# JAMES UNDERWOOD & ASSOCIATES

## PRODUCTIVITY COMMISSION INQUIRY

## CARING FOR OLDER AUSTRALIANS
JULY 2010

JU&A
JAMES UNDERWOOD
& ASSOCIATES PTY LTD
Ageing Matters

# SUBMISSION TO PRODUCTIVITY COMMISSION INQUIRY
# CARING FOR OLDER AUSTRALIANS

by James Underwood & Libby Madden

## KEY RECOMMENDATIONS

### A. Re-assess the Number of Residential Care Places Needed.

- There is a perception that there are too few residential aged care places being built and that this means there will be, or currently is, a great shortage of places in Australia. This is not the case. Whilst in some areas there may be temporary shortfalls, the reality is that the number of places being built exceeds demand. National occupancy rates have been in decline for many years. (Details attached.)

The current level of places being brought on line is around 4,700 pa.# Building just 4,700 places pa. appears to have been quite enough for many years, as evidenced by declining occupancy levels. Despite this, the numbers of places being offered and/or successfully applied for in ACAR is far above 4,700 pa., as below:

| ACAR Places Approved | | |
|---|---|---|
| **2006** | 6,811 | |
| **2007** | 6,525 | |
| **2008/09** | 7,096 | (Includes ZRIL places) |
| **2009/10** | 8,140 | (per 2009/10 Essential Guide) |
| **2010/11** | 9,076 | (per 2009/10 Essential Guide) |

There is believed to be a record high number of provisionally-allocated places that are not yet built. This is unsurprising with so many being allocated. Having a certain level of vacant places facilitates exercise of choice on the part of consumers. Having too high a level of vacancies in an inadequately planned process will likely give rise to viability concerns and unexpected consequences for the sector.

It is recommended that the planning process be reconsidered to have regard to actual current outcomes and projected future outcomes, including a planned and agreed target level of occupancy that considers outcomes for **both** consumers **and** providers.

There is no significant projected change in the rate of growth of the key 80+ and 85+ aged groups for at least another decade and a half. It may be inappropriate to unduly stimulate growth in **numbers** of residential care places when average occupancy is declining.

# (Total places per DoHA service list at 30 June 2004 = 154,891. Total places as per DoHA service list at 30 June 2009 = 178,379. Five year average is 23,488/5 = 4,698 places pa.).

### B. Provide More Assistance to Financially-Disadvantaged Persons

A great positive of the Australian residential aged care system has been the availability of access to quality care regardless of financial capacity.

In recent years, the maximum available supported resident supplement – $26.88/day or $9,800 pa. – has fallen far behind the income that can be received from investing a typical accommondation bond of $275,000 at a return rate of, say, 6% pa. This means that it has become less economically viable to accept financially-disadvantaged persons.

It is recommended that this inequality be corrected by:

- Increasing supported resident supplement. (Possibly funded by decreasing "general" subsidies, **if** providers are also given reasonable opportunity to maintain their net income through greater flexibility in fee and bond charging arrangements.)

- Consider retaining minimum regional supported resident ratios for all services, including those with new or increased extra service status approvals

- Consider expanding Residential Care (Capital) Grants, not just ZRIL's. (Many special needs groups with large numbers of financially-disadvantaged persons and/or only a capacity to fill a smaller service, eg. rural services, can not expect to ever be able to repay a loan. Hence, a ZRIL can not be accessed by them)

- Target ZRIL's more clearly to financially-disadvantaged persons/groups unless there is a clear incapacity to get needed residential care infrastructure to a region or locality in any other way

**C. Fully Cost Residential Care, then Fully Fund it**

- Recommend undertake a costing exercise to identify the actual cost of appropriate quality care, accommodation and services for residential aged care. Current funding models – outside of extra services – do not cover the cost of appropriate quality, single-room High Care services

- Once the cost of providing appropriate care is determined, only then can the appropriate funding models be considered to meet that cost. National surveys have always shown that the current model is insufficient to meet the full cost of providing High Care in single-room services

  If the cost is higher than currently funded, as it appears certain to be, then increased support to financially-disadvantaged places would be necessary. In addition, increased income would be needed for **non**-financially disadvantaged places. This increased income could come from increased subsidies and/or greater user-pays initiatives

