Caring for Older Australians

Submission to Productivity Commission

30 July 2010

Key issues and recommendations

Issue	Recommendations
Inquiry term of reference (TOR) 2: Regulatory and funding options for residential and community aged care that support access, independence and financial sustainability	
Effectiveness of the aged care system Consumer choice is constrained as is the availability of affordable flexible and sustainable services, resulting in unmet need across community and residential aged care services.	1. The Australian Government redesign the aged care system to improve: ▪ Availability: Liberalise consumer choice and enable the market to determine prices. ▪ Affordability: Fund the full economic cost of service delivery for those who cannot afford to pay. ▪ Flexibility for healthy ageing: Create and fund a model which enables a seamless transition for consumers that meet their changing needs along the health and self care continuum. This model should be broader than combining CACPs/EACH/EACHD packages. What is also required is a shift in funding to encompass continuity of care across acute/post-acute/sub-acute and residential domains. ▪ Choice: Un-bundle care, personal needs and accommodation and create equity of subsidy across care delivery modes which in addition will provide consumers with access to meaningful choices in the services they receive and the settings for those services. Alignment of assessment tools/methods across both community would facilitate equal entitlement and choice for consumers at the same care need level. ▪ Workforce sustainability: Improve education, training and scope of practice. Fund the full economic cost of service delivery to enable aged care providers to offer remuneration in line with competing sectors. ▪ Long term sustainability: Develop and implement a long term funding mechanism to ensure long term funding of future care needs in the manner in which the Superannuation Guarantee was introduced in 1992.
Residential aged care user charges Consumer choice and providers' capacity to provide supply is presently constrained by: ▪ capped fees for care and	2. Uncapping user charges to residents who have the capacity to pay with the market determining the pricing cap subject to adequate price competition.

Issue	Recommendations
accommodation ▪ prohibition of bonds for consumers entering high care ▪ regulation to limit the supply of extra service places.	3. Remove regulations and associated restraints on extra services.
Consumer access to high care places is constrained and bonds in low care are higher than they otherwise would be because of their prohibition in high care. There is a deprivation of capital in the segment where there is most need - high care places. This also results in providers using low care bonds to cross-subsidise the capital requirements of ordinary high care places and placing upward pressure on the level of these bonds.	4. Remove restrictions on high care bonds, including retentions, and deregulation of bed supply should follow in the longer term.
In June 2009, the National Health and Hospital Reform Commission (NH&HRC) in recommendation 43 gave conditional support to high care bonds.	5. Blue Care supports deregulation of the number of places so long as there is a transitional period allowing for adjustment over time. However, the need for access to user capital is immediate. 'Stapling' access to user equity to increased competition will be detrimental to the urgently needed development of replacement/new bed stock and constrain supply and choice for consumers
Residential aged care recurrent funding	
Consumer choice and availability of services is threatened as care subsidies do not meet the full economic cost of efficient service provision. Recurrent funding for residential aged care and the current indexation formula are an inadequate basis upon which to provide quality care and do not reflect the real cost of care. Blue Care estimates that care is currently under funded by $15 per resident per day (prpd). Based on the current population in residential aged care and allowing for income tested fees this represents approximately $900 million annually is required in additional care funding for the sector. Consumer choice and the availability of services in rural and remote areas is constrained by inadequate compensation to providers for the full cost of service provision in those areas.	6. To ensure sustainable, quality care for consumers, rigorously measure the cost of quality care and compensate providers for the full economic cost. 7. Implement a transparent method of estimating input cost increases that is relevant to the residential aged care and community care sectors and capable of being subjected to external scrutiny and review. 8. Measure the structural delivery cost imposts including, inter alia, variables such as facility size and rural and remote locations and fund them accordingly. 9. Establish an independent body to benchmark each year the true cost of care including regional variations and to estimate input cost increases and the required level of indexation of subsidies.

Issue	Recommendations
Capital funding is not sufficient to encourage investment in new capacity	
Supported consumers are deprived of choice and availability of new bed stock because of inadequate capital funding. Modern competitive beds cost in excess of $250,000 each to establish in metropolitan Brisbane. The maximum accommodation supplement of $26.88 prpd is insufficient to fund investment in *new* beds.	10. Increase of the maximum daily accommodation supplement for *new* facilities to reflect the current costs of development. 11. Adjust the accommodation supplement over time based on independent evidence as to building development costs, clinical and community norms regarding standards of accommodation and regional disparities.
Community care funding is inadequate	
Consumer access to sufficient community care is constrained because providers' capacity for service delivery is impacted by inadequate indexation of HACC funding.	12. Ensure indexation matches input cost increases 13. Develop national policies and guidelines surrounding fees for HACC services.
Inquiry TOR 3: Examine the future workforce requirements of the aged care sector and develop options to ensure access to a sufficient and appropriately trained workforce	
Workforce A range of systemic issues compromise the sustainability of the aged care workforce, requiring fundamental reform across a range of areas. Consumer aged care services are constrained by availability and skills of staff. One key issue is that current funding is insufficient to allow for aged care and community care providers to compete with the acute sector for care staff and this has a detrimental effect on both the residential aged care sector's capacity to recruit, train and retain staff.	14. Introduce a transparent mechanism and sufficient recurrent funding to achieve and maintain comparable wages and working conditions with the acute health care sector for all staff working in residential and community aged care. 15. Establishment a base pay remuneration parity for similar roles across all fields in the health and community services sector. 16. Create consistency across states and territories for employment conditions, training and qualifications and clinical scope of practice (particularly with regard to medications) 17. Trial and implement new e-health and assistive technology advances that aim to reduce the demand for some types of labour intensive services and create efficiencies in work systems and promote increased consumer independence levels 18. Dedicate funding to ensure all staff in aged care and community care have access to education and training that furthers their qualifications and skill levels 19. Increase numbers of clinical placements for undergraduate nursing and allied health students 20. Develop a strong indigenous and culturally diverse component of our workforce.

Issue	Recommendations
A range of systemic issues compromise the sustainability of the aged care workforce, requiring fundamental reform across a range of areas. Consumer aged care services are constrained by availability and skills of staff. One key issue is that current funding is insufficient to allow for aged care and community care providers to compete with the acute sector for care staff and this has a detrimental effect on both the residential aged care sector's capacity to recruit, train and retain staff.	21. Expand the scope of the role of RNs to nurse practitioners in aged care 22. Increase the scope of practice, professional development and training, and vocational education to help to enrich aged care employment 23. Implement reforms to better meet older workers' needs as they age 24. Improve general practitioner support of residential aged care facilities to assist staff to provide better quality care and increase work satisfaction 25. Consider establishing a stream of licensed nurses who are limited to practicing in Aged Care 26. Consider introducing a state and/or national Volunteers in Caring Services Network or 'Program' (with potential to link to similar international programs) to provide a centralised coordination point for volunteering and cost neutral participation in the workforce.
Inquiry TOR 4: Regulatory arrangements	
Regulatory burden	
The level of consumer care is reduced because regulation is stifling efficiency and optimal use of resources. .	27. Implement the reforms to address regulatory burden identified by the Productivity Commission (2009). 28. Establish an independent agency measure and benchmark the cost of compliance and the government explicitly and separately fund the cost of compliance.
Inquiry TOR 5: Examine whether the regulation of retirement living options should be aligned more closely with the rest of the aged care sector	
Retirement villages	
Providing care into retirement living complexes is compatible with an ageing population as it facilitates efficient delivery of care and other support. However, extension of aged care regulation to retirement villages would increase the cost of services without benefiting consumers who live independently or with support.	29. To not extend the aged care regulatory environment to retirement villages.

Issue	Recommendations
Inquiry TOR 6: Assess the medium and long-term fiscal implications of any change in aged care roles and responsibilities	
Fiscal arrangements	
Existing capital funding incentives do not support residential aged care providers in attracting equity and debt from capital markets and lenders. Provision of future services to consumers will be constrained unless Australia implements measures to fund the present shortfall in aged care funding and long term needs. Blue Care estimates that the care component of the residential aged care sector is presently under-funded by $900 million per annum. Additionally, we estimate a sector capital funding shortfall of over $100 million per annum to replace bed stock.	30. Discontinue the use of opaque funding mechanisms and explicitly fund the full economic cost of efficient service delivery for supported residents. 31. The government considers: • introducing social insurance by increasing the present Medicare levy by around 0.15% to 0.2% (percentage points) to fund the present shortfall • raising the above levy over time to meet the rising cost of care of the ageing population • evaluating elements of overseas health care funding systems to augment explicit funding of aged care via an increased Medicare levy.

Abridged submission

Blue Care is one of Australia's largest not-for-profit aged care providers with a diverse range of community and residential care services that interface with most special needs groups, specialised community social and health agencies, and the acute health care sector. We also provide a range of retirement living options, many of which are integrated with community and residential aged care services. This diversity ideally places us to deliver consumer centred care to the HACC, DSQ and DoHA target groups across Queensland and northern New South Wales.

We operate 4,240 residential aged care beds and provide over 1.5 million days of care per annum in our residential aged care facilities. Blue Care also delivers in excess of 3 million occasions of service annually for community clients in their homes or in our community centres.

However, to do so we must navigate across a multitude of program silos to care for individual consumers, both on initial presentation and as their needs change over time. We encounter significant barriers that result in unnecessary administrative complexity, resource inefficiencies, and high cost solutions at many levels (e.g. bedside, care facility and corporate).

Most importantly though, government policy and program barriers frequently prevent consumers from accessing the services they need in a timely manner. Consumers can be denied vital assistance through overly rigid eligibility criteria, long waiting lists for assessment and/or services, and a focus and 'maintenance' rather than maximising independence through prevention and rehabilitation. Additionally, many providers and consumers with complex needs simply don't understand how to navigate the maze of systems and programs.

The consequences of these broad flaws in the current aged care system include increased consumer dependence levels, carer burnout, social isolation, depression, falls and medical emergencies, hospital presentations and premature (or preventable) admissions to residential aged care facilities (RACFs). Once in hospital or a RACF, any potential pathway back to community living is hindered by a policy culture that considers the direction to be one-way and which does not seriously value investing in restorative interventions or promoting community care where appropriate.

Blue Care understands the challenges our industry is facing and supports reforms towards a more integrated, seamless, responsive, equitable and efficient aged care system that will motivate and facilitate providers to:

- deliver a benchmark high standard of care that is accountable and transparent
- attract, train and retain a suitably skilled and flexible workforce
- design service delivery models featuring a consumer centred holistic and system-wide perspective that promotes maximum consumer independence via pro-active plans of care
- offer a wide range of care and accommodation choices that will meet the projected diverse needs and expectations of older and disabled Australians into the future.

Blue Care, as part of the UnitingCare Australia network shares the National Aged Care Alliance 'vision for support and care for older Australians' (NACA, 2009) as well as the conclusions and recommendations made in the Productivity Commission research paper 'Trends in Aged Care Services: Some implications (2008).

Details about key reforms that Blue Care supports are outlined in this 'Abridged Submission Paper' and more detail if required is offered in the 'Comprehensive Submission Paper'.

Inquiry term of reference (TOR) 2: Regulatory and funding options for residential and community aged care that support access, independence and financial sustainability

Effectiveness of the aged care system

There is an urgent need for widespread reform of care for older Australians, particularly in residential aged care. *Blue Care **recommends** reforms including**:***

- *Availability:* In residential aged care there is a need to liberalise consumer choice and enable the market to determine prices
- *Affordability: There is a need to fund the full economic cost of service delivery for those who cannot afford to pay*
- *Flexible and healthy ageing: Program parameters should be streamlined to meet gaps in unmet need and allow for predictable changing needs to be addressed in a timely manner without administrative or financial barriers. Streamlining needs to occur not just across the community care domain, but also at the interface of acute care and residential care. More emphasis is required on preventive and restorative approaches to maximise independence and quality of life. Advance care planning should be specifically funded at a much earlier stage in the disease process for people with progressive terminal conditions such as dementia, palliative care*
- *Workers: There is a need to improve education, training and flexibility in scope of practice. Additionally, funding needs to meet full economic cost of service delivery to enable aged care providers to offer remuneration in line with competing sectors*
- *Long term sustainability: There is a need to develop and implement a long term funding mechanism to ensure long term funding of future care needs in the manner in which the Superannuation Guarantee was introduced in 1992.*

Residential aged care

Inadequacy of present funding

Present government funding of residential aged care places for those residents who cannot pay the full cost of care and accommodation is inadequate. Rather than support viability, present funding arrangements and associated regulation have served to either limit or deny providers with access to income and capital.

Numerous financial surveys in the public domain over many years have found that many providers of residential aged care are incurring losses and returns on investment are insufficient to encourage the necessary level of reinvestment.

Blue Care provides evidence that technical efficiency gains of a substantial magnitude are *not* achievable from sector assets. As most income is sourced from government and as asset utilisation is high, we also conclude that funding is manifestly inadequate and regulation prevents operators from extracting market prices from consumers where they have the capacity to pay the cost of care and accommodation.

Blue Care provides evidence that our input cost increases have far exceeded operational funding indexation.

Blue Care is Queensland's largest provider of residential aged care. Our residential aged care facilities on 54 sites across the state are on average 20.5 years old. We estimate in our commercial-in-confidence submission the impact on bed stock by 2020 if reform does not provide for long term industry viability.

Inappropriate user charges

Providers' capacity to provide supply and choice to consumers is presently constrained by:

- capped fees for care and accommodation
- prohibition of bonds for consumers entering high care
- regulation to limit the supply of extra service places.

As is the case for most goods and services, Blue Care considers that consumers, who are able, should pay the market price for aged care and accommodation where the consumer has a capacity to pay and subject to there being competitive supply available in the market catchment. Blue Care as a not-for-profit church based organisation maintains a high level (close to 50%) of concessional beds to ensure equity in care provision.

It is reasonable to conclude that providers will withdraw supply if market prices are not paid by consumers, and government subsidies for those who cannot afford to pay, do not provide a market level income.

*Blue Care **recommends** that charges to residents who do not meet the definition of a 'supported' or 'partially supported' resident be uncapped with the market determining the pricing cap subject to adequate price competition (for example, to protect consumers in small communities).*

Presently, there is a deprivation of capital in the segment where there is most need – high care places.

Much of the needed capital is readily available from user equity and could be made available in the form of either a high care bond or an alternative equivalent payment that could be derived through such mechanisms as a reverse mortgage or periodic payments that might be made from rental income.

In June 2009, the National Health and Hospital Reform Commission (NH&HRC) in recommendation 43 gave conditional support to high care bonds.

*Blue Care **supports** deregulation of the number of places so long as there is a transitional period allowing for adjustment over time.* However, the need for access to user capital is immediate. 'Stapling' access to user equity (in the form of high care bonds or similar) to increased competition is illogical. Should this approach proceed, it may well see the financial failure of existing providers and will be detrimental to the development of replacement/new bed stock and constrain supply and choice for consumers because providers will not be able to develop bankable business cases on the present accommodation supplement/charge.

Blue Care notes that uncoupling of residential aged care places from physical built stock will raise the risk profile of providers and consequently increase the cost of capital. Necessarily, this can be expected in time to increase the cost to government in compensating providers for the full economic cost of service provision to supported residents.

*Blue Care **recommends** that restrictions on high care bonds, including retentions, be removed and deregulation of beds should follow in the longer term. Further, user charges for accommodation for those with the capacity to pay should be uncapped. These are relatively simple reforms with no budget cost to government.*

The supply of extra services is regulated by the Department of Health and Ageing (DoHA).

The regulation of extra services, rather than allowing supply to be determined by the market, has resulted in market imperfections with over supply in some market catchments, and deprivation in others.

As the Productivity Commission (2008) notes, the Hogan Review (2004, p10) argued 'the ability of some to purchase a higher standard or another form of care should not be denied'.

*Blue Care **recommends** that regulations and associated restraints on extra services should be removed. This is a relatively simple reform with no budget cost to government.*

Are care subsidies sufficient?

Blue Care's service delivery costs differ for comparable levels of acuity across our residential aged care facilities as set out in our commercial-in-confidence submission. Analysis of the cost of care within income bands for 54 residential aged care sites revealed that there is significant variability in costs of care for comparable income levels.

Under-funding and inadequate indexation of subsidies has occurred for many years and can only continue for so long. In the long term, unless providers are compensated for the full economic cost of provision of service to supported residents, supply will be eventually withdrawn.

Blue Care estimates that care is under funded by $15 per resident per day (prpd)[1]. Based on the current population in residential aged care and allowing for income tested fees this represents approximately $900 million annually in required additional care funding for the sector.

*To ensure sustainable, quality care for consumers, Blue Care **recommends** that providers be compensated for the full economic cost* (including cost of capital/market rent) of efficient service provision or, rationally, providers will withdraw supply. *Further, full economic cost:*

- *be sustained through transparent indexation*
- *include delivery cost imposts for special needs individuals*
- *include compensation for regional delivery cost imposts*
- *include payment of competitive wages for employees.*

There is a *need to implement a transparent method of estimating and funding*:

- ***true costs of care*** at different acuity levels, allowing for regional cost imposts
- ***input cost increases*** that are relevant to the residential aged care and community care sectors and capable of being subjected to external scrutiny and review.

