



**TWO YEAR REVIEW
OF
AGED CARE REFORMS**

INDUSTRY RESPONSE

Prepared by Aged and Community Services Australia for
the

National Aged Care Industry Council

Key Points

The Aged and Community Care industry wants to set the record straight on the current state of aged care in Australia and to ensure that outstanding issues are addressed. The report of the *Two Year Review of Aged Care Reforms* and the Government's self-congratulatory response, contain significant flaws, including:

Viability

- The report's claims concerning industry viability are based on false premises, five year old data and calculations of dubious validity.
- It cannot address the issue of whether the increase in funds provided over the past three years is sufficient to meet demand and cost increases because it contains *no meaningful analysis of costs*.
- Its assumptions about what comprises capital costs do not include all relevant costs, including the costs of meeting the Government's certification requirements. At most, only two-thirds of the real costs are included (\$65,000 out of \$98,000, building only no fit out or land costs).
- It assumes a Return on Investment based on historical data with no reference, or regard, to increased expenditure.
- In the absence of the real data, the review engaged consultants to conduct 'micro economic modelling' to shore up its conclusions on viability. This modelling does not withstand close scrutiny.

Access

- The Report makes no comment on the question of whether the supply of aged care services is *sufficient* to meet demand. It also glosses over the fact that there are no effective supply ratios in place for community care.
- The experience of older people and their families around Australia suggests strongly that access to services remains a key problem.

Quality

- The Report acknowledges that there are real question marks concerning the objectivity and consistency of Accreditation assessments.

Efficiency

- Residential aged care continues to be characterised by labour intensive administrative processes which divert scarce resources from the provision of care to the processing of 'red tape'.

State and Territory Programs

- The Report identifies some of the problems of poor coordination in this area which result in poor service.

Choice and Appropriateness

- The report does not identify the factors which have compromised the Government's 'Ageing in Place' policy.
- Continuing problems with the provision of care for people with dementia are acknowledged.

Conclusion: Older people in Australia deserve better!

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Introduction

The Federal Government's reform of Commonwealth-funded residential aged care services has been an ambitious undertaking, requiring a substantial effort, not only from the Government but also from the funded aged care industry. A formal assessment of the reforms titled *Two Year Review of Aged Care Reforms* prepared by Professor Len Gray was released by the Federal Government in early May 2001. The Government has issued a formal response to the report and it is appropriate that another major party to the reform process, the aged care industry, also puts its response on record¹.

The reforms required an enormous effort on the part of the residential aged care industry and the people who work in it. Many hundreds of thousands of dollars have been spent by providers on documentation, systems improvements, building improvements and staff training. A huge degree of commitment has been required of staff to ensure that the many-faceted reform process was implemented with as little disruption to the lives of residents as possible.

The Government's response is entirely self-congratulatory in tone and is concerned to emphasise those aspects of Professor Gray's report (the Report) which it believes show the current Government in a favourable light compared to its predecessor. The industry's perspective is different. It has no interest in comparing the past performance of political parties. Rather the industry is concerned that the record of the reform process is accurate, so that incorrect assertions about important issues are not left unchallenged, and that Governments, of whatever political persuasion, are committed to addressing the outstanding issues facing the care of older Australians.

Much has been achieved in the reforms but much remains to be done. It is of vital importance to the well-being of older Australians in need of care that the very real problems facing the provision of this care are recognised, and dealt with. Unfortunately, the Report glosses over some of these and in one critical area, industry viability, presents a picture so much at variance with the facts as to be dangerous.

The report's claims concerning industry viability are based on false premises and calculations of dubious validity. If they succeed in promoting a false sense of security on the part of Government, and the Government Response indicates that this has occurred, the consequences for the continuing provision of (particularly high) care for the steadily growing number of older Australians who need it will be severe.

In other areas, while many of the Report's conclusions are not disputed in their own terms, they do not fully identify the problems remaining to be addressed in the aged and community care industry.

The report has been described as an 'independent review' by many commentators and by the Government. While it was indeed conducted by an eminent person independent of Government, it relies on Government provided data and dubious, unreleased modelling to support many of its key findings. No independent research has been conducted, little consultation with key stakeholders occurred and very few sources of information other than Government reports have been considered.

¹ Consumers of aged care services and their family carers; and staff working in aged care are the other principal parties to the reform process. Their interests and concerns are vital to a full evaluation of the reform process and are dealt with in this industry response as they arise.

In reality then, the Government has supplied virtually all the data for an analysis of its own reform program². This is a very restricted definition of ‘independent’.

This response has been prepared by Aged and Community Services Australia (ACSA) with substantial input from ANHECA for the National Aged Care Industry Council (NACIC) which represents the providers of approximately 90% of aged residential services in Australia. NACIC comprises ACSA and the Australian Nursing Homes and Extended Care Association (ANHECA) and was formed in 1999 to progress industry wide issues of concern to both bodies.

This response addresses each of the chapter headings in the Report, beginning with the most problematic chapter on industry viability.

Industry Viability

The Report’s findings in this area strain credibility beyond the breaking point. The Report claims that “...*the analysis suggests that the industry is viable and able to achieve at least a 12% return on its investment, even if substantial re-building is required to meet building certification standards required to be met by 2008*” (p. xxvii).

To make sense of this claim, which is at such variance with other published data³ and with reports from throughout the industry, as to beggar belief, it is firstly necessary to understand exactly how it is constructed. There are four main components to the Report’s argument (p 143-4). These are: an examination of the recurrent funding available to the industry from both Government and residents; a similar treatment of capital funding; a ‘macro-economic analysis’ of secondary indicators of viability and a micro-economic analysis of factors influencing viability.

In terms of recurrent funding, the report concludes that there is now more money in the system, though it notes that this is mainly due to the fact that there are now more people receiving care at higher levels of dependency⁴. However the Report makes no attempt to address the issue of whether this increase is sufficient to meet demand and cost increases because it contains *no analysis of costs*.

The supposed “extra funding” has not been quantified in the report other than to state that it takes into account the effects of indexation, increases in the number of residents, increases in the frailty of residents and the introduction of the pensioner contribution. Analysis of these issues reveals the following:

- The COPO indexation has not kept pace with increased costs and wages. The report recognises the indexation problem at P 166 where it states that, “*Perhaps the most important factors affecting the rate of return are upward movements in wage rates in the high care sector, a change of workforce requirements in the low care sector and a widening gap between AWE and the SNA.*” In other words COPO has not kept pace with wage increases.
- In the period 1 July 1996 to 30 June 2000 approximately 3,500 additional residents received aged care. This equates to an annual figure of approximately **\$92 million** .

² In fact as Professor Gray makes clear on p 143 he has been forced to rely on such data since independent research was not provided for in the resources made available for his review.

³ Such as the 2000/2001 Bentley’s survey.

⁴ The report does cite an estimate made by the Department of Health and Aged Care that the new funding system has provided \$200 million more than the old system would have but no basis is provided for this assertion. It is not clear, for example whether any allowance has been made for the loss to the industry of approximately \$34 million pa, from the change from rent assistance (indexed by CPI) to the pensioner supplement (indexed by COPO a much lower index). In any event this is not the critical point.

