged Care Facilities in Australia, Centre for Efficiency and Productivity Analysis*, University of Queensland

4 *Efficiency of a Consolidated Residential Aged Care Industry: A Quantitative Analysis of Provider Financial Data*, ACIL Tasman

5 *Aged Care Data: Statistical Analysis*, Australian Bureau of Agricultural and Resource Economics (ABARE)

Capital and Operating Costs

6 *Access to Capital Financing by Providers of Residential Aged Care*, Caversham Capital

7 *Outline Design and Pricing of Model Aged Care Building Projects*, Rider Hunt Melbourne

8 *Comparative Rates of Return: A Survey for the Review of Pricing Arrangements in Residential Aged Care*, ACIL Tasman

9 *Financial Survey*, KPMG

Workforce

10 *Employment Frameworks in the Residential Aged Care Sector*, ACIL Tasman

11 *Efficient Workforce Structures in the Australian Aged Care Sector*, ACIL Tasman

12 *Employment Demand in Nursing Occupations*, Access Economics

13 *Australian Average Weekly Earnings 1900–2002*, ACIL Tasman

14 *Options Paper on Workers Compensation and Other Insurable Risks in Residential Aged Care*, PriceWaterhouse Coopers

Prudential Risk

15 *Underwriting Risk to Accommodation Bonds in Residential Aged Care Facilities*, PriceWaterhouse Coopers/Australian Nursing Homes and Extended Care Association

Legislation and Regulation

16 *Regulation of Residential Aged Care—Review of Legislation: Commonwealth, State and Territory Legislation*, Peter Hanks QC

17 *Regulation of Residential Aged Care: Compliance with Selected Legislation and Regulation*, Peter Hanks QC

18 *Regulation of Community Services in Five OECD Countries*, ACIL Tasman

19 *Regulation of Quality in Service Industries*, Allen Consulting

Other

20 *Review of Submissions*, ACIL Tasman

21 *Location and Demographics of the Australian Aged Population*, ACIL Tasman

22 *The Impact of Dementia on the Health and Aged Care Systems*, Australian Institute of Health and Welfare

23 *Factors Affecting the Provision of Extra Service*, Westwood Spice

24 *The Prevalence and Use of Unfunded Places in Australian Government Funded Residential Care Services*, James Underwood & Associates

25 *The Role of Not-for-Profit Bodies in Residential Aged Care*, Allen Consulting

APPENDIX F:
RESIDENT CLASSIFICATION SCALE

Scores to be applied to the appraisal

Question	Question description	Level of support	Score
Q1	Communication	A	0.00
		B	0.28
		C	0.36
		D	0.83
Q2	Mobility	A	0.00
		B	1.19
		C	1.54
		D	1.82
Q3	Meals and drinks	A	0.00
		B	0.67
		C	0.75
		D	2.65
Q4	Personal hygiene	A	0.00
		B	5.34
		C	14.17
		D	14.61
Q5	Toileting	A	0.00
		B	5.98
		C	10.65
		D	13.70
Q6	Bladder management	A	0.00
		B	2.22
		C	3.82
		D	4.19
Q7	Bowel management	A	0.00
		B	3.32
		C	5.72
		D	6.30
Q8	Understanding and undertaking living activities	A	0.00
		B	0.79
		C	1.11
		D	3.40
Q9	Problem wandering or intrusive behaviour	A	0.00
		B	0.80
		C	1.58
		D	4.00
Q10	Verbally disruptive or noisy	A	0.00
		B	1.19
		C	1.75
		D	4.60
Q11	Physically aggressive	A	0.00
		B	2.34
		C	2.69
		D	3.05