*Blue Care **recommends** the establishment of an independent body to benchmark the true cost of care including regional variations and to estimate input cost increases and the required level of indexation of subsidies**.***

Is the capital subsidy sufficient?

Blue Care provides evidence in this submission which suggests that $250,000 is a baseline cost for developing a residential aged care bed in metropolitan Brisbane (excluding land).

Based on the analysis set out in this submission, Blue Care estimates that the required daily accommodation supplement for supported residents is $76.15 prpd. If deregulation mooted in the National Health and Hospital Reform Commission report proceeds, the risk profile of providers and hence the cost of capital will increase. In such circumstances, Blue Care estimates that the required accommodation supplement is $82.67 prpd at the current date.

*Blue Care **recommends** that the accommodation supplement be adjusted over time based on independent evidence as to building development costs and clinical and community norms regarding standards of accommodation and regional disparities.*

Is funding in rural and remote settings adequate?

Section 5 discusses the adverse impacts on operating costs in rural and remote areas.

[1] Blue Care uses prpd as a metric. It is based on operational bed days not occupied bed days.

In December 2009, ACAA released an article referring to the Minister for Ageing providing a set of answers to questions in the Senate which set out the average cost of care in each state and territory. Blue Care's estimate of a shortfall in funding in one remote area accords with the ACAA estimate.

To address regional variations in the cost of service delivery, Blue Care **recommends** that:

- *an independent agency collect data on regional premia applying to the major input costs for residential and community aged care*
- *based on this collected data, the government identify specific regions where cost premia apply*
- *the government explicitly adjust residential aged care subsidies, HACC unit prices and other fees according to the regional cost premium and respective mix of input costs.*

Funding of community care

Blue Care's Home and Community Care Program (HACC) contract unit prices vary across individual projects (SPIDs). The wide degree of variation in prices means that some SPIDs are better able to meet contractual output requirements whilst maintaining quality care than others. Many variations are arbitrary and historical.

The inability to regularly review the allocation of base funding in terms of SPIDs and service types means that services cannot respond to changes in demography, models of care or availability of resources in a timely manner.

Unit prices are eroded by input cost increases exceeding indexation. Blue Care's ability to meet contracted outputs is therefore adversely affected.

Fee structures also create transition issues between HACC and CACPs. There is currently a financial disincentive for a client to move onto a CACP.

Blue Care **recommends** that reform of community care funding include:

- *Regular review of HACC contracts:*
  - *to provide some flexibility in service provision so output requirements can be responsive to changes in demography and models of care, and encourage innovation*
  - *to avoid perpetrating historical variations in prices across the state which may no longer be relevant*
  - *to ensure indexation matches input cost increases.*
- *Recognition of increasing reliance on client contributions and development of national policies and guidelines for setting fees for HACC services.*
- *Recognition of decreasing numbers of hours of care provided each year on a CACPs, EACH, or EACHD package and ensure indexation matches input costs*.

Inquiry TOR 3: Examine the future workforce requirements of the aged care sector and develop options to ensure access to a sufficient and appropriately trained workforce

Workforce

A range of systemic issues compromise the sustainability of the aged care workforce, requiring fundamental reform across a range of areas. Consumer aged care services are constrained by availability and skills of staff. One key issue is that current funding is insufficient to allow for aged care and community care providers to compete with the acute sector for care staff and this has a detrimental effect on both the residential aged care sector's capacity to recruit, train and retain staff. *Solutions include:*

- introduce a transparent mechanism and sufficient recurrent funding to achieve and maintain comparable wages and working conditions with the acute health care sector for all staff working in residential and community aged care
- cross-industry wage parity is required. Establish base pay remuneration parity for similar roles across all fields in the health and community services sector
- create consistency across states and territories for employment conditions, training and qualifications and clinical scope of practice (particularly with regard to medications)
- Examine regulation and current industry practice in terms of staffing mix and fund pilot programs to evaluate less expensive models of residential care
- trial and implement new e-health and assistive technology advances that aim to reduce the demand for some types of labour intensive services and create efficiencies in work systems and promote increased consumer independence levels
- strengthen the aged care workforce, especially those that target personal carers' vocational education and work satisfaction
- dedicate funding to ensure all staff in aged care and community care have access to education and training that furthers their qualifications and skill levels.
- increase numbers of clinical placements for undergraduate nursing and allied health students
- develop a strong indigenous and culturally diverse component of our workforce
- expand the scope of the role of RNs to nurse practitioners in aged care
- increase scope of practice, professional development and training, and vocational education to help to enrich aged care employment. Facilitate the abolition of demarcations of duties; provide appropriate training and remuneration incentives to develop a multi-purpose workforce that will allow sharing of staff across program and care domains
- implement reforms to better meet older workers' needs as they age
- better general practitioner support of residential aged care facilities will assist staff to provide better quality care and increase work satisfaction
- consider establishing a stream of licensed nurses who are limited to practicing in Aged Care
- consider introducing a state and/or national Volunteers in Caring Services Network or 'Program' (with potential to link to similar international programs) to

provide a centralised coordination point for volunteering and cost neutral participation in the workforce.

Inquiry TOR 4: Regulatory arrangements

Regulation

Residential aged care is a highly regulated industry with a range of accreditation, inspection and compliance regimes. The need for regulatory controls is not disputed - older Australians who are vulnerable and dependent on others for shelter, care and management of their finances are entitled to the highest levels of security and veracity. The Commission is well aware of industry frustrations with the inefficient and burdensome regulatory regime currently in place, and the corresponding suggestions from the industry to standardise quality/accreditation frameworks. For example, Blue Care conducted research in 2008-09 to quantify the cost of regulatory burden on our residential aged care services. The study found:

- compliance with major residential aged care compliance activities costs Blue Care approximately $5.4 million per annum
- staff time engaged in compliance activities is 147,000 hours per annum. Assuming an average of 3.5 hours of care per resident per day, this represents 10 days of staff time diverted from resident care *for each* resident per annum.

For a large organisation like Blue Care, tapping into a multitude of government community care subsidies enables us to provide an extensive range of care options, but each funding program applies a separate set of administrative and legislative obligations, which amplifies our burden of compliance. The inefficiencies of managing compliance activities across multiple programs are enormous. *Reduction of regulatory burden* would enable aged care providers like ourselves to better deploy resources towards providing care to consumers.

Blue Care agrees with the Productivity Commission's view that the dual gate-keeping approaches are duplicative in that they serve to control supply and demand simultaneously. While we would agree that the better control mechanism for aged care allocation is via an ACAT assessment, process improvements to the way ACATs function would be warranted to reduce duplicative administration and to prevent uncertainty for clients. ACAT work practices and processes must also be nationally consistent.

Additionally, *Blue Care* ***recommends*** *that an independent agency measure and benchmark the cost of compliance in community and residential aged care, with the aim of developing a model to explicitly and separately fund the cost of compliance. This mechanism should focus on risk based evaluation measures rather than perpetuate the present burdensome regime which drains resources that could be redirected to improve and increase consumer care.*

Inquiry TOR 5: Examine whether the regulation of retirement living options should be aligned more closely with the rest of the aged care sector

Retirement living

Segmentation of the retirement village industry is occurring with the development of:

- integrated communities: resort style villages collocated with a residential aged care facility
- supported living: villages targeting the older old cohort emphasising the availability of personal care and support services (but not with a residential aged care facility). In large part, care is delivered by community care providers in the form of CACPS and EACH packages into these apartments.

The main barrier to older Australians accessing retirement living options are:

- their ability to pay an ingoing contribution which normally requires an incoming resident to have the ability to realise their own home
- reticence to incur the deferred management fee.

To meet the needs of low income or disadvantaged old Australians, Blue Care offers affordable retirement living units for less than $150,000. We also offer financial structuring arrangements that enable the ingoing amount to be substantially reduced and the incoming resident the ability to access rent assistance.

Retirement living is compatible with an ageing population. The collective living offered facilitates efficient delivery of care and other support services.

An integrated community (with care options, including residential aged care) is an effective way of assisting residents with social inclusion, lifestyle choices and extending independence. Unlike supported living style communities, a Blue Care integrated community (with a residential aged care facility) does not require residents to move off campus when their care needs advance to the higher end of traditional low care residential status or high care.

Extension of the aged care regulatory environment to retirement villages is not appropriate for people living independently or with support. The burden of regulation would add to the cost of retirement living for consumers and may lead to reduced supply.

Blue Care is strongly supportive of the place for supported living environments in the spectrum of care for older Australians.

However, we are concerned that representations regarding aged care offered in some supported living villages may lead vulnerable consumers to believe that the care being offered is comparable to, or indeed, exceeds that available from an approved residential aged care provider when that may not necessarily be the case. Blue Care recommends that the Aged Care Act restrict the use of the terms ‘residential aged care’ or ‘aged care’ in advertising and promotion to approved providers.

Inquiry TOR 6: Assess the medium and long-term fiscal implications of any change in aged care roles and responsibilities

Fiscal arrangements

The future outlook for increasing demand for care by older Australians is well documented.

In this submission, *Blue Care* ***emphasises*** *that services for those consumers who can afford to pay should be provided at unfettered market prices (provided there is sufficient competition in a market catchment). User pays principles will ease the burden on public funding.*

Presently and for many years into the future, the vast majority of consumers are, and will be, pensioners and there will be a need to publicly fund aged care services for those consumers and others.

There is also a need to develop and implement mechanisms to ensure the long term funding of future care needs. Blue Care considers that Australia needs to meet the cost of future care needs through a combination of government subsidies and individual responsibility**.** Options which could be investigated are set out in the full submission.

Blue Care estimates that the care component of residential aged care is presently under-funded by $900 million. Additionally, we estimate a capital funding shortfall of over $100 million annually to replace bed stock.

Against the background of the present Federal Budget deficits, *Blue Care* ***recommends*** *that the government considers introducing social insurance by an increment to the present Medicare levy be introduced to close the present residential aged care funding gap of some $1 billion. We estimate that the required increment at around 0.15% to 0.2% (percentage points). In the longer term, the increment could be increased to meet the rising cost of care of the ageing population.*

Blue Care also recommends evaluating elements of overseas health care funding systems to augment explicit funding of aged care via an increased Medicare levy.

Full submission

Users should read our full submission which follows and provides evidence from Blue Care's data and experience in respect of the terms of reference and outlines herein further options for reform.

Full submission: table of contents

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1. Preface

1.1. Caring for older Australians

Blue Care shares the concerns of many in the Australian community as to the capacity of the aged care sector to meet the needs of older Australians.

Blue Care considers that widespread reform of funding and deregulation is required for efficient resource allocation and to better meet future demand for services. In particular, the residential aged care sector faces several critical issues constraining the supply and choice of services available for consumers, including financial sustainability, capacity to reinvest in our services and to compete for workforce with the acute sector and regulatory burden.

1.2. Blue Care's scale of care

Blue Care is a UnitingCare agency. An overview of Blue Care's scale of services is shown in the table below:

Table 1: Overview of the scale of Blue Care's services

Staff employed	8,288
Volunteers	2,100
Residential aged care	
No. of residential aged care facilities (sites)	54
No. of residential aged care beds	4,240
Days of residential care provided to consumers per annum	1.5 million
Community care	
No. of client home visits per annum	2.5 million
No. of occasions of service per annum	3 million
No. of home nursing, respite, day therapy, Carelink centres	155
Community Aged Care packages	1,386
Extended Aged Care at Home packages	188
No. of National Respite for Carers Programs	22
Retirement living	
No. of villages	43
No. of independent living units	1,108
Affordable	566
Middle market	542
UQ/Blue Care Research & Practice Development Centre	
External competitive funding - Clinical research (2006-09)	$7.1 million
External competitive funding - Workforce research (2006-09)	$2.9 million

Source: Blue Care

1.3. Blue Care's submission

Blue Care's submission considers matters included in the Productivity Commission's terms of reference for this inquiry, the Commission's 21 May 2010 Issues Paper and other matters as follows:

- Regulatory and funding options for residential and community aged having regard to:
  - Access (in terms of availability and affordability) to an appropriate with particular attention to specific needs groups
  - Appropriate planning mechanisms for the provision of aged care services across rural, remote and metropolitan areas and the mix between residential and community care services
  - Support independence, social participation and social inclusion and infrastructure that support older people remaining in their own homes for longer
  - Are based on business models that reflect the forms of care that older people need and want, and that allow providers to generate alternative revenue streams by diversifying their business models into the delivery of other service modalities
  - Are financially sustainable for government and individuals with appropriate levels of private contributions, with transparent financing for services, that reflect the cost of care and provide sufficient revenue to meet quality standards, provide an appropriately skilled and adequately remunerated workforce, and earn a return that will attract the investment, including capital investment, needed to meet future demand
  - Consider the regulatory framework, including options to allow service providers greater flexibility to respond to increasing diversity among older people
  - Minimise the complexity of the aged care system and provide appropriate protection
  - Allow smooth transitions for consumers between different types and levels of aged care
- Future workforce requirements of the aged care sector
- Transitioning from the current regulatory arrangements
- Whether the regulation of retirement specific living options should be aligned more closely with the rest of the aged care sector
- Assess the medium and long-term fiscal implications of any change in aged care roles and responsibilities.

Blue Care has outlined below our vision of care for Australians so as we may frame our submission.

1.4. Blue Care's vision of care for older Australians

Blue Care, as part of the UnitingCare Australia network shares the National Aged Care Alliance 'vision for support and care for older Australians' (NACA, 2009). In particular, we envision a system of care for older Australians which includes these attributes:

- *For care recipients, their families, partners and carers*
  - Choice. Every older Australian is able to live with dignity and independence in a place of their choosing with a choice of appropriate and affordable support and care services as and when they need
  - Holistic care with the compassion of Christ that promotes healthy ageing in-place, independence and social participation
  - Infrastructure, particularly digital technologies, that support
    - older people remaining in their own homes for longer
    - smooth transitions for consumers between different types and levels of aged care
  - Primacy of the care and wellbeing of elders is valued ahead of the cost of care
- *For workers*
  - A supportive environment that values their compassionate care
  - A workplace that provides training, job flexibility and competitive remuneration (parity with the acute sector)
- *For government and the wider Australian community*
  - Cognisance of the good work of carers and care organisations for older Australians who cannot care for themselves at home
  - Acknowledgement and responsibility for the cost of care of present and future older Australians through insurance and/or levy
  - Financial sustainability
- *For providers*
  - Capacity to provide quality of care and services wanted by consumers
  - Just, supportive, efficient regulation focussed on protection of those in care
  - Transparent funding that encourages better wellbeing outcomes
  - An independent body assessing costs of care and indexation required to maintain funding in real terms
  - Economic profit commensurate with capital employed and business risk so as to support future needed investment.

2. Effectiveness of the current aged care system

2.1. Objectives

Blue Care considers that the aged care system should serve to meet the following objectives, among others:

- Care recipients:
  - Availability and affordability of appropriate services and accommodation for all Australians including those in rural and remote areas
  - Flexibility to support independence, social participation, diversity and healthy ageing
- Workers: Providing meaningful and financially rewarding occupation
- Government: Financial sustainability
- Providers: Provide a rate of return commensurate with risk and cost of capital.

Blue Care's considers that the current system does not these objectives as summarised below:

Table 2: Effectiveness of the current system in meeting these objectives

Objective	Achieved	Evidence (includes)
Availability and affordability	Failure	Restricted choice. Constrained 'extra services'. High industry occupancy limiting choice averaging 95% (Productivity Commission 2009[2])
Flexible/healthy ageing	Failure	Residential aged care providers' income increases as a resident's acuity increases. The quantity of funded places/packages is regulated.
Providing meaningful and financially rewarding occupation	Failure	Remuneration is substantially less than similar sectors (Productivity Commission 2008[3]). Staff are weighed down with overbearing and inefficient regulation and enforcement 'some existing regulations have shown little concern for minimising compliance costs' (Productivity Commission 2009)
Adequate investment return for providers	Failure	Inadequate financial returns as evidenced by numerous industry financial surveys and Blue Care's submission
Government sustainability	Failure	Under subscription to ACAR rounds, presence of opaque incentives such as zero real interest rate loans[4] and data as to the number of beds Blue Care will take off line as set out in this submission. Absence of any structural fiscal device, such as a levy or mandatory insurance to meet long term funding needs.

Source: Blue Care

The implications of the abovementioned failings of the current system in redesign include:

[2] Annual Review of Regulatory Burdens on Business, August 2009
[3] Trends in Aged Care Services, September 2008
[4] Zero real interest rate loans are a consequence of a failed system where explicit funding does not support providers in attracting equity and debt from capital markets and lenders

2.2. Future challenges, flexible care and system interfaces

From a consumer's perspective, community aged care accessibility is confusing due to the multitude of access points, assessment processes, eligibility criteria, service types and funding programs.