- The increased frailty of residents has two implications. Firstly, the need for higher, more expensive levels of care – in 1996 3.7% of all residents received the highest level of care compared with 14.5% at June 2000, whilst in 1996, 32% of residents needed the lowest level of personal care compared with 2.3% at June 2000. The incremental cost of care is estimated to be approximately **\$700 million**. Secondly, there is the effect of ageing in place where residents in low care facilities can receive high care subsidies. At 30 June 2000 there were approximately 10,700 residents in low care facilities receiving high care subsidies and this equates to approximately **\$153 million**.
- The inclusion of the pensioner contribution in the total is a pea and thimble trick! The payment of rent assistance does not represent new income for providers it is simply a payment by the Government direct to providers rather than a payment by Government to providers via the resident. At 30 June 2000 this equated to approximately **\$230 million**. Rent assistance was paid by the Government to 91% of all residents.

In all, the “extra” cost to Government, over the period ending 30 June 2000 is approximately **\$1,300 million**. This ignores the true cost of inflation on the industry and accepts the actual indexation under COPO. It is therefore apparent that the current financial structure has not delivered an additional \$200 million. Indeed if the actual cost of services, cost increases, accreditation, occupational health & safety and building layout is considered there is a demonstrated shortfall of approximately \$355M as at June 2001.

Still on the issue of recurrent funding, the report quotes the RCS review as stating that the new instrument provides a 1% increase in funding for nursing home level and a 10% increase in funding for hostel level care. We have mentioned earlier the cost of ageing in place. What has been overlooked in the report is the Federal Budget “initiative” to recoup a net \$96 million through the RCS validation arrangements.

Furthermore, little has been said in the report about the providers’ loss of variable fees. Prior to the reforms, hostel providers were able to charge a higher daily fee in direct relation to the resident’s income. The reforms now require all residents of aged care facilities to undergo an income test and if the resident can pay more they are required to do so BUT **the Government subsidy is reduced by an identical amount**. This cost the industry approximately **\$80 million** and has saved the government a further **\$160 million**.

In the report Professor Gray states, “*Bonds can be paid by periodic payments and hence can produce income streams equivalent to those of variable fees.*” Prior to the Review hostels could charge Accommodation Bonds (Entry Contributions) and charge variable fees. With the loss of the variable fees to the Government, the industry is supposed to believe that the income stream will be unaltered? In any event, the Accommodation Bond is for capital expenditure not recurrent expenditure.

The report also states that hostels can now charge the equivalent of variable fees through an extra service arrangement. However, what the report fails to state is that all aged care facilities wishing to become extra service facilities must be approved by the Government. Also extra service and more lavish accommodation must be provided and an extra 25% must be charged to the resident because the Government reduces the subsidy by 25% of the extra service fee.

On capital funding, the Report notes that the system was facing a crisis prior to the reforms and asks whether the reforms have addressed these deficiencies (p152). It attempts to show that, in aggregate, there is now enough capital in the system to cover the estimated requirements of the industry (p153-4). This analysis is immediately vulnerable because some 35% of the funds alleged

to be available come from the ‘capital component of Commonwealth recurrent funding’ (Table 5.1 p153). Since, as we have seen, the Report has not considered the costs of recurrent service provision, it cannot assume that *any* funds are available for capital purposes from this source.

It is interesting to note that the supposed “capital component” of the subsidy was also available prior to the reforms and the variations from the pre reform to the post reform are:

- The introduction of the accommodation charge for nursing homes;
- The loss of capital grants for not-for profit facilities;
- The loss of the Additional recurrent funding for facilities ineligible to receive capital grants; and
- Increased expenditure required to meet the Government’s Certification and Accreditation arrangements.
- Non-recognition of increased statutory costs such as workers’ compensation premiums and payroll tax.

The Government has always stated that the subsidy is a “no component” subsidy and therefore one wonders where the “capital component” figure quoted and stated in Table 5.1 came from? Especially when there is no component of the subsidy for workers’ compensation premiums. It is, however, obvious that the Department needed a balancing figure and the best guess would be the former Return on Investment component of SAM.

However, this was not available as SAM was set based on 1984-85 figures indexed and therefore the Department has used the Adjusted Subsidy Reduction (the amount by which the subsidy for State government operated facilities is reduced). Based on the estimated high care beds, this can be proven as follows:

Details	1999	2000	2001
Estimated Beds	74450	75050	76650
Adjusted Subsidy Reduction	\$9.06	\$9.25	\$9.46
Days	365	366	365
Result (\$M)	246.199	254.082	264.665
Per Report (\$M)	246.20	254.10	264.80

Based on the figures quoted at P 159 of the report, the industry will need to spend approximately \$8.5 billion by 2008. Given that the income from accommodation bonds and charges can be estimated, as can the Commonwealth targeted grants, it is obvious that the “capital component of the subsidies” is merely a balancing figure!

From the Return on Investment included in SAM, Providers had to meet, the cost of depreciation on buildings, the cost of interest and, where the facility was under leasehold, the cost of rent. It is interesting to note that the so called “capital component” of the subsidy indicated in Table 5.1 is less than the depreciation on buildings indicated in Table 5.2

Table 5.1 also shows that twice as much income for capital purposes is derived from residents in low care facilities as it is from those in high care. This is consistent with the industry’s experience that capital availability is particularly problematic for high care⁵.

Table 5.2 indicates that:

- \$2,425.0 million will be spent on new aged care facilities;

⁵ Because this difference is due to the use of the bond system in low care, similar problems arise for low care in geographic areas where bond levels are low because of property values or low rates of home ownership.

- \$3,922.8 million will be for depreciation of buildings;
- \$1,030.8 million will be spent meeting Certification requirements; and
- \$500.0 million will be spent repaying existing debt.

The report provides no insight as to how the estimates for industry spending on new aged care facilities have been calculated. The report also provides no insight as to how the estimates for industry spending to meet Certification requirements have been calculated. The amount for depreciation of buildings is greater than the so-called “capital component” of the subsidy and the current debt of \$500 million is an obvious guess, all supposedly repaid in the first year!

Furthermore, the depreciation, after allowing for depreciation on new works and certification requirements, is also greater than the so-called “capital component” of the subsidy. Therefore, using the figures provided by the Government, the “capital component” of the subsidy, after allowing for depreciation (not to mention interest or rent) is negative.

Table 5.2 also indicates that the depreciation ranges between \$320.3 million in 1998-99 to \$484.8 million in 2007-08. Using the ATO taxation guide, this indicates that the capital value ranges from \$12,812 million to \$19,432 million over the same period. Assuming the total capital available in Table 5.2 equals the Return on Investment (and the industry disputes that fact) the return on capital for the same period ranges between 3.62% and 6.0%. A far cry from the supposed Benchmark return of 12%!!

Using the calculated capital value and assuming 142,000 places, the sale value per place in 1998-99 was in excess of \$90,000 and therefore greater than the cost that the Review indicates is the cost to build. Experience indicates that it is more expensive to build a facility than to buy an existing facility.

The Report does *appear* to partly address the question of costs in relation to capital. Its assumptions about what comprises capital costs do not, however, withstand a close examination. The Report relies on Rawlinson’s Construction Cost Guide for its key assumption that a new residential facility can be built for \$68,500 per bed. It does not trouble itself to inform the reader that this is a guide to building costs only, not the full capital costs of a new aged care bed. No allowance is made for the cost of land, demolition, balconies, covered ways, external services (eg power, telephone, water or sewerage connections), landscaping, equipment or other fitout⁶, professional fees (eg architects) or parking and no allowance is made for the cost of capital itself ie. interest. This cost data has also not been updated to include the new requirements for aged care buildings arising from the certification process⁷.

