Health Reform - the Aged Care Chapter

A review of the *Aged Care Act 1997* (Cth)

ACAA

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& Business Advisers

16 July 2010

The Hon. Justine Elliot MP
Minister for Ageing
House of Representatives
Parliament House
Canberra ACT 2600

Dear Minister

'*Health Reform – the Aged Care Chapter***'**
A review of the *Aged Care Act 1997* (Cth) (Act)

Aged Care Association Australia together with Hynes Lawyers and PKF Chartered Accountants are pleased to present this report entitled '*Health Reform – The Aged Care Chapter*'. This report details a series of legislative reforms proposed to the regulation of aged care in Australia.

A copy of this report has been delivered to the Shadow Minister for Ageing, Senator Concetta Fierravanti-Wells.

It is our intention to publish this report and to that end we have organised a series of launch events to be held in Sydney on 29 July 2010, Brisbane on 3 August 2010 and Melbourne on 4 August 2010. We would like to invite you to attend all or one of these events.

We would also welcome the opportunity to meet with you in advance of the launch dates to discuss the contents of the report. I will contact you to discuss such a meeting.

Yours faithfullv

Rod Young
Chief Executive Officer
Aged Care Association Australia

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Overview

Scope and purpose of this report

This report, entitled *Health Reform - The Aged Care Chapter*, is the culmination of an extensive review of the *Aged Care Act 1997* (Cth) (**Act**) and the *Aged Care Principles* (**Principles**) undertaken on behalf of Aged Care Association Australia (**ACAA**) by Hynes Lawyers, with the assistance of PKF Chartered Accountants (**PKF**).

This report has been delivered to the Commonwealth Minister for Ageing (**Minister**) and the Commonwealth Shadow Minister for Ageing. The primary purpose of this report is to persuade the Minister that the reforms proposed are essential to ensure the financial viability and sustainability of the residential aged care sector in Australia.

The review process included a comprehensive series of consultations with aged care providers and industry stakeholders (see **Annexure 1**) and the collation of the results of a national survey (**Survey**). The Survey was answered by over 200 approved providers, many of whom operate multiple residential aged care facilities across Australia. The consultations and the Survey were directed at obtaining the aged care industry's views as to the legislative reforms the industry regards as urgent and necessary.

The results of the Survey are contained in **Annexure 2** to this report.

We acknowledge that many reports and studies have been presented before this report which have identified the myriad of problems that exist within the current regulatory environment. This report does more than simply restate the concerns expressed in previous reports and studies. This report identifies a series of pragmatic reforms which are supported by members of the aged care industry and which can be implemented without compromising the policy objectives of the Act. The funding reforms propose that the real costs of providing care and accommodation should be met by residents to the extent they can afford to pay and otherwise by government.

This report provides an opportunity for the Government to implement the reforms required to create a regulatory framework that enables approved providers to:

- improve the choice and quality of accommodation that can be offered to aged care recipients by increasing access to capital funding;
- improve the quality of services that can be offered to aged care recipients by ensuring that recurrent funding is reflective of the real cost of care;
- plan for the construction and renovation of services in response to consumer demand; and
- direct resources lost on unreasonable regulatory compliance requirements back to care provision.

Key challenges

The key challenges for the aged care industry, as identified by the results of the consultation process and of the Survey, are detailed below.

- Capital and recurrent funding mechanisms are inadequate

  Aged care providers operate in a regulatory environment which imposes increasingly high standards on services and accommodation but strictly controls supply and price. The cost of providing services and accommodation is increasing as are the demands of government and the expectations of consumers.

  The current funding restrictions imposed by the Act create a significant impediment to the ability of aged care providers to raise capital to maintain, upgrade and build modern residential aged care facilities.

  Government subsidies do not meet the real cost of care delivery and restrictions in the legislation prevent aged care providers recovering the shortfall from residents who can afford to pay.

  There is a deficiency between the level of care and accommodation that approved providers are funded to provide and what they must actually provide.

- Planning and allocation mechanisms are not responsive to need

  The planning and allocations framework does not provide certainty to support the investment necessary for approved providers to change and grow to meet the demand for residential and community care places.

  The aged care industry does not seek full deregulation of the current planning and allocations framework. The industry seeks measured reform to maximise the industry's ability to respond to the needs of aged care recipients.

- The regulatory compliance framework is unreasonable

  The aged care industry supports sensible, proportionate and effective regulation to ensure aged care providers meet an appropriate standard of service delivery and accommodation quality.

  Over the last five years, compliance costs have increased exponentially due to increased unannounced visits, compulsory reporting of abuse, compulsory reporting of missing residents, police checks and increased investigations by the Complaints Investigation Scheme. These new regulations have been imposed without adequate regard for the costs to approved providers or consideration for whether they actually improve the quality of care and services provided to aged care

recipients.

The indirect effect of the current regulatory framework is that it diverts already limited resources away from direct care delivery by imposing an unreasonable compliance burden. This view is supported by the Productivity Commission, as follows:

'Without additional funding, existing resources must stretch to cover the costs of complying with the new regulations. Meeting regulatory requirements can come at the expense of providing better care as staff are directed to paperwork - a perverse outcome in a regulatory system that is designed to improve the quality of care.' [1]

Reform of the regulatory compliance framework is essential to restore an appropriate balance.

Recommendations at a glance

This report acknowledges that any reform to the regulation of the aged care industry must be undertaken in a measured, coordinated and cost-efficient way.

The recommendations proposed:

- build on existing efforts to improve the aged care system;
- offer practical ways to address the critical issues impeding the viability of the aged care sector;
- are sensitive to the political and financial constraints of the Government; and
- seek to promote the policy objectives of the Act.

The recommendations proposed are set out in the body of this report and in the table of recommendations below.

Table of recommendations

	No	Recommendation
Capital funding	1	Extend the right of approved providers to require that all permanent residents (who can afford to do so) pay an accommodation payment, which may be either: • a lump sum accommodation payment (accommodation bond); or • a daily accommodation payment (which provides an equivalent financial outcome to the provider as an accommodation bond); or • a combination of a lump sum payment and a daily payment.
	2	If Recommendation 1 is not adopted, accommodation charges should be indexed to provide an equivalent financial outcome to the provider as an average accommodation bond.
	3	If Recommendations 1 and 2 are not adopted, the Government should introduce a zero or low interest loan scheme which provides incentives for approved providers to develop and improve high care facilities.
	4	Adjust the accommodation supplement, ratios and penalties.
Recurrent funding	5	Benchmark the costs of residential care.
	6	Implement a new indexation formula for subsidies.
	7	Clarify charges for additional fees for services.
Planning and allocation of places	8	Replace existing residential allocations categories with one allocation category for permanent residential care.
	9	If Recommendation 8 is not adopted, increase the current 15% extra services ratio to 30% and apply a state based cap.
	10	If the current Aged Care Approvals Round is maintained, establish an ongoing approvals process that enables additional places to be distributed in response to demand.
	11	Adjust the role of Aged Care Assessment Team to approve the type rather than the level of care.
	12	Review the demographic age on which planning ratios are based.
	13	Undertake a cost benefit analysis of abolishing the Aged Care Approvals Round.

	No	Recommendation
Accreditation	14	Introduce an agreed minimum data set to reduce regulatory burden, facilitate targeted Agency audits and improve information available to the public.
	15	Link the frequency and timing of unannounced site visits to a facility's compliance history via data obtained from the minimum data set outlined in Recommendation 14.
	16	Permit the Administrative Appeals Tribunal to review any decision made by the Agency.
	17	Require a registered nurse to participate in all audits where clinical expertise is relevant to the Accreditation Standards being reviewed.
Complaints Investigation Scheme (**CIS**)	18	Require CIS investigators to undergo compulsory orientation and ongoing training, competency based assessments and accredited mediation training.
	19	Expand the grounds on which the CIS can decline or cease an investigation or mediation.
	20	Incorporate more robust alternative dispute resolution mechanisms into the Act and Principles.
	21	Establish key performance indicators for the CIS and make the performance data publicly available.
	22	Review the regulatory impact and effectiveness of compulsory reporting in residential aged care.
Role of the Aged Care Commissioner	23	Provide the Commissioner with determinative powers.
	24	Reject Associate Professor Walton's recommendation to enable any person who makes a complaint to request a review of the outcome of their complaint by the Commissioner.
Building certification	25	Incorporate the privacy and space requirements into the Accreditation Standards and remove the certification requirements from the Act.

Funding

Overview - funding

Approved providers operate within a regulatory framework where they have

'limited influence over cost increases and no capacity to adjust the price of their services'.[2]

The results of the consultation process and of the Survey indicate that approved providers regard capital funding and recurrent funding as the two areas of regulation requiring urgent reform.

This report provides a series of recommended reforms to the current capital and recurrent funding mechanisms. It also provides recommendations about the regulation of additional service charges.

Capital funding - current regulatory arrangements

Aged care facilities that are not eligible for capital grants or zero real interest loans,[3] principally rely on obtaining capital funding from residents who can afford to pay an accommodation bond or a daily accommodation charge.

The Act currently allows approved providers to request payment of an accommodation bond from low care residents and high care residents in extra service places. The accommodation bond can be paid as a lump sum, as a periodic payment or as a combination of the two.

The Act does not prescribe a maximum accommodation bond but does prescribe the minimal level of assets that must be retained by the resident after they have paid the accommodation bond. Once the accommodation bond is received the approved provider may deduct a retention amount of (currently) up to $307.50 per month[4] for five years from the date of entry.

High care residents may be asked to pay an accommodation charge up to a maximum daily amount of $26.88 a day depending on the resident's assets.

For residents who are unable to make a capital contribution, the government pays an accommodation supplement of up to the equivalent of the maximum accommodation charge for supported residents (**Supported Residents**).[5] The accommodation supplement paid depends on whether the aged care facility meets the Supported Resident Ratio (**SRR**). The SRR is set by the Department of Health and Ageing (**Department**) and provides the number of eligible care days that a facility should provide to supported residents. The current maximum SRR is 40% of a facility's eligible care days.

If the 40% target is not reached, a 25% reduction is applied to the supplement paid for all supported residents in care.[6] The accommodation supplement is currently paid at $26.88 per resident per day.

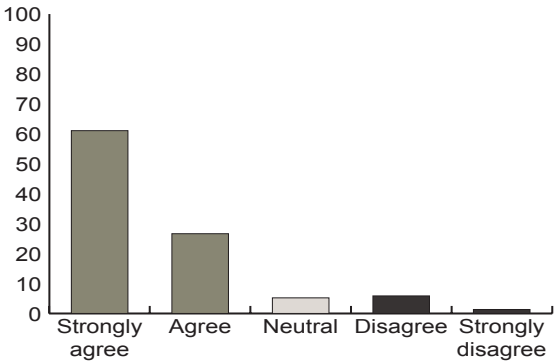
Capital funding - critical issues

There is a significant shortfall between the costs of maintaining, upgrading and building residential aged care facilities and the capital contributions that approved providers can obtain from government (by way of capital grants and zero interest loans) or from residents in the form of

accommodation payments (by way of accommodation bonds or charges).

Approved providers have inadequate access to capital funding because standard high care residents do not have to pay an accommodation bond and the accommodation charge is inadequate. The results of the Survey provide compelling evidence for reform.

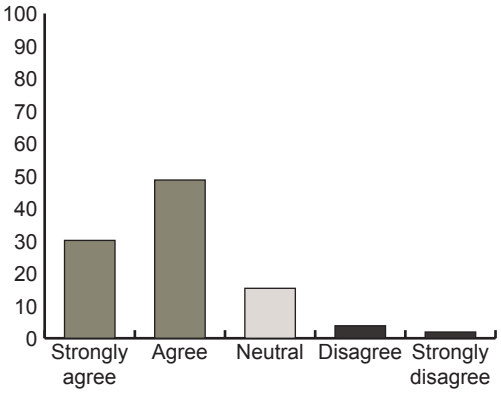
88% of approved providers surveyed agree that they should be able to ask any permanent resident who can afford to pay an accommodation bond to do so.



84% of approved providers surveyed state that accommodation charges do not provide sufficient capital to maintain existing facilities to community standards.