While the Commission acknowledges the potential for Access Points to simplify entry and access to aged care information and services, the evaluation of this trial should not be deferred, as we are unsure whether Access Points functions overlap with the existing Commonwealth Respite and Carelink Centres (CRCC). Similarly, it would be useful to gain consumer feedback on the capability of existing aged care websites or mobile access hubs at community centres such as churches and supermarkets to improve service accessibility.

While our community care services are generally expanding in line with government subsidies, we see service gaps in the availability of care packages and in the range of respite options (especially non centre-based respite). Our community service mix is determined by the funding we acquire, and in the case of respite this is mainly HACC, which excludes overnight care. This is just one example where the availability of services to consumers' is restricted.

Aged care consumers will continue to benefit from the government's policy to progressively expand the numbers of available community care packages, which allow more people to receive care and social support at home. However, there is a significant and fast growing gap in demand for packages that provide greater than five hours of service (which is the limit for a CACP) but fewer than 16 hours (which is the minimum eligibility for the next level of package - EACH). In addition, in an environment of increased levels of acuity and chronic illness, activity-based funding fragments the care continuum and restricts service providers to specific outputs, which in turn limits client flexibility, service accessibility and innovation.

Recurrent funding for health promotion programs and community capacity building initiatives that target preventive health and rehabilitation rather than acute treatment and maintenance is uncommon. Even when time-limited seed funding is acquired, service providers still need to source ongoing funding to embed new programs (Thomas, 2010).

It is inevitable that consumers' needs will change over time, and although it is a predictable event current fragmented programs of support are not sufficiently responsive. This is not unique to Australia's aged care system, as described in the Hastings Centre Special Report no 35 (USA):

> "Society could build (aged) care arrangements around the major patterns of decline and dying. For any population, one could estimate the care needs and arrange to have them available at the right time. This approach conceives of the challenge of end of life care as a problem of system design" (Lynn, 2005).

A lack of program integration means that, for older Australians, a gradual increase in personal care needs may mean they remain 'in limbo' with higher needs than a CACPs package can deliver but lower needs than those triggering eligibility for an EACH package. Acute health or social episodes can temporarily result in greater needs and involve services not normally required (rehabilitation, overnight care).

Solutions could include:

- Ideally, adopt a single continuous community care program that can provide the right type of care at the right time, and interface with other health and social programs.
- Adopt pooled funds models for consumers with complex needs (such as Retirement Village Care Packages, Multi-Purpose Services) in all suitable regional and metropolitan areas, and incorporate rehabilitation and step down services as determined by a provider case manager/assessor.
- Allow approved providers to conduct assessments and approve temporary or permanent increased service levels when there are unacceptable waiting times for ACAT to attend or for urgent cases. Provider assessments could then be subjected to regular audit.
- Chronic Disease Self Management program initiatives can ultimately will reduce or delay demand for care and services include a Supported Self Management Model, Community Capacity Building, and Building Partnerships and "In-Reach" models with Primary Health Care Organisations / Super Clinic's / Existing practices. For example, a Community Health Worker/Nurse model comprises of a community specialist with a close working relationship to the GP 'Practice Nurse'. The worker has local sector knowledge and can facilitate/support client links across programs/agencies/services to promote a seamless continuum of care for consumers. This would additionally strengthen collaboration and knowledge of primary health sector professionals. (Thomas, 2010).
- Co-located specialist health and social services could make it convenient and seamless for aged care consumers to access services (particularly as needs become complex over time) as well as being efficient from an integrated multi-system perspective. One model has been proposed that combines a range of evidence based approaches into an "Integrated Care Centre" (a model illustration is attached) for the frail aged with complex needs. This service model encompasses cross-disciplinary collaboration via a multi-purpose clinic approach, combined with a day respite and social support service with the aim of using social benefits as a prime motivation for consumers to regularly attend the centre (similar to the 'leg club' model (Lindsay, 2007). Clinics and/or referral could include geriatrician, specialist nursing, allied health and social worker services in a preventive health and rehabilitation focus, with emphasis on a holistic approach. Clinics and referrals could be internal to Blue Care, or externally funded or brokered services, and the model would be developed in a collaborative, staged and formally evaluated approach. Staff would be trained to additionally cater for (screen, treat and appropriately refer if required) a range of special needs groups such as Forgotten Australians, Veterans, Indigenous, CALDB communities, financially and socially disadvantaged, socially isolated, homeless, and those with dementia or mental illness.
- Special needs groups, particularly Indigenous communities, rural and remote communities and those who are homeless will require greater levels of subsidisation and greater flexibility in the parameters that dictate how funds can be used to meet consumer need. Blue Care also supports mobile specialist professional and social service models for rural and remote areas.
- Palliative care should be re-defined and subsequently funded to include 'support over many years and allow for an unpredictable time of death' (Productivity

Commission 2008, p46). In the case of people with dementia and other long term chronic disease, palliative care should be an essential component of packaged care. The categorisation of a person as reaching palliative status should be based on a clinical decision by an appropriately experienced and qualified health practitioner.

Blue Care is concerned over the range and accessibility of respite services providing support that enables carers to maintain their own health and wellbeing. Respite appears to be an undervalued component of the care continuum. The number of respite services and the range of respite service types available in the community needs to increase drastically. Respite funding is generally insufficient to engage in extended or contemporary care models that promote active ageing or maintain independence skills. Also, the standardised output-based approach to respite funding is in reality a disincentive to offering respite care to high needs clients (e.g. dementia, severely disabled, etc.) who ironically are often supported by informal carers who are in most need of respite.

Significant growth in and improvements to respite services are required, and reforms in this arena should include the following:

- Supported client access and linkage across the sector, and improved interface with Commonwealth CareLink
- Recognition of Centre Based Respite as a point of entry to community services
- Earlier intervention in client journey to assist establish supports when needed and prevent 'crisis'
- Provide more flexible eligibility criteria that accommodates clients' needs across a broader range of disabilities, respite types and emergency requirements
- Promote ongoing support and funding for 'futures planning' for families to assist transition through health, aged care and disability sector.
- Increase the base funding of respite services and extend specific funding for active ageing programs and other activities that promote and teach independent lifestyle skills; and which also allows and encourages clients to have a self directed choice of social activities
- Extend the proportion of non-centre based respite options to meet national and local needs (i.e. cottage/overnight, in-home, residential and emergency)
- Introduce a tiered funding system that allows for the higher cost of respite care delivered to complex clients and which enables extended and more flexible time periods
- Review remuneration rates and funding subsidies to ensure higher input costs (as with overnight respite) are met through provision of fair wages workers and are affordable to organisations through adequate levels of base government subsidies

HACC relocation to the Commonwealth should trigger its amalgamation with DoHA-funded services, and in turn a range of standardisation measures should be implemented including: more flexible funding, extended eligibility criteria, greater equity between different service types, and tiered funding for different levels of client or situational complexity. Such measures to create a single continuous community care program, as suggested by the AIHW, are strongly supported by Blue Care.

Amalgamation of HACC and DoHA funded services (community care packages and NRCP) will greatly enhance the funding efficiencies and therefore care delivery. This change presents key opportunities to:

- overcome service gaps between existing programs with a more flexible funding approach, which is especially necessary with respite care
- amalgamate multiple contractual agreements to create administrative efficiencies
- fix existing anomalies that create disincentives for HACC clients to move to packaged care where they potentially receive less care at a higher cost
- introduce tiered levels for care services (HACC) and packages (especially CACP), that recognise the higher service input costs incurred by those organisation who offer care to more complex, special needs and geographically isolated clients.

The vast majority of government subsidies for community care are block funds provided for individual activity-based interventions. This approach commonly presents problems for staff due to narrow eligibility criteria and the funding level being inadequate to meet individual client needs. These issues constrain service providers, and result in operational problems as Service Managers often have to:

- combine several funding 'buckets' to meet the individual care needs of clients with complex or chronic conditions
- stretch inadequate funding levels across larger numbers of clients, who at the individual level receive only sufficient care so as to maintain their health
- suffer financial losses related to rendering care to clients at their required levels (clinically indicated), which may be beyond what is funded
- forego any substantial involvement in 'unfunded' active care models like supported self-management, that seek to improve rather than sustain health status
- forego any substantial involvement in 'unfunded' community capacity building initiatives, which are vital in creating mechanisms that support independence.

Blue Care recommends the introduction of cross-funding program recognition of specific accreditation standards (i.e. 'core' standards) that are currently consistent across the multiple government accreditation programs applied to community services. This should begin with immediate amalgamation of HACC and DoHA community care standards (which are closely aligned already), but should be extended over time to include all community care accreditation programs. Eventually, this process should result in the development of one, nationally-recognised accreditation program containing 'core' standards (accounting for 80% of its content), with a allowance (e.g. 20% of content) for supplementary standards to be applied by separate funding programs where (and if) these are applicable.

While the disability and aged care systems are both currently under reform, and may in fact benefit from similar reform outcomes (e.g. accessibility, funding, workforce development etc.), fundamental differences suggest they should be dealt with as separate entities for the time being. Above all, the alignment of care and disability in this context presents problems for the trend toward active ageing and restorative care

initiatives, which are based on 'wellness' rather than 'disability' principles for aged care. Furthermore, unlike the disability sector, distinct changes in demographics and disease patterns will impact the aged care industry in the next decade, requiring a tailored response.

As part of national reform, with streamlining of multiple programs being considered, it may be time to also consider whether DVA health and aged care needs to be an entirely separate program with associated unique legislation, standards, eligibility parameters, documentation and reporting requirements. Rather, veterans could become a special needs group. This would reduce another layer of administrative burden for providers and associated expense which could be redirected towards additional services to veterans.

With regards to transition arrangements:

- The government is encouraged to consider a phased approach to the introduction of self-provision options (aged care insurance) to augment immediate increases to care subsidies which could be tapered as a more sustainable long-term funding platform is established.
- Community care organisations are clearly facing financial pressures that are only likely to increase with anticipated changes in aged care demographics and disease patterns in Australia. The full costs that service providers incur in the delivery of community care should be assessed and appropriate subsidy levels provided.
- Ensure that future government funding programs truly embrace the principle of flexibility, by inserting contract conditions giving service providers the discretion to expend pre-set funds (e.g. up to 5% of total contract) on any direct care activities (with full disclosure), to meet local or emerging requirements not foreseen at the initiation of the contracted period.
- In a similar way as packaged care was progressively phased in to enable more people to receive care in their own homes, government programs should phase in funding for approved self-management (CDSM) interventions and community capacity building initiatives. The funding of preventive health programs at the individual and community level is also essential if our society is going to meet the demands of an ageing population, where we will need to promote active ageing and restorative care to keep people independent and in good health for as long as possible.

2.3. Consumer-directed care

We acknowledge the Commission's cautions in applying consumer-directed care. These are particularly relevant to consumers who may not welcome choice, and those who depend on other peoples' voices to exercise their choice. Blue Care supports the Commission's stance on introducing consumer-directed care in a way that prevents any discrimination over care accessibility, minimise the risk of exploitation, and ensures that consumers are indeed provided with the choice to accept and decline consumer-directed care arrangements.

As consumer-directed care is still a relatively new concept in Australia, further consideration is required in relation to promoting higher levels of consumer expectation (e.g. if greater 'choice' is widely publicised) when, at least at the present time, aged

care service availability and accessibility is generally accepted to be limiting consumers' options.

The CDC model will enable more people to remain in their homes because, for those who choose to maximise their choices, the pool of potential higher quality and available workers will be greater (i.e. friends, neighbours and commercial agencies could be employed). Further flexibility in the model as part of reform would allow additional choice when an unusual request seems reasonable to the provider, particularly for rural and remote consumers and special needs groups. This might mean allowing the package to fund additional types of services or purchases (extra therapy, household appliances, car modification, incidentals), or temporarily access a larger budget when necessary such as during acute care episodes or when carer health issues arise. Greater flexibility in the range of allowable purchases has resulted in higher satisfaction with care and 'life' as well as decreased unmet needs and adverse events (Carlson et al 2007, in Productivity Commission 2008, p116). Models of consumer directed care currently used in the disability field could be applied in aged care.

Systems must be developed for preventing fraud/abuse and managing quality of care and workplace health and safety when workers are privately employed by consumers.

If agencies like Blue Care are taking on a greater role in coordinating and monitoring the quality of services provided by others, then the CDC Program must properly reimburse the full costs of providing that service. We look forward to seeing this information in the evaluation report of Australia's first CDC packages.

2.4. Are anomalies created by allowing bonds on low care and not high care?

The Productivity Commission identified a number of anomalies resulting from distinguishing low care and high care and created by accommodation bonds being available to providers of low' care and 'extra service' high care places but not 'ordinary' high care places (see PC 2008). Briefly these include:

- Providers use low care bonds to cross-subsidise the capital requirements of ordinary high care places. This places upward pressure on the level of these bonds. Commentators have observed that the average level of low care accommodation bonds now appears to materially exceed the replacement cost of a residential place (citing Ergas 2006). (This is not Blue Care's experience with 234 bonds taken in the 11 months to 31 May 2010 at an average amount near the lower end of our assessed range of the replacement cost of a new residential place)

- Providers might discriminate among elderly Australians requiring residential care. Those lacking substantial wealth - not only pensioner and part-pensioner residents but also those of relatively modest wealth - are not able to offer anything to support the provision of services for them (citing Hogan 2007). (Blue Care notes that the point raised here "to support the provision of services" alludes to the fact that care is under funded)

- The capital funds available to providers of ordinary high care places are considerably more limited than those available for low care places (PC 2003). (Blue Care notes that the present maximum accommodation supplement of $26.88 per resident per day (prpd) is a grossly inadequate in funding the

replacement cost of a new bed). Blue Care estimates the breakeven accommodation payment point, at which the investment would proceed, later in this submission.

- Providers have an incentive to invest in low care rather than high care even though there is increasing demand for high care relative to low care.

Blue Care agrees with the Productivity Commission that the equity, efficiency and sustainability of residential care would be improved by permitting bonds in low care. This would involve all permanent residents, subject to a safety net, having the choice of paying either a lump sum bond or an equivalent periodic rental charge (at a level equivalent to the stream of capital available to providers through the bond).

2.5. Are fully ensuited, single bedrooms the best environment?

As specifically requested of Blue Care by the Productivity Commission, we have provided information to assist consideration as to whether fully ensuited, single rooms are the best environment for residential aged care.

Room choices broadly include:

- Single room, single ensuite – a room with an individual attached ensuite.

- Single room with shared ensuite – a room with an ensuite shared with the neighbour

- Shared room - a two-bed room with an ensuite shared by the "room mates". Shared rooms may meet regulatory requirements so long as the number of residents in a facility does not exceed the ratio of 1.5 residents per room[5]. The practical effect of this is that a new facility may be comprised by no more than 50% shared rooms.

  A further variant is a 'connecting room' ie two adjacent single rooms with an adjoining door (with a single or shared ensuite). This can be a positive attribute for consumers who are couples or companions.

Providers appear to be predominantly developing fully ensuited single bedrooms rather than shared rooms or rooms with shared bathrooms[6].

[5] Privacy and space standards for new residential aged care buildings set a maximum service average of 1.5 residents per room (with no individual room accommodating more than two residents), and no more than three residents per toilet or four residents per shower (Department of Health and Ageing, Aged Care in Australia, May 2006)

[6] In 2007, Blue Care requested three architectural firms to advise the proportion of bed types in recent projects in which they had been involved. Shared rooms comprised approximately 10% of those projects' beds.

The acceptability of each room type in terms of certain criteria is considered below:

Table 3: Acceptability of each room type

Criteria	Acceptability of Room Type		
	Single Room, Single Ensuite	Single Room, Shared Ensuite	Shared Room
Stakeholder preferences			
Residents generally	✓	×	×
Residents not-ambulatory, wanting companionship	✓	✓	✓
Couples (note 1)	✓	✓	✓ and ×
Privacy			
High care residents (note 2)	✓	✓ (compromise)	✓ and ×
Other residents	✓	✓ (compromise)	×
Cost to the provider			
Construction (note 3)	✓ and ×	✓ and ×	✓
Operating (note 4)	✓	✓	✓
Competition (note 5)	✓	×	×
Market	✓		
Self funded/bond payers	✓	×	×
Supported	✓	✓ (compromise)	×

Notes:

1 Single rooms can meet needs of couples with an adjoining doorway.

2 There are issues of resident privacy and security – especially in the day to day care of a resident and how that is delivered in a shared room environment with unrelated persons with visiting families and guests. Clever design may remedy this.

3 The construction cost of a single room is acceptable to a provider where the net income stream from the resident's occupation provides an adequate return on investment. This is presently not achievable where reliance is placed on high care accommodation payments or supported resident's funding.

4 As a high proportion of double rooms is unacceptable to the market, the operating cost impost of a small number of shared rooms is negligible.