If some of the items not included in the Rawlinson’s figures are added back in, the cost of building an aged care bed (still excluding land, professional fees, furniture, fittings and equipment and specific requirements for different climatic regions) rises to \$98,035 (single storey) or \$108,286 (two storey) using capital city average costs⁸.

So far then, the Report’s analysis of industry viability contains no credible analysis of costs.

In the absence of real, current data on industry costs, the Report relies very heavily on secondary indicators of viability to support its conclusions in this area. The arguments used are very similar to those contained in the Federal Government’s own direct pronouncements on this issue. The

⁶ Including the very expensive fitting out of kitchens and laundries.

⁷ This has been confirmed with Rawlinsons. The work of UnitingCare NSW and ACT and UnitingCare Australia on this issue is gratefully acknowledged.

⁸ UnitingCare data. The Report uses data for Sydney, for comparison the comparable figures are \$105,010 (one storey) and \$115,990 (two storey). Melbourne and many regional centres have higher building costs than Sydney.

similarity is hardly surprising because the Report relies very heavily on data supplied by the Department of Health and Aged Care and an unreleased analysis of this data by consultants.

The Two Year Review conducted no independent assessment of the facts relating to this issue. In fact the Report notes (p143) that this would have been beyond the resources made available for the review by the Government and that such work may have been inconclusive. Given that a truly independent analysis would almost certainly have produced a very different picture to the rosy one contained in the Report, it may well have been difficult to reconcile the two!

In passing it may be noted that the Report's claim is that the industry *as a whole* has access to sufficient capital to meet its needs. While this claim is not true anyway, it may also be noted that it would only be *meaningful* if it were possible to transfer capital freely from low to high care providers and from one geographic area to another. In other words, if the aged residential care industry had only a small number of very large providers, willing to compensate for the shortcomings in Government policy in this way, there would be less of a problem in gaining access to capital.

This may make for interesting modelling but it is so far removed from the industry reality that it should have no place as a basis for Government policy setting⁹.

Macro-economic Indicators

In the absence of direct measurement of costs and income streams, the Report seeks support from what it refers to as 'Macro economic indicators' of industry viability. Essentially its argument is that while providers are still applying for new beds in the context of the annual funding rounds in a ratio of 10.45 applications for each place, the places must be worth something. Again though the finer print in the Report contains the seeds of its own critique. The Report notes (p157) that the interest in new places might be temporary, reflecting the imperative for providers to optimise the size of their operations in response to the new economic settings introduced by the reforms¹⁰.

The term 'place' also includes the very large number of Community Aged Care Packages allocated over the period. These really should be analysed separately since the economic drivers in the community care sector bear almost no comparison with those applying in residential aged care, particularly since it is principally capital (ie. building) costs which render the provision of high care in particular increasingly uneconomic. It is worth noting in this context that most of the demand evidence available relates to low care since until this year low care beds have comprised the great majority of new bed allocations.

It is also possible that some of the newer entrants to the aged care industry, whose core business is in the retirement living sector, may be prepared to accept a low or negative return on their Government-funded aged care because of the marketing edge it can give their core, retirement village business. On the basis of the information in the Report this remains speculative.

The report also considers the secondary market for aged care places but acknowledges that all of the arguments applying to the interest shown in funding rounds apply with equal force here.

⁹ It may also be noted here that the Report uses different assumptions about the costs of meeting 2008 Certification requirements when it is assessing the quantum of capital available (p154) and when it is micro-economic modelling (p 159). No explanation is offered for this.

¹⁰ ACSA's and ANHECA's members indicate that their principal reasons for applying for new beds are to do with achieving viable economies of scale. Meeting the needs of the community is also cited as an important factor.

The Report concludes this discussion by saying that "...at least two more [funding] rounds would need to be reviewed before this trend [to increased competition for places] is verified".

In short, the support available from this 'macro-economic analysis' for the Report's conclusions on viability is heavily qualified. It amounts to "Wait and see". This is an unsatisfactory conclusion both for the aged care industry, and, more importantly, for the people it serves.

Capital and Building

The Report also cites the high level of current building activity in the sector as evidence for its claims about viability. The fact that much of this building work is compulsory, to meet the new building standards introduced as part of the reforms, is acknowledged but the Report goes on to claim that providers would not undertake this work if they did not believe that they could fund it. The Report notes (p 158) that 'Providers, after all, always have the choice of leaving the industry'.

Well the facts are that a number of large providers are close to making exactly this decision¹¹. Now while this may be an even more difficult decision for charitable aged care providers than it is for for-profit ones¹², NACIC members are increasingly reporting that they are reaching the end of their capacity to finance new capital works. Reserves carefully built up over the years have been exhausted and while some financiers may be upbeat about the aged care industry (p 158)¹³, mainstream lenders are becoming much less confident. The Department has had many meetings with the major banks since the introduction of the reforms yet the Report is silent on that issue. In reality the major banks are loath to become further involved with aged care unless accommodation bonds are a part of the equation.

Many providers are simply forced to undertake works to avoid the loss of a major funding stream.

Micro-economic Modelling

In the absence of the real data, the review engaged consultants to conduct 'micro economic modelling' to shore up its conclusions on viability. This modelling however does not withstand close scrutiny¹⁴.

It is based on cost data from the mid 1990s, uses building costs that bear little relation to the actual costs of putting a new aged care facility into operation and its calculation of the Net Present Value of investment in aged care homes have proved impossible to replicate using real industry data and defensible accounting methodology.¹⁵ In fact calculations using actual data and correct approaches to calculating Net Present Value show that it is impossible to return a surplus at all, let alone 12%, on the construction and operation of new high care beds¹⁶.

The Report cites the 1995/96 *National Aged Care Survey Data* published by Bentley's as one of its sources for this section. This is really the only independent source of data in this whole analysis of

¹¹ A number of medium to large providers in both the charitable and for-profit sectors have indicated publicly that they will not invest further in particularly high care and may close existing facilities.

¹² In passing it may be noted that the charitable mission of not-for-profit providers reduces the risk to Government of its market-based approach to providing aged care because they may choose to continue an uneconomic service in order to fulfill their mission. In aged care this is becoming very difficult to sustain.

¹³ The Report actually only mentions one financial institution.

¹⁴ To date the Government has been reluctant to allow this analysis to be properly assessed. It has repeatedly refused to release this material prompting the question "Why not, if it really proves the case?"

¹⁵ NACIC has applied the claimed 12% rate of return to actual industry data on costs and in every case the NPV calculation showed a negative return, a loss in other words. The Government has repeatedly refused to reveal the analysis conducted to support the Report's conclusions prompting the question "Why not, if it really proves the case?"

¹⁶ Some better figures on actual industry viability are presented in Attachment 1.

industry viability. Since the Bentley's survey is conducted and published annually, the question is prompted as to why data from five to six years ago, before the reforms, is used in this Report to model outcomes when more current data is available. If the real 2000/2001 data from Bentley's had been used for example, a very different picture emerges. This shows a return of only 33 cents per resident per day in not-for-profit high care facilities and a loss of \$1.69 per person per day in a for-profit high care home¹⁷. Nothing like 12%.