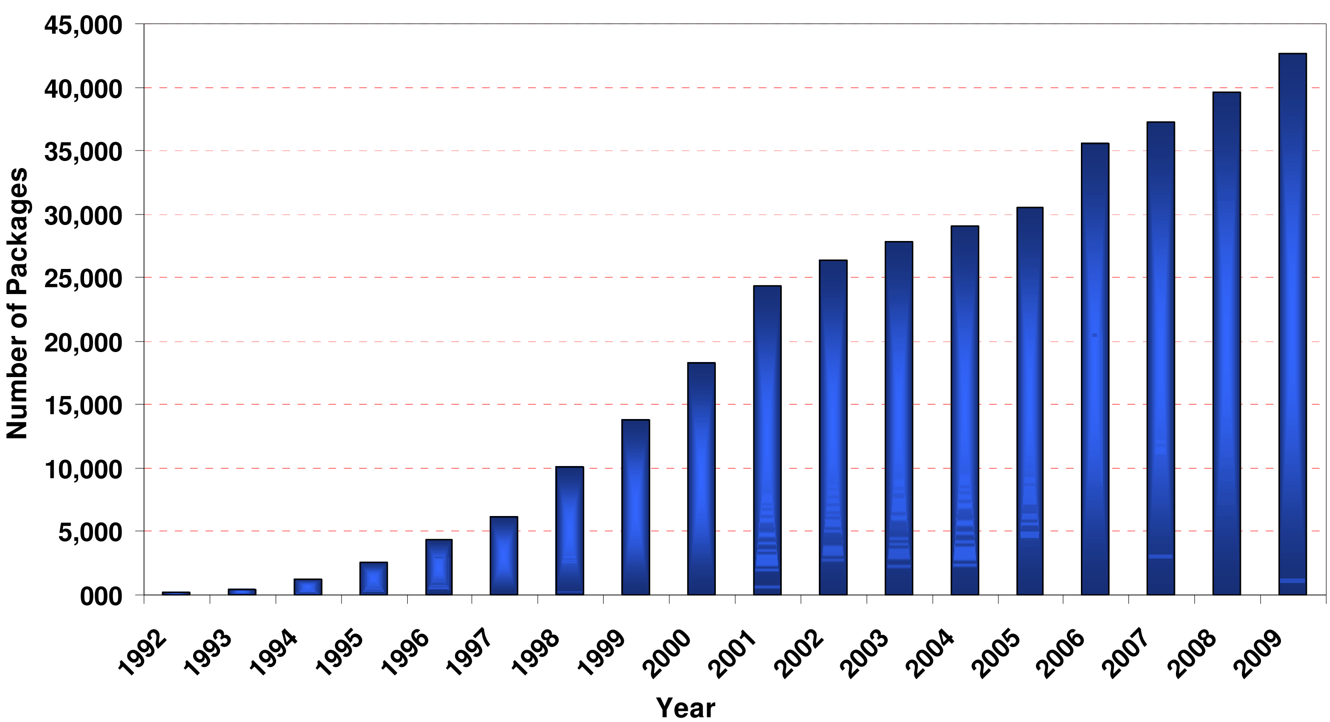
- Only those services that meet the standards of the costed model should be able to access increased subsidy and/or greater user-pay initiatives. Services provided in older paradigm models – eg. in multiple bed ward-type services – could access the enhanced income models after they update their buildings