5 In a specific building decision, the competitive supply in a catchment should be considered. Generally, competitors appear to be offering single rooms, single ensuite.

Source: Blue Care

The primary advantage of a modern fully ensuited single room is privacy. Blue Care's experience is that family members of residents favour these and strongly influence room selection. Privacy is an identified quality of life indicator for residents in an aged care facility[7].

The primary advantage of a shared room is companionship and socialisation that is preferred by some residents, particularly residents who are not ambulatory.

To assist this submission, Blue Care's Central Admissions Unit advised:

- Virtually all enquiries are for single rooms, except for couples who sometimes want to be with their partner
- Blue Care presently has 12 husbands and wives wanting a shared (double) room. The majority prefer a double room, however, if one is not available, a connecting room (ie single rooms with a connecting door) is the second preference.

[7] Kane et al

Resident feedback to Blue Care's residential service managers regarding shared rooms is mixed:

Positive

- A few residents do enjoy shared rooms for companionship
- Residents in a shared room, particularly non-ambulatory residents, have more staff contact as our staff will be providing care to the other resident in the room and will have the opportunity to speak with both residents
- Shared rooms are larger and have the feeling of more space

Negative

- Most residents prefer their own privacy and they have greater opportunity to display a few of their own possessions and memorabilia
- Privacy is an issue with visitors
- Often residents cannot have their televisions and radios on too loud as it is a distraction to the other resident
- If a difference in opinion arises between the residents there is, at times, a need to find separate rooms
- Except for meeting the needs of residents who want companionship from someone in the next bed, adjoining single rooms with a sliding door between the two may meet the needs of spouses/partners
- It is sometimes difficult to fill shared rooms as most families prefer single room accommodation for their loved ones.

In summary:

- *Consumer perspective:* Fully ensuited single bedrooms are virtually always preferred. They are not always the best environment as shared rooms are preferred over single rooms by a small proportion of consumers. These are usually couples
- *Cost of accommodation/ funding perspective:* Shared rooms offer an insignificant opportunity for construction cost savings and operational economies because they are wanted by only a small proportion of consumers
- *Cost of accommodation/ user pays perspective:* From a provider's perspective, the key advantage of a single room is marketability. In the case low care beds, the loss of potential bond value deters development of shared rooms
- *Design/ development perspective:* Shared rooms represent a consideration in residential aged care building development as a minor proportion of the total residential aged care site beds (2 to 4 rooms in a typical development). In view of the insignificant savings of, say, 2 to 4 shared rooms, in capital and in operating costs, a more flexible alternative may be connecting rooms (with a sliding door between the two) which often meet the needs of couples.

3. Funding options for residential aged care

3.1. Inadequacy of present funding

Present government funding of residential aged care places for those residents who cannot pay the full cost of care and accommodation is inadequate.

Rather than support viability, *present funding arrangements and associated regulation have served to either limit or deny providers with access to income and capital*[8].

For many years industry participants and stakeholder organisations have made representations to government regarding the inadequacy of funding. The responses over a number of years have been a series of financial 'patches' including Conditional Adjustment Payments and pension increases. These patches have enabled most providers to survive but have inhibited reinvestment in much needed capacity.

The Federal Budget for FY2011 does not include such a patch.

3.1.1. Evidence of the impact of present funding and regulation on sustainability

Numerous financial surveys in the public domain over many years have found that many providers of residential aged care are incurring losses and returns on investment are insufficient to encourage the necessary level of reinvestment.

Examples of survey results include:

- Bentleys: FY2009 survey of performance "of more than 100 service providers operating approximately 350 residential aged care services, found that more than 40% of providers are currently operating at a loss"[9]
- Grant Thornton: Grant Thornton Aged Care FY2008 Survey of almost 700 nursing homes and hostels reported that aged care service providers' average earnings before interest, taxation, depreciation and amortisation (EBITDA) in 2008 was $2,934 per bed per annum "This represents an average return on investment of approximately 1.1% for modern, single bedroom facilities"[10]
- Stewart Brown: FY2009 survey of 333 facilities found 22% of high facilities and 39% of low care facilities achieved an operating profit[11].

Department officers have suggesting that participants need to achieve top quartile financial performance. This implies that technical efficiency gains of substantial magnitude are achievable from sector assets.

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[8] Capped co-payments for care and a restrictive regime in respect of bonds and also non-care services (known as Extra Services) are examples.

[9] http://www.bentleys.com.au/industry_specialisations/health_and_aged_care/aged_care_article_aged_care_evolution

[10] http://www.grantthornton.com.au/files/aged_care_survey_2008-final.pdf. The cited 1.1% is measured by EBITDA and, of course, the return at net profit level would be significantly less.

[11] http://www.sbbsolutions.com.au/files/8MB3RTNNP5/ACFPS_0609_Highlights_Report.pdf

Blue Care considers that this is not likely to be the case and suggests that the Productivity Commission obtain data and conduct statistical analysis of financial performance to establish whether there are statistically significant factors that impact financial performance such as facility size, location, resident acuity level. This understanding may also be required in any reform process to develop a funding model that sustains providers.

As reported by the Productivity Commission (2008), Hogan in 2004 commissioned a study of the efficiency of Australia's residential aged care sector.

In assessing the scope for improving technical efficiency within the sector, the study looked at the performance of residential facilities relative to the best performers. Using this approach, it found that the cost of providing these services could have been reduced by 17% or $1.1 billion in 2002-03. The study also suggested that costs could be reduced by a further 7% (or $470 million) in 2002-03 through structural adjustment to improve the scale efficiency of the sector.

As the Productivity Commission noted, 'in practice, realising the full gamut of these potential gains would not be possible because not all providers are capable of matching the performance of the industry leaders. Some face higher costs or have less scope to raise productivity because they operate in rural or remote locations or provide care for a high proportion of clients with special needs. In addition, there may be significant up-front costs associated with improving technical and/or scale efficiency. Even so, as noted by the Hogan Review, the current regulatory framework impairs incentives for productivity improvement'.

Blue Care considers that if opportunities exist to realise technical efficiency opportunities and achieve market rates of return from underperforming aged care assets then rational investors/aggregators would have by now acquired these assets to extract those returns through efficient management.

Aggregation in the residential aged care sector has not occurred and average financial performance has continued the downwards trend since 1997 (Stewart Brown, June 2009).

It is apparent that ***market rates of returns are not available from much of the sector's assets. As most income is sourced from government and as asset utilisation is high, we consider that the causes of poor financial performance are inadequate funding*** and ***regulation prevents that operators from extracting market prices from consumers where they have the capacity to pay the cost of care and accommodation***.

3.1.2. Evidence of the impact of present funding and regulation on Blue Care

3.1.2.1. FY2010 financial performance

Blue Care accounts for care income separately from accommodation income. A *care* surplus or loss is determined after all operating costs. An *accommodation* surplus is determined after deducting building depreciation from all accommodation income including residential bond interest.

Case example:

Under the present funding and regulatory arrangements, Blue Care's FY10 financial performance is summarised below:

- Blue Care incurs substantial losses in the provision of residential aged care

- Blue Care is not compensated for the full economic cost of providing *accommodation* to 4,240 residents. Blue Care estimates that this income stream supports investment of $68,000 in a new residential aged care place (bed). New places cost considerably more than this amount. This is elaborated in our commercial-in-confidence submission

- Blue Care provides residential aged care services in small communities, rural areas and provides 47% of our beds to the financially needy. Whilst providing this charity, Blue Care manages to achieve EBITDA per bed that approximates reported industry averages.

Blue Care's residential aged care services will be unsustainable should present funding and this level of financial performance continue. Given that in financial terms, Blue Care performs around surveyed industry averages, it is reasonable to conclude the residential aged care sector is presently unsustainable.

An analysis of Blue Care's month FY10 residential financial performance is separately provided in our Commercial-in-Confidence submission.

3.1.2.2. Financial projections FY2011-2020

Section 4 of Blue Care's submission to the Senate Standing Committee on Finance and Public Administration's 2009 Inquiry into Residential and Community Aged Care in Australia (SSCFPA) provided evidence that our input cost increases have far exceeded operational funding indexation.

Recently, the DoHA announced a 1.7% increase to ACFI subsidy rates from 1 July 2010.

Having regard to this recent announcement, Blue Care's 10 year financial projections include an assumption of 2.0% annual increments in care subsidy income and 4.0% in client fee income. Care staff costs are indexed in line with our enterprise bargaining agreements. Other operating costs have been indexed at 2.5%. This particular assumption is conservative. Estimates of expected fuel and utility cost increases substantially exceed this estimate and are available in the public domain.

With these optimistic assumptions, our financial modelling projects our present overall small residential aged care surplus turning to loss by FY 2013 and then increasing to high magnitude losses from FY2015 to FY2020.

Blue Care will not be able to withstand these projected losses. ***Should current funding arrangements and indexation of the magnitude of the recent care subsidy increase continue, it is apparent that Blue Care will not have the financial capacity to sustain our residential aged care services.***

Blue Care's 10 year financial performance projections are separately provided in our Commercial-in-Confidence submission.

3.2. Reform of funding

3.2.1. Who should pay for aged care services?

Based on the population in residential aged care and allowing for income tested fees this represents approximately $900 million annually in required additional care funding for the sector. Later in this submission Blue Care has estimated that accommodation payments of $15 prpd would be required to support investment in residential aged care for supported residents.

The Productivity Commission has been asked to develop funding options that ensure access to services at an appropriate standard of care, deliver diverse and fiscally sustainable care modes and allow smooth transitions between different types and levels of care.

The projected increase in aged care needs over the next 40 years is well known and there is expected to be a growing funding gap.

Blue Care considers that fundamental changes are needed to urgently address inadequacies of current funding.

There is also a need to develop and implement mechanisms to ensure the long term funding of future care needs. Suggestions for this are set out in section 9 of this submission.

3.2.2. How appropriate are accommodation *user charges* in residential care?

3.2.2.1. Present user charge structure

Residents in Australian Government subsidised residential aged care may be charged:

- Basic daily fee - all residents are asked to pay a basic daily fee not exceeding 84% of the basic single age pension
- Income tested fee - residents with assessable income above the full pension are asked to pay an income tested fee (in addition to the basic daily fee) dependent upon their income and the level of care. This fee is capped
- Accommodation charge - residents with assets in excess of $37,500 who require high level care may be asked to pay an accommodation charge. The maximum is $26.88 per day for residents with assets of $93,410 or greater
- Accommodation bonds - residents who require low level care or who enter an extra service high care place may be asked to pay a bond so long as it does not leave them with less than $37,500 in assets. Retentions of $299 per month may be deducted. Bonds are exempt from the pension assets test as is the former home if it is rented out to pay some or all of a periodic payment, the former home and the rental income are also exempt
- Extra service charges - for the provision of a higher standard of accommodation services and food

- Additional service fee — where the resident requests or agrees to additional services (such as newspapers and hairdressing).

Fees and charges

Providers' capacity to provide supply and choice to consumers is presently constrained by:

- Capped fees for care and accommodation
- Prohibition of bonds for consumers entering high care
- Regulation to limit the supply of extra service places.

As is the case for most goods and services, Blue Care considers that consumers should pay the market price for aged care and accommodation where the consumer has a capacity to pay and subject to there being competitive supply available in the market catchment.

It is reasonable to conclude that providers will withdraw supply if market prices are not paid by consumers, and government subsidies for those who cannot afford to pay, do not provide a market level income.

Blue Care recommends that ***charges to residents who do not meet the definition of a 'supported' or 'partially supported' resident be uncapped with the market determining the pricing cap subject to adequate price competition*** *(for example, to protect consumers in small communities)*.

Restrictions on high care bonds

In our commercial-in-confidence submission, Blue Care estimates the impact on our bed stock by 2020 if reform does not provide for long term industry viability.

The principal reasons for this are:

1. The restriction on high care bonds
2. The present accommodation supplement of $26.88 prpd.

Presently, there is a deprivation of capital in the segment where there is most need – high care places.

Much of the needed capital could be made available in the form of either a high care bond or an alternative equivalent payment that could be derived through such mechanisms as a reverse mortgage or periodic payments that might be made from rental income.

Presently, retentions of $299 per month may be deducted from bonds. This legislative limit on retentions has also contributed to a scarcity of capital. In the retirement village industry, retentions are determined by the market not legislation.

In June 2009, the National Health and Hospital Reform Commission (NH&HRC) in recommendation 43 gave conditional support to high care bonds:

> "We recommend that consideration be given to permitting accommodation bonds or alternative approaches as options for payment for accommodation for people entering high care, **provided that** removing the regulated limits on the number of places has resulted in sufficient increased competition in supply and price." (emphasis added)

Blue Care is disturbed by the conditional support given to bonds in high care contained in recommendation 43.

We support deregulation of the number of places so long as there is a transitional period allowing for adjustment over time. However, the need for access to user capital is immediate. 'Stapling' access to user equity in the form of high care bonds (or similar) to increased competition is illogical and may well see the financial failure of existing providers.

Delay to user capital will be detrimental to the development of replacement/new bed stock and constrain supply and choice for consumers because providers will not be able to develop bankable business cases on the present accommodation supplement/charge.

Blue Care notes that uncoupling of residential aged care places (known as 'bed licences') from physical built stock will raise the risk profile of providers and increase the cost of capital. Necessarily, this can be expected in time to increase the cost to government in compensating providers for the full economic cost of service provision to supported residents.

Blue Care recommends that ***restrictions on high care bonds, including retentions, be removed*** and deregulation of bed supply should follow in the longer term. Further, ***user charges for accommodation for those with the capacity to pay should be uncapped***. These are relatively simple reform with no budget cost to government.

Regulated extra services

Blue Care takes seriously its missional objective to provide services for those who are financially disadvantaged. This is reflected in the considerably higher rate of concessional consumers living in our residential aged care facilities. Greater numbers of financially disadvantaged consumers could be accommodated if motivators were introduced to reward providers who cater for this special needs group.

Blue Care is supportive of increased consumer choice, including the ability to access discretionary 'extra' services and different levels of accommodation (basic good quality through to grand style) according to personal preference and their ability 'top-up' the government subsidy with their own contributions.

The supply of extra services is regulated by DoHA. This regulation adds to the costs of bureaucracy whilst depriving frail, elderly Australians of consumer services.

It is difficult to understand the policy and legislative rationale which actively engages the government agency, responsible for the provision of *care* to frail, elderly Australians, in rationing the supply of *non-care services* to those same elderly.

As the Productivity Commission (2008) notes, the Hogan Review (2004, p10) argued 'the ability of some to purchase a higher standard or another form of care should not be denied'.

The regulation of extra services, rather than allowing supply to be determined by the market, has resulted in market imperfections with over supply in some market catchments, and deprivation in others.

Case examples:

Blue Care has visited extra service facilities of other providers and observed low take-up in catchments with lower average income and property values. Residential aged care market analysts have advised Blue Care that extra service place facilities are accepting standard care residents just to fill beds.

Contrary to this, Blue Care has first class residential aged care facilities in higher than average socio economic areas and is yet denied extra service places in these services by the rationing agency.

Blue Care recommends that ***regulations and associated restraints on extra services be removed***. This is a relatively simple reform with no budget cost to government.

3.2.3. Are there costs that may be unbundled and be the consumer's responsibility?

Reasons for considering unbundling of care subsidy payments include:

- To better target funding of service responses based on need
- To provide equity between subsidies paid to recipients irrespective of their accommodation situation
- To provide for efficient provision of services - a care subsidy need not necessarily be paid to a provider and might be paid to a recipient
- To explicitly fund care. For example, living expenses are generally the responsibility of a care recipient prior to admission to a residential aged care home and arguably need not necessarily be funded post admission to residential aged care.

There are issues to be considered in operationalising unbundling, including:

- *Measuring and achieving equity:* Admission to residential aged care is often brought about by advancement of care needs and also a consumer not having an informal carer at home. In a residential setting 3 hours of care, say, may be delivered prpd. Providing and equivalent 3 hours of care in the home is problematic for reasons including:
  - Nurses and professional carers are supervising/ on standby 24 hours a day, 7 days a week in residential aged care which is cannot be replicated in traditional community care
  - Staff costs in travelling to work in a residential aged care service are funded by the staff (as in most employment). In a community setting, travel time and costs consume subsidy/package payments

  - Residential aged care assists the Government to avoid the costs of admission to hospital relative to care in the community

- *Achieving value for money in traditional community living compared to supported living environments:* Emerging trends for supported living in retirement village serviced apartments are reminiscent of hostel care prior to 1997 when some very low care individuals resided in residential aged care. Supported living environments have the potential to go someway between closing the gap between community living and residential aged care and lower the cost to Government.

- *Achieving equity is problematic when many older Australians have no alternative to residential aged care and the cost would be prohibitive to them:* For older Australians who cannot be supported in their home by informal carers or whose needs exceed that what can be provided in the community, residential aged care often becomes the only option. Many older Australians are not able to access the capital value of a bed (eg through their equity in their own home or other assets). In those situations, the cost of accommodation will necessarily fall to government.