90% of approved providers surveyed state that accommodation charges do not provide sufficient cash flow to build new aged care facilities.

79% of approved providers surveyed state that minimum asset thresholds are an appropriate way to protect people who have a limited ability to pay an accommodation bond.



There is a significant difference between the return on an accommodation bond and the return on an accommodation charge. For example, the estimated annual capital shortfall between an average accommodation bond and charge is about $12,846 per resident.[7] For an average 100 bed facility with 70 high care residents, this equates to an annual shortfall of $899,220 or the funding required to construct 3.5 new residential care beds each year.[8]

The shortfall between the revenue derived from an accommodation charge and the costs of constructing new residential care beds was highlighted by UnitingCare Queensland (Blue Care) in its position paper on residential aged care funding. UnitingCare Queensland stated that the current maximum accommodation charge is sufficient to provide only $120,000 in capital funding of the $266,000 (excluding

land) that it actually costs to build each new residential aged care bed.[9]

The limited choice in accommodation payment methods currently available under the Act, has a discriminatory effect on high care residents applying for an aged pension. As noted by Aged & Community Services Australia:

'…high care, accommodation charge paying residents are treated differently to accommodation bond paying low care residents if they sell their home. For high care entrants any lump sum they hold, and use to pay their accommodation charge, is included for pension assessment purposes whereas the lump sum accommodation bond payment made by a low care resident is exempt.'[10]

Capital funding - political policy influences

Historically, the government has been reluctant to allow approved providers to request payment of an accommodation bond from high care residents.

This policy position was adopted principally because it was considered inequitable to require high care residents to pay an accommodation bond (which would be likely to necessitate the sale of the resident's home) when those residents were, like hospital patients, only likely to require a short period of care.

The profile of the average high care resident has changed and this policy position can no longer be relied upon to support the argument for no accommodation bonds in high care.

The Australian Institute of Health and Welfare's report on aged care shows high care residents are not comparable to hospital residents, as 73% of all aged care recipients reside in residential care for more than one year, with the average length of stay being 143.7 weeks or 2.76 years.[11] The majority of residents at 30 June 2007 were assessed as high care (70%) compared to 58% of residents in 1998. In addition, 62% of permanent residents who were admitted during 2006-07 were high care.[12]

Professor Warren Hogan, who conducted a two-year pricing review of aged care services for the government, stated that limiting accommodation bonds in high care had no merit as:

'...the justification for the discrimination based upon preserving the family home was inexplicable. If there was any merit in that proposition, this should mean the prohibition of accommodation bonds altogether… an accommodation bond did not substantially reduce the estate as it was repayable to the family, except for an annual charge, with the interest accruing to the provider'.[13]

Capital funding - future impact of shortfall

The capital shortfall required to meet the care needs of ageing Australians is predicted by Price Waterhouse Coopers to reach $5.7 billion by 2020.[14]

The impact of this capital shortfall is evidenced by the sharp decline in building works planned by approved providers from 7.7% in 2004-05 to 3.2% in 2008-09.[15] This decline is particularly alarming given the National Health and Hospitals Reform Commission (**NHHRC**) has estimated that the number of aged care places needs to double over the next 20 years.[16]

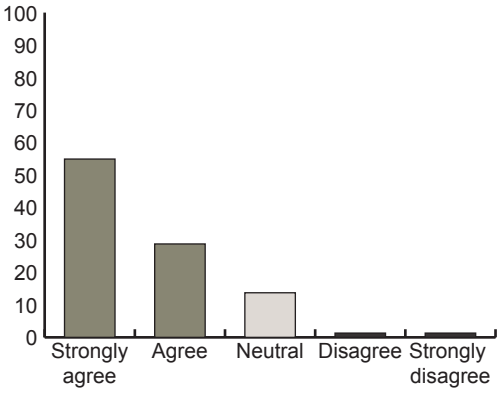
The funding crisis is made worse by reason of the changing demographic of aged care residents (see paragraph entitled 'Capital funding - political policy influences' above) and more onerous space and privacy requirements.[17]

The Grant Thornton Australia 2008 survey of 700 residential aged care facilities identified that:

'Providers of residential aged care services are experiencing low and deteriorating financial returns at a time of unprecedented demand for high care services. This is particularly the case for modern, single room facilities most preferred by consumers. Older, institutional facilities with shared rooms consistently out performed new services. These results reveal a lack of incentive to renovate old facilities, or to build new ones. This decline in investment severely limits choice for consumers.' [18]

The results of the Survey indicate that without legislative reform approved providers can not afford to build new aged care places.

84% of approved providers surveyed agree that they can not meet the capital expense of building new high care facilities when they are unable to negotiate payment of an accommodation bond from those residents who can afford it.



Capital funding - preferred solution

The Government has three real choices available to secure the future capacity of the aged care industry to upgrade and build new aged care beds:

- allow accommodation bonds to be paid by all residents capable of paying; or
- increase accommodation charges

to an equivalent amount of funding received from an accommodation bond; or

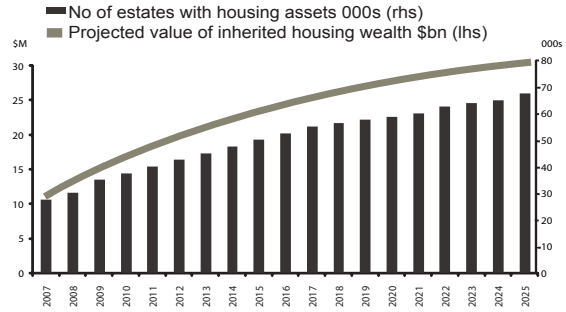
- significantly increase Government contributions to meet the predicted $5.7 billion capital shortfall.

The most sustainable and immediate way to meet the capital shortfall is by adjusting resident contributions.

There is reliable evidence that most elderly Australians can (or are likely to be able to) afford to contribute to their accommodation costs.

For example, the 2010 Bankwest Inherited Housing Report[19] indicates there is significant wealth being held by ageing Australians, with $400 billion of housing assets projected to be inherited over the next 15 years.

Projections for Australian housing inheritance (2010 - 2025)



Source: Bankwest Inherited housing report 2010

The Productivity Commission in its 2008 review of the trends in aged care services identified that:

'A large number of baby boomers will also have higher levels of income and wealth to pursue the aged care services they want. They represent the wealthiest households in Australia, having a net worth of around $381,000 on average compared to about $292,500 on average for all Australians.'[20]

The aged care industry has clearly stated that their preferred solution is for the Act and the Principles to be amended to allow approved providers to require that all permanent residents (who can afford to do so) pay an accommodation payment, which may be either:

- a lump sum accommodation payment (accommodation bond); or
- a daily accommodation payment (which provides an equivalent financial outcome to the provider as an accommodation bond); or
- a combination of a lump sum payment and a daily payment.

This report supports changing the regulation of capital funding to be consistent with the industry's preferred solution.

Adjusting regulatory restrictions on accommodation bonds to promote consumer choice and increase the capital funding available to support the development of high care accommodation is supported in principle by:

- the Productivity Commission in its 2009 Annual Review of the Regulatory Burdens on Business;[21]
- the NHHRC (provided there is sufficient competition in the supply

and price of aged care services);[22] and

- Professor Warren Hogan in the Pricing Review of Residential Aged Care.[23]

  Professor Hogan stated:

  > ***'The most desirable outcome would be to have accommodation bonds applicable to standard high care on the same basis as applies now to extra service high care and all low care places.'***

  Professor Hogan advocated that if a daily rental payment was paid in lieu of a lump sum accommodation bond an equivalent level of interest should be included in the daily payment.

Capital funding - financial modelling

Scope

To support the recommendations of this report, PKF have prepared two financial models - Model A and Model B.

Model A illustrates a hypothetical 100 place facility with no accommodation bonds. Model B illustrates the same hypothetical 100 place facility with accommodation bonds available for all 100 places.

The financial summaries of Model A and Model B are set out in **Annexure 3.** An explanatory statement of the models (which includes the key assumptions on which they are based) is set out in **Annexure 4**.

These models illustrate the stark difference in financial viability brought about by the availability of accommodation bonds in the development and operation of a residential aged care facility.

Results

A comparison of the results of Model A and Model B highlights the impact that the availability of lump sum accommodation payments is likely to have on financial viability issues such as:

- improving access to finance for capital works;
- achieving profitability to sustain operations in a minimal trade up period to full capacity;
- servicing and repaying borrowings related to construction and trade up requirements; and
- increasing the value of the business for growth and adequate return on investment.

The results of Model A clearly show that a facility in which no accommodation bonds can be obtained is not financially viable because:

- The income available from the accommodation charge is insufficient to access borrowings for construction within usual bank lending covenants. The level of

borrowings that would be likely to be accessible from the result of operations is less than half that required to undertake construction.

- Despite higher EBITDA than in Model B (due to the inclusion of accommodation charge income rather than retentions from accommodation bonds) the proposed facility is not profitable after interest and depreciation.
- There is no ability to service or repay debt after meeting operational needs during trade up or thereafter.
- There is insufficient liquidity to meet operational needs.
- There is no prospect of return on investment to shareholders.

In contrast, (and entirely due to the availability of capital funding from accommodation bonds for all residential places), Model B is a viable proposition because:

- Reduced recurring revenue from accommodation bond retentions as opposed to accommodation charge income, is more than compensated by reduced interest charges and interest revenue earned from utilisation of the accommodation bond pool.
- The resultant ramp up of profitability is directly attributable to interest savings and interest earned from retirement of bank borrowings and the accumulation of invested cash from accommodation bonds.
- Accommodation bonds can be applied to the reduction of overall debt.
- Operational funding is sustainable in the trade up period.
- Liquidity is quickly established as the ratio of cash over accommodation bonds accumulates due to increasing profitability and expansion of the accommodation bond liability pool.
- There is potential for reinvesting profits and for raising funds for future expansion.
- Return on investment is likely.

Capital funding - recommendations and implementation

Recommendation 1: Extend the right of approved providers to require that all permanent residents (who can afford to do so) pay an accommodation payment, which may be either:

- **a lump sum accommodation payment (accommodation bond); or**
- **a daily accommodation payment (which provides an equivalent financial outcome to the provider as an accommodation bond); or**
- **a combination of a lump sum payment and a daily payment.**

The accommodation payment (whether it is paid as a lump sum payment or on a daily basis) would consist of an agreed accommodation payment amount, plus a capped retention amount over a maximum five year period.

The amendments to the Act and Principles should stipulate that aged care recipients and approved providers have an unrestricted discretion to negotiate the accommodation payment amount and whether the payment will be paid as a lump sum, an equivalent daily amount or a combination of a lump sum and a daily payment. The amount and type of payment will be determined by the aged care recipient's assets, assessable income and preferences. It is not proposed to amend the maximum retention amount or the five year maximum retention period.

If the aged care recipient elects to pay the agreed accommodation payment amount on a daily basis, the daily payment must provide an equivalent financial outcome to providers as a lump sum payment. Accordingly, the daily payment would also include a component for interest calculated at a daily rate. The daily rate would be agreed between the provider and the aged care recipient but could be capped at the Maximum Permissible Interest Rate (**MPIR**) set by the Department.

If the aged care recipient elects to pay the agreed accommodation payment partly as a lump sum and partly as a daily payment, the Act and Principles should be sufficiently flexible to allow the parties to agree that the retentions can be deducted from the lump sum or paid on a daily basis.

This report also recommends that the minimum permissible asset level and the concept of an accommodation supplement, (though not the method of its calculation - see Recommendation 4 below) should be maintained to protect aged care recipients who are genuinely unable to pay an accommodation payment.

Examples of the calculation of an accommodation payment are set out in **Annexure 5**.

To implement the proposed changes, the Minister should firstly instruct the Department to consider the implications of removing the legislative restrictions on accommodation payments so that the Minister may seek Cabinet approval.

Subject to Cabinet approval, the Minister is requested to then place a bid for the amendments to be included in the legislation program for the next sitting of Parliament. The Minister should request that this matter be given high priority from the Parliamentary Business Committee.

If the amendments are adopted as recommended, the legislative changes could be implemented by 1 March 2011.