The Report's claims that providers are able to make a 12% return on investment rests then on very shaky ground as shown above. In fairness, the Report itself contains many qualifications and places many caveats on its conclusions. It admits, for example, that if labour costs were to increase by more than the indexation rate, then return on investment would be eroded¹⁸. However it is the 'short version', the simple claim that aged care providers are able to make a 12% return, that is usually referred to by Government and others because it suits them to do so. The Government can, and to date has, used this assertion to justify turning a deaf ear to real industry concerns about the ongoing viability of residential aged care in this country. The Australian Nursing Federation has asked¹⁹ why aged care providers are not paying its members more and some Boards of aged care service providers have asked their CEOs why they are not seeing a 12% return when Professor Gray says they can.

NACIC members report that if they are able to make any surplus for future reinvestment at all, and many report that they cannot, it is nothing like 12%.

This is not an academic argument, unless recurrent funding levels are increased to match real wage costs²⁰, the viability, let alone the quality, of existing services will be under threat and the residential care industry will be unable to meet current and future demand for beds.

Access

On the issue of access to services, the Report is overly constrained by its Terms of Reference. These required it merely to ask whether access to aged care services had been affected by the reform process. The Report's slightly tentative conclusion: "...*access to care has improved, or at least been maintained, under the Aged Care Act 1997 and within the constraints of the existing planning framework.*" contains significant qualifications. Not surprisingly, these are not picked up in the Government's response.

The Report makes no comment on the more pertinent question of whether the supply of aged care services is *sufficient* to meet demand and whether, therefore, the existing planning framework is an appropriate supply benchmark. In fact it notes (p25) that "*The former planning and allocation arrangements have generally been maintained.*" and that the Government had not sought to change these through the reform process. The Report notes in passing (p30) that this would appear to make it difficult for the current Government to claim credit for simply following a formula established long before it took office.

¹⁷ This difference is due to the fact that the not-for-profit facilities in the Bentley's sample had lower actual costs of capital due to previous capital grants, bequests, donations etc. If the true value of this capital were captured by factoring in depreciation a negative figure would also apply to this sector.

¹⁸ This is, of course, exactly what has happened.

¹⁹ Possibly with its tongue firmly in its cheek.

²⁰ The Report itself notes that its analysis of viability is very sensitive to movements in wages costs (pp 163, 171). However it does not examine any real data relating to current actual wage movements, had it done so it may have reached a very different conclusion.

However there are two more important factors which should have been considered in this regard. The first is that the planning ratios (100 beds and community places per 1,000 persons aged 70 or more) were established to cap growth in the aged care program in the context of an ageing population. In fact, supply levels for high care have been *declining* towards these ratios for a number of years as Australia's older population has increased. This means that the adequacy of these ratios for high care are only now being tested against real levels of demand²¹. The Report's Table 1.2 (p 28) shows that supply levels for high care have declined consistently since 1985 while those for low care (and CACPs) have increased by a marginally larger amount, due largely to the CACPs.

The adequacy of these ratios for meeting the needs of older people needs to be, and has not been, assessed before any broader, and more meaningful, conclusions can be reached about the overall adequacy of supply. The report notes (p27) that occupancy levels for residential care have increased since the reforms, despite the increases in user charges. This is consistent with a situation of tightening supply.

Secondly, there are no effective supply ratios in place for community care since only the, relatively small (though growing) Community Aged Care Package program is covered by the existing ratios.

In the area of community care the Report's conclusions are in fact compromised beyond redemption because it did not consider access to community care services not provided under the *Aged Care Act*.

The fact that the supply of Community Aged Care Packages has increased exponentially under the current Government is presented independently of some important contextual facts. This growth, in a relatively new program, occurred on a very low base and during the same period the (much more significant) supply of community care services under the *Home and Community Care Act* declined on a per capita basis.²²

The key measure of whether supply levels are sufficient to provide adequate access to services must be found in an assessment of how difficult it is for people in need to obtain the services they require. While changes to reporting methods have drawn a dense smokescreen in front of the facts²³, the data Professor Gray does cite (p34) shows a persistent increase in waiting times for both high and low residential care. There is no published data on waiting periods for community care. However ACSA is aware from its extensive membership base that waiting times for CACPs are often longer than those for residential places and that the supply of HACC services is rationed severely.²⁴

Access to services by people with special needs has not changed a great deal as a result of the reforms and may even have improved slightly in the case of Aboriginal and Torres Strait Islander people and people from non English-speaking backgrounds. It should be noted that services that specialise in this way are much less able than 'mainstream' services to optimise their mix of

²¹ The evidence increasingly suggests that they are not adequate. The inability of public hospitals to find nursing home places for patients on discharge and the lengthening waiting times for high care (see the Report p34) both point to inadequate levels of supply.

²² The Productivity Commission in its *Report on Government Service Provision 2001* notes that per capita monthly expenditure by Government on HACC services declined from \$254 to \$224 between 1993/94 and 1999/2000. This occurred principally as a result of a measure in the 1996 Federal Budget to introduce a more uniform, and higher, level of user charges. The *assumed* revenue from this source was taken out of the appropriation for the following four years ie. until 2000.

²³ Or, as Professor Gray refers to it "...the weakness of current information systems to provide useful information to assess the adequacy of residential care places" p34 In some States ACAT approvals are not given until a place is available, this has the effect of understating the real level of unmet demand for both residential and community care.

²⁴ The most common form of rationing of HACC services is to reduce the number of hours of assistance provided per person, ie to spread the services more thinly.

residents from a financial viewpoint. Since the new funding system requires providers to do this, it is inevitable that some people will find it harder to access services or that some providers will be disadvantaged. The report does not identify this darker side of the Government's market-based reform program.

Access for people in unstable housing has probably become even more difficult under the new funding regime, the concessional resident arrangements are not sufficient for this group and the defunding of the lowest level of the previous hostel care (the new RCS 8) has not helped either.

The Report recommends (p35) that the indicators of demand for residential and community care be reviewed. The Government has accepted this recommendation (p5 of its Response) but such a review needs to go beyond looking at the balance between high and low care, as suggested, and deal with the real issue of whether levels of supply are adequate. The experience of older people and their families around Australia suggests strongly that they are not.

Affordability

One of the principal thrusts of the Reform process was to increase the extent to which the costs of residential care are borne by residents. The question of affordability is therefore a very important one. The Report concludes that user contributions have increased (p.xxiv) but that they remain affordable for high care, the area most affected by the Reforms. (p xv). This is consistent with the Report's findings on access and occupancy rates and with an argument that shortages of supply have negated any disincentive created by increased resident contributions.

Quality

The Report notes, correctly, that there is "*general industry endorsement of the philosophical basis of the quality assurance system introduced under the reforms*" (p xxv). As a generalisation, this is true but there are also many issues which remain outstanding if ongoing quality of care is to be maintained.

The report starts this section with an assessment of the impact of the new requirements for aged care buildings. There is no doubt that an enormous effort has been put in by the industry to meeting the new requirements and that, as a result, building standards have significantly improved. Whether this effort is sustainable given the, at best, marginal viability provided by current levels of recurrent funding remains a key concern.