Blue Care supports further investigation of unbundling if it leads to improved equity, consumer choice, flexible and efficient service provision and value to the Government - as long as a safety net protects those needing residential aged care and those unable to pay market prices.

3.2.4. Are current *care* subsidies sufficient to provide adequate levels of care?

3.2.4.1. Care subsidies are not based on a determination of the true costs of care

The principal care subsidies are:

- an Aged Care Funding Instrument (ACFI) subsidy
- the Conditional Adjustment Payment (CAP), 8.75% as a percentage of the ACFI subsidy.

To the best of Blue Care's knowledge, neither the Resident Classification Scale (RCS) care subsidy system nor its successor, the ACFI were developed through the determination of the true costs of delivering care and accommodation to residents. Certainly, if reliable detailed costing does exist to support ACFI subsidy levels, it is not available in the public domain.

3.2.4.2. Care delivery costs are not 'vanilla'

Blue Care's evidence

Blue Care's service delivery costs differ for comparable levels of acuity across our residential aged care facilities. Location specific factors which influence service delivery cost include:

- *Catchment demographics* – the availability of residents of a particular acuity level affects the capacity of a provider to optimise resident placement and roster
- *Facility layout and size* – both these factors influence capacity to optimise roster. Stewart Brown (2009) report that a majority of single bed rooms in a facility means, on average, that its operating result will be worse than those facilities with a majority of multi-bed rooms. Blue Care's experience though is that our facilities with multi-bed wards, on average, do not outperform our portfolio average
- *Workforce availability* – availability of casuals to cover vacancies at the appropriate level of staff in particular locations influences roster optimisation.

Case example:

Even with common management structures, processes and a support team focusing on financially underperforming services, Blue Care has great variability in facility performance. Care delivery costs are not 'vanilla'. Whilst our best performing facilities achieve industry top quartile EBITDA per bed, at the other end of the spectrum we support our loss making services in regional areas.

Blue Care's care surpluses and losses for each of our residential aged care facilities is shown in our commercial-in-confidence submission.

Industry evidence

In December 2009, Aged Care Association of Australia (ACAA) released an article referring to the Minister for Ageing providing a set of answers to questions in the Senate which set out the average cost of care in each state and territory. This information detailed significant variations between the costs of care as calculated by government in each jurisdiction[12].

ACAA compared the average cost of care with the average income received by an aged care provider and estimated the shortfall between income and cost.

The CEO of Aged Care Association Australia (ACAA) Rod Young said 'the figures highlight a serious gap in subsidies received with an average shortfall prpd of *$10.17*. That translates into an annual shortfall of $630 million across the whole industry.' Blue Care considers that the shortfall exceeds this indicative estimate because it suppliers will not, in the long term, provide services and incur business risk just to break-even.

3.2.4.3. Does indexation fund rising input costs?

As noted earlier, Section 4 of Blue Care's submission to SSCFPA provided evidence that our input cost increases have far exceeded operational funding indexation.

On 28 May 2010, the Minister for Health and Ageing announced a 1.7% increase to ACFI subsidy rates from 1 July 2010. We expect that the Productivity Commission is able to assess whether this increment is likely to fund input cost increases.

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12 http://www.agedcareassociation.com.au//content/CEOs%20Report%20Dec%2009%20final%2Epdf (1 July 2010)

3.2.4.4. Required reform

Under-funding and inadequate indexation of subsidies has occurred for many years and, rationally, can only continue for so long. In the long term, unless providers are compensated for the full economic cost of provision of service to supported residents, supply will withdrawn in time.

Based on the current population in residential aged care and allowing for income tested fees this represents approximately $900 million annually in required additional care funding for the sector.

In our Commercial-in-Confidence submission, Blue Care has set out the effect on Blue Care's financial performance of an increase of this magnitude (together with other reforms which we consider necessary).

To ensure sustainable, quality care for consumers, providers must be compensated for the full economic cost (including cost of capital/market rent) of efficient service provision or, rationally, providers will withdraw supply. Full economic cost must:

- Be sustained though transparent indexation
- Include delivery cost imposts for special needs individuals
- Include compensation for regional delivery cost imposts
- Include payment of competitive wages for employees.

***Blue Care recommends implementing a transparent method of estimating and funding*:**

- ***True costs of care at different acuity levels, allowing for regional cost imposts***
- ***Input cost increases that are relevant to the residential aged care and community care sectors and capable of being subjected to external scrutiny and review.***

Blue Care recommends the establishment of an independent body to benchmark the true cost of care including regional variations and to estimate input cost increases and the required level of indexation of subsidies.

3.2.5. Is the current *capital* subsidy, the accommodation supplement of $26.88, sufficient?

3.2.5.1. Accommodation supplement

Capital funding for providers for accommodation is in the form of an accommodation supplement which is currently a maximum of $26.88 prpd. Blue Care submitted to SSCFPA that this supplement is inadequate for new beds.

We note that the paltry current level of accommodation supplement has served to adversely impact older Australians in a rural community.

Case example:

Blue Care spent $700,000 design and development work for replacement of a 96 bed service in country Queensland which mainly serves supported residents.

Cost estimates provided by quantity surveyors on detailed design drawings indicated a development cost of $270,000 per bed. As the accommodation supplement supports an investment per bed of less than $100,000, Blue Care has abandoned the replacement of the facility and a decision has now been made to refurbish 64 beds.

Cost estimates for refurbished beds are $137,622 per bed. It is interesting that even the cost of refurbishment exceeds that the capital amount supported by the accommodation supplement.

Blue Care projects care losses will be incurred at the redeveloped site. However, as the community is not served by any other provider, for Missional reasons Blue Care is proceeding with the refurbishment.

3.2.5.2. Development cost of new beds

However, we are involved in the development of a number of proposed projects which are proceeding to this point in anticipation of reform of residential aged care. Quantity surveyors have provided cost estimates based on detailed design drawings in two instances and schematic plans in another, in respect of these projects. A summary of these project cost estimates are shown below:

Case examples:

Table 3: Comparison bed costs for proposed Blue Care RAC developments

	Metro 1 per bed	Metro 2 per bed	Country per bed
Number of beds	***96***	***128***	***64***
Construction (incl basements)	228,515	226,711	145,082
Other (including fees, charges and FFE)	37,566	63,791	36,413
Land	12,000	13,592	5,000
Total including land value	**$278,081**	**$304,094**	**$186,495**

Source: Quantity surveyor estimates (2010)

Notes:

1 Metro – land constrained hence multiple level development with basement car parking. Built to a standard expected to withstand potential metropolitan competition. All rooms fully ensuited. Proposed kitchen is a 'receiving kitchen' and the laundry will only process 'personals'. This development is intended to replace a residential aged care service closed on the site some years ago

2 Regional – Location where competitors are unlikely. Designed to be built to domestic grade to the extent it is achievable. Single level with on-grade car parking. 50% of rooms share an ensuite. Receiving kitchen only. Personals laundry only. This new service is being built for Missional reasons will result in a reduction of 27 Blue Care beds in the particular country township

3 Metro 2 project costs include infrastructure contributions of more than $20,000 per bed demanded by Brisbane City Council. Metro 2 will result in a reduction of 57 beds from the number of beds in the service it is intended to replace.

We note that none of the above proposed facilities include a full service kitchen and full laundry facilities. These facilities would be required and add capital costs for many providers.

The details of these estimates are separately provided in our Commercial-in-Confidence submission.

Hanna Newman Associates estimated capital costs in Queensland at $238,818[13].

Whilst costs of developing a new bed will vary considerably based on a range of factors, Blue Care's detailed costing advice and corroboration suggests that $250,000 is a baseline cost for metropolitan Brisbane (excluding land). It may be possible to deliver beds for around $200,000 in some regional areas, with little alternative supply, by constructing low set, domestic grade buildings, sharing ensuites and utilising on-grade car parking.

[13] Economic evaluation of capital financing of high care, Access Economics, February 2009, p16

3.2.5.3. Required accommodation supplement

As the Productivity Commission is aware, Access Economics (2009) assessed the amount of daily rent at which investment would proceed in residential aged care development. They assessed the breakeven point for the accommodation payment of $40.32/bed-day as the base case from March 2009.

Blue Care has reviewed that assessment and considers that it substantially underestimates the capital cost of new beds, omits periodic capital replacements, excludes the cost of land, underestimates the required rate of return and appears to contain calculation errors.

Notwithstanding this, we have utilised that discounted cash flow modelling approach and have made adjustments for these factors to assess the breakeven point at which investment would proceed in a new bed.

Assumptions:

- Building cost per bed - $250,000
- Land cost per bed - $12,500
- Occupancy - 95%
- Income inflation - 3%
- Land price inflation - 4%
- Refurbishment/replacement costs – as advised by Napier Blakely, quantity surveyors for a proposed Blue Care development (% of original cost):
  - After 5 years – 1%
  - After 10 years – 2%
  - After 15 years – 4%
  - After 20 years – 6%
  - Stage 5, after 25 years – 9%.
- All other property outlays are paid by the 'tenant' (assumes there is sufficient 'care' surplus to pay for these. Currently, few providers have a care surplus)
- Residual value of buildings - nil at 30 years
- Weighted average cost of capital (WACC):
  - Current regulated environment – 12.0%
  - De-regulated environment – 13.0%

  These WACC assessments are set out in Appendix A.

  Blue Care notes that in an efficient market, the property assets of a residential aged care facility might be held by property investors who would demand a lower rate of return than an investor in residential aged care operations.

  Indeed, the residential aged care industry would appear prima facie to be the ideal industry to separate the ownership of physical assets from operations to

lower the cost of capital. An example in another industry is the Bunnings Warehouse Property Trust which holds over 50 Bunnings warehouse properties.

The residential aged care sector has not seen large scale investment in property assets with an operator as an arm's length tenant. Based on residential aged care financial performance surveys, Blue Care suspects that the absence of this reflects poor industry earnings and financial unsustainability. Many, if not most, operators would *not be* financially capable of paying an arm's length market rent.

Projected cash flows have been discounted over an explicit forecast period of 30 years under the current regulated environment scenario and also a de-regulated environment.

The projected cash flows to assess the breakeven point at which investment would proceed in a new bed which produce a zero net present value (NPV) are shown below:

Table 4: Projected cash flows to assess the breakeven point at which investment would proceed in a new bed

Year	Outflows	'Current' Inflow	'De Reg.' Inflow	Residual	'Current' Net Cash Flow	'De Reg.' Net Cash Flow
0	(262,500)	0	0	0	(262,500)	(262,500)
1	0	26,404	28,664	0	26,404	28,664
2	0	27,196	29,524	0	27,196	29,524
3	0	28,012	30,410	0	28,012	30,410
4	0	28,852	31,322	0	28,852	31,322
5	(2,625)	29,718	32,262	0	27,093	29,637
6	0	30,609	33,230	0	30,609	33,230
7	0	31,528	34,226	0	31,528	34,226
8	0	32,473	35,253	0	32,473	35,253
9	0	33,448	36,311	0	33,448	36,311
10	(5,250)	34,451	37,400	0	29,201	32,150
11	0	35,485	38,522	0	35,485	38,522
12	0	36,549	39,678	0	36,549	39,678
13	0	37,646	40,868	0	37,646	40,868
14	0	38,775	42,094	0	38,775	42,094
15	(10,500)	39,938	43,357	0	29,438	32,857
16	0	41,136	44,658	0	41,136	44,658
17	0	42,370	45,997	0	42,370	45,997
18	0	43,642	47,377	0	43,642	47,377
19	0	44,951	48,799	0	44,951	48,799
20	(15,750)	46,299	50,263	0	30,549	34,513
21	0	47,688	51,771	0	47,688	51,771
22	0	49,119	53,324	0	49,119	53,324
23	0	50,593	54,923	0	50,593	54,923
24	0	52,110	56,571	0	52,110	56,571
25	(23,625)	53,674	58,268	0	30,049	34,643
26	0	55,284	60,016	0	55,284	60,016
27	0	56,942	61,817	0	56,942	61,817
28	0	58,651	63,671	0	58,651	63,671
29	0	60,410	65,581	0	60,410	65,581
30	0	62,222	67,549	30,341	92,563	97,890

Under the abovementioned assumptions, the required daily accommodation supplement in each scenario is as follows:

- Current environment: *$76.15*
- Deregulated environment: *$82.67.*

For comparison, budget motel room day rates are offered for sale at around $75 to $100[14]. Whilst motels do not enjoy the same level of occupancy as residential aged care facilities, Blue Care observes that many modern facilities are built to a higher standard than this type of asset. An example is Blue Care's new service at Labrador, Queensland[15].

Blue Care has provided evidence of the establishment of a modern competitive bed in metropolitan Brisbane as being in excess of $250,000. ***Blue Care recommends that the maximum accommodation supplement be increased from $26.88 prpd to $76.15 prpd to adequately fund investment in new beds in Brisbane*.**

If deregulation recommended in the NH&HRC report regarding removal of the regulated limits on the number of places proceeds, the risk profile of providers and hence the cost of capital will increase. In such circumstances, Blue Care estimates that the required accommodation supplement is $82.67.

Blue Care recommends that the *accommodation supplement be adjusted over time based on independent evidence as to building development costs having regard to clinical and community norms regarding standards of accommodation and regional disparities*.

[14] http://www.budgetstay.com.au/ (30 June 2010)
[15] http://www.bluecare.org.au/LabradorGardens/SlideShow.aspx (14 July 2010)

3.2.6. Is funding in rural and remote settings adequate?

3.2.6.1. Cost imposts on Blue Care's own rural and remote services

Blue Care's submission to SSCFPA sets out in section 5 discussion of the adverse impacts on Blue Care's own operating costs in rural and remote areas.

3.2.6.2. Cost impost on another providers service in remote community

Case example (It is stand alone isolated provider supported by Blue Care):

Since that submission, Blue Care was invited to provide significant management assistance to another provider's small residential aged care service in a remote part of Far North Queensland which serves mainly indigenous residents. Blue Care has formed the view that:

- The service was not viable as a residential aged care facility under present funding residential aged care funding

- Even after including the present level of remote funding, on an on-going basis, the service will incur operating losses in excess of $400,000 per annum equating to a loss of approximately $40 prpd

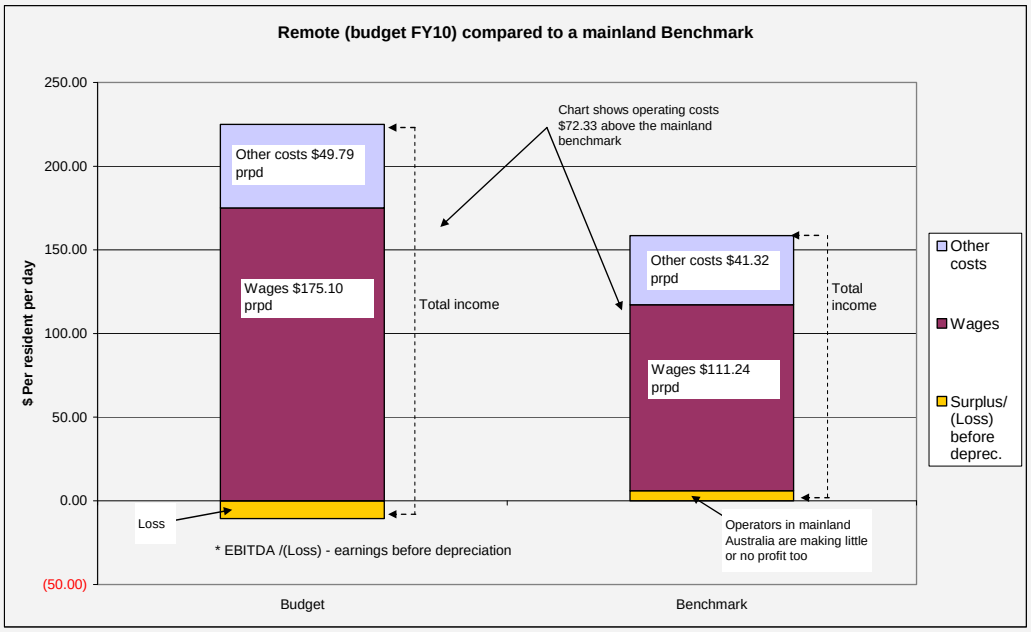
- If allowance was made for required maintenance the expected loss equated to approximately $45 prpd – the amount needed to enable long term survival of the residential aged care facility

- A remote allowance of around $70 prpd was required to ensure viability. The statutory remote allowance of $24.32 prpd is inadequate for that service.

Case example cont'd:

Blue Care's analysis of the cost profile of the provider's residential aged care service is shown below:

Figure 1: Analysis of the cost profile of residential aged care service in remote community



Source: Blue Care

The above chart shows operating costs being approximately $70 prpd above that of a benchmark mainland provider with comparable acuity levels. Blue Care considers that this operating cost burden is genuine and not a consequence of poor management and reflects much a higher input costs, in particular, the costs of attracting, housing and retaining senior staff.