The Department should also develop a guide on accommodation costs to provide consumers with information to assist them to negotiate a reasonable

accommodation payment. The accommodation payment guide could include information on the average accommodation bond data collected by the Department each year and information about the MPIR.

To achieve equity in the affect of the proposed arrangements on pension entitlements, a resident's assessable assets for pension purposes should exclude the agreed accommodation payment amount, regardless of whether the resident elects to pay the amount as a lump sum payment or a daily payment.

Recommendation 2: If Recommendation 1 is not adopted, accommodation charges should be indexed to provide an equivalent financial outcome to the provider as an average accommodation bond.

To provide equity in the accommodation contributions of low and high care residents, the accommodation charge should be based on the MPIR applied to the average accommodation bond data collected by the Department, plus an equivalent maximum retention amount.

The same legislative approvals process as outlined in Recommendation 1 applies.

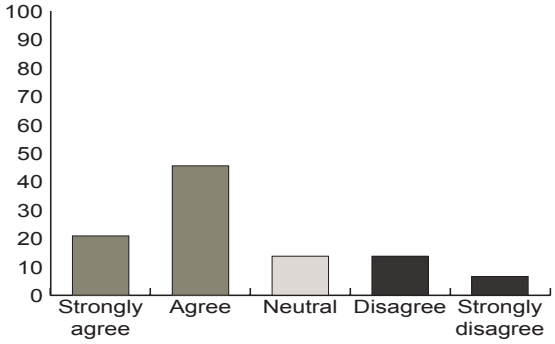
Recommendation 3: If Recommendations 1 and 2 are not adopted, the Government should introduce a zero or low interest loan scheme which provides incentives for approved providers to develop and improve high care facilities.

If the Government will not amend the Act and Principles as recommended above, the only remaining source of capital funding is the Government. The Government should open up the existing Zero Real Interest Loan Scheme, or develop a new low or zero real interest loan scheme which provides real incentives for approved providers to develop and improve high care facilities.

Accommodation supplements - critical issues

72% of approved providers surveyed state that there are inadequate financial incentives for approved providers to meet the Supported Resident Ratio (SRR).

66% of approved providers surveyed agree that the SRR should be calculated according to the demographics of the area in which the facility is located.



The SRR and penalties undermine one of the principal objectives of the Act which is to facilitate access

to aged care services by aged care recipients who are unable to contribute to the cost of their care. Approved providers reported during the consultation process that the SRR is problematic because it is based on regional demographic data rather than the local demographics of the area in which the facility operates.

For example, a facility in an affluent area may have a 40% SRR target which can realistically never be met because of the demographic of their likely residents. However, under the current system the accommodation supplement will be reduced for all supported residents being provided care which consequently results in a significant reduction in revenue for the facility.

The current method of calculating the SRR and the penalties imposed for not meeting it, do not offer adequate incentives for approved providers to offer places to supported residents.

Accommodation supplements - recommendation and implementation

Recommendation 4: Adjust the accommodation supplement, ratios and penalties.

To ensure that approved providers who provide care for supported residents are adequately incentivised to continue to provide care to that group, this report recommends that the Government:

- Ensure the accommodation supplement provides an equivalent financial outcome to an average accommodation bond and is calculated in the same manner as the accommodation charges outlined in Recommendation 2 above.
- Base the SRR on local census data rather than regional level demographics.
- Adjust the penalty by applying a pro rata reduction of the accommodation supplement based on the percentage of the supported resident places not met.

The same legislative approvals process and timeframe outlined for Recommendation 1 can apply to adjustments to the supplement. The recommended changes to the SRR and associated penalties should take effect by 31 December 2010 as no significant legislative changes are required.

Recurrent care subsidies - current regulatory arrangements

Funding to meet the direct and indirect costs of delivering care is intended to be derived from:

- resident contributions in the form of a basic daily care fee (**BDCF**) and an income tested fee (for those residents with capacity to pay); and
- daily care subsidies and

supplements paid by government.

The care subsidies paid by government are determined according to the resident's care classification under the Aged Care Funding Instrument (**ACFI**) and reduced in line with any income tested fees paid by the resident.

The maximum funding the Government permits approved providers to receive under the Act to care for a resident with the highest level of care needs is about $213.34 per day. The maximum funding comprises $89.85 to assist the resident with activities of daily living, $29.72 for behaviour management and $55.12 to meet complex health procedures,[24] plus the maximum $38.65 BDCF paid by the resident.[25]

The minimum funding that is provided is $38.65 from the BDCF, as no subsidies are paid if the resident requires no assistance with activities of daily living, behaviour management or complex health procedures.

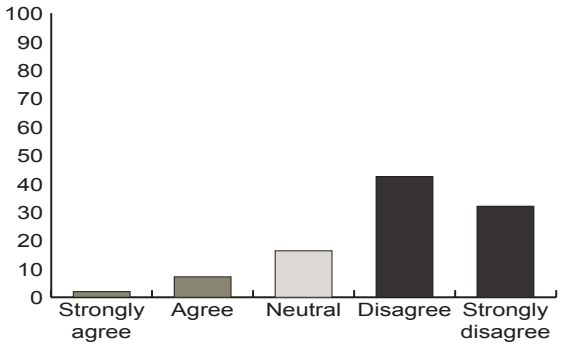
The average amount of government subsidies paid per resident per day is $110.00.[26]

The funding provided must cover the cost of direct care provision to the resident and all other indirect costs listed in **Annexure 6**.

Subsidies are indexed using the Commonwealth Own Purpose Outlays (**COPO**), which comprises 25% Consumer Price Index (**CPI**) and 75% labour costs calculated using the value of the safety net adjustment divided by average weekly earnings.[27]

Recurrent care subsidies - critical issues

74% of approved providers surveyed do not agree that care subsidies are sufficient to provide the services required in the Quality of Care Principles 1997.



During the consultation process the following concerns were consistently reported by approved providers:

- Subsidies should be benchmarked to establish the real costs of care.
- The indexation of subsidies should be adjusted to be consistent with the rising costs of care delivery.
- The funding model should provide dedicated funding to meet indirect care costs and ensure that any new regulations or increased training required to perform more complex health care services are funded.

The primary concern with the COPO based indexation of subsidies is that it does not appropriately account for salary adjustments and is often well below the CPI. For example, in 2008

the COPO increased by 2.3%, while the CPI was 5% and annual salaries increased by 4%.[28] As a result, the COPO indexation formula left providers with about a 2.7% funding gap. This gap compounds each year.

The industry's funding concerns are reinforced by the Government's announcement in 2010 to increase subsides only by 1.7%.[29]

Aged & Community Services Australia CEO, Greg Mundy, described the increase as:

> ***'...a blow for aged care…when the CPI alone was 2.9 per cent for the March quarter…the 1.7 per cent will do nothing to stop the erosion of community care hours or help to pay more competitive wages for valued staff.'[30]***

Sustained underfunding from applying the COPO index and limited dedicated funding to meet indirect care delivery costs[31] means even the most efficient approved providers incur an ongoing loss in meeting the increasing costs of care.

Since its introduction, COPO has necessitated a sustained workforce rationalisation to enable the industry to achieve relative labour efficiency. It is generally agreed that there is little opportunity for further labour cost efficiencies.

ACFI and BDCF are intended to cover direct and indirect care costs; however, the funding is barely sufficient to meet direct care costs. The only temporary source of funding that relates partially to indirect care delivery is the Conditional Adjustment Payment (**CAP**). The CAP was introduced as a short term measure to encourage providers to improve their management practices. The Government has failed to provide the CAP increase in 2010-2011 and the CAP does not provide a long term solution.

The funding climate has forced many approved providers to offer uncompetitive wages, reduce direct care delivery hours and reduce general services delivery as the disparity between care subsidies and regulatory compliance costs increases.

The failure by successive governments to take decisive action on this issue has contributed to nearly 2000 residential aged care places not being taken up in the 2008-09 Aged Care Approvals Round (**ACAR**) and in the last two years 786 bed licenses being handed back because providers could not afford to build and operate the beds.[32] The reduced number of operational places has had a direct impact on service delivery for ageing Australians through reduced competition and reduced access to services.

Recurrent care subsidies - recommendations and implementation

The indexation of subsidies using COPO has created a significant disparity between subsidies received and the operational costs associated with delivering high quality care services. This disparity should be quantified by benchmarking the direct and indirect costs of care.

As there is already a review being undertaken into the ACFI but there has been little research to date on indirect care delivery costs and funding sources, it is recommended that data be collected on those indirect costs.

After the current cost of care delivery is established, subsidies should be increased by the Government to meet those costs. Once subsidies are set at the correct levels, an appropriate indexation method should be established to ensure future subsidies match the real costs (both direct and indirect) of delivering care.

Reviewing the indexation formula for subsidies is supported by:

- the Senate Standing Committee on Finance and Public Administration in 2009;[33]
- the Productivity Commission in its 2009 Annual Review of the Regulatory Burdens on Business[34] and in its report, Trends in Aged Care Services in 2008;[35] and
- Grant Thornton's 2008 Aged Care Survey which includes financial data of 700 aged care facilities in Australia.[36]

The recommendations proposed, where possible, seek to minimise the administrative burden on the Government by utilising existing committees and data collection exercises to benchmark care costs.

Recommendation 5: Benchmark the costs of residential care.

It is recommended that the industry wide benchmarking exercise which is planned as part of the Government's Building an Australian Aged Care System: Improving Business Practices (**BAACS**) be expanded.[37]

The BAACS benchmarking exercise should be expanded to include data collection on the indirect care costs as detailed in **Annexure 6,** which include the costs associated with:

- parts 1 and 4 of the Accreditation Standards (as set out in the *Quality of Care Principles 1997*);
- items 1.1-1.9 of the Specified Care and Services (as set out in the *Quality of Care Principles 1997*); and
- regulatory compliance activities, such as compulsory reporting of abuse and missing residents, police checks, accreditation etc.

After the data is collected and the ACFI review concluded, benchmarks

should be set for the direct and indirect costs of care.

The benchmarking could be performed by the Hospital Pricing Authority which is to be established by the Government as part of its National Health and Hospitals Reform program. Alternatively, an aged care pricing committee could be established to supplement the role of the Aged Care Funding Instrument Reference Group (**ACFIRG**). The ACFIRG currently provides a forum for discussion and advice to the Department on the development of the new funding model for residential aged care.

The Minister should direct that these changes be implemented immediately as they will build on the current BAACS benchmarking exercise.

After the benchmarking exercise, the authority (or the committee as may be appropriate) should brief the Minister on their recommendations for funding and implementation - see Recommendation 6.

Recommendation 6: Implement a new indexation formula for subsidies.

This report recommends that the proposed pricing authority/committee identify a range of indexation options for the Minister to replace the existing COPO based indexation method.

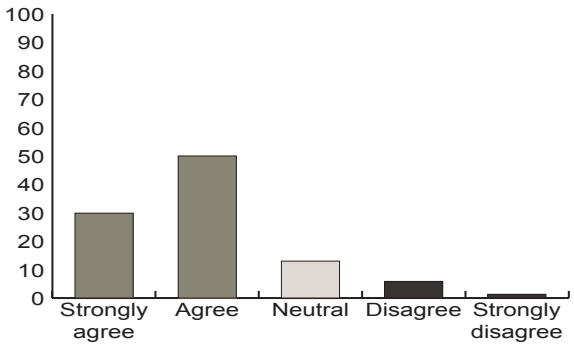
The pricing authority/committee should consider the merits of adopting:

- the greater of the CPI and the All Groups Pensioner Beneficiary Living Cost Index for the year ending 31 March 2010; or
- an aged care specific indexation method.

Consideration of the appropriate indexation method should be determined by the pricing authority/ committee concurrently with the benchmarking exercise recommended above. This will ensure the funding deficiency perpetuated by inadequate indexation and inadequate funding for indirect care costs is addressed as a matter of urgency.

Additional service charges - critical issues

80% of approved providers surveyed agree that they should be able to levy additional fees for services in addition to those required by the Quality of Care Principles 1997.



Section 56-1(d) of the Act provides that an approved provider may charge additional fees for additional services, if the resident has asked for and agreed to pay for the services in the resident agreement.