Question	Question description	Level of support	Score
Q12	Emotional dependence	A	0.00
		B	0.28
		C	1.50
		D	3.84
Q13	Danger to self or others	A	0.00
		B	1.11
		C	1.54
		D	1.98
Q14	Other behaviour	A	0.00
		B	0.91
		C	1.82
		D	2.61
Q15	Social and human needs — care recipient	A	0.00
		B	0.95
		C	1.98
		D	3.01
Q16	Social and human needs — families and friends	A	0.00
		B	0.28
		C	0.55
		D	0.91
Q17	Medication	A	0.00
		B	0.79
		C	8.55
		D	11.40
Q18	Technical and complex nursing procedures	A	0.00
		B	1.54
		C	5.54
		D	11.16
Q19	Therapy	A	0.00
		B	3.64
		C	6.10
		D	7.01
Q20	Other services	A	0.00
		B	0.71
		C	1.46
		D	2.93

Classification levels

Aggregate figure range	Classification level
0–10.60	Classification level 8
10.61–28.90	Classification level 7
28.91–39.80	Classification level 6
39.81–50.00	Classification level 5
50.01–56.00	Classification level 4
56.01–69.60	Classification level 3
69.61–81.00	Classification level 2
81.01+	Classification level 1

APPENDIX G:
SCHEDULE OF SUBSIDIES AND SUPPLEMENTS

The subsidy rates applicable from 1 July 2003 are:

Basic Subsidy

Classification

Level	NSW	VIC	QLD	SA	WA	TAS	ACT	NT
RCS 1	$116.47	$119.51	$115.80	$115.80	$115.80	$120.26	$115.80	$117.00
RCS 2	$105.51	$108.14	$105.00	$105.00	$105.00	$108.94	$105.00	$106.01
RCS 3	$90.88	$93.10	$90.46	$90.46	$90.46	$93.96	$90.46	$91.30
RCS 4	$64.33	$65.91	$63.94	$63.94	$63.94	$66.86	$63.94	$64.60
RCS 5	$38.95	$38.95	$38.95	$38.95	$38.95	$38.95	$38.95	$38.95
RCS 6	$32.27	$32.27	$32.27	$32.27	$32.27	$32.27	$32.27	$32.27
RCS 7	$24.77	$24.77	$24.77	$24.77	$24.77	$24.77	$24.77	$24.77
Respite High *	$90.88	$93.10	$90.46	$90.46	$90.46	$93.96	$90.46	$91.30
Respite Low *	$32.27	$32.27	$32.27	$32.27	$32.27	$32.27	$32.27	$32.27

* These Subsidies are only payable for the “Maximum Number of Days” prescribed by Residential Care Subsidy Principles 1997.

Other Supplements

	All services	Certified Services	Non-certified Services
Respite Supplement			
Respite Care — High Level		$30.34	$24.16
Respite Care — Low Level		$19.11	$12.93
Concessional Supplement			
Assisted residents	$3.93		
More than 40% concessional residents	$13.49		
40% or fewer concessional residents	$7.87		
Charge Exempt Supplement			
Charge exempt residents who are not assisted residents	$13.49		
Charge exempt residents who are assisted residents	$9.56		
Oxygen and Enteral Supplement			
Oxygen Supplement	$8.21		
Enteral Feeding Supplement — Bolus	$13.01		
Enteral Feeding Supplement — Non-bolus	$14.58		
Transitional Supplement			
Care recipients who entered the service after 30 September 1997.		$2.25	$1.69
Care recipients who occupied a hostel place in the same service before 1 October 1997 and who were financially disadvantaged persons under the terms of the 10F General Conditions in operation at the time they entered that hostel		$5.06	$3.83
Care recipients who occupied an approved nursing home bed in the service before 1 October 1997.		$2.25	$1.69
Community Care Subsidy	$31.41		
Pensioner Supplement	$5.96		
Adjusted Subsidy Reduction	$9.90		

Viability Supplement — 40 point scheme

Score	Amount of Supplement
Eligibilty score of 100	$20.27
Eligibilty score of 90	$12.48
Eligibilty score of 80	$9.67
Eligibilty score of 70	$6.87
Eligibilty score of 60	$4.07
Eligibilty score of 50	$1.40
Eligibilty score of 40	$1.24