## 1. Occupancy

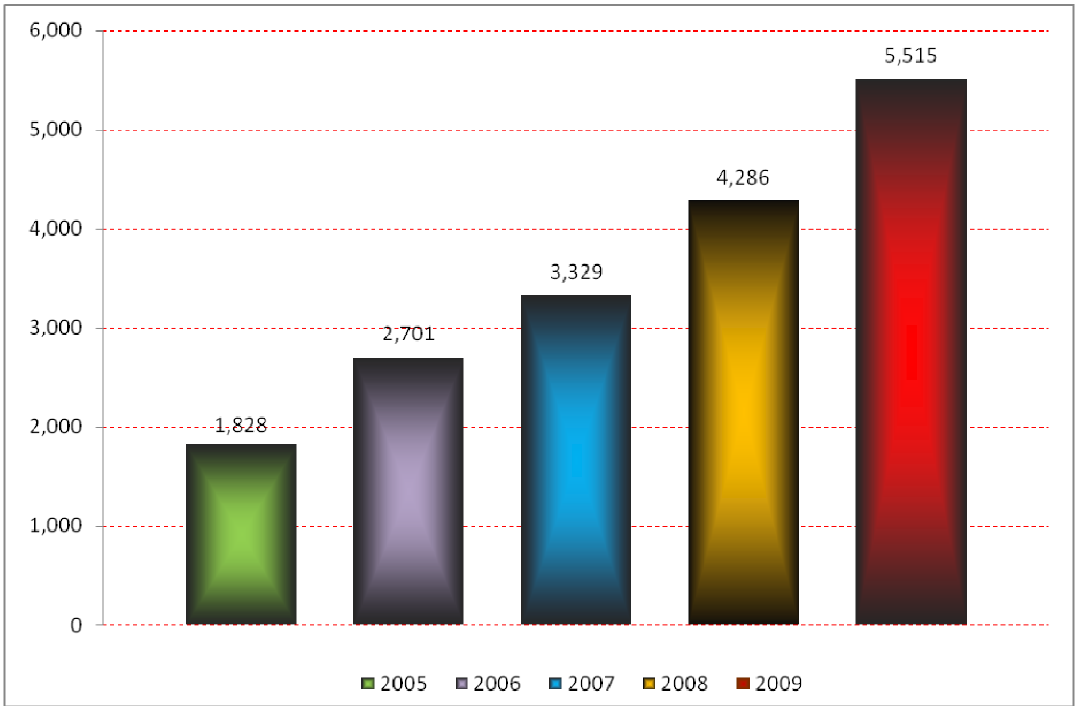
Average occupancy in residential aged care has fallen each year for a number of years. Many factors are involved in this, including:

- Growth in CACP's (as below)
- Growth in EACH's and EACH(D)'s (as over)
- Providing more and enhanced types of non-RACS options to persons who would previously have entered Low Care services (eg. retirement villages; pensioner rental accommodation; other congregate living environments
- Building new residential care places (mainly High Care)
- Changing Low Care places into High Care places by:
  - Requests to change status.
  - Ageing-in-place
  - Using "pre-97" Low Care places for High Care entry (whilst concurrently using ES to continue growth in levels of Accommodation Bonds received from new residents – Low **or** High Care – who are not financially-disadvantaged).