Some approved providers indicated during the consultation process that they have a level of uncertainty about their right to charge additional fees, as many additional services are traditionally only paid by residents in extra services places. A lack of clarity in the type of additional services that may be agreed upon may have had the affect of limiting the choice of services offered to residents.

Additional service charges - recommendation

Recommendation 7: Clarify charges for additional fees for services.

It is recommended that the Minister request that the Department:

- clarify the right of approved providers to charge fees under section 56-1(d) of the Act for services that have been agreed to by the aged care recipient as services in excess of those required by the *Quality of Care Principles 1997*; and
- differentiate between an extra services fee and fees that may be permitted to be charged under section 56-1(d) of the Act.

This recommendation can be implemented immediately as it involves no legislative change.

Planning and allocation of places

Planning and allocation of places - critical issues

The majority of approved providers support regulation of the allocation of places, if it is undertaken effectively.

The results of the consultation process and of the Survey, as well as many previous reviews of the planning and allocations framework, show that:

- The allocations process is not responsive to demand

  57% of approved providers surveyed do not regard the ACAR as responsive to increased demand for aged care places.

  56% of approved providers surveyed do not regard the current process of allocating places as appropriate.

  59% of approved providers surveyed do not regard the ACAR as being an effective mechanism to facilitate industry viability.

  The current planning ratios impose 44 low care, 44 high care and 25 community care places for every 1000 people aged over 70 years. However, the demographics of aged care recipients has changed.

  The Productivity Commission in its 2008 review of the trends in aged care services identified that:

  'Older people are more likely to use residential aged care facilities for high level care than in the past. Between 1998 and 2007, the proportion of all permanent residents receiving high care increased from 58 to 70 per cent, an increase of around 32,000 Australians.'[38]

  The Productivity Commission has stated that quantity and price restrictions associated with the allocation process:

  '...combine to limit the scope and effective competition between providers, weaken incentives for innovation and delivery, hinder investment decision making, and risk the long term sustainability of aged care services.'[39]

- The Aged Care Assessment Team (**ACAT**) approval process produces poor outcomes for aged care recipients

  An approval by an ACAT determines whether the aged care recipient needs permanent (or respite) high or low level residential care or community based care and therefore whether a resident may be required to pay an accommodation bond. Once a resident enters care, the ACFI is used to determine a resident's level of care and the subsidies payable.

  This process is inefficient. It necessitates the assessment of a resident's needs by two entities under different criteria. These assessments can reach different conclusions which increases the administrative burden and creates planning and resources issues for approved providers.

  If the assessments are inconsistent and the resident needs to be moved but refuses to do so, the ACAT (or two other medical practitioners)

have to reassess the resident to confirm that the move is necessary.

If the resident has been assessed as high care but is actually low care, it is very difficult for the approved provider to attempt to free up the place for a genuine high care resident as the approved provider would be unable to show that they can not meet the resident's care needs. It also means that the facility has lost an opportunity to ask a genuine low care resident to pay an accommodation bond.

Conversely, if the resident is ACAT assessed as low care but is actually high care the approved provider then has to accommodate and provide services to a high care resident when they have planned for (and are possibly only able to) provide care for a low care resident.

The ACFI assessment provides a more accurate representation of a person's level of care as the ACFI assessment process is much more detailed than the assessment undertaken by an ACAT.

- The allocations process is inflexible

  There is no current mechanism which enables an increase or adjustment in the supply of places based on market indicators identified at the local level.

- The extra services ratios do not reflect community preferences

  At present only 15% of residential care places in each state, territory or region can be extra services places. This rigid cap denies ageing Australians choice of services.

  Limiting the extra services places was originally predicated on concerns that an unlimited supply of extra services places may result in an unreasonable reduction in access to standard services for aged care recipients unable to afford extra services.

  The Productivity Commission has acknowledged that these concerns are not justified:

  '...it is unlikely in most regions that any growth in demand for extra service places (from such a low base) would create problems for those seeking access to standard places. For this reason, the regional quota system for extra service places appears to be unnecessary.'[40]

- The age demographics on which the ACAR are based are inaccurate

  In response to projected increase in demand for aged care services, the NHHRC has considered increasing the age of residents on which planning ratios are based.

  This report does not support the immediate implementation of changes to the demographic age on which the ACAR is based, as the Survey identified mixed views on whether age should be increased and if so, by how much.[41]

  The Department's submission to the

Senate's review of *Residential and Community Aged Care in Australia* raised concerns that moving the ratio from 70 to 80 years of age would produce a reduction in places from 2013 and a corresponding surge of places in 2021 because of the growth in the population over 80 would be less rapid than the growth in those aged over 70 between 2013-2021.[42]

It is acknowledged that the Department is concerned that the predicted surge may challenge the industry's capacity to meet the increase supply in places. As such the Department has recommended the demographic age remain at 70 years of age to produce a '*steadier growth path*'.

Planning and allocation of places - recommendations

This report recommends that the planning and allocations process be restructured as detailed below.

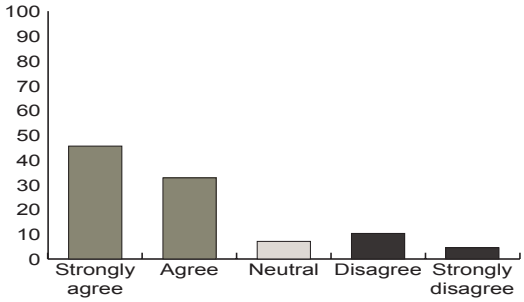
Recommendation 8: Replace existing residential allocation categories with one allocation category for permanent residential care.

The existing residential allocation categories should be replaced with one allocation category for permanent residents.

This will result in two significant changes:

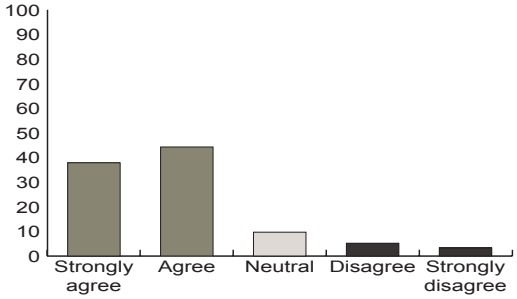
- Removing the distinction between high and low care places in future allocation rounds. This is consistent with the recommendation to require an accommodation payment from all residents who can afford to pay - see Recommendation 1.

78% of approved providers surveyed agree that the distinction between low and high care places should be removed and approved providers should simply be allocated 'residential places'.



- Abolishing the extra services place category in future allocations rounds.

82% of approved providers surveyed agree that all aged care providers should be able to offer extra service equivalent hotel and accommodation services in response to market demand.



Recommendation 9: Increase the current 15% extra services ratio to 30% and apply a state based cap.

If Recommendation 8 is not adopted, the current 15% extra services ratio should be increased to 30% with a state, rather than regional, cap applied.

The Act and *Extra Service Principles 1997* should be amended to omit reference to the proportion of extra services places in a region as a relevant consideration in allocating extra services places.

As the measures proposed involve minor adjustments, the Prime Minister has authority to approve the implementation of this recommendation. Therefore, this report recommends the Minister write to the Prime Minister seeking approval to implement this recommendation before the next Extra Services Round is announced.

If this recommendation is adopted, a post-implementation review should be undertaken within three years of the increased ratios taking effect. If the review identifies no or only minimal access issues for those Australians who can not afford an extra service fee, the cap should be removed or increased.

This reform is supported by the Productivity Commission which has recommended that until supply constraints on places are addressed:

> ***'...where there appears to be unmet demand for such 'extra service' places in a particular region, the Department should consider freeing up the regional cap and adopting a lighter-handed monitoring approach, only intervening where extra service provision is resulting in an unreasonable reduction of access.'[43]***

Recommendation 10: Establish an ongoing approvals process that enables additional places to be distributed in response to demand.

If the current approvals process is maintained, approved providers should be able to apply to the Department for additional places outside of the ACAR.

An ongoing approvals process would enhance the flexibility of the allocation process by enabling the Department to immediately increase the supply of places if there is evidence of demand for services in a particular region.

In considering whether there is unmet demand for services the Department should be required by the Act and associated Principles to consider market research. If a request for additional places is not granted, a statement of reasons outlining the decision should be provided. This decision should be a reviewable decision under the Act.

Recommendation 11: Adjust the role of the ACAT to approve the type rather than the level of care.

The ACAT's role should be limited to determining whether an aged care recipient needs permanent residential

care, community care, respite or flexible care.

Recommendation 12: Review the demographic age on which the planning ratios are based.

This report recommends that further analysis be undertaken by a pricing authority/committee, in consultation with the Aged Care Planning Advisory Committees, to better understand the probable impact on the provision of services and costs if the planning demographics are increased from 70 to 75 or 80 years of age.

Recommendation 13: Undertake a cost benefit analysis of abolishing the ACAR.

A cost benefit analysis should be undertaken to consider the implications for providers and residents of abolishing the ACAR.

While the current process is inflexible, the Survey results identified that there are mixed views within the industry on replacing the ACAR with an open market scheme with no limits on the number, type and location of places.

52% of approved providers surveyed state that full deregulation of the allocation of aged care places may have a negative affect on their balance sheets.

Planning and allocation of places - implementation

Unless otherwise specified, Cabinet approval is necessary for the reforms proposed which have significant policy implications. The Minister could however seek Cabinet approval in time to table the proposed legislative amendments for the next sitting of Parliament. On this basis, the Department should immediately be directed to brief the Minister on the implications of the recommendations proposed.

The following recommendations do not require legislative reform and it is proposed that the Minister immediately:

- Request that a pricing authority/committee, in consultation with the Aged Care Planning Advisory Committees, provide a cost benefit analysis of changing the demographics on which the planning ratios are based from 70 years and over to 75 or 80 years and over.
- Request the Productivity Commission as part of its *Caring For Older Australians* review, undertake a cost benefit analysis of abolishing the ACAR and of developing a range of alterative ways to allocate places that:
  - enables the Government to budget;
  - ensures equitable delivery of aged care services between and within the aged care planning regions; and
  - ensures access to services for special needs groups is not diminished.

Accreditation

Overview - accreditation

The results of the consultation process and of the Survey indicate that approved providers regard the following areas of the accreditation process as those in most urgent need of reform:

- the performance indicators of quality and regulatory compliance;
- the frequency and timing of unannounced visits;
- the review rights of accreditation decisions; and
- the qualifications of the assessors performing audits.

Quality and regulatory compliance indicators - critical issues

Only 36% of approved providers surveyed consider that the Accreditation Standards are specific enough to allow an objective and consistent assessment of compliance.

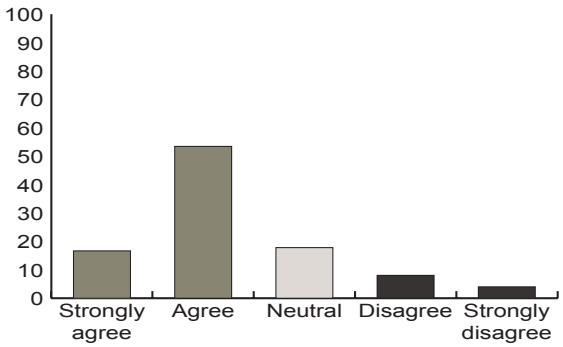
The current accreditation process imposes a significant administrative and financial burden on residential aged care providers.

'Residents, family members, staff and managers asserted that the time taken to comply with the accreditation requirements and to prepare for audits took time away from residents and that this had an impact on the quality of care and most especially quality of life.'[44]

Quality and regulatory compliance indicators - recommendation

Recommendation 14: Introduce an agreed minimum data set.

70% of approved providers surveyed support the introduction of a minimum data set to establish clear indicators of quality and regulatory compliance.



This report recommends that the Government introduce an electronic data set (**Data Set**) which establishes a minimum set of indicators for meeting the Accreditation Standards. The Data Set could be extended to include more general quality and regulatory compliance data required under the Act.

Providers could be required to input information to comply with the Data Set. The information collected could be used for accreditation audits and to assess a facility's risk of non-compliance, which could then be linked to determining the frequency and timing of unannounced visits at a facility (see paragraph entitled 'Unannounced visits - critical issues' below).