As mentioned earlier, in December 2009, ACAA released an article referring to the Minister for Ageing providing a set of answers to question in the Senate which set out the average cost of care in each state and territory.

ACAA calculated an average shortfall prpd of $44.59 in the Northern Territory. Interestingly, Blue Care's estimate of a shortfall in funding of $45 prpd for this particular remote community is similar.

3.2.6.3. Required reform

To address regional variations in the cost of service delivery, ***Blue Care recommends that:***

- ***An independent agency collect data on regional premia applying to the major input costs for residential and community aged care***
- ***Based on this collected data, the government identify specific regions where cost premia apply***

- ***The government explicitly adjust residential aged care subsidies, HACC unit prices and other fees according to the regional cost premium and respective mix of input costs.***

3.3. Impact of potential reforms on Blue Care

We have detailed in our Commercial-in-Confidence submission the effect on Blue Care's financial performance of a number of potential reforms.

Case example:

These are outlined below:

	Notes	Reform $'000	Proforma $'000 prpd
Care Op Surp/(Deficit)	1	23,214	(Refer to our commercial-in-confidence submission)
	2	3,600	
	3	(7,513)	
	4	1,295	
	5	11,250	
Accommodation net income			
Total Surplus	6		
KPIs			
EBITDA prpa	6		
Return on invested capital	6		

Notes:

1 *Increase in ACFI funding and co-payments:* Increment of $15.00 prpd for 4,240 residents

2 *Introduction of high care bonds:* 1,000 high care bonds x $3,600 retention per annum (no cost to government)

3 *Introduction of high care bonds:* Reversal of accommodation income 1,000 x $20.58 x 365

4 *Increase in accommodation supplement income:* New Labrador site ($76.15-$26.88) x 160 beds x 45% x 365.

5 *Introduction of high care bonds:* 1,000 high care bonds x $250,000 x 4.5% (no cost to government)

6 These illustrative reforms produce a proforma surplus and investment return for Blue Care as set out in our commercial-in-confidence submission.

4. Funding options for community care

4.1. Present funding

HACC contract unit prices vary across individual projects (SPIDs).

Case examples:

Blue care receives funding from a range of community programs. For the purpose of this submission, we will focus on the Home and Community Care Program (HACC), Community Aged Care Packages (CACP) and Extended Aged Care at Home (EACH).

Blue Care's HACC contract unit prices vary across individual projects (SPIDs). The base prices for our core funding were agreed in May 2005 and implemented in July 2006 (with indexation for 2005-06). Since then, base funding has been subject to annual indexation, with no opportunity for reviewing the amount or allocation of that funding or the corresponding output requirements by service type.

The table below highlights the variation in unit prices received by Blue Care across the state, as at June 2010:

Table 5: HACC programs – variation in units prices

Service Type	SPID	HACC District	Unit Price (per hour)	No. of Units (per annum)
Personal Care	27	B	$29.74	2,495
Personal Care	929	R	$38.57	12,881
Allied Health	61	B	$64.56	5,769
Allied Health	12	R	$73.22	7,154
Allied Health	29	N	$71.74	1,965
Nursing	60	R	$63.76	14,134
Nursing	5	T	$79.84	9,867
Nursing	324	Q	$74.98	37,399

Source: Blue Care

Due to the block funding approach used by HACC, quality of service per hour is not compromised by a lack of funds. However, input cost increases have exceeded and Blue Care's ability to meet contracted outputs is therefore adversely affected. In order to maintain quality and cover input costs, outputs may fall.

The inability to regularly review the allocation of base funding in terms of SPIDs and service types means that services cannot respond to changes in demography, models of care or availability of resources in a timely manner.

The wide degree of variation in prices means that some SPIDs are better able to meet contractual output requirements whilst maintaining quality care than others. Although some variation is justified by different models of care and cost structures, many variations are arbitrary and historical.

Due to the inadequacies of current funding, there is an increasing reliance on client contributions to deliver services.

Fee structures also create transition issues between HACC and CACPs. There is disincentive for a client to move onto a CACP (even though their needs assessment may recommend this).

National guidelines for client contributions are needed to assist providers in developing appropriate policies and transitioning clients from HACC services to packaged care.

Blue Care supplements core government funding where the program permits such a contribution. These co-payment rates are capped to a maximum contribution, and vary across programs. The co-payments are consistent with Blue Care's not for profit status, guided by a philosophy of delivering non-discriminatory services to all community members assessed as requiring a service. Therefore a consumer's inability to afford a co-payment will not be a barrier to services being delivered.

4.2. Reform options

We share the Commission's concerns that an assessment methodology must be developed to ensure equity in the determination of levels of care subsidies so they are transportable across community and residential domains. The dual assessments for functional need and financial capacity described in the WCOP model (Productivity Commission, 2008, p5) seems to be an equitable approach.

Funding rates, client eligibility criteria, service inclusions and allowable user charges vary greatly across the government subsides that cover community-based aged care services. This creates widespread client confusion, inefficient duplicative administration and service gaps and distortions. On average, government subsides for community care cover up to 70% (much less in some cases) of the total service cost. While this shortfall drives service efficiency, the gap is too great to be met by fundraising and allowable client co-payments, and nor is it balanced by more profitable user-pays arrangements.

Market acceptance of (allowable) client co-payments and supplementary fees is growing and shows the extent that clients value community care. However, some government subsidies exclude such payments on the grounds that their fixed subsidy covers the service costs, but this is not the reality. Those government subsidies that do allow client co-payments either require means-testing by the service provider, or fail to endorse any specific rates, or set rates that (because of the high volume nature of community care) are so small as to be clinically inefficient and administratively preclusive to transact without substantial technology investment and organisational change. In short, the administration of approved client payments is very costly for Blue Care.

Blue Care's community services make approximately 2.5 million home visits annually, which demonstrates the efficiency potential of a bulk billing solution. This will help to minimise duplicative administrative burdens on community care services, resulting in more efficient use of government subsidies on direct client care. The government *should give strong consideration to operationalising means-testing and administration of client payments for community care (and possibly other care services) through the social welfare or Medicare system, rather than at the service interface*.

Similar community care funding programs across different government layers and service types should be amalgamated where possible, or at least administered under consistent subsidy policies and service eligibility criteria. Transitioning the HACC program to the Commonwealth will assist here, and is supported by Blue Care. In the short-term however, the government should release a clear national policy on client co-

payments and review existing subsidy levels to ensure they more closely reflect real service delivery costs.

Blue Care recommends:

- ***Regular review of HACC contracts***:
  - to provide some flexibility in service provision so output requirements can be responsive to changes in demography and models of care, and encourage innovation
  - to avoid perpetrating historical variations in prices across the state which may no longer be relevant
  - to ensure indexation matches input cost increases.
- Recognition of increasing reliance on client contributions and ***development of policies to assist providers in developing appropriate policies and in transitioning clients from HACC services to packaged care***.

5. Future workforce requirements

5.1. Key issues

Blue Care supports the range of aged care workforce views canvassed in the Commission's Research Paper, especially the following:

- Cross-industry wage parity is required
- Workforce pressures will rise in line with population ageing
- Staff morale, workloads and safety are key concerns
- Increased scope of practice, professional development and training, and vocational education will help to enrich aged care employment
- Informal carers play a significant role in supporting formal care
- Volunteers need deserve streamlined recruitment and cost-neutral participation.

Our staff say that working in aged care is personally and professionally meaningful and enables them to make a difference to others' wellbeing. Despite the dedication of staff, a range of systemic issues compromise the sustainability of the aged care workforce, requiring fundamental reform across a range of areas. Issues most relevant to Blue Care at present are detailed here and evidenced by recent Blue Care workforce statistics (Ray, 2010):

- Workplace Challenges – Our staff commit themselves to work in an undeservingly stigmatised field erroneously viewed by the public with fear and apprehension. Workloads are stressful. Financial returns for aged care providers are low. The work itself is excessively regulated, physically demanding, emotionally draining and poorly remunerated. Against this backdrop, Australia's population changes will increase the demand for aged care and the level of age-related disability, and will contribute to a rise in consumer expectations of service access and quality.
- Remuneration Inequities – Anomalies between minimum pay rates in aged care and acute health (and other fields) have been well documented by the Commission. While cross-industry standardisation of remuneration rates is vital, the key challenge for government is to increase the baseline for subsidy levels, as these are the primary income source to fund care services, and therefore wages. Correspondingly, this also impacts on organisations' capacity to fund innovation and service improvement.
- Ageing Workforce – The Blue Care workforce average age of 46.4 years is more than four years higher than the average age of workers in the health and community services sector (42 yrs), and seven years higher than the Australian workforce average age of (39.4 yrs). At present over 60% of our staff are 45 years and over. On current trends, we could have around 40% of our workforce aged 60 or over within a decade. Our key challenges here relate to knowledge management and maintaining the effectiveness of our ageing workers.
- High Rates of Early Turnover – 38.1% of staff have been with Blue Care for two years or less. We experience high turnover with personal care workers, especially in the first year when almost one quarter of new starters in this group exit. The

average tenure of personal care workers is four years so, given they represent 55% of our workforce, there are substantial time and cost impacts in recruiting and training around 1200 of these employees per annum.

In addition, Blue Care faces difficulties in recruiting, training and retaining an effective volunteer workforce, and significant time and energy is expended on managing volunteers once they settle into the organisation.

5.2. Future workforce options

A range of systemic issues compromise the sustainability of the aged care workforce, requiring fundamental reform across a range of areas. Consumer aged care services are constrained by availability and skills of staff. One key issue is that current funding is insufficient to allow for aged care and community care providers to compete with the acute sector for care staff and this has a detrimental effect on both the residential aged care sector's capacity to recruit, train and retain staff. Blue Care ***recommends*** the following reforms to address the above workforce challenges:

- Introduce a transparent mechanism and sufficient recurrent funding to achieve and maintain comparable wages and working conditions with the acute health care sector for all staff working in residential and community aged care.
- Cross-industry wage parity is required. Establish base pay remuneration parity for similar roles across all fields in the health and community services sector.
- Create consistency across states and territories for employment conditions, training and qualifications and clinical scope of practice (particularly with regard to medications)
- Examine regulation and current industry practice in terms of staffing mix and fund pilot programs to evaluate less expensive models of residential care.
- Trial and implement new e-health and assistive technology advances that aim to reduce the demand for some types of labour intensive services and create efficiencies in work systems and promote increased consumer independence levels. Examples include Smarthome; Palliative Care Online, and remote telehealth.
- Strengthen the aged care workforce, especially those that target personal carers' vocational education and work satisfaction
- Dedicate funding to ensure all staff in aged care and community care have access to education and training that furthers their qualifications and skill levels.
- Increase numbers of clinical placements for undergraduate nursing and allied health students
- Develop a strong indigenous and culturally diverse component of our workforce
- Expand the scope of the role of RNs to nurse practitioners in aged care
- Increase scope of practice, professional development and training, and vocational education to help to enrich aged care employment. Facilitate the abolition of demarcations of duties, provide appropriate training and remuneration incentives to develop a multi-purpose workforce that will allow sharing of staff across program and care domains.

- Implement reforms to better meet older workers' needs as they age. This should include applying or strengthening incentives that (a) keep older workers productive, such as redesigning industrial provisions to cover flexible working hours, increased carers' leave, policies that minimise physical work demands and tasking that promotes knowledge sharing, and (b) keep older workers in the aged care field with tax concessions, increasing workforce participation entitlements and relaxing pensioner income thresholds.
- Better general practitioner support of residential aged care facilities will assist staff to provide better quality care and increase work satisfaction.
- Construct a state and/or national Volunteers in Caring Services Network or 'Program' (with potential to link to similar international programs) could be developed to provide a centralised coordination point for volunteering and cost neutral participation in the workforce.
- Develop and consistently apply an indexation formula that aligns government subsidies underpinning funded care services with increases in base remuneration rates, to ensure a predictable margin is maintained between government funding and the true cost of care services, thus allowing aged care providers to fund workforce attraction and retention measures.
- Construct a state and/or national Volunteers in Caring Services Network or 'Program' (with potential to link to similar international programs) could be developed to provide a centralised coordination point for volunteering. Potential volunteers could nominate their skills and areas of interest at a regional or local area. Participating agencies would draw upon the pool of volunteers who are 'work ready', and collaborate with the centralised program to monitor quality and manage consumer and participant needs. The program would:
    - screen and register approved organisations to receive volunteers
    - promote volunteering, screen and recruit volunteers, arrange police checks
    - deliver consistent high quality volunteer training
    - implement and promote volunteer management policies and guidelines
    - implement a framework for matching consumer and volunteer needs, cultures and personalities
    - offer volunteers a variety of roles in a range of modes such as travelling tourists or 'grey nomads', social contact, transport and shopping assistance, office work, palliative care support, bereavement, and a choice of agencies to work for, geographic areas, and client types
    - address nation-wide regulatory barriers to participation (including age restrictions for both young and old volunteers, insurance, reimbursement of costs, etc).

Blue Care is ideally placed to pilot a program such as this, as we have a volunteer workforce of over 2,200 people and a comprehensive Volunteer Management Manual with associated policy and guidelines that are specific to the aged care industry.

6. Regulatory compliance burden

6.1. Is the level and scope of regulation and enforcement appropriate?

6.1.1. Issues

Blue Care agrees with the Productivity Commission (2009) findings in particular:

- The aged care industry is characterised by centralised planning processes which result in a heavy regulatory burden on aged care providers in order to maintain the quality of care. Without tackling the underlying policy framework that stifles competition it is unlikely that the regulatory burden can be substantially reduced
- Limiting the number of subsidised aged care places and associated price controls impede competition between providers undermining their capacity to respond to the needs of residents and their incentive and ability to plan for future growth in the industry, driven by the ageing population
- The regulatory framework is complex and fragmented due to the existence of several programs regulated by numerous government departments across three tiers of government resulting in an unnecessary cost imposition on providers
- While intended to protect vulnerable and aged consumers, some existing regulations have shown little concern for minimising compliance costs to providers as well as reducing adverse side effects such as encroaching on the rights of clients and their quality of life. The extensive increase in regulation in recent years does not reflect the high standards of care by the vast majority of providers.

Residential aged care is a highly regulated industry, with a range of accreditation, inspection and compliance regimes. The need for regulatory controls is not disputed - older Australians who are vulnerable and dependent on others for shelter, care and control of their finances are entitled to the highest levels of security and dignity.

However, there are questions as to whether the existing regulation is effective, especially as development of regulation can be seen as reactive and overlapping.

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

Senior staff in leadership roles in residential care, due to their reported interactions with the regulatory agencies, report accreditation and validation as being a negative and demoralising experience.

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

There are a range of agencies that may undertake unannounced visits including ACSAA, the Office of Quality and Complaints and the Commissioner of Complaints.

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

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

Blue Care agrees with the Commission's view that the dual gate-keeping approaches are duplicative in that they serve to control supply and demand simultaneously. A better control mechanism for aged care allocation is via ACAT assessment and process improvements to the way ACATs function would be warranted.

The ACAT tendency to immediately place newly-approved EACH clients on CACP lists is placing undue pressure on CACP providers, who often do not have available packages for EACH clients let alone other community clients already on their CACP waiting list.

ACAT referral processes vary across jurisdictions. Some ACATs 'hold' approved clients until a local service provider has capacity to take the new referral. In contrast, other ACATs simply complete the assessment and notify multiple service providers, who then collectively 'hold' the new referral themselves until a place is available. Each of them manages a waiting list database and each communicates independently with the client.

This approach creates duplicative administration for each of the services notified. ACAT work practices and processes must therefore be nationally consistent. Specifically, new referrals approved for aged care packages should be held on ACAT waiting lists, managed through communication between ACATs and Service Providers, to avoid duplicative administration for services and to prevent uncertainty for clients.

Significant advances in the standard of care have occurred in combination with, but not necessarily caused by an increase in accountability. In fact, accountability measures have been well documented by the Commission as being burdensome. In addition to the heavy regulatory load placed on residential services, the different funding types covering community care all impose separate accreditation standards, amplifying their administrative burden.

The Commission is well aware of industry frustrations with the inefficient and burdensome regulatory regime currently in place, and the corresponding suggestions from the industry to standardise quality/accreditation frameworks.

For a large organisation like Blue Care, tapping into a multitude of government subsidies enables us to provide an extensive range of care options, but each funding program applies a separate set of standards, which amplifies our burden of compliance. Many of our community services are accountable for regulatory compliance under four external funding programs (i.e. HACC, DoHA, DSQ and DVA), and sometimes, accreditation is even applied at the sub-program level. The inefficiencies of managing our compliance activities across multiple programs are enormous.

Current residential and community quality and accreditation systems include an expectation that a written consumer satisfaction survey has regularly occurred and a 'satisfaction rating' report is available for scrutiny at the time of audit. However, for many consumers written surveys may not be the best methodology to assess satisfaction, and surveys are a notoriously inaccurate reflection of satisfaction for vulnerable or special needs groups.