**Number of Community Aged Care Packages, 1992 to 2009**

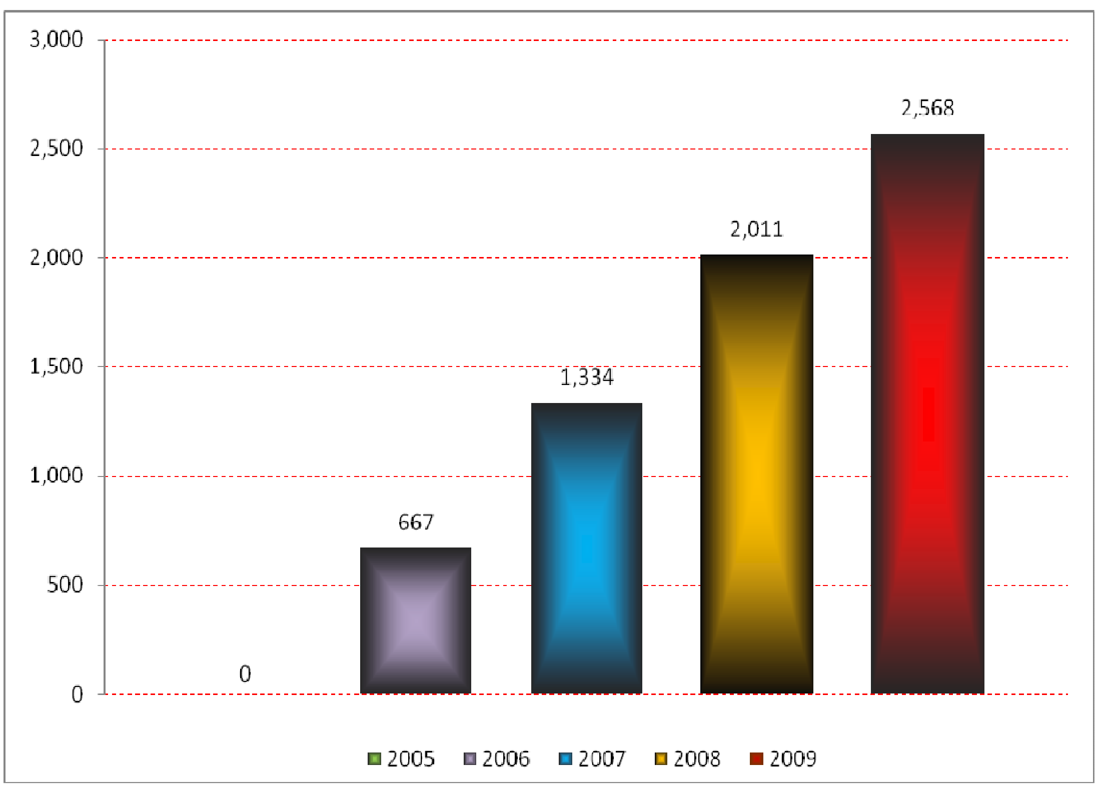


## Numbers of Operational EACH Packages as at 30 June, 2005-2009




*Source: Report on the Operation of the Aged Care Act 2008-09*

## Numbers of Operational EACHD Packages as at 30 June, 2005-2009

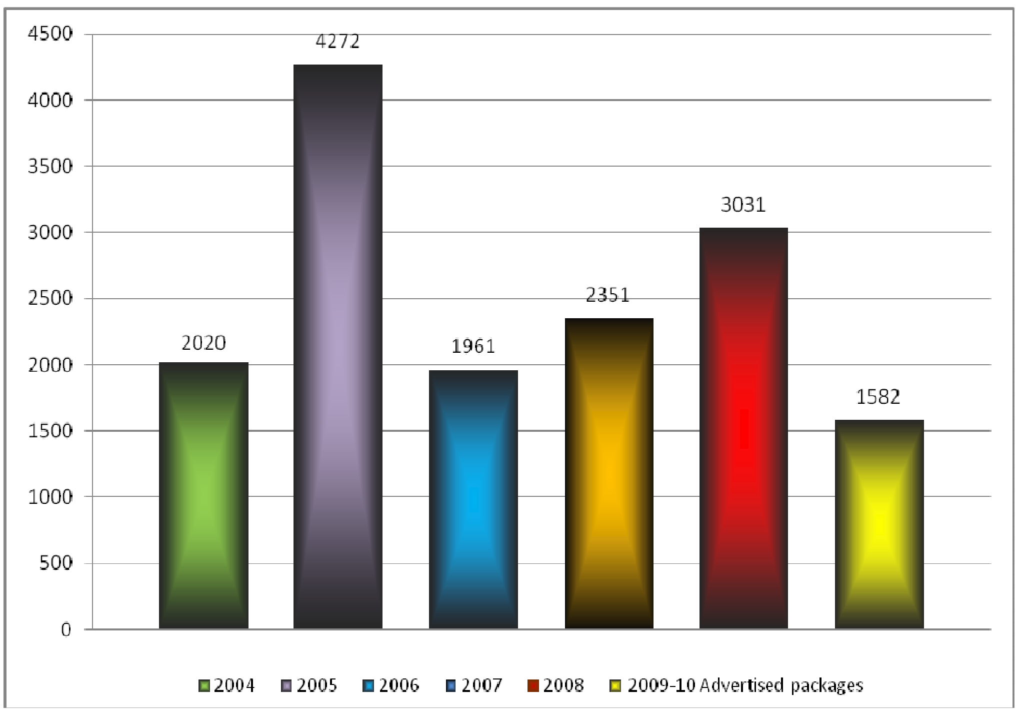



*Source: Report on the Operation of the Aged Care Act 2008-09*

| | Increase in Residential Care Places | Total Residential Care Places |
|---|---|---|
| **30 June 2004** | | 154,891 |
| **2005** | 5,790 | 160,681 |
| **2006** | 4,739 | 165,420 |
| **2007** | 4,081 | 169,501 |
| **2008** | 5,146 | 174,647 |
| **2009** | 3,732 | 178,379 |