The Data Set could be shared with the Aged Care Standards and

Accreditation Agency (**Agency**), the Department and the public.

It is acknowledged that the Aged Care Industry IT Council (created under the auspices of Aged & Community Services Australia and Aged Care Association Australia) has proposed an industry wide deployment of an electronic medication chart. If the hardware and software to facilitate the electronic medication chart is adopted by the majority of approved providers, this should sufficiently strengthen the IT capability of the industry to facilitate adopting the electronic collection of the Data Set proposed.

Implementing the Data Set should be a two stage process.

The first stage should involve developing a minimum set of indicators for the Data Set. The indicators should enhance:

- the level of information available to aged care consumers to compare aged care services;
- government's ability to undertake risk monitoring; and
- the ability of approved providers to analyse their performance and make any necessary improvements.

The second stage should involve an analysis of the costs of developing and implementing the software for the Data Set.

This report recommends that the Minister immediately request that the Ageing Consultative Committee:

- develop a minimum set of indicators which will form the basis of the Data Set by 1 December 2010; and
- undertake a feasibility assessment which will take into account the costs of development and implementation of the Data Set, with this analysis to be completed by 1 March 2011.

This process should complement the current review of the accreditation process being undertaken by the Department.

Unannounced visits - critical issues

In 2006, the Government introduced a policy requiring the Agency to undertake at least one unannounced visit at each residential aged care facility in every year. Consequently, the number of unannounced visits conducted increased dramatically from 536 in 2004-05 to 3,105 in 2007-08.[45]

The Productivity Commission stated in 2009:

'...while both random and targeted unannounced visits should be part of the visits program, the focus should be on targeted visits. Only facilities that meet certain risk profile parameters should be subject to targeted unannounced visits. And to reduce the burden on providers, only a further small proportion of facilities should be

subject to random unannounced visits."[46]

Approved providers generally agree that audit and support contacts are an effective method for monitoring compliance with the Accreditation Standards.[47] Approved providers also accept that unannounced visits are a useful tool to assess an approved provider's compliance with the Accreditation Standards. However, an overwhelming proportion of approved providers surveyed maintain that the way in which unannounced visits are administered imposes a significant administrative and financial burden with no consequent improvement in quality of care or services.

80% of approved providers surveyed state that unannounced visits impose a significant administrative burden on approved providers.

61% of approved providers surveyed state that unannounced visits have a significant financial impact on approved providers.

61% of approved providers surveyed do not agree that unannounced visits have improved the quality of care and services provided to residents.

The Survey results confirm the following concerns consistently expressed by approved providers about unannounced visits during the consultation process:

'There is no link between the introduction of unannounced visits and improvements in outcomes for residents.' (approved provider)

'We work on the basis that accreditation should be demonstrable at any time so in principle unannounced visits should not be a problem, but in practice they can be very dysfunctional.' (approved provider)

Unannounced visits - recommendation

Recommendation 15: Adjust the policy for undertaking unannounced visits.

This report recommends that the Government's policy requiring the Agency to undertake at least one unannounced visit at each residential aged care facility in every year, be amended.

The policy should be amended to require the Agency to implement a risk assessment framework which provides that the frequency and timing of unannounced visits must be directly linked to a facility's compliance performance.

The risk assessment framework should utilise the quality and compliance indicators contained in the Data Set recommended above.

Amendments to the policy should not be delayed pending a decision in relation to implementation of the Data Set. The policy should be

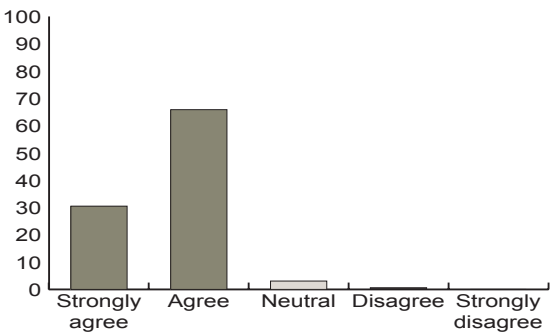
amended immediately to provide that an unannounced visit can only be conducted if the Agency has a reasonable basis to believe that the aged care facility has, or is at risk of, non-compliance. The policy can subsequently be amended, to the extent necessary, to achieve consistency with the Data Set.

Inadequate review rights - critical issues

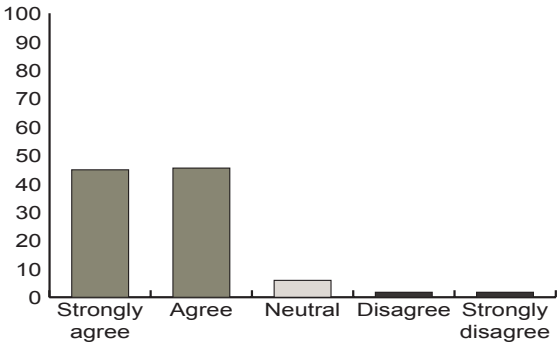
While most accreditation decisions are subject to reconsideration by the Agency and can be reviewed by the Administrative Appeals Tribunal (**AAT**), some decisions such as a decision not to vary the period of accreditation or a decision not to accredit the home, are only reviewable by the Agency.

The results of the Survey provide overwhelming evidence that approved providers are dissatisfied with their rights to apply for review of accreditation decisions.[48]

96% of approved providers surveyed agree that all decisions relating to compliance with the Accreditation Standards and the period of accreditation should be reviewable.



91% of approved providers surveyed agree that they should have a right to apply to the AAT for the review of an accreditation decision.



There must be a consistent, independent and transparent review system for all accreditation decisions.

Inadequate review rights - recommendation

Recommendation 16: Permit the AAT to review any decision made by the Agency.

This report recommends that the list of reviewable decisions under section 7.1 of the *Accreditation Grant Principles 1999* be amended to enable the AAT to review any decision by the Agency relating to a facility's compliance with the Accreditation Standards.

No further consultation is required before these changes are implemented as the changes do not fundamentally alter existing legislative arrangements and can be authorised by the Minister. The tabling of the amendments should complement the Department's current review of the accreditation process.

Qualifications of Agency assessors - critical issues

More than 60% of approved providers surveyed state that they do not regard Assessment Teams as being appropriately qualified or competent to assess compliance against the Accreditation Standards.

The Survey results confirmed concerns expressed by approved providers about the qualifications of Agency assessors during the consultation process, for example:

> ***'Many assessors have no experience in aged care, or are not abreast of contemporary aged care practice.'***
> ***(approved provider)***

> ***'Assessors skills and competence vary widely as do individuals attitudes and behaviours. Assessors who have an open communication style and assess with complete transparency are in short supply.'***
> ***(approved provider)***

The Senate Community Affairs Inquiry, similarly noted:

> ***'...some concerns were raised about the qualifications and training of quality assessors, particularly the fact that they are not required to have clinical qualifications in order to become assessors.'***[49]

Qualifications of Agency assessors - recommendation

Recommendation 17: A registered nurse should be required to participate in all audits where clinical expertise is relevant to the Accreditation Standards being reviewed.

This report recommends that the Minister direct that the Agency's policy and procedures be amended to provide that a registered nurse should be required to participate in all audits where clinical expertise is relevant to the Accreditation Standards being reviewed. The Survey results indicate that this amendment would be supported by the overwhelming majority of approved providers.[50]

This direction should be given immediately.

Complaints Investigation Scheme

Complaints Investigation Scheme (CIS) - overview

The results of the consultation process and the Survey demonstrate that approved providers have significant concerns about:

- the qualifications and competence of CIS investigators;
- a chronic failure by the CIS to manage complaints in an effective and timely manner;
- a lack of transparency and public accountability of the CIS;
- the manner in which compulsory reporting is administered by the CIS; and
- the Aged Care Commissioner's (**Commissioner**) powers (or lack thereof).

The recommendations in this report largely endorse the recommendations made by Associate Professor Merrilyn Walton in her recent review of the CIS (**Walton Review**).[51] This report does not, however, endorse the recommendation in the Walton Review to expand section 16A.21 of the *Investigation Principles 2007* to allow any person who has made a complaint to require that a review of their complaint be undertaken by the Commissioner[52] (see paragraph entitled 'Current appeals provisions - critical issues' below).

Qualifications and competence of CIS investigators - critical issues

Only 25% of approved providers surveyed regard CIS investigators as being appropriately qualified to determine compliance with the Act.

Only 29% of approved providers surveyed regard CIS investigators as being competent to determine compliance with the Act.

The Walton Review found that the training provided to CIS investigators is inadequate. CIS investigators interviewed during the Walton Review conceded that the CIS compulsory training modules do not equip them for investigating aged care complaints.[53]

The Walton Review also identified that approved providers are concerned that CIS investigators do not have a good understanding of the aged care industry or the ageing process, particularly in relation to dementia and mental illness.[54]

'It is difficult to make comment on the qualities of individual investigators. Some are obviously experienced in clinical areas but that doesn't mean they are good investigators.' (approved provider)

The results show a disturbing lack of confidence by approved providers (and by CIS investigators themselves) in the quality of CIS investigators and in their ability to investigate aged care complaints.

Qualifications and competence of CIS investigators - recommendation

Recommendation 18: Require CIS investigators to undergo compulsory orientation and ongoing training, competency based assessments and accredited mediation training.

This report acknowledges that Government is already taking action to improve the CIS.[55] These recommendations focus on how the Department may further improve the qualifications and competence of CIS investigators.

This report recommends the introduction of:

- a compulsory orientation and ongoing training program which is developed by the Department in conjunction with the Ageing Consultative Committee (**ACC**);
- competency based assessments which are reviewed annually by an independent review body, such as the Commissioner to promote best practice in complaints handling; and
- compulsory accredited mediation training for CIS investigators who conduct mediations/conciliations.

The Act and *Investigation Principles 2007* should be amended to expand the Commissioner's powers to include a quality review function, particularly focused on ensuring competency based assessments of all CIS investigators are performed. The Commissioner could also assume the broader quality review function currently provided in an ad hoc fashion by the Australian National Audit Office.

These recommendations should be implemented immediately to complement the Government's implementation of changes arising from the Walton Review, as that review does not provide specific detail on compulsory training programs or competency based assessments.

Effective and timely complaints management - critical issues

The results of the consultation process and the Survey show that approved providers have serious concerns about the CIS.

More than 50% of approved providers surveyed state that investigations are not completed efficiently or within reasonable timeframes.

During the consultation process, approved providers consistently reported that many complaints made are minor complaints that should (and could) be resolved between the facility and the complainant but that the CIS does not promote the local resolution of complaints.

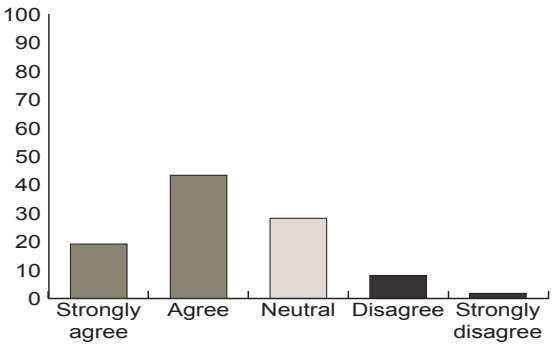
The Survey results are consistent with the concerns expressed by Associate Professor Walton who stated:

'Many complaints are not appropriate for the standard investigation track and are better managed by the provider, the care recipient and the family or advocacy group without the involvement of the CIS.'[56]

The *Investigation Principles 2007* do not facilitate the resolution of minor complaints as the complainant is able to refuse to engage with the approved provider and can insist that the CIS investigate the matter.

Approved providers also expressed the view that the number of frivolous, vexatious and trivial complaints would be significantly reduced if complainants were required to record their complaints in writing. It is a common feature of other regulatory complaints bodies[57] that complaints must be made in writing unless it would be unreasonable to do so.[58]

62% of approved providers surveyed agree that the majority of complaints investigated by the CIS were found to be without merit.



Approved providers also expressed dissatisfaction about the level of feedback provided by the CIS in its statement of reasons at the conclusion of its investigation. Approved providers stated that they were often uncertain as to whether the complainant was satisfied with the outcome of the complaint. This creates challenges where an ongoing relationship with the resident is required.