In response to quality legislation, providers like Blue Care devote significant resources towards producing an annual consumer satisfaction survey report across all service domains. Despite tool refinement aiming to increase the sensitivity of our tool, our consumer satisfaction results remain predictably high.

Investigation of satisfaction by other more appropriate methods may identify and address quality issues more quickly and accurately for consumer groups (e.g. CALDB communities, Residents' Committees) and individuals (e.g. a complex young disabled client, a remotely located client).

Acceptable evidence of quality assessment by auditors should be inclusive of a range of methods that facilitate a continuous culture of relationship building, seeking information and solving barriers to quality care and service provision.

6.1.2. Blue Care's study of the cost of compliance

Blue Care conducted research in 2008-09 to quantify the cost of regulatory burden on residential aged care services.

Case example:

Blue Care incurs substantial costs and staff time in complying with the numerous criteria mandated by all levels of government and the various funding and accreditation agencies.

The study assessment of costs included direct costs, such as fees, and the cost of staff time diverted from resident care activities. The study found that:

- The cost to Blue Care of major residential aged care compliance activities is in the order of $5.4 million per annum (representing approximately 2.3% of residential aged care revenue)

- Staff time engaged in compliance activities is 147,000 hours per annum. Assuming an average of 3.5 hours of care prpd, this represents 10 days of staff time diverted from resident care *for each* resident per annum.

Blue Care's study confirmed the cost of compliance is substantial and significantly deprives consumers of care staff time.

The study methodology is outlined in Appendix B.

6.2. Regulatory burden reform

Reduction of regulatory burden would enable residential aged care providers to better deploy resources for providing care to consumers. Blue Care agrees with the

Productivity Commission (2009) recommendations in relation to regulatory burden reform, in particular:

- DoHA should conduct a publicly available evaluation of the current police check requirements to explore whether the benefits of the existing regime could be achieved in a less costly manner
- The Aged Care Standards and Accreditation Agency should redesign the unannounced visit program using a risk management approach that focuses on under-performing aged care homes
- The government should amend the prudential standards to remove the requirement on aged care providers to disclose to care recipients or prospective care recipients financial and compliance statements
- The Australian Government should amend the Residential Care Subsidy Principles 1997 to remove requirements on aged care providers to lodge separate written notices with the Secretary of DoHA demonstrating compliance with Conditional Adjustment Payment reporting
- The government should introduce amendments to the Age Care Act 1997, and Aged Care Principles as necessary, to provide a clearer delineation of responsibilities between DoHA and the Aged Care Standards and Accreditation Agency regarding monitoring of provider compliance with the accreditation standards
- The government should amend the missing resident reporting requirements to allow providers to report to the Department on missing persons once every twelve months
- DoHA, in consultation with relevant state and territory government departments, should use current reviews of the accreditation process and standards to identify and remove, as far as possible, onerous duplicate and inconsistent regulations
- The Australian Government should abolish the annual fire safety declaration for those aged care homes that have met state, territory and local government fire safety standards
- The Australian Government should allow residential aged care providers choice of accreditation agencies to introduce competition and to streamline processes for providers who are engaged in multiple aged care activities.

Additionally, ***Blue Care recommends that an independent agency measure and benchmark the cost of compliance and the government should explicitly and separately fund the cost of compliance. This mechanism would focus government on risk based compliance measures rather than perpetuate the present burdensome regime where all cost falls on providers to the detriment of consumer care time.***

As recommended in our submission to the Productivity Commission review on regulatory burden in July 2009.
Blue Care recommends the redesign the unannounced visit program using a risk management approach that focuses on under-performing aged care homes.

- We confirm our support for changing to a risk management approach to the use of unannounced visits.
- Our concern focuses on the definition of "underperforming", and we assume this is related to poor accreditation or audit scores. Based on our extensive experience in the management of aged care facilities, we have identified the following lead indicators of risk:
  - Facilities which are new
  - Facilities which have new owners
  - Facilities with a high staff turnover.
- A similar risk management approach could be considered for 'announced visits'. Blue Care has costed the administrative burden of both types of visits, and found that 'announced visits' have been calculated at greater than three times the cost of unannounced visits (because of preparation activities).
- We are concerned about some of the processes surrounding unannounced and announced visits which can cause greatly excessive burdens to individual facilities, seemingly without good reason. The following examples illustrate this well:
  - Blue Care's Emerald facility was dealing with tropical storms and flooding in early 2009, and for two weeks was on standby for immediate evacuation. Standby involves readying evacuation packs for medications and ADL care, filling out evacuation forms, and daily contact with next of kin to keep them updated. All this occurred at a time when staff were dealing with their own personal flood crises at home. The department had previously arranged an announced accreditation visit which happened to be due at the end of the two week standby period. The facility had not yet completed their pre-visit preparations when the storms began. Afterwards, the department called the facility to check whether floodwaters had receded from the facility grounds, however they made no offer to postpone the visit and it went ahead as scheduled.
  - Blue Care's Iona facility at Kenmore began participating in what was meant to be a two-day unannounced visit recently. Half way through the first day the assessors realised they had come to the wrong facility (due to a RAC ID mix up) and decided to terminate the visit. It they had continued with the visit, the time spent would not have been wasted and the facility would have experienced its mandatory visit for the year. Two managers wasted half a day of their time as well as the time of other staff through scheduling numerous interviews for later in the visit, and the facility can expect another unannounced visit yet to come.
  - In 2009, three Blue Care facilities experienced multiple unannounced visits within a short period of time.

One of the major frailties of the current system is the position of the Aged Care Standards and Accreditation Agency (The Agency) in relation to the Federal Department of Health and Ageing (DoHA).

- Whilst there is much rhetoric around The Agency being an independent body, effectively, The Agency is a corporation wholly owned by the Australian Government and responsible to the Minister for Ageing and therefore it is somewhat absurd to assert they have independence.

- In Residential Aged Care there are multiple layers of regulation and therefore multiple layers of regulators. These layers include DoHA (including the Complaints Investigation Scheme), State statutory requirements and Local government requirements as well as accreditation with Aged Care Standards as judged by The Agency.

- The Agency states it liaises with the Department of Health and Ageing about services that do not comply with the relevant accreditation standards reinforces the inspectorial nature of the services. What is possibly more appropriate would be for The Agency to liaise with the Department of Health and Ageing about the level of compliance found in all facilities rather than concentrating on a negative in their core functions.

- Some examples of overlapping responsibilities that cause administrative burden for providers include:

    - The DoHA Complaints Investigation Scheme (CIS) investigates all complaints made to them by visiting the facility usually for a whole day and asking for a large range of seemingly irrelevant material including interviews with people unrelated to the incident in question. In some cases the matter will be referred to the Accreditation Agency, but it is unclear when this is meant to occur.

    - The Accreditation Agency investigates compliance with standards on a regular basis. Many of the standards are related to the key areas of complaint dealt with by the CIS (clinical care, continence management, nutrition, staffing levels). Often, facilities will endure the same investigation of care practices from both departments, and often a short time apart. For instance, an accreditation visit will occur that finds the facility fully compliant with particular standards, and shortly afterwards a complaint will cause the CIS to initiate an investigation on the same topic.

7. Retirement living

7.1. Overview

7.1.1.1. Retirement living trends

The number of retirement villages has increased substantially in Australia over the past 10 years. There were 1,756 villages accommodating between 145,000 and 150,000 people aged 65 plus, representing a penetration rate of 5.25% of that population[16]. In 2006, IBIS World estimated that the penetration rate for that cohort would increase to over 10% over the next 20 years.

A major for-profit industry provider recently stated at an industry conference that the average entry age of people to their retirement villages is now over 80. The average age of entrants to Blue Care's retirement villages during FY10 has been 80.3 years. We have also recently taken over 40 deposits on a new upper-middle market retirement village development. The average age of depositors is 78. By the time the new development opens, the average age of those people is expected to be 80.

Based on average entry age data, Blue Care's view is that the term 'retirement villages' is not an instructive descriptor and that the villages are more accurately described as places of independent, community living for the older, old cohort. Notwithstanding this, there are many entrants to retirement villages who are much younger than the average entry age and whose needs for companionship and lifestyle, among other things, are well met by retirement village living.

The average entry age data also suggests that measurement of penetration rates in the over 65 cohort in not particularly meaningful. The rate of adoption of retirement living may be better understood if industry analysts measured the penetration rates among the over 75 cohort.

In recent times, there has been segmentation of the retirement village industry with the development of:

- *Integrated communities:* Resort style villages collocated *with a residential aged care facility*. These tend to offer independent living, supported living with a care facility on-site should the care needs of an individual progress to that level

- *Supported living:* Villages targeting the older old cohort emphasising the availability of personal care and support services (but *not with a residential aged care facility*). In large part, care is delivered by community care providers in the form of CACPS and EACH packages into these apartments.

Subject to reformation of residential aged care that enables financial viability, Blue Care intends to expand its offerings of villages collocated with aged care facilities. These sites would offer residents a continuum of care from independent living, to supported living and full residential aged care. Should a resident advance to residential aged care, collocation offers the opportunity for residents to age in place and remain on the same campus as a partner and also close to a network of friends.

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[16] Jones Lang LaSalle 2008. The proportion of over 65s in retirement village's varies considerably around Australia. For example, it is 17.1% in Maroochy.

7.1.1.2. Tenure and barriers to entry

Tenure in a retirement village is the right to occupy a unit, apartment or villa and to use available services. The typical types of tenure in retirement villages are:

- Loan and licence agreements: Where the village operator retains ownership of the village accommodation units and the resident pays an ingoing contribution before occupying a unit. This ingoing contribution is characterised under the Retirement Villages Act (RVA) as a loan. The operator will typically charge a departure fee (or deferred management fee as it is known in Queensland (DMF)) and may share in any capital gain. The DMF may be calculated as a percentage of the ingoing contribution or the exit value.

  The DMF is often deducted over a period of about 10 years. An example for a new village is 6% per annum over 5 years and then 1% per annum for the remaining 5 years (based on the ingoing amount). The DMF provides the investment return for the operator. Residents incur no direct cost for new and replacement capital for the village.

- Leaseholds: The operator grants the resident a lifetime lease of their accommodation unit for which the resident pays the initial price of the unit. The initial price is made up of prepaid rent and a refundable loan, thus making this form of tenure similar to a loan and licence structure.

The main barrier to older Australians accessing retirement living options are:

- Their ability to pay an ingoing contribution. Generally, to pay an entry contribution and gain access to a modern integrated community or a supported living environment, a resident would have to own and be able to realise an existing property
- Reticence to incur the deferred management fee.

Industry participants acknowledge that the retirement village industry has not firstly, communicated the benefits of retirement living as effectively as it could and secondly, demystified the financial arrangements. Blue Care has developed a methodology for clearly articulating the DMF arrangements which appears to be successful based on prospective resident feedback.

The DMF is used by operators to pay for the cost of new and replacement capital which is fully the responsibility of the operator.

Many providers offer capital gain sharing which can provide the opportunity for a long staying resident to exit a village with a nominal capital sum that is greater than the ingoing contribution.

Industry operators comment that resident surveys consistently reveal that most residents wished they had moved to a village sooner. It appears, a priori, for most consumers there is a value proposition in retirement village living.

To meet the needs of low income or disadvantaged old Australians, Blue Care has over 350 affordable units where the capital value and hence, the ingoing contribution, is less than $150,000. We also offer financial structuring arrangements that enable the ingoing amount to be substantially reduced and the incoming resident the ability to access rent assistance.

Blue Care also offers a pure rental model (under rental tenancies legislation) which we run along the lines of a retirement village model with features for consumers such as community centres and shared activities. Residents using this model are mostly in receipt of rental assistance so it becomes a most affordable housing option.

Blue Care notes that operators of supported living communities which are generally registered under retirement village legislation (without a residential aged care service) will access the capital of their residents through departure fees. A prospective entrant to residential aged care who is exiting such a supported living community may have a relatively smaller amount of capital available to pay as a bond for a residential aged care place than an otherwise equivalent incoming resident who owned their own home. This 'ticket clipping' may ultimately affect the amount of capital available that an incoming resident may have for later residential care accommodation.

7.2. Interaction with aged care

Retirement living is compatible with an ageing population. It interacts with aged care services through delivery of community aged care packages into villages and the trend towards collocation.

The collective living offered by retirement villages facilitates efficient delivery of care and other support services.

The Retirement Villages Care Pilot (RVCP) evaluation (AIHW, 2006) showed that flexible packaged care is an effective model for delivering the right type of care at the right time for ageing Australians.

Pilot service centres that were co-located with multiple consumers also realised economies of scale. Frequent short visits to individuals per day for medications and monitoring were quite economical to provide. Overall program costs were less than anticipated.

Accessing low cost basic care at an earlier stage acted as a preventive factor. This, as well as allowing necessary levels of nursing and allied health care into the mix of packaged services, resulted in a trend towards fewer emergency department presentations and delayed admissions to residential care. There was high consumer satisfaction with the RVCP model, with an unexpected extra benefit of an increased sense of support and security for consumers.

An integrated community (with care options, including residential aged care) is an effective way of assisting residents with social inclusion, lifestyle choices and extending independence. For example, Blue Care's integrated community offering for consumers includes:

- Accommodation
  - Independent living apartments and villas
  - Serviced apartments
- Care services
  - Community care packages
  - Other community services including HACC services

  - Residential aged care - low care and high care
- Other support services
  - Food services
  - Laundry services
  - Cleaning services
- Recreational activities such as pool and gym
- Social activities such as restaurant/ café, theatre, activities centre, library/ internet, hairdressing, podiatry, village bus and meeting rooms.

Retirement village environments support independence lessening the demand on publicly funded services through:

- Peace of mind for residents knowing that care is available on site
- Safety via a secure gated community

Unlike supported living style communities, a Blue Care integrated community (with a residential aged care facility) does not require residents to move off campus when their care needs advance to the higher end of traditional low care residential status or high care.

In Blue Care's experience, retirement village living is generally ***not*** *the most appropriate place of care for residents who require support in daily life and have complex behaviours and care needs*[17]*.*

7.3. Regulatory issues

Blue Care supports the unbundling of 'care' and 'accommodation' across the Residential Aged Care Program. Care services are provided to community dwellers (HACC, CACPs, EACH, EACHD) in their choice of private accommodation. Blue Care sees retirement villages as simply one variant of private accommodation types.

Retirement villages do not need to be brought into regulatory alignment with residential aged care facilities, as the accommodation quality is a private matter (although with some standards were recently regulated), and the care service quality from approved providers is already aligned with community care service standards.

'Care' services provided by private arrangements with individuals or commercial organisations such as those under the consumer directed care model are a separate matter, and care quality issues in retirement villages should be examined in the same manner as for CDC packages.

Retirement villages are regulated by state legislation which is aimed primarily at protecting the interests of people living in those villages.

Retirement village residents are distinguished from residents of a residential aged care facility in that they are either living independently or they are supported to some extent.

[17] In other words, residents without a fulltime carer and whose care needs could be categorised at the upper end or low care or high care in a residential aged care setting.

The Productivity Commission (2009) stated:

> The aged care system is characterised by centralised planning processes which result in a heavy regulatory burden on aged care providers.

Extension of the aged care regulatory environment to retirement villages is not appropriate for people living independently or with support. The burden of regulation would add to the cost of retirement living for consumers and may lead to reduced supply.

Blue Care has observed retirement village operators representing supported living services in a retirement village as 'aged care facility', 'whole new benchmark in residential aged care' and 'simply better aged care'. Examples are shown at Appendix C.

As indicated, Blue Care is strongly supportive of the place for supported living environments in the spectrum of care for older Australians. However, we are concerned that representations made by some operators regarding aged care may lead vulnerable consumers to believe that the care being offered by some retirement village operators is comparable to, or indeed, exceeds that available from an approved residential aged care provider when that may not necessarily be the case.

Whilst consumers are already protected from misrepresentations under existing consumer legislation, Blue Care recommends extension of protection may benefit older Australians by the Aged Care Act restricting the use of the terms 'residential aged care' or 'aged care' in advertising and promotion to approved providers.

8. Fiscal implications and options

8.1. Future outlook

The future outlook for increasing demand for care by older Australians is well documented having regard to factors such as:

- Older cohorts are living longer
- Proportion of population in care rises through the 70s, 80s and 90s cohorts
- Growth in the very elderly means growth in the number of sufferers of dementia, extreme fragility and other impairments
- Younger cohorts are having fewer children (which means fewer carers when they reach old age)[18].

8.2. Reform options

8.2.1. Considerations

Earlier in this submission, Blue Care has emphasised that we consider that services for those consumers who can afford to pay should be provided at unfettered market prices (provided there is sufficient competition in a market catchment). User pays principles will ease the burden on public funding.

Presently and for many years into the future, the vast majority of consumers are, and will be, pensioners and there will be a need to publicly fund aged care services for those consumers and others.