The Accreditation system, introduced to improve the quality of care, is currently under review by the Government, a process which has not concluded at the time of writing. The evidence to date from other sources is rather mixed. A recent study in NSW for example,²⁵ confirmed industry support for the concept of Accreditation but identified a number of significant flaws in the process as it was actually applied. These include: the publication of inaccurate and out-of-date information on the Accreditation Agency's (the Agency) web site; poor quality documentation provided by the Agency; significant inconsistency of approach between assessors; very negative impacts on staff and residents' morale; and the apparently arbitrary nature of decisions to modify initial assessments on the basis of further information. While some providers did report a positive experience, there is clearly ample room for 'continuous improvement' on the part of the Agency as well as by the industry.

²⁵ Conducted by independent consultants for the Aged Services Association of NSW and the ACT, now Aged and Community Services NSW &ACT. Only a selection of the problems identified in this study are mentioned here.

As the Report highlights in its recommendation in this area (p 93), there are real question marks concerning the objectivity and consistency of Accreditation assessments. In addition there is concern that quality improvement strategies and compliance measures have been confused throughout the system. The mix of supportive and punitive measures stems in part from the Aged Care Act which gives the Department the power to direct the Accreditation Agency to conduct review audits and requires matters raised with the Complaints Resolution Service to be referred to the agency if they appear to relate to system failure in a residential home. Accreditation systems work best when there is genuine ownership of the processes and outcomes by key stakeholders and the current model, in which the Accreditation Agency's Board is simply appointed by the Minister does not achieve this.

Matters are complicated by the fact that politicians, from both major parties, do not wish to be seen as being 'soft' on abuses in the aged care system. The use of surprise spot checks of facilities is a policy that enjoys bi-partisan support. NACIC too is committed to the provision of high quality care but the increasing reliance on the 'stick' rather than the 'carrot' is unlikely to do much to improve quality of care across the whole system.

A sufficient supply of staff with an appropriate mix of skills is an essential pre-requisite to the ongoing provision of quality care. As the Report notes (p 97) there is currently major concern over the inability of the aged care industry to recruit and retain particularly²⁶ registered nursing staff. While it is correct to note that there is a national shortage of nurses, this is not helped in the case of aged care by the fact that wage levels in this sector are up to 20% lower than in public hospitals²⁷. The Government's current subsidy levels need to be increased to allow parity with public sector wages.

The Government's refusal to fund wages parity, coupled with the fact that many new registered nurses face hefty HECS bills, ensures that the industry is unattractive to younger registered nurses. The average age of nurses in aged care is in excess of 50. These loyal staff members are left to do the mundane and heavy nursing duties and this exacerbates an already burdensome workers' compensation problem.

Recruitment and retention are not helped either by the fact that much of the time of skilled staff is required to be spent on paperwork (see Efficiency), by the number of highly publicised instances of care failure, or by the often heavy-handed approach of the regulators – principally the Department but also, increasingly the Agency – which creates a climate of fear and stress rather than one of 'continuous improvement'.

The complaints process has also been revamped as part of the reform process with, as the Report acknowledges (p109), a mixed response. One of the critical issues which has still, nearly four years after the new Aged Care Act was passed, not been properly addressed is the provision of clear, easy to follow information about how the system is supposed to work. No flow chart of the possible paths a complaint might take has been drawn up and providers have no clear statement of their rights in the complaints process. Providers are often given the impression they are "Guilty until proven innocent" in the current complaints process.

Effective client feedback including a complaints channel is an important part of a quality management regime. However a process which tends to deny natural justice, to any party, is fundamentally flawed and is likely to prove ineffective in the long run because it will not be respected.

²⁶ Particularly, but not exclusively, registered nursing staff. There is also concern about the attractiveness of the industry in pay and conditions for other categories of staff.

²⁷ The wages differential is different in each State, as is the composition of the aged care workforce.

Efficiency

The Report is a little equivocal on the question of how the Reforms have affected efficiency. It concludes that savings to Government as a result of the increased emphasis on user-pays have been less than initially anticipated; that paper work requirements may have increased and recommends that the complexity of admissions procedures be streamlined. In NACIC's view there is scope for the whole administrative regime associated with residential aged care to be subjected to a rigorous process of review.

The Report concludes that the volume of administrative 'paperwork' has only changed a little as a result of the reforms. It should be noted though that the table summarising the changes contains more increased requirements than diminished ones (pp138-141)²⁸.

The more significant point is the fact that residential aged care is characterised by labour intensive administrative processes which divert scarce resources from the provision of care to the processing of 'red tape'²⁹. Things may have been as bad, or nearly as bad, prior to the reforms but that is hardly the relevant point. NACIC members report that up to 30% of nursing time can be spent on paperwork, and this in a context where the recruitment and retention of nursing staff is a particularly pressing issue. While attention is now being given to the overlap between the accreditation and certification processes, a factor not commented on in the 'Efficiency' chapter in the Report, the one thing that cannot be said of the aged care reforms is that they have resulted in a deregulated aged care industry.

A particular area of concern is the process of validating subsidy levels known as 'RCS Validation'. The Report notes the very high level of changes (49.9%) made by the Department's assessors to the initial ratings given by the staff actually providing the care but concludes, cautiously, that it is a new system, that the 'error' rate is inflated by the fact that validation is targeted not random, and that: "Therefore, it is not possible to comment with any confidence on the current error rate across the industry at large, except to suggest that it is likely to be lower than 50%, perhaps substantially" (p 131). The Report recommends that the Department extend its review program to gain a more accurate picture, a recommendation taken up by Government in the 2001/02 budget which provided for an increased degree of scrutiny of claims and a resultant additional clawback of funds from the industry of \$71 million³⁰ over four years.

In NACIC's view there is something fundamentally wrong with a system which, after three years of implementation, still has close to a fifty per cent 'error' rate. It is also a system which, in practice, diverts a huge amount of nursing time from care provision to paperwork further reducing the attractiveness of the aged care industry as a career for nursing staff.

In NACIC's view, urgent attention needs to be paid to streamlining the administrative systems used in residential aged care. This is not to argue that providers should not be accountable for the quality of their care (or facilities) or for the expenditure of public funds. Rather it is a plea for a rigorous assessment of the value added by each of the current processes and a consideration of whether there may be more effective and efficient means of achieving these ends.

²⁸ Of the 20 processes listed, 10 were described as new or requiring additional work, 1 as "reduced Complexity" and 9 as "similar". The workload associated with accreditation and certification is referred to in this table but not discussed at any length in the chapter, a major omission given the workload and cost associated with these tasks.

²⁹ Moreover much of this 'red tape' seems to be aimed more at protecting the Minister and the bureaucracy from criticism rather than ensuring the provision of high quality, client-centred care.

³⁰ Net of the costs of the increased scrutiny

A guiding principle in this should be a return to one of the fundamental underpinnings of the whole reform enterprise, one which now seems to be largely forgotten, that quality of service needs to be incorporated into a provider's culture rather than being externally imposed. It is this thinking that lies behind the Accreditation system but there remains a lot of work to be done for this to realise its full potential.

Sate and Territory Programs

The Report's recommendations in this area – that the Commonwealth and the States and Territories work together to critically analyse the supply of, and linkages between, the services for which they are responsible to “...ensure client-focussed transitions...between Commonwealth and State programs” - appropriately reflect the very untidy set of ad hoc arrangements which are currently in place. The poor state of data in this area is referred to and indeed is reproduced in the Report in its analysis of the issue of Access (where services not funded under the Commonwealth Aged Care Act are not considered qv).