'It is difficult to know if the complainant is satisfied as the CIS does not complete the process of communicating outcomes to the approved provider.' (approved provider)

Effective and timely complaints management - recommendations

Recommendation 19: Expand the grounds on which the CIS can decline or cease an investigation or mediation.

This report recommends that the *Investigation Principles 2007* be amended to provide that the CIS can require complainants and approved providers to attempt to resolve complaints before the CIS investigate or mediate. While there are provisions currently for the CIS to decline to investigate if a complaint is trivial, frivolous, or vexatious,[59] that power appears to be rarely invoked.

This report recommends that section 16.A7 of the *Investigation Principles 2007* be amended to enable the CIS to decline or cease to investigate a complaint:

- until the complaint is put in writing, unless after consideration of the complainant's capacity and circumstances, such a request would be unreasonable;
- where the Department is satisfied that the approved provider has investigated, or will investigate the action complained of at a level at least substantially equivalent to the level at which the CIS would otherwise investigate the complaint;
- where the nature of the complaint is such that it would be reasonable in the circumstances to require the person in the first instance to attempt to resolve their concerns with the approved provider;
- where the complaint is of a type that the CIS can direct that the parties attempt alternative dispute resolution; and
- where the investigation, or the continuance of the investigation, is unreasonable given the resources of the CIS and the nature of the complaint.

To support these changes it is recommended that the industry be encouraged, to the extent necessary, to bolster their internal complaints management procedures and that the Agency be directed to consider these procedures in its reviews. These safeguards should give the public and the Government confidence in the industry's capacity to manage complaints at the local level.

Recommendation 20: Incorporate more robust alternative dispute resolution mechanisms into the Act and Principles.

This report recommends that alternative dispute resolution schemes utilised by other regulatory complaints bodies[60] should be considered with a view to incorporating a more robust alternative dispute resolution mechanism in the Act and Principles.

The combined affect of Recommendations 19 and 20 should:

- significantly reduce the number of trivial, frivolous and vexatious complaints investigated by the CIS and the consequent resources spent by approved providers in responding to such complaints;
- facilitate the resolution of complaints directly between the complainant and the approved provider either at a local level or via alternative dispute resolution, which would be less likely to damage the ongoing relationship between approved providers, aged care recipients and families; and
- enable the CIS resources to be redirected towards undertaking more detailed and timely investigations of substantive complaints which relate to the health and welfare of residents.

If these amendments are adopted, appropriate consequential amendments will need to be made to the CIS procedures manual and

appropriate training given to CIS investigators on alternative dispute resolution.

The proposed amendments should be implemented immediately, to complement the action being taken in response to the Walton Review.

Transparency and public accountability - critical issues

Approved providers consulted were not confident that the CIS was either transparent or publicly accountable.

This report acknowledges the Walton Review's recommendation to establish a new Aged Care Complaints Commission to:

- facilitate greater independence between the CIS and the Department; and
- increase transparency and more effective management of complaints.

This report generally accepts the concept recommended in the Walton Review of transferring the functions of the CIS to an agency independent of the Department provided that to do so:

- facilitates a new structure which increases confidence of consumers and approved providers in the management of aged care complaints; and
- does not increase the regulatory burden on approved providers in responding to complaints.

Regardless of whether the CIS operates under the direction of the Department or the proposed Aged Care Complaints Commission, the performance and public accountability of the CIS should be improved.

Transparency and public accountability - recommendation

Recommendation 21: Establish key performance indicators for the CIS and make the performance data publicly available.

This report recommends that the Act and *Investigation Principles 2007* be amended to:

- establish key performance indicators for the CIS that encourage the timely assessment and resolution of complaints; and
- provide that the CIS must publish data demonstrating their performance in the management of aged care complaints in every year (this may be facilitated by a requirement that data on the CIS's performance be included in the '*Report on the Operation of the Aged Care Act 1997*' tabled in Parliament each financial year).

The performance indicators may include:

- timeframes for assessing and resolving complaints;

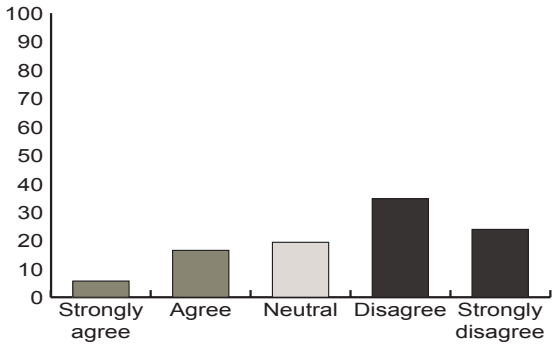
- the outcome of any quality checks undertaken by the Commissioner; and
- releasing feedback data provided by complainants and approved providers on the performance of the CIS.

Action to implement these amendments should be commenced immediately, to complement the action being taken in response to the Walton Review.

Compulsory reporting - critical issues

Approved providers are mostly supportive of the concept of compulsory reporting of physical and sexual abuse, even though they largely do not regard compulsory reporting as having created a safer environment for residents living in residential aged care facilities.

59% of approved providers disagree with the proposition that compulsory reporting of 'reportable assaults' has created a safer environment for residents living in aged care homes.



Approved providers stated during the consultation process and in the Survey (as well as in the myriad of industry statements and reports that have come before) that the administrative burden associated with meeting the compulsory reporting requirements has imposed a very significant drain on their already limited resources. The costs of implementing and maintaining the compulsory reporting regime are costs for which approved providers receive no additional funding (see comments on absence of funding for indirect care costs as set out in paragraph entitled 'Recurrent care subsidies - critical issues' above).

The Government's policy on '*Best Practice in Process for Regulation*' requires that a Regulation Impact Statement (**RIS**) should be prepared for all proposed new or amending legislation which directly affects or which has a significant indirect effect on business. A RIS was never prepared prior to the introduction of the compulsory reporting regime because the Office of Regulation Review (**ORR**) advised:

> ***'...that a RIS was not required as the amendments are of a minor or machinery nature and do not substantially alter existing arrangements.'***[61]

Compulsory reporting has had a very significant regulatory impact on approved providers.

Compulsory reports are the second most reported issue behind complaints relating to health and personal care.

Of the 7,962 contacts created by the CIS in 2008 – 2009, 2,034 were reports of abuse, with the majority of those reports arising from compulsory reports.[62]

The compulsory reporting requirements are extremely onerous and because the legislation does not facilitate any analysis of the risk to residents, the result is that a large number of reports are made to the Department and to the Police, often about trivial matters and without any regard for the wishes of the resident.

'The police are jaded when we call and we are often given the impression that we are wasting their time, particularly when the resident and their family do not want the police contacted.' (approved provider)

As the Productivity Commissioner, Robert Fitzgerald, told the Aged & Community Care Victoria State Congress on 18 June 2010:

'It's already clear to us that the regulatory burden in the aged care system is disproportionate… The regulation in this sector is greater than the regulation required for running a hospital – the reason is that we no longer understand risk….We are not good at understanding risk; at assessing it, managing it and ultimately financing it.'[63]

The Productivity Commission has recommended that the Department undertake a publicly available evaluation of the current safeguards that protect elderly people receiving care.[64] The Government has accepted the Productivity Commission's recommendation and initiated a number of reviews to consider the regulation of the health, safety and well being of elderly people receiving care, including the review of the CIS and of the accreditation process.[65]

However, to date none of the reviews initiated have specifically considered the regulatory impact of compulsory reporting of instances of abuse. The review of the accreditation system will not cover the regulatory impact of these requirements and the Productivity Commission's terms of reference for its *Caring for Older Australians* review are too broad to include a detailed analysis of them.

It has been three years since the implementation of compulsory reporting and a review of the impact of the current regulatory regime (compared with its potential benefit to residents) must occur.

Compulsory reporting - recommendation

Recommendation 22: Review the regulatory impact and effectiveness of compulsory reporting of abuse in residential aged care.

This report recommends that the Productivity Commission undertake a post-implementation review of the impact of compulsory reporting.

The review should consider:

- the effectiveness of the 24 hour reporting timeframe;
- the nature of the incidents that are being reported, including the number of resident on resident assaults being reported outside the discretion not to report;
- the time spent by approved providers on meeting their compulsory reporting responsibilities;
- the rights of residents and their family not to have matters reported;
- the police response to compulsory reports;
- the number of notices issued and whether the notices are proportionate to the breach identified; and
- the number of charges laid by the police and successful prosecutions as a result of the compulsory reporting legislation.

The post-implementation review on the impact of compulsory reporting should form part of the Productivity Commission's *Caring for Older Australians* review and should commence immediately.

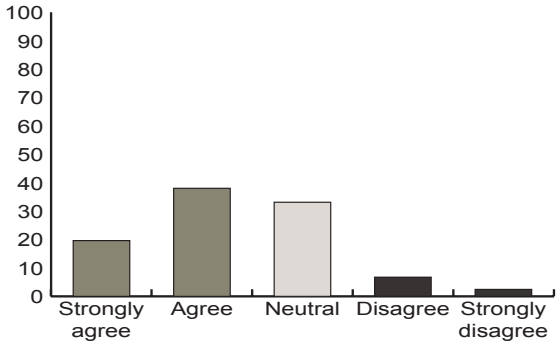
Aged Care Commissioner - critical issues

The purpose of the Commissioner was to establish a body to review the investigation of complaints by the CIS and the conduct of the CIS and of the Agency. This is an appropriate brief, but given neither the Department nor the Agency are currently required to implement any recommendations made by the Commissioner, this role can not be effectively carried out.

A clear consensus was expressed amongst approved providers consulted that the Commissioner's role was of little value and did nothing more than add to the existing regulatory burden.

Only 23% of approved providers surveyed regard the Commissioner as playing a useful role in the industry.

58% of approved providers surveyed agree that the Act should compel the Department to implement the Commissioner's recommendations.



The Commissioner conceded in the Walton Review:

> ***'...the current limitation on the Commissioner did not engender confidence in the system by providers and residents alike.'***[66]

Aged Care Commissioner - recommendation

Recommendation 23: Provide the Commissioner with determinative powers.

This report supports the Walton Review's recommendation that the Act and the *Investigation Principles 2007* be amended to empower the Commissioner to direct the Department to implement its recommendations.[67]

Current appeal provisions - critical issues

Any person can apply to have the CIS's process for handling a complaint and the conduct of the investigator reviewed. The Commissioner's jurisdiction to review the complaint itself however is limited to applications for review lodged by the aged care recipient or their representative.[68]

Associate Professor Walton has proposed that section 16A.21 of the *Investigation Principles 2007* be expanded to enable **any** person who makes a complaint to request a review of the outcome of their complaint by the Commissioner.[69]

If this amendment was implemented it would grant staff and members of the public the right to apply to review a decision about the care and services provided to any aged care recipient. Such persons are currently provided limited information on the outcome of an investigation so as to protect the personal information of the aged care recipient. The only person who should have the right to appeal a decision about the care provided to a named aged care recipient, should continue to be the aged care recipient or their representative.

Current appeal provisions - recommendation

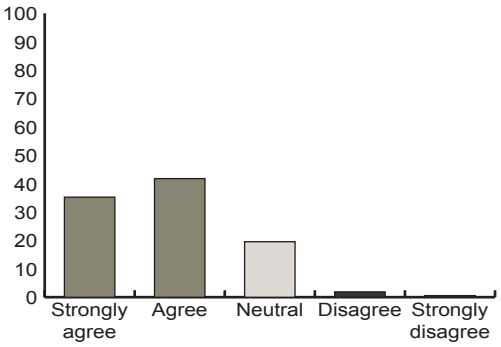
Recommendation 24: Reject Associate Professor Walton's recommendation to enable any person who makes a complaint to request a review of the outcome of their complaint by the Commissioner.

This report does not support the recommendation of the Walton Review to expand section 16A.21 of the *Investigation Principles 2007*.

Building certification

Building certification - critical issues

81% of approved providers surveyed agree that many of the certification requirements imposed on approved providers under the Act are already imposed by other regulations.