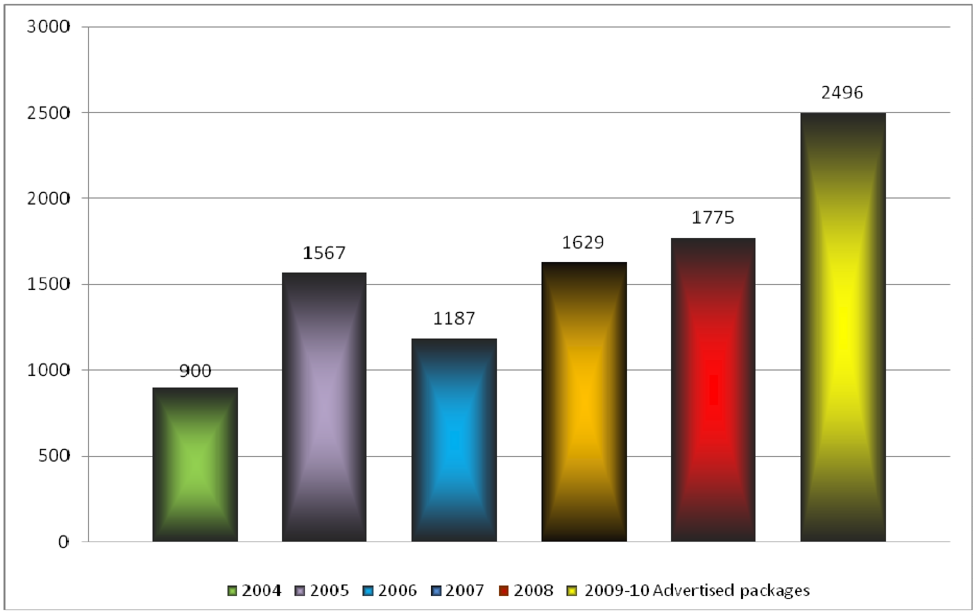
Source: DoHA Service Lists

**Allocated Numbers of CACPs**
**ACARs 2004-2009/10**




Note: 2008 figures include CACPs allocated in the ZRIL Round

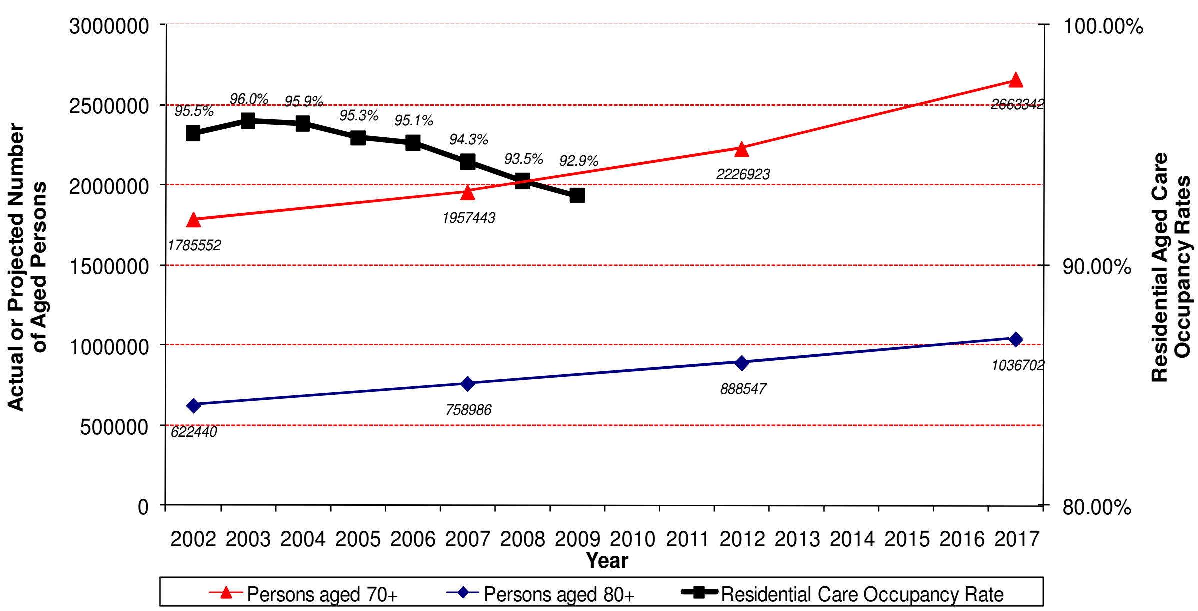
## Allocated Numbers of EACH & EACHD (combined) ACARs 2004-2009/10