Linkages between the Commonwealth funded aged care and primary health care systems and State or Territory managed programs including health, housing and disability services have been recognised as a major issue impeding the delivery of effective, efficient and client centred care for a long time. The report canvasses only a sub set of these. Together they represent something of an indictment of Australia's federal political system in which cost and blame shifting appear more common than genuine attempts at solutions. The most common example of this is the unedifying spectacle of Commonwealth Ministers berating State Ministers for the closure of hospital beds and State Ministers complaining about the lack of aged care beds for older people on discharge from hospital. The fact is that people in residential care are quite old and frail and are likely to need other medical services and older people make up over half of all patients in public hospitals. Developing a comprehensive system of care which recognises this reality is overdue in Australia.

For any new attempt to succeed in this area, a considerable degree of political will would be required.

The involvement of the aged and community care industry in such a process is also essential.

Choice and Appropriateness

One of the major objectives of the reforms was to remove a number of the artificial barriers that existed within the Commonwealth aged care program particularly those between the former hostels and nursing homes. The concept of 'Ageing in Place' was central to the reforms and has been partly successful. The report does not identify some of the current problems which inhibit its full operation though, such as the Government's back flip on the introduction of accommodation bonds for high care³¹; the 'belt and braces' approach which requires an ACAT assessment for people moving from low to high care' (ie in addition to the RCS auditing process)³² or the fact that the reforms effectively removed the only solution to the issue of low care residents with short term needs for higher levels of assistance.³³

³¹ Arguably the single greatest cause of the current capital crisis in high care.

³² Not mentioned under 'Efficiency' either.

³³ Before ageing in place, hostel residents were theoretically eligible for HACC-funded District Nursing services (theoretically because of the perennial excess of demand over supply). After the reforms this access is no longer possible even theoretically.

Other Issues

This section of the Report mainly concerns itself with the issue of care for people with dementia. Access to services for people suffering from dementia is acknowledged in the Report as still being problematic and it recommends that “...*further investigation be undertaken...*”. This continuing deficiency is consistent with the industry’s experience.

One of the specific issues is directly related to the issue of whether the reforms have made things better or worse. This is the provision of dementia specific accommodation and care. The construction of homes specifically designed for people with dementia was a big step forward in Australian aged care in the 1980s and 90s. The fact that these were hostels meant that the high capital costs could be met to a significant degree from user contributions. The higher costs of care however could not be met from the hostel level subsidy.

The reforms promised to address this conundrum but have only succeeded in reproducing it, particularly after the Government changed its approach to the capital funding of high care in November 1997. Providers are still faced with a dilemma in that low care residents can bring with them (more or less) adequate capital funding and high care residents attract (more or less) adequate recurrent funding for care. High quality dementia care requires both. This continuing set of perverse incentives must be seen as a clear failure of the reforms with particularly damaging consequences in the area of dementia care.³⁴

Conclusion

The Report concludes that the aged care reforms have delivered substantial improvements to the aged care system (p225). It adds that the required fine-tuning to address unanticipated anomalies has been largely successful. The real problem with these conclusions is that they leave the reader with a view that the reforms have fixed all the significant problems in aged care and that all of the measures introduced since 1997 are working smoothly and effectively.

As this Industry Response has shown, nothing could be further from the truth.

The aged care industry is fast reaching a crisis point in terms of its ongoing viability. It is unable to gain access to the capital required to make necessary building improvements or to finance the new beds needed. The industry is drowning in an increasing volume of red tape and is facing increasing difficulty in recruiting the staff it needs to provide quality care. Some of the goals of the reforms appear to have been lost sight of in the face of day-to-day political and budgetary pressures and compliance is routinely confused with ongoing quality improvement.

Older people still suffer the consequences of poor coordination between the health and aged care systems. They still experience significant problems in gaining access to the services they need. They still suffer from failures in the quality of care.

Older people in Australia deserve better. Resting on its laurels is not a viable option for any Federal Government. That should be the real conclusion of the Two Year Review of Aged Care Reforms and the basis for a genuine Government response.

³⁴ This problem is not unique to dementia care, merely sharper in the context of higher care *and* building costs.

APPENDIX 1

REAL WORLD AGED CARE ECONOMICS

Example 1

This example looks at the economics of constructing and operating a new high care facility in metropolitan Melbourne. The figures for building and operating costs are representative of typical private sector (for profit) operations. They are low compared with *average* industry costs since the not-for-profit sector, which accounts for nearly two-thirds of all beds, tends to build to a higher specification (more like the high end of the cost range shown) and operate 'richer' staffing models.

1) CONSTRUCTION COSTS

Cost per bed	Low end of range	High end of range
Building	\$60,000	\$80,000
Fitout	\$10,000	\$15,000
Land	\$15,000	\$25,000
Total Cost per Bed	\$85,000	\$120,000
Interest cost per bed day @9% ³⁵	\$20.96	\$29.59
Depreciation cost per bed day (2.5% on building, 15% on fit out)	\$8.22	\$11.64

2) OPERATING SURPLUS/DEFICIT

	Per Bed day
Fees and Resident Contributions (Victorian average RCS mix)	\$129
Income	\$129
Wages	\$98
Non wage costs	\$19
Direct Expenses	\$117
Surplus before interest and depreciation	\$12

3) VIABILITY OF BUILDING A NEW HIGH CARE HOME

	Low end of range	High end of range
Concessional funding/Accommodation Charge ³⁶	\$12	\$12
Surplus before interest and depreciation	\$12	\$12
Interest	-\$20.96	-\$29.59
Depreciation	-\$8.22	-\$11.64
Surplus/Deficit	-\$5.18	-\$17.23
Annualised for 60 bed high care home	-\$113,400	-\$377,400

It should be noted that these figures are for a high care home with no access to income from bonds. In the example above, if bond income (interest and retention amount) is included, as it would be in a low care facility, then the home can make a surplus after interest and depreciation. The amount of this surplus depends on the amount of the bond but at \$80,000 an additional \$14.81 income per bed day is received, assuming the same 9% interest rate³⁷

³⁵ It could be argued that lower rates *may* be possible currently. However this is real data not a model. Reducing the interest rate to 5% (hard to achieve for a commercial loan) would only make the lower range costs marginally positive.

³⁶ This amount would be shown in some accounts on the operating side, though it is a capital-related payment. This makes no difference to the bottom line outcome.

³⁷ It will be noted that, if interest rates are lower for borrowing, they will also be lower in terms of income generation.

Example 2

The second example is taken from analysis conducted by a large charitable sector provider evaluating the prospect of acquiring a 100 bed residential care home. This provider investigated a number of scenarios, based on purchasing an existing facility. This analysis was not carried out for the purposes of this response, the provider concerned was evaluating real world business options.