Residential aged care facilities built after May 2005 are built in accordance with the Building Code of Australia (**BCA**) Class 9c Building Standards, which are specifically designed for aged care buildings.[70] The BCA sets the minimum community standards for safety, health and the amenity of buildings.[71]

In 1997, prior to the development of the BCA Class 9c Building Standards, the Department established its own certification process. The BCA Class 9c Building Standards largely duplicate the Department's certification process. The only notable exception is the Department's privacy and space requirements which are not covered by the BCA Class 9c Building Standards. The Department's privacy and space standards impose restrictions on the number of residents per room and the number of baths and toilets per resident.[72]

Under the Department's certification process all residential aged care facilities had to comply with fire and safety standards by the end of 2005 and with the privacy and space requirements by the end of 2008. As at 30 June 2009, 98.5% of residential aged care facilities have met the privacy and space requirements and 99% have met the fire and safety requirements.[73]

This report acknowledges that the Government has announced it will reform the certification process by:

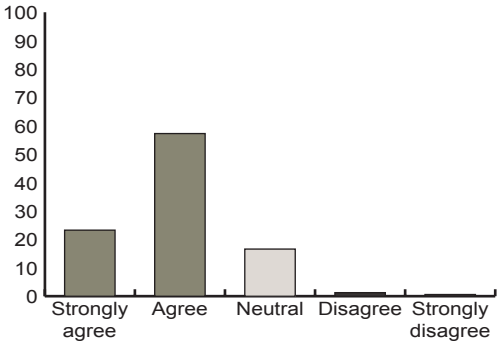
- abolishing the annual fire safety declaration for residential aged care facilities that have met state, territory and local government fire safety standards; and
- requesting the Department to submit a proposal for change to the Australian Building Codes Board requesting that the privacy and space requirements contained in the Department's current building certification standards be incorporated into the BCA.[74]

While this proposal would seem appropriate, aged care providers are concerned that this process will take many years to implement, as the development of the BCA Class 9c Building Standards took nearly four years to finalise. This report contends that a simpler course would be to include the privacy and space requirements in the Accreditation Standards.

Building certification - recommendation

Recommendation 25: Incorporate the privacy and space requirements into the Accreditation Standards and remove certification requirements from the Act.

77% of approved providers surveyed agree that the certification process for aged care providers could be streamlined significantly.



If the privacy and space requirements are added to the Accreditation Standards, then provided that all new residential aged care facilities comply with the BCA Class 9c Building Standards, the certification requirements in the Act become obsolete. Established residential aged care facilities must meet the existing certification requirements set by the Department.

This report recommends that the *Quality of Care Principles 1997* be amended to include an additional outcome under Part 4 of the Accreditation Standards which specifies all new facilities must meet the BCA Class 9c Building Standards and the privacy and space requirements.

The Agency is already tasked with ensuring residents live in a safe and comfortable environment. These amendments will not impose any significant additional administrative costs as Agency assessors would simply need to confirm, that for **new** buildings:

- there are no more than 2 and an average of 1.5 residents per room;
- there are no more than 3 residents per toilet;
- there are no more than 4 residents per shower or bath; and
- the residential aged care facilities has evidence of compliance with the BCA Class 9c Building Standards.

Existing facilities will only continue to be required to meet the relevant certification requirements set by the Department.

Once these amendments are made to the Accreditation Standards, the provisions relating to certification in the Act and associated Principles can be removed and the usual process for non-compliance (including sanction for continued or serious non-compliance) would apply.

These amendments, if adopted, would significantly reduce the compliance burden on approved providers with no consequent risk to resident safety and at no cost to government.

No further consultation is required before these changes are implemented as the changes do not fundamentally alter existing legislative arrangements and involve only technical amendments which can be authorised by the Minister. The amendments can be tabled to complement the review of the accreditation process for residential aged care facilities underway by the Department.

Annexure 1 - List of contributors to the consultation process

- Able Community Care
- Astoria Platinum Villages
- Australia and New Zealand Banking Group Limited
- Bankwest
- Baptistcare
- Bendigo and Adelaide Bank Group
- Bentleys (Qld) Pty Ltd - Chartered Accountants and Business Advisors
- BlueCare
- Catholic Health Australia
- Catholic Healthcare
- Churches of Christ Care
- Colonial First State
- Columbia Aged Care Services
- Commonwealth Bank of Australia
- Cook Care Group
- Halcyon Days
- HammondCare
- Holy Spirit Care Services
- IBIS Care Holdings Pty Ltd
- Leary and Partners
- McKenzie Aged Care Group
- National Australia Bank
- Paynter Dixon
- Premier Consulting
- Presbyterian Aged Care NSW and ACT
- Presbyterian Aged Care Qld
- St Paul de Chartres Residential Aged Care
- St. George Bank
- The Regis Group
- The Australian Finnish Rest Home Association Incorporated
- Thompson Health Care
- Westpac

Annexure 2 - Survey data

Section 1 - Quality of care

Part 1 - Aged Care Complaints Investigation Scheme (Scheme)

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
The Scheme's role and purpose is clear and unambiguous.	2.54%	36.04%	18%	31.47%	11.68%
Scheme investigators are appropriately qualified to determine compliance with the Act.	1.55%	23.20%	31.44%	34.54%	9.28%
Scheme investigators are competent to determine compliance with the Act.	1.03%	27.69%	33%	32.31%	5.64%
The Scheme conducts efficient investigations.	1.05%	24.21%	23.68%	34.21%	16.84%
The Scheme completes investigations within reasonable timeframes.	2.13%	28.19%	19%	28.19%	22.34%
Scheme investigations usually result in satisfaction for the complainant.	2.72%	21.74%	51.09%	22.28%	2.17%
The majority of complaints investigated are found to be without merit.	18.95%	43.16%	28%	7.89%	1.58%
The Aged Care Standards and Accreditation Agency (Agency) and the Scheme act independently of each other in monitoring approved provider responsibilities.	3.70%	32.80%	20.63%	32.80%	10.05%
It is difficult to differentiate between the role of the Scheme and the role of the Agency.	13.61%	41.88%	18%	25.13%	1.57%

Part 2 - Residential accreditation process

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
The accreditation process is uncomplicated.	2.13%	18.62%	12.77%	43.62%	22.87%
The accreditation process is effectively managed by the Agency.	2.67%	29.41%	29.95%	29.41%	8.56%
The current three year accreditation cycle is effective in ensuring high quality care and services.	3.76%	38.17%	15.05%	31.72%	11.29%
There should be a contestable market for accreditation services rather than a monopolistic service contracted to the Agency.	30.48%	28.34%	16.58%	18.18%	6.42%
The 'self assessment' process is an effective tool for approved providers to monitor compliance with the accreditation standards (**Standards**).	10.16%	45.45%	13.90%	22.46%	8.02%
Self assessment is an important tool referred to extensively during an accreditation audit.	6.95%	40.64%	21.93%	22.46%	8.02%

Part 3 - Audit and support contacts

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Audits are an effective mechanism for determining compliance with the Standards.	8.29%	54.14%	15.47%	19.34%	2.76%
Support contacts are an effective mechanism to monitor compliance with the Standards.	3.91%	52.51%	15.64%	20.11%	7.82%
Unannounced visits have improved the quality of care and services provided to residents.	3.91%	20.11%	14.53%	32.40%	29.05%
Unannounced visits have minimal administrative impact on aged care providers.	1.12%	11.73%	7.26%	32.40%	47.49%
Unannounced visits have minimal financial impact on aged care providers.	0.56%	14.53%	24.02%	31.84%	29.05%

Part 4 - Accreditation agency assessment teams (Assessment Teams)

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Assessment Teams are appropriately qualified to assess compliance against the Standards.	0.56%	31.64%	35.59%	26.55%	5.65%
Assessment Teams are competent to assess compliance against the Standards.	1.13%	33.33%	40.11%	20.34%	5.08%
Assessment Teams should always include a registered nurse.	38.98%	38.42%	13.56%	6.78%	2.26%
Assessment Teams currently have two roles: (i) to assess compliance; and (ii) to assist the approved provider to undertake continuous improvement. It is appropriate for both roles to be performed by one body.	5.65%	41.81%	14.12%	22.60%	15.82%

Part 5 - Mandatory reporting

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Mandatory reporting of 'reportable assaults' is an effective legislative response to concerns about resident safety.	7.95%	31.82%	11.93%	25.57%	22.73%
Mandatory reporting of 'reportable assaults' has created a safer environment for residents living in aged care homes.	5.68%	16.48%	19.32%	34.66%	23.86%
Mandatory reporting of 'reportable assaults' has improved public confidence about the safety of residents living in aged care homes.	5.14%	21.71%	26.86%	30.86%	15.43%

Part 6 - Accreditation standards (Standards)

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Industry wide reporting against an agreed minimum data set would establish clear indicators of quality and regulatory compliance.	16.67%	53.45%	17.82%	8.05%	4.02%
Outcome based Standards are effective measures of quality in aged care.	10.34%	55.75%	19.54%	12.07%	2.30%
The Standards are specific enough to allow objective and consistent assessment of compliance.	1.73%	34.68%	27.17%	26.59%	9.83%
The Standards should be measured against specific criteria such as those published by the Agency in the Results and Processes Guide.	9.77%	43.10%	24.14%	17.24%	5.75%

Part 7 - Accreditation decisions and natural justice

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Accreditation decisions generally reflect an approved provider's level of compliance with the Standards.	5.36%	56.55%	17.26%	16.67%	4.17%
The accreditation process provides natural justice for approved providers.	2.37%	23.67%	26.63%	34.91%	12.43%
The Agency's decision about compliance is independent of the Assessment Team's recommendation.	2.41%	24.10%	30.12%	32.53%	10.84%
The Agency gives the approved provider all information under consideration before making an accreditation decision.	4.79%	35.33%	30.54%	23.95%	5.39%
The Agency allows approved providers to remedy a compliance issue before making an accreditation decision.	4.22%	40.36%	23.49%	26.51%	5.42%
The Agency always provides an adequate statement of reasons when making an accreditation decision.	4.17%	47.02%	26.19%	16.67%	5.95%

Part 8 - Reviewable decisions

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
All decisions related to compliance with the Standards and the period of accreditation should be reviewable.	30.49%	65.85%	3.05%	0.61%	0.00%
The avenues of review of an accreditation decision are clear and accessible to approved providers.	3.03%	49.70%	21.21%	22.42%	3.64%
The Agency alone should have powers to review accreditation decisions.	3.64%	12.12%	15.15%	44.85%	24.24%
An approved provider should have a right to apply to the Administrative Appeals Tribunal for review of an accreditation decision.	44.91%	45.51%	5.99%	1.80%	1.80%

Part 9 – The Aged Care Commissioner (Commissioner)

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
The Commissioner's powers are adequate.	2.44%	25.00%	45.73%	13.41%	13.41%
The Commissioner plays a useful role in the industry.	2.45%	20.25%	52.15%	14.72%	10.43%
The Act should compel the Department of Health and Ageing to implement the Commissioner's recommendations.	19.63%	38.04%	33.13%	6.75%	2.45%

Section 2 - Supply of places

Part 1 - The Aged Care Approval Round (ACAR)

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
The current process of allocating aged care places is appropriate.	2.50%	22.50%	19.38%	36.25%	19.38%
The ACAR is responsive to increased demand for aged care places.	1.89%	22.01%	19.50%	34.59%	22.01%
The ACAR minimises the risk of over supply of aged care places.	1.28%	21.79%	22.44%	35.90%	18.59%
The ACAR is an effective mechanism to facilitate industry viability.	0.64%	14.74%	25.64%	36.54%	22.44%
The demographics on which the ACAR is based should be increased from people aged 70 to 75 years.	7.01%	26.75%	33.12%	25.48%	7.64%
The demographics on which the ACAR is based should be increased from people aged 70 to 80 years.	14.65%	32.48%	21.66%	24.84%	6.37%
The ACAR should be replaced by an open market scheme with no limits placed on the number, type and location of places that an approved provider operates under the Act.	16.34%	25.49%	15.69%	32.68%	9.80%
The ACAR process should be modified to provide an allocation of places that are not tied to a geographic location or a level of care.	18.47%	36.31%	14.65%	26.11%	4.46%
Full deregulation of the allocation of aged care places would have a negative affect on the balance sheets of aged care operators.	13.64%	38.31%	25.32%	16.23%	6.49%
The distinction between high and low care places should be removed and approved providers should simply be allocated residential places.	45.51%	32.69%	7.05%	10.26%	4.49%

Section 3 - Fees, accommodation bonds and charges

Part 1 - Accommodation bonds

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Accommodation bonds should only be payable by low care residents.	5.13%	5.77%	5.13%	32.05%	51.92%
Approved providers should be able to ask any resident who can afford it to pay an accommodation bond.	61.04%	26.62%	5.19%	5.84%	1.30%
Minimum asset thresholds are an appropriate way to protect people who have a limited ability to pay an accommodation bond.	30.13%	48.72%	15.38%	3.85%	1.92%
An approved provider should be able to enter an accommodation bond agreement with a third party who is paying an accommodation bond on behalf of a resident.	41.40%	45.86%	10.19%	1.91%	0.64%
The Commonwealth Government accommodation bond guarantee is appropriate.	12.18%	42.31%	32.05%	10.26%	3.21%
Current accommodation bond prudential requirements within the Act are adequate.	8.44%	43.51%	32.47%	12.99%	2.60%
Accommodation bond prudential reporting arrangements are not onerous.	2.60%	30.52%	46.75%	15.58%	4.55%
Accommodation bond payment options allowable under the Act offer appropriate choices for residents.	6.00%	44.00%	20.00%	23.33%	6.67%
Approved providers can not meet the capital expense of building new high care facilities when they are unable to negotiate payment of an accommodation bond from those residents who can afford it.	54.90%	28.76%	13.73%	1.31%	1.31%

Part 2 - Accommodation charges

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Accommodation charges provide sufficient capital to maintain existing facilities to community standards.	0.00%	2.58%	13.55%	50.97%	32.90%
Accommodation charges provide sufficient cash flow to build new residential aged care facilities.	0.65%	1.94%	8.39%	44.52%	44.52%
Concessional resident occupancy targets should be calculated according to the demographics of the area where the facility is located.	20.78%	45.45%	13.64%	13.64%	6.49%
There are adequate financial incentives for approved providers to meet concessional resident occupancy targets.	0.00%	9.68%	18.06%	47.10%	25.16%

Part 3 - Care fees

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Approved providers should be able to levy additional fees for services in addition to those required by the *Quality of Care Principles 1997*.	29.87%	50.00%	12.99%	5.84%	1.30%
Care subsidies and supplements are sufficient to provide services outlined in the *Quality of Care Principles 1997.*	1.96%	7.19%	16.34%	42.48%	32.03%

Section 4 - Certification

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Current certification requirements are too onerous.	17.76%	40.13%	27.63%	11.84%	1.97%
Many of the certification requirements imposed by the Act and Principles are requirements already imposed on providers under other regulations.	23.33%	57.33%	16.67%	1.33%	0.67%
The certification process could be streamlined significantly.	35.29%	41.83%	19.61%	1.96%	0.65%
Certification requirements specific to the aged care industry should be abolished.	12.42%	16.99%	28.10%	33.99%	7.84%

Annexure 3 - Financial summary

Model A - no accommodation bonds					
INCOME STATEMENT	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Revenue	$0	$3,361,142	$6,246,064	$6,942,078	$7,384,968
Expenses	$0	$3,177,460	$5,522,988	$5,441,070	$5,365,979
Corporate overhead	$100,000	$20,000	$20,000	$20,000	$20,000
EBITDA	-$100,000	$163,682	$703,076	$1,481,007	$1,998,989
Depreciation	$0	$626,465	$590,680	$557,720	$527,329
EBIT	-$100,000	-$462,783	$112,396	$923,287	$1,471,660
Bed licenses revenue	$0	$0	$0	$0	$0
Interest revenue	-$1,854	-$25,072	-$61,709	-$81,778	-$75,639
Interest expense	$498,871	$1,492,462	$1,497,791	$1,497,791	$1,497,791
Net profit before tax	-$600,725	-$1,980,316	-$1,447,104	-$656,282	-$101,770
Tax	$0	$0	$0	$0	$0
Net profit after tax	**-$600,725**	**-$1,980,316**	**-$1,447,104**	**-$656,282**	**-$101,770**
BALANCE SHEET	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Current assets					
Cash at bank	-$101,854	-$1,083,510	-$1,939,933	-$2,038,495	-$1,612,936
Trade debtors	$0	$0	$0	$0	$0
Total current assets	-$101,854	-$1,083,510	-$1,939,933	-$2,038,495	-$1,612,936
Non current assets					
Bed licences	$0	$0	$0	$0	$0
Fit-out (residents rooms)	$1,500,000	$1,356,687	$1,227,067	$1,109,830	$1,003,795
Fit-out (common areas)	$1,500,000	$1,356,687	$1,227,067	$1,109,830	$1,003,795
Land	$5,000,000	$5,000,000	$5,000,000	$5,000,000	$5,000,000
Buildings (at cost)	$13,750,000	$13,410,161	$13,078,722	$12,755,474	$12,440,216
Revaluation	$ 0	$ 0	$403,247	$808,792	$1,216,953
Buildings	$ 13,750,000	$ 13,410,161	$13,481,969	$13,564,267	$13,657,169
Total non current assets	$ 21,750,000	$21,123,535	$20,936,102	$20,783,927	$20,664,759
Total assets	**$21,648,146**	**$20,040,026**	**$18,996,169**	**$18,745,433**	**$19,051,823**
Current liabilities					
Accommodation bonds	$0	$0	$0	$0	$0
Total current liabilities	$0	$0	$0	$0	$0
Cash over accommodation bonds	N/A	N/A	N/A	N/A	N/A
Non current liabilities					
Bank loan	$17,248,871	$17,621,067	$17,621,067	$17,621,067	$17,621,067
Total non current liabilities	$17,248,871	$17,621,067	$17,621,067	$17,621,067	$17,621,067
Total liabilities	**$17,248,871**	**$17,621,067**	**$17,621,067**	**$17,621,067**	**$17,621,067**
Net assets	$4,399,275	$2,418,959	$1,375,102	$1,124,365	$1,430,756
Equity					
Shareholders' equity	$5,000,000	$5,000,000	$5,000,000	$5,000,000	$5,000,000
Asset revaluation	$0	$0	$403,247	$808,792	$1,216,953
Retained earnings	-$600,725	-$2,581,041	-$4,028,145	-$4,684,427	-$4,786,197
Total equity	**$4,399,275**	**$2,418,959**	**$1,375,102**	**$1,124,365**	**$1,430,756**
FINANCIAL ANALYSIS	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Number of beds occupied at year end	0	100	100	100	100
Average beds	0.0	49.9	93.3	95.0	95.0
Total beds	0	100	100	100	100
Occupancy percentage	N/A	49.9%	93.3%	95.0%	95.0%
EBITDA per average bed	N/A	$3,279	$7,540	$15,590	$21,042
EBITDA per total beds	N/A	$1,637	$7,031	$14,810	$19,990
Number of accommodation bonds at year end	0	0	0	0	0

Model B - accommodation bonds on all places					
INCOME STATEMENT	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Revenue	$0	$3,151,393	$5,778,664	$6,484,874	$6,898,962
Expenses	$0	$3,177,460	$5,522,988	$5,441,070	$5,365,979
Corporate overhead	$100,000	$20,000	$20,000	$20,000	$20,000
EBITDA	-$100,000	-$46,067	$235,676	$1,023,804	$1,512,983
Depreciation	$0	$626,465	$590,680	$557,720	$527,329
EBIT	-$100,000	-$672,532	-$355,004	$466,083	$985,654
Bed licenses revenue	$0	$0	$0	$0	$0
Interest revenue	-$1,854	-$19,706	$164,647	$286,343	$350,053
Interest expense	$498,871	$715,308	$0	$0	$0
Net profit before tax	-$600,725	-$1,407,546	-$190,357	$752,426	$1,335,706
Tax	$0	$0	$0	$0	$0
Net profit after tax	**-$600,725**	**-$1,407,546**	**-$190,357**	**$752,426**	**$1,335,706**
BALANCE SHEET	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Current assets					
Cash at bank	-$101,854	$927,067	$6,605,345	$7,854,946	$9,807,989
Trade debtors	$0	$1,000,000	$257,500	$278,100	$290,000
Total current assets	-$101,854	$1,927,067	$6,862,845	$8,133,046	$10,097,989
Non current assets					
Bed licences	$0	$0	$0	$0	$0
Fit-out (residents rooms)	$1,500,000	$1,356,687	$1,227,067	$1,109,830	$1,003,795
Fit-out (common areas)	$1,500,000	$1,356,687	$1,227,067	$1,109,830	$1,003,795
Land	$5,000,000	$5,000,000	$5,000,000	$5,000,000	$5,000,000
Buildings (at cost)	$13,750,000	$13,410,161	$13,078,722	$12,755,474	$12,440,216
Revaluation	$0	$0	$403,247	$808,792	$1,216,953
Buildings	$13,750,000	$13,410,161	$13,481,969	$13,564,267	$13,657,169
Total non current assets	$21,750,000	$21,123,535	$20,936,102	$20,783,927	$20,664,759
Total assets	**$21,648,146**	**$23,050,603**	**$27,798,947**	**$28,916,973**	**$30,762,748**
Current liabilities					
Accommodation bonds	$0	$20,058,873	$24,594,327	$24,554,381	$24,656,289
Total current liabilities	$0	$20,058,873	$24,594,327	$24,554,381	$24,656,289
Cash over accommodation bonds	N/A	4.6%	26.9%	32.0%	39.8%
Non current liabilities					
Bank loan	$17,248,871	$0	$0	$0	$0
Total non current liabilities	$17,248,871	$0	$0	$0	$0
Total liabilities	**$17,248,871**	**$20,058,873**	**$24,594,327**	**$24,554,382**	**$24,656,290**
Net assets	$4,399,275	$2,991,729	$3,204,620	$4,362,591	$6,106,458
Equity					
Shareholders' equity	$5,000,000	$5,000,000	$5,000,000	$5,000,000	$5,000,000
Asset revaluation	$0	$0	$403,247	$808,792	$1,216,953
Retained earnings	-$600,725	-$2,008,271	-$2,198,627	-$1,446,201	-$110,495
Total equity	**$4,399,275**	**$2,991,729**	**$3,204,620**	**$4,362,591**	**$6,106,458**
FINANCIAL ANALYSIS	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Number of beds occupied at year end	0	100	100	100	100
Average beds	0.0	49.9	93.3	95.0	95.0
Total beds	0	100	100	100	100
Occupancy percentage	N/A	49.9%	93.3%	95.0%	95.0%
EBITDA per average bed	N/A	$(923)	$2,527	$10,777	$15,926
EBITDA per total beds	N/A	$(461)	$2,357	$10,238	$15,130
Number of accommodation bonds at year end	0	81	100	100	100

Annexure 4 - Explanatory statement Model A vs Model B

The purpose of this hypothetical case study is to illustrate the broad financial effect if approved providers were able to charge lump sum accommodation payments for all permanent residential aged care places.

Given that the underlying model used in the case study is a projection for the purposes of illustration, some of the underlying assumptions, which are set out below, have been purposely simplified. The assumptions are in themselves indicative of the complexity inherent in the current aged care funding model and the challenges presented in planning new facilities and assessing projects for finance purposes.

The financial data is presented in a summarised format to highlight the key financial aspects of allowing lump sum accommodation payments in standard high care. The projections cover a five year period from the commencement of construction, through a two year uptake period to full occupancy, and two years beyond. This is illustrative of the operational trade up anticipated when Approvals in Principal are granted in the ACAR and emphasises the critical time line for achieving sufficient profitability, cash flows and liquidity for a sustainable operation.

Overview of case study

The model is based on a proposed residential aged facility of 60 low care and 40 standard high care beds in terms of the current legislation. The financial data for this is presented in two scenarios:

- Model A - in which there are no accommodation bonds for any of the 100 places; and
- Model B - in which accommodation bonds can be charged for all 100 places.

Model B therefore also illustrates the case for abandoning the delineation between high care and low care residential aged care places.

It is also noted that Model B takes into account a fully accommodation bonded facility which is only