Note: 2008 figures include EACHs allocated in the ZRIL Round

The decline in occupancy is despite a period of growth in the residential aged care target groups, as below:

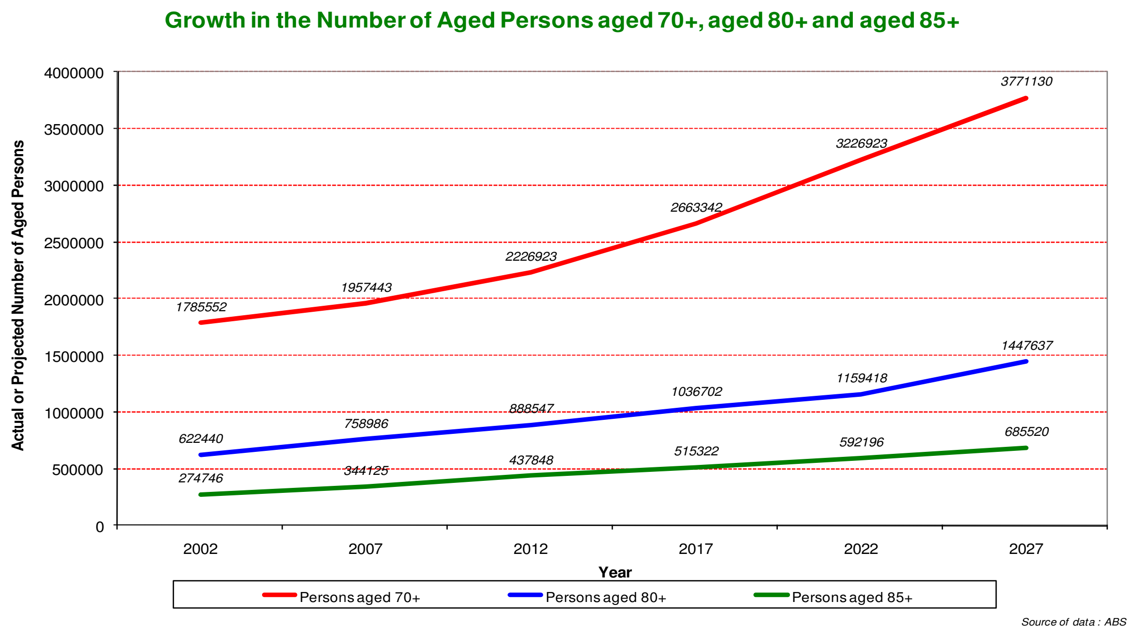
**Comparison of the Growth in the Number of Aged Persons aged 70+ and aged 80+ to the Occupancy Rates in Australian Residential Aged Care**




*Source of data : ABS, AIHW & DoHA2009 Report on the Operation of Aged Care Act 1997*

The Department of Health and Ageing has a benchmark for provision of aged care services based on the number of persons aged 70+. There will be a high growth in numbers of persons aged between 70 and 80 from 2016 as the first of the "baby boomers" turn 70. However, persons aged between 70 and 80 years old are **not** the main users of the residential aged care, so growth in this group will have limited relevance to the need for residential care places now and even less relevance in the future (as the average age at time of entry continues to be pushed back).

The **key** target groups are persons aged 80+ and 85+. Currently, almost 75% of all persons are aged 80+ at time of their first admission to residential care. The persons aged 80+ group is **not** going to grow rapidly until well **after** the 2026, the year when the first of the "baby boomers" turn 80, as below :




## 2. Consolidation

There has been a very significant level of consolidation of services since 1998. The number of "small" services – 40 or less places – has been almost halved in that time. The number of large services – 100 places or more – has almost tripled in that time. (Partly, it must be acknowledged, this has been through **merging** of approval numbers. Mostly, this has been through building good-sized new services and adding wings to existing services). Some 75,903 places – or 43.3% of all beds as at 30 Jun 09 – are now in services of 81 places or more, up from 44,456 or just 28.7% at 30 Jun 04.