The calculations are too detailed to reproduce in full here but a sample to show how they were done is shown below:

	Year -1 2001/02	Year 1 2002/03	Year 2 2003/04	ETC Projected over 30 year timeframe to 2032/33
Cash Inflows				
Entry Contributions		\$3,116,750	\$2,118,767	Projected over 30 year timeframe to 2032/33
Accommodation Charge		\$157,516	\$162,241	Projected over 30 year timeframe to 2032/33
Subsidy (State Average)		\$3,423,445	\$3,526,148	Projected over 30 year timeframe to 2032/33
Subsidy -Concessional		\$80,483	\$82,897	Projected over 30 year timeframe to 2032/33
Fees and Pension Supp.		\$1,048,645	\$1,080,104	Projected over 30 year timeframe to 2032/33
Total Cash Inflows		\$7,826,839	\$6,970,157	Projected over 30 year timeframe to 2032/33
Cash Outflows				
Repay Contributions			\$1,963,500	Projected over 30 year timeframe to 2032/33
Operating Expenses		\$4,837,548	\$4,982,675	Projected over 30 year timeframe to 2032/33
Capital Upgrade				Projected over 30 year timeframe to 2032/33
Bed Licence	\$3,500,000			Projected over 30 year timeframe to 2032/33
Land Cost	\$3,133,333			Projected over 30 year timeframe to 2032/33
Building value	\$8,297,674			Projected over 30 year timeframe to 2032/33
Demolition Costs				Projected over 30 year timeframe to 2032/33
Total Cash Outflows	\$14,931,007	\$4,837,548	\$6,946,175	Projected over 30 year timeframe to 2032/33
Total Cash Inflow/Outflow	-\$14,931,007	\$2,989,291	\$23,982	Projected over 30 year timeframe to 2032/33
Cumulative Cash Flow	-\$14,931,007	-\$11,941,716	-\$11,917,734	Projected over 30 year timeframe to 2032/33
MISF Investment Balance	-\$14,931,007	-\$11,533,264	-\$11,193,777	Projected over 30 year timeframe to 2032/33
MISF Earnings		\$408,454	\$315,505	Projected over 30 year timeframe to 2032/33

The analysis considers a range of scenarios from a worst case³⁸, to a best case,³⁹ considers the rate of return on each and performs a Net Present Value calculation at a number of levels. The 'Example Shown' column is the result of the extrapolation of the figures shown on the previous page.

	Lowest	Highest	Example Shown
Net Present Value@5%	-\$14,804,840	-\$822,780	-\$10,799,040
Net Present Value@8%	-\$15,264,070	-\$5,168,990	-\$11,559,340
Net Present Value@10%	-\$15,355,490	-\$6,847,180	-\$11,828,650
Net Present Value@12%	-\$15,373,920	-\$7,988,100	-\$12,003,330
MISF (Rate of return/30 yrs)	-3.6%	4.60%	-2.7%

³⁸ In which no income is received from entry contributions (ie a purely low care facility), the licences have no residual value (not a silly assumption on these figures) and no surplus is made on recurrent operations;

³⁹ In which there is a mix of Accommodation Bonds and charges, the licences still have a residual value and recurrent operations break even.

Example 3

The following case studies are all real examples too:

Case 1 – 65 Bed Nursing Home - Metropolitan		
	1999/2000	Year to date May 2001
Operating Income	\$2,952,592	\$2,715,767
Operating Expenses	\$3,045,890	\$2,785,938
Operating Surplus/(Loss)	(\$93,298)	(\$70,171)
Add back depreciation	\$132,057	\$137,500
Sub Total	\$38,759	\$67,329
Plus Capital Income	\$51,086	\$82,535
Profit/(Loss) before Depreciation	\$89,845	\$149,864
Value of Facility	\$4,269,085	\$4,269,085
Return on Investment	2.10%	3.51%

Case 2 – 36 Bed Special Purpose Nursing Home - Metropolitan		
	1999/2000	Year to date May 2001
Operating Income	\$1,697,304	\$1,174,397
Operating Expenses	\$1,868,143	\$1,100,735
Operating Surplus/(Loss)	(\$170,839)	\$73,662
Donations and Interest	\$70,368	
Profit/(Loss) before Depreciation & Interest	(\$100,471)	\$73,662
Value of Facility	\$2,160,000	\$2,160,000
Return on Investment	(4.65%)	3.41%

Case 3 - 30 Bed Nursing Home – Large Country Town		
	1999/2000	Year to date May 2001
Operating Income	\$1,435,320	\$1,340,118
Operating Expenses	\$1,603,010	\$1,375,045
Operating Surplus/(Loss)	(\$167,690)	(\$34,927)
Non Operating Income	\$36,560	\$7,148
Capital Income	\$43,497	
Sub Total	(\$87,633)	(\$27,779)
Add back depreciation	\$41,500	\$38,500
Profit/(Loss) before depreciation, interest	(\$46,133)	\$10,721
Value of Facility	\$833,620	\$833,620
Return on Investment	(5.53%)	1.29%

Case 4 – 24 Bed Hostel – Large Country Town		
	1999/2000	Year to date May 2001
Operating Income	\$669,758	\$647,550
Operating Expenses	\$695,721	\$796,946
Operating Surplus/(Loss)	(\$25,963)	(\$149,396)
Non Operating Income	\$11,265	\$18,101
Sub Total	(\$14,698)	(\$131,295)
Add Bank Interest	\$1,312	\$20,593
Add back depreciation	\$62,844	\$53,167
Profit/(loss) before depreciation, interest	\$49,458	(\$57,535)
Value of Facility	\$2,766,864	\$2,766,864
Return on Investment	1.79%	2.08%

Case 5 – 36 Bed Nursing Home – Small Country Town		
	1999/2000	Year to Date May 2001
Operating Income	\$1,467,940	\$1,304,255
Operating Expenses	\$1,540,440	\$1,347,792
Operating Surplus/(Loss)	(\$72,500)	(\$43,537)
Add Capital Income	\$66,055	\$65,096
Add Non Operating Income	\$4,767	\$4,246
Less Non Operating Expenses	\$251	\$210
Profit/(Loss) before depreciation, interest	(\$1,678)	\$25,595
Value of facility	\$949,531	\$951,759
Return on Investment	(0.18%)	2.68%

Case 6 – 32 Bed Hostel – Small Country Town		
	1999/2000	Year to Date April 2001
Operating Income	\$551,298	\$496,682
Operating Expenses	\$548,057	\$505,774
Operating Surplus/(Loss)	\$3,241	(\$9,092)
Add Capital Income	\$62,143	\$53,635
Add Non Operating Income	\$6,034	\$8,073
Sub Total	\$71,418	\$53,246
Less Non Operating Expenses	\$3,363	\$2,603
Profit/(Loss) before depreciation, interest	\$68,055	\$50,643
Value of facility	\$1,603,373	\$1,603,373
Return on Investment	4.24%	3.16%

AGED CARE FACTS AND FIGURES

An Ageing Australia

- In 1998 there were 2.3 million older people (aged 65+) in Australia, representing 12% of the total Australian population. In 2030 older people will represent 19% of the total population (or 5 million people) and by 2051 they will represent one quarter of our population.
- The increase in the older old, those over 85 is even more marked rising from 9.1% of those aged 65 years and over in 1996 to 20.1% by 2051.
- Older people are predominantly women. 51% of people aged 65 – 69 are women rising to 66% of people aged over 80 years.
- Today, older people from diverse linguistic and cultural backgrounds comprise nearly 1 in 4 older people in Australia.
- Only 3 % of indigenous people are aged 65 years or over due to the lower life expectancy for aboriginal Australians.
- The average age of people living in residential care homes is 83 years.⁴⁰
- The average length of stay in residential care is approximately 32 months for high care and 23 months for low care.⁴¹

Aged Care Services

There are a range of residential and community based care options available to support older people who require assistance. Residential care is operated under a uniform management system by the Federal Government. Community Care operates under a confusing system involving a plethora of individual programs and Federal and State government involvement.