We have also emphasised that unless providers are compensated for the full economic cost of those services, in time, supply will be withdrawn. There is a need for the government to assess and implement reforms arising out of this Productivity Commission review or services and bed supply will decline during a period when demand is expanding.

We have also noted in this submission that the funding instrument, the zero real interest rate loan is a consequence of a failed system where explicit funding levels do not support residential aged care providers in attracting equity and debt from capital markets and lenders. We therefore consider that future funding mechanisms should be explicit and not opaque.

There is also a need to develop and implement mechanisms to ensure the long term funding of future care needs. If present care levels are to be sustained for more older Australians who are unable to meet all the costs of care themselves, a relatively diminishing number of working Australians will need to pay more.

8.2.2. Options

The Superannuation Guarantee was introduced in 1992 to contribute to meeting Australia's looming future retirement income needs. In a similar manner, ***Blue Care***

[18] Strategic Issues in Aged Care, Henry Ergas, Deloitte (May 2010)

considers that Australia needs to meet the cost of future care needs through a combination of government subsidies and individual responsibility.

Understandably, individuals would be reticent to actively contribute to funding their future aged care needs because the consumption of services, if at all, will be generally in the distant future. Hence, mechanisms such the Medicare surcharge are an approach for consideration.

The National Aged Care Alliance (NACA)[19] identified funding options. These included:

- Increase in the Medicare levy
- Stronger means testing for eligibility for subsidy. (More recently, commentators have raised uncapped fees for those who can afford to pay, subject to availability of competitive supply)
- Long term care insurance
- Aged care savings accounts.

Aged care savings accounts are elements of the Singapore health care funding system. Blue Care recommends that that system and others in countries, such as the Netherlands and Japan, be evaluated.

Blue Care has estimated earlier in this submission that the care element of residential aged care is presently under-funded by $900 million. Additionally, funding of new residential aged care beds based on an accommodation supplement of $76.15 prpd suggests a capital funding shortfall of over $100 million annually to replace bed stock (for supported residents).

Against the background of the present Federal Budget deficits, ***Blue Care recommends that the government consider introducing social insurance by an increment to the present Medicare levy be introduced to close the present residential aged care funding gap of some $1 billion. We estimate that the required increment at around 0.15% to 0.2%*** *(percentage points).* ***In the longer term, the increment should be increased to meet the rising cost of care of the ageing population.***

[19] A Summary of Options for Long Term Financing of Community and Residential Aged Care prepared by Warwick Bruen, September 2006

Appendix A: Residential aged care WACC

Determining a discount rate is primarily a matter of judgement as to the discount rates that would be used by a hypothetical acquirer of the subject asset. The Capital Asset Pricing Model (CAPM) is a body of theory that has wide acceptance as a means of determining a likely range of appropriate discount rates.

In estimating the appropriate commercial equivalent weighted average cost of capital (WACC) for Blue Care, and in applying the CAPM we have considered observed equity betas and first principles.

Blue Care has estimated WACC under the current regulatory regime and has made an assessment of the cost of capital assuming bed licences are uncoupled from physical bed stock post reform.

Blue Care has also endeavoured to reconstruct two other estimates in the public domain. Hogan (2004) assessed a pre tax WACC of 10.0%. Grant Samuel[20] who appear to have assessed a post tax WACC of 9.0% in 2006 for the purpose of cross checking their valuation of DCA Group Limited's residential aged care assets (Amity)[21]. These assessments serve as references for the reasonableness of Blue Care's estimates.

Table 6: Blue Care's assessment of residential aged care WACC

	Notes	Hogan	Grant Samuel	Blue Care Current	Blue Care De Reg.
Risk free	1	5.3%	5.5%	5.5%	5.5%
Risk premium		6.0%	6.0%	6.0%	6.0%
Beta	2	0.67	0.90	0.70	0.95
Alpha	3	0.7%	0.0%	0.0%	0.0%
Cost of equity post tax		9.2%	10.9%	9.7%	11.2%
Cost of debt pre tax		6.6%	6.8%	6.8%	6.8%
Debt/(Equity + Debt)	4	51%	30%	30%	30%
Effective tax rate		30%	30%	30%	30%
Gamma	5	0.2	0.0	0.0	0.0
Nominal pre tax WACC		9.8%	12.9%	11.7%	13.2%
Rounded nominal pre tax WACC	6	**10.0%**	13.0%	**12.0%**	**13.0%**
Nominal post tax WACC		6.8%	9.0%	8.2%	9.3%
Rounded nominal post tax WACC		7.0%	**9.0%**	8.0%	9.0%

Notes:

1 The Commonwealth 10 year bond rate was 5.5% as at 31 May 2010.

[20] Grant Samuel & Associates is the market leader in the preparation of business valuations and independent expert's reports. Consistently ranked number 1 in public valuation work in both Australia and New Zealand, Grant Samuel & Associates has completed reports on some of the largest and most complex transactions in the Australian and New Zealand markets (http://www.grantsamuel.com.au/index.cfm?s=2167FB2D-3048-1075-63A7464E2D3590B4).

[21] Independent expert's report for the scheme of arrangement in relation to the proposed transfer of DCA shares to CAID Pty Ltd, 3 November 2006

2 Beta is a measure of systematic risk. To assess a range of beta for Blue Care from first principles requires consideration of whether a residential aged care provider's returns are likely to be more or less volatile than the market when affected by market wide factors such as economic activity, oil prices and inflation.

Most of the income of a residential aged care provider is regulated. The major unregulated component is low care bond interest income. Among other factors, this income stream is a function of housing prices in the relevant catchment, the quality of the providers facility and competition.

The supply of residential aged care places is regulated so that supply approximates demand in a geographical area.

Wages are the major cost component comprising around 70% of operating costs. These costs are subject in large part to enterprise bargaining agreements and annual increments for the life of the agreement are known.

The above analysis of a provider's income and costs and the factors affecting those cash flows suggest that a residential aged care provider's systematic risk is relatively low and that the high end of the range for a provider's beta does not exceed 1.0.

Having regard first principles and proxy data, Blue Care considers that it is appropriate to apply an equity beta for residential aged care in the range of 0.70 to 0.90.

3 Alpha is a measure of unsystematic risk (outside the CAPM). Hogan made allowance for 'specific risk'.

4 Hogan's debt/equity ratio was around 50/50. The debt equity ratio should be based on the market values of debt and equity.

5 Hogan included adjustment for the effect of dividend imputation on the CAPM. This approach appears to be favoured by regulators but appears to have little following in the corporate sector as global capital markets are open and foreign investors are not able to access the benefits of imputation available to domestic investors.

6 Blue Care's estimates of WACC are similar to the pre tax WACC implied in Grant Samuel's public independent expert report.

For information, Blue Care's full WACC assessment is enclosed in our Commercial-in-Confidence submission.

Appendix B: Regulatory compliance cost study methodology

The project estimated the direct and indirect costs of monitoring, preparing for and participating in, legislative and accreditation activities.

The study evaluated the following accreditation and legislative activities:

- Site audits, unannounced and announced support visits, and accreditation fees
- Incident reporting, mandatory reporting and complaints
- Probity
- Internal audits
- ACFI
- Workplace health and safety and fire safety
- Accommodating new or changing legislation.

This is not an exhaustive list of compliance activities. Blue Care's study included only the identified major activities.

The participants for this study included residential aged care advisory staff, area managers, facility managers, care staff, support officers and policy officers.

A cost model was developed for each identified key compliance or legislation related activity. The models were developed in collaboration with Professor Paul Scuffham, Chair of Health Economics, Griffith University.

Each model was linked to a variables spreadsheet containing data such as wage rates, numbers and categories of employees within RAC.

Data fields were populated from information contained within organisational databases, from interviews with stakeholders, and from direct observation of staff activities during the times they were undertaking compliance or legislation related activities.

Except for accreditation site audit fees, the cost of compliance was measured over a single year. The cost of accreditation site audit fees was averaged over a three year time period because most facilities had three year accreditation cycles (73%).

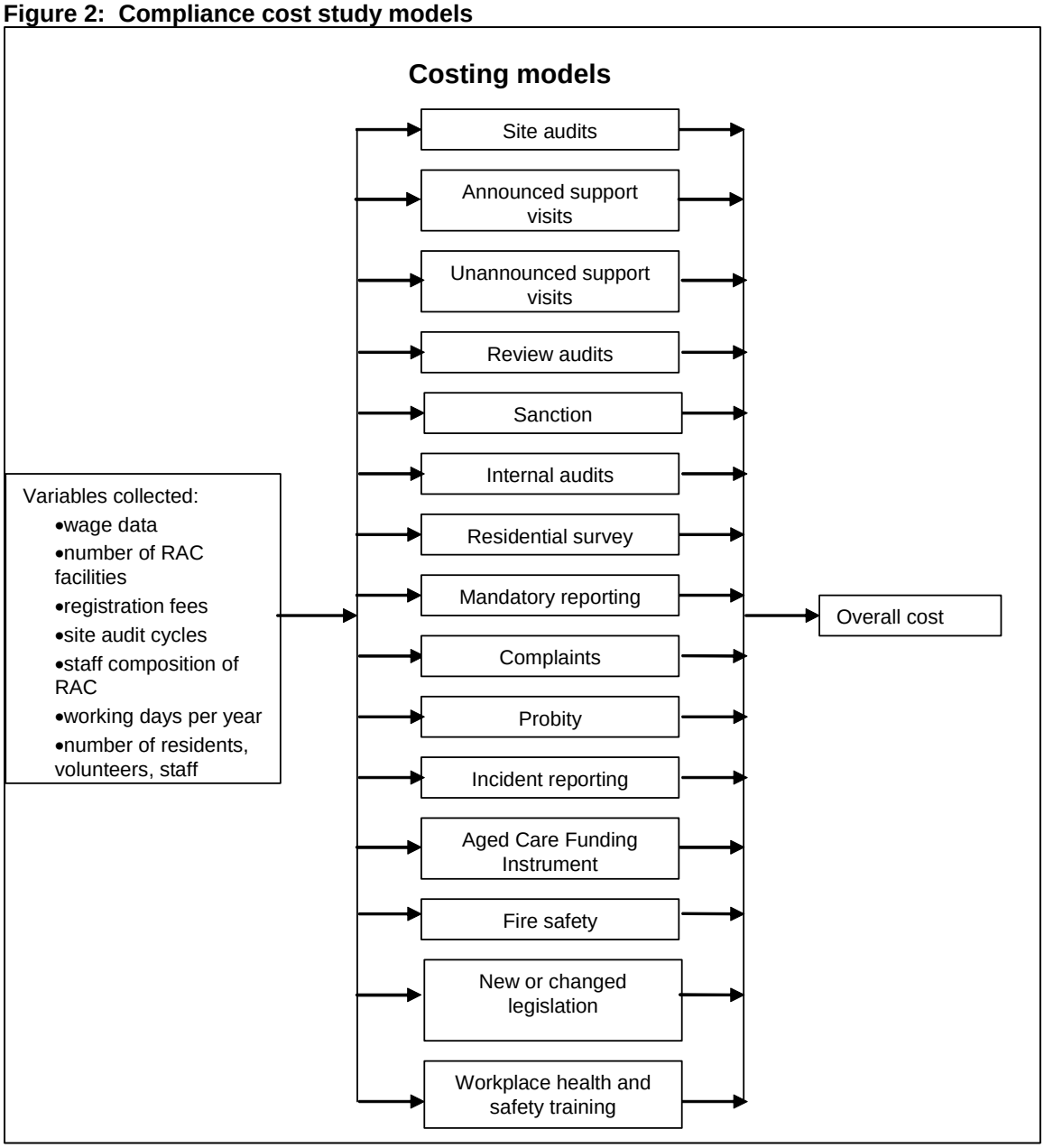
A representative study sample of facilities was selected by including:

- All facilities that had completed a site audit, support visit, or managed a complaint/mandatory report within the previous six months (2009)
- Services situated in all service regions of Queensland
- Facilities ranging in size from 40 to 134 beds
- Low and high care services.

Sensitivity analyses were performed within each model to determine the variables that most affected the final cost.

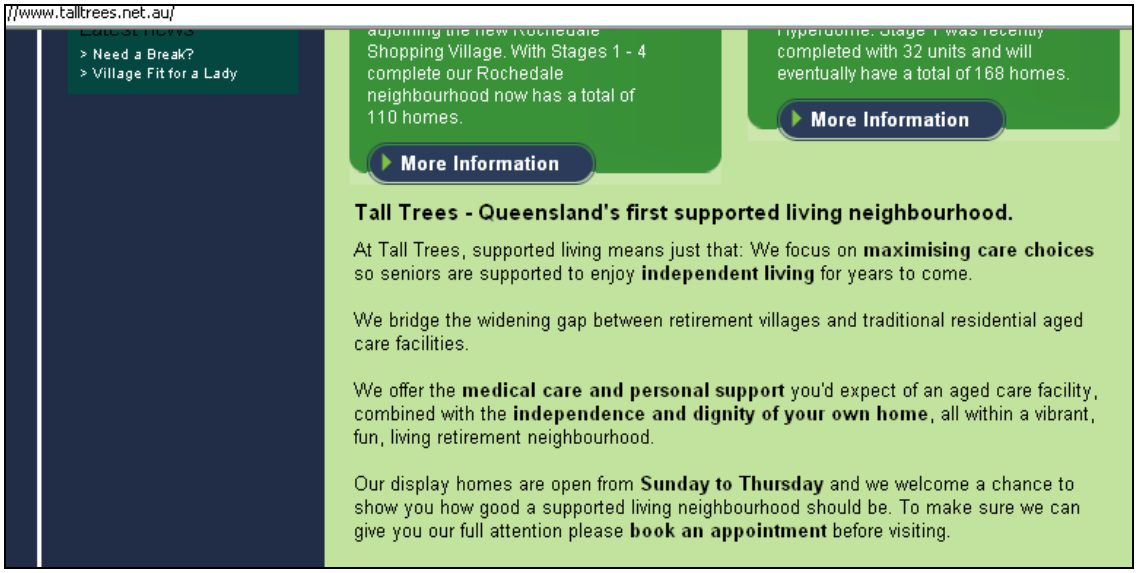
The activities that were modelled are shown below:

Figure 2: Compliance cost study models

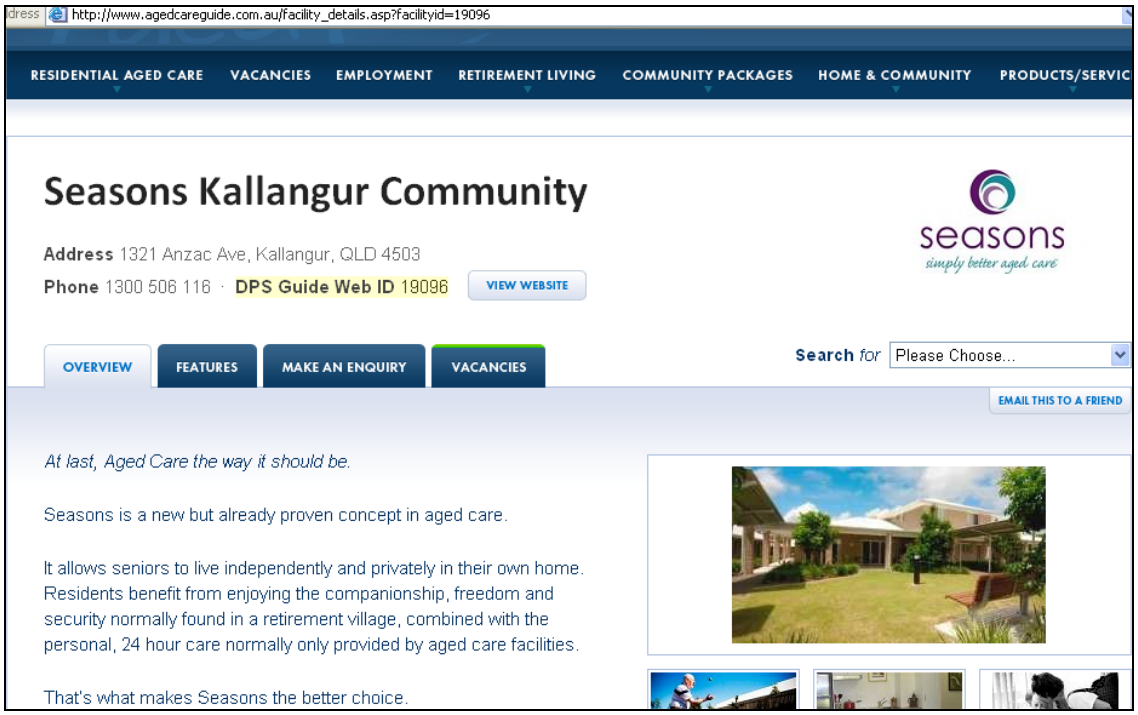


Appendix C: Retirement village promotional representations

Examples of retirement village operators promotional representations regarding aged care:



Source: Website 23 June 2010



Source: Website 23 June 2010

Source: Website 23 June 2010