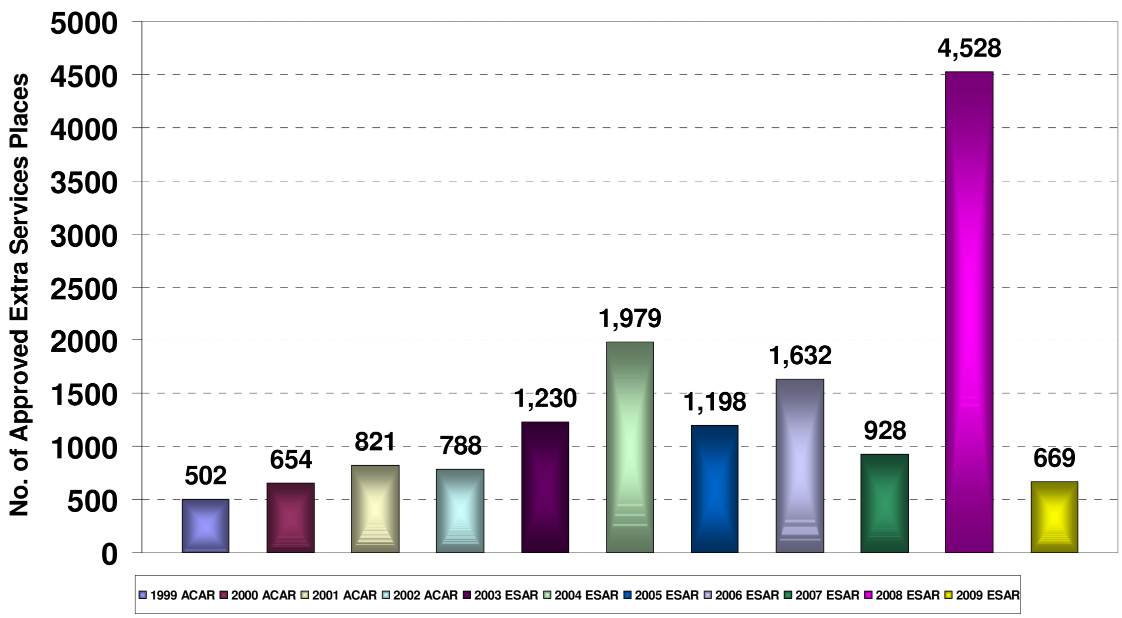
Many services have still not "merged" the RACS ID Numbers of co-located High Care and Low Care services. If we counted all the services that have more than 80 places actually on the one site when both RACS ID Numbers are considered, we would see that there has already been a very large move to consolidation and, hopefully, greater economies of scale, throughout the sector. Further incentives to achieve more consolidation may not be necessary.

## 3. Extra Services

Extra Services has been used for several years as a way of obtaining capital for new services. Most new High Care services have a wing or two of Extra Services. As a result of this practice, there have been as many new ES approvals as there have been new services built.

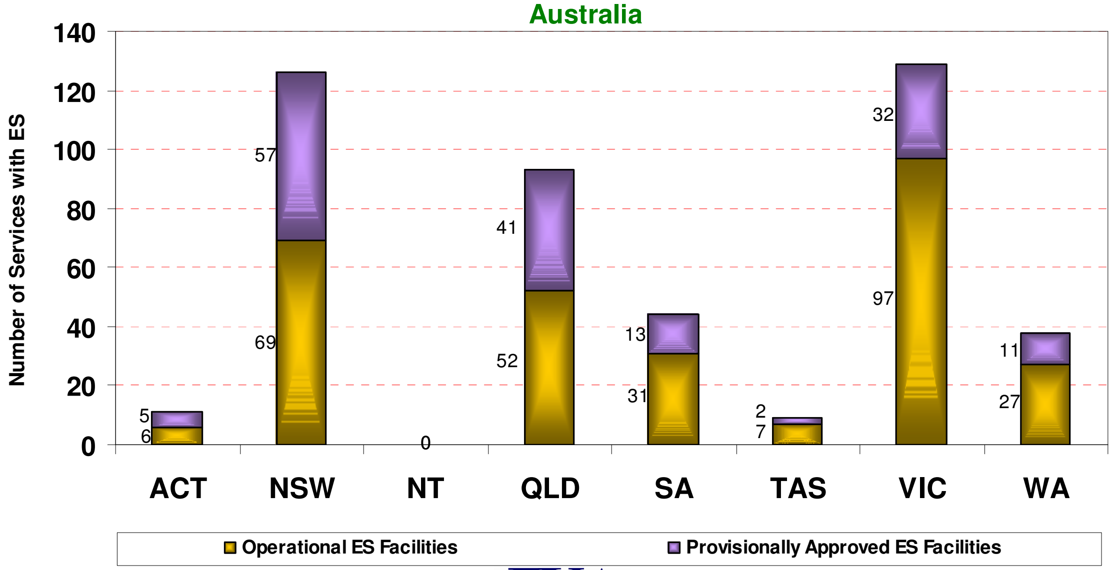
E.g: there were 132 new ES approvals in the two 2008 ES rounds, or **4.7%** of all services. There were only 3.1% of services providing new building work in 2008/09 (per Report on Operation of the *Aged Care Act 1997*).