Key services are:

- Assessment
- Residential Care
- Case Management & Purchasing Programs - Community Options Program (COP); Community Aged Care Packages (CACP); Extended Aged Care at Home (EACH) pilots
- Home and Community Care (HACC)
- Carers Programs (various)
- Day Therapy Centres

A brief description of each of these services is at Appendix 3.

- Services are provided by charitable, not for profit organisations, local government, private (for profit) organisations and in some instances directly by State Governments.

⁴⁰ Australian Institute of Health and Welfare analysis of Department of Health & Aged Care supplied data.

⁴¹ Australian Institute of Health and Welfare analysis of Department of Health & Aged Care supplied data.

- ❑ Services for older people are provided in response to their frailty or disability rather than as an age related entitlement.
- ❑ Some of these services are also used to support younger people with a disability.

Service Models

- In rural and remote areas integrated health and community care service models known as Multi Purpose Services (MPS) have been established. These models bring together hospital, residential care and community care services and resources to flexibly meet consumer needs.
- The Department of Veterans Affairs (DVA) introduced the Veterans Home Care Program in January 2001. This program is estimated to provide assistance to 50,000 veterans and war widows/widowers at a cost of \$147 million in a full year. DVA also purchases/provides a range of other supports including community nursing, in-home and residential respite care, allied health services, home modifications and transport for health care.

Other Related Supports and Services

- Older people access a range of other services, which link into the specific aged care services provided. For example after hospitalisation an older person may access Post Acute Care supports, such as Hospital in the Home, rehabilitation services, disability services, community health and palliative care.
- The social security system provides a range of age related (means tested) financial assistance payments.
- Even with the formal services that exist, informal care networks such as family, friends and neighbours provide the majority of assistance received by older people in the community. 83% of households with a person aged 65 years and over reported receiving assistance from informal networks in the 1998 ABS Survey of Disability, Ageing and Carers.

The Aged Care Industry

- Financially aged care is a significant expenditure outlay for the Australian community :
 - Government \$4.7 billion in 1999/2000
 - Co-payments from consumers contribute to the costs of residential care. In 1999/2000 \$95.8 million was provided through this source.
- Community care services also charge, usually minimal, fees to clients.
- While it can't be quantified precisely service providers also contribute financially to aged care services, either through financial or in kind provisions.
- The industry is a major employer. In residential care alone there are over 100,000 people employed. Around three-quarters of paid aged care employees work part time and 90% are female.
- In smaller rural communities aged care is often a major employer.
- Community based aged care employs people with a similar profile to that of residential care.
- Volunteers are also active in all forms of aged and community care service provision particularly in the charitable sector.

SPECIFIC PROGRAMS AND SERVICES TO SUPPORT OLDER AUSTRALIANS

The expenditure figures shown are based on the 1999/2000 financial year, which is the most recent full year figure available. There have been increases in funding particularly in residential care and Community Aged Care Packages, which have had 2 allocation rounds this financial year.

Assessment

1999/2000 Expenditure - \$37 million (Federal)

A network of 125 regionally based multidisciplinary Aged Care Assessment Teams (ACATs) provide assessment services throughout Australia. An older person has to be assessed by an ACAT to be eligible to enter a residential care home or to receive a Community Aged Care package (CACP). ACAT's may also refer people to community based services.

Most often community care providers undertake their own assessment of an older person who wishes to access their service.

Residential Care

1999/2000 Expenditure - \$3.6 billion (Federal)

Residential Care homes (previously called hostels and nursing homes) cater for people with both high and low care needs who can no longer manage to live in their own homes. There are just **under 3000 residential aged care homes** in Australia. The majority (64%) of residential care bed days are provided by charitable, not for profit organisations. Private (for profit) organisations provide 24% and the remainder is provided by state governments.

Aged care beds and CACP's are allocated on a population basis of 100 (40 high care/50 low care/10 CACP's) places per 1,000 people aged 70 years and over.

Funding is provided for each individual resident on a need based model called the Resident Classification System (RCS). Generally, the higher the level of care required the higher the funding for that individual.

Residents pay fees, which contribute to the ongoing, and capital, costs of residential care.

Community Aged Care Packages (CACP)

1999/2000 Expenditure - \$150 million (Federal)

People who require care equivalent to low level residential care can remain at home with a CACP. The service provides a case manager and funding to purchase the right levels and mix of community services that will support the person at home.

There is also a pilot program – Extended Aged Care At Home (EACH) – trialing this type of service for high level equivalent care. This is currently being reviewed and could potentially be extended.

Community Care Programs, including Home and Community Care, Community Options, Carers Programs.

1999/2000 Expenditure - \$908 million (Federal/State)

Home & Community Care provides a range of community based support services to frail older people, younger people with disabilities and their carers. It is the main Program for the delivery of community care.

It provides assistance with domestic chores, personal care, nursing, meals, transport, respite care and social activity programs. In 1999 there were 4000 organisations providing services to 240,000 clients.

HACC includes the *Community Options Program (COP)* which is similar to CACP for those people who are not eligible for residential care but still require significant levels of support to be able to remain living successfully at home.

Carers Program

The Federal Government, and many State Governments, have created a range of assistance specifically to support the needs of carers of older people and younger people with disabilities. Support is predominantly provided through Carer Respite Centres and Carer Resource Centres that provide information, advice and assistance to access respite care services.

Day Therapy Centres

1998/99 Expenditure (most recently available separated figure) \$27.3 million

Day Therapy Centres offer a range of therapy services, such as physiotherapy, occupational therapy and podiatry. Most centres are located at residential care homes and provide services to residents and frail older people living in their own homes.

DEPARTMENT OF VETERANS AFFAIRS (DVA) HOME CARE PROGRAM
Estimated full year expenditure of \$147 million

In January 2001 the DVA introduced the Veterans Home Care Program. It is estimated that the Program will provide services to 50,000 veteran and war widows/widowers at a cost of \$147 million in a full year. The Program purchases a range of services to enable veterans and war widows/widowers to remain living in their own home. New services available under the Program include domestic assistance, personal care, home and garden maintenance and respite care.

This extends the range of care services already purchased/provided by DVA which includes community nursing, in-home and residential respite care, allied health services, home modifications and transport for health care.

BIBLIOGRAPHY

Aged Services Association of NSW and ACT *Lessons Learned from Accreditation*
(Unpublished submission to Government 2001)

Bentleys MRI *1999/2000 National Aged Care Survey Results*
(Bentleys MRI 2001)

Commonwealth of Australia *Report on Government Services 2001*
(Productivity Commission 2001)

Commonwealth of Australia *Two Year Review of Aged Care Reforms*
(Department of Health and Aged Care 2001)

Commonwealth of Australia *Two Year Review of Aged Care Reforms Government Response*
(Department of Health and Aged Care 2001)

Department of Health and Aged Care *2001 Budget At a Glance*
(Department of Health and Aged Care 2001)

Rawlinsons *Australian Construction Handbook* (Rawlinsons 2001)

UnitingCare NSW and ACT *Construction Cost Analysis of Residential Aged Care Services*
(Unpublished 2001)