Viability Supplement — 60 point scheme

Degree of Isolation	Number of Places	Amount of Supplement
Isolated Remote Area*	1–15	$20.27
Isolated Remote Area*	16–29	$12.48
Isolated Remote Area*	30 or more	$1.24
Remote Centre*	1–15	$9.67
Remote Centre*	16–29	$6.87
Remote Centre*	30 or more	$1.24
Rural Outside Large Centre*	1–15	$4.07
Rural Outside Large Centre*	16–29	$1.24
Rural Outside Large Centre*	30 or more	$1.24
All Other Areas	Any	$1.24

* “Isolated Remote Area” refers to Statistical Local Areas classified as “Other Remote”, “Remote Centre” refers to Statistical Local Areas classified as “Remote Centre”, “Rural Outside Large Centre” refers to Statistical Local Areas classified as “Other Rural” or “Small Rural Centre” in the “Rural Remote and Metropolitan Area Classification, 1991 Census Edition.” AGPS 1994.

APPENDIX H:
RESIDENT FEES AND CHARGES

Schedule of Fees and Charges[1]

Fees and Charges are updated six-monthly (March and September) in line with changes to the pension. Some rates are also updated in July.

Description	Rate as at 20 Sept 2003
Maximum Basic Daily Care Fee	
Respite residents (pensioners and non-pensioners)	up to $26.47
Other residents who receive full or part means tested Australian pension#	up to $26.47
Other non-pensioner residents##	up to $33.05
Transitional residents [Residents receiving care in a hostel on 30 September 1997*] receiving full or part means tested Australian pension	up to $25.67
Non-pensioner transitional residents	up to $32.25
Maximum daily income tested fee	
Residents receiving a full means tested Australian pension	No fee
Single residents receiving part means tested Australian pension with a private income per annum of $32, 924	up to $20.47
Married residents receiving part means tested Australian pension with a private income per annum of $65,121	up to $20.47
Single non-pensioner residents with a private income per annum of $70,620	up to $46.36
Married non-pensioner residents with a private income per annum of $140,512	up to $46.36

The non-pensioner rate of basic daily care fee (above) may apply for residents whose accommodation bond is over $113,500

1 As at 20 September 2003

Accommodation Bonds and Charges	
Minimum amount of assets a person must be left with when calculating the maximum accommodation bond or charge	$28,500
Maximum daily accommodation charge may be levied for assisted residents with assets at entry of at least $45,500 and for other residents with assets at entry of	$53,886

Maximum rate of daily Accommodation Charge	
Concessional residents	No charge
Assisted residents	$6.96
Other residents	$13.91
Asset cut-off level	
Concessional*** resident status	$28,500
Assisted*** resident status	$45,500

Maximum permissible interest rate for Accommodation Payment agreements entered into	
Accommodation bond agreements entered into from 1 July 2003–30 Sept 2003	8.78%
Accommodation bond agreements entered into from 1 October 2003–31 December 2003	8.82%
Accommodation charge agreements entered into from 20 March 2003	5%
Pensioner Supplement from 1 July 2003	$5.96
Maximum basic rate of age pension	$436.10
Maximum basic rate of age pension + GST supplement	$452.80

This 'pensioner rate' also applies to blind pensioners & non-pensioner residents who have a dependent child

This 'non- pensioner rate' also applies for those 'pensioner' residents who agree to pay a bond of more than the above 'limit to accommodation bond size for pensioner supplement eligibility'

* These rates apply for 30 September 1997 hostel residents who have not moved into a former nursing home

** Otherwise, the accommodation charge may be the lesser of the maximum permitted rates and the amount calculated as the margin of assets over $28,500 divided by 5 years

*** See Residential Care Manual for concessional and assisted status additional criteria.