**New Approvals for Extra Services Places through ACAR and ESAR Processes 1999-2009 – Australia**




This increase in ES approvals has been a little curtailed recently, but may come back on track in the year ahead. (Most states have less than 10% of places approved as ES, compared to a gazetted maximum available of 15%.) In any event, there are many ES approvals already in place for **as yet unbuilt** services or extensions or rebuilds, as below:

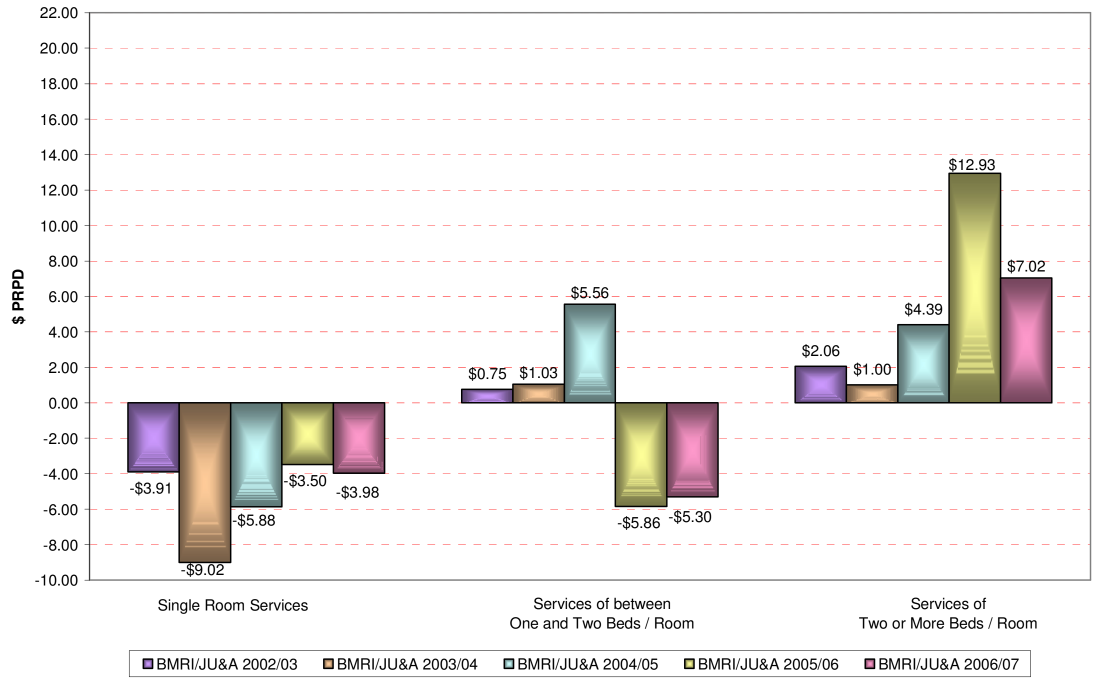
**Operational and Provisionally Approved Extra Services Facilities as at June 2010 Australia**



## 4. High Care Costs and an Option for the Future

We are building mostly High Care places, mainly with single ensuited rooms. Non-ES High Care services in single rooms lose money, as below:

**Average Return on High Level Residential Aged Care Services by Room Type Australia**




So, we need a methodology to ensure that what we build is viable. The ES methodology **was** working in doing just that. Continuation of same may be a good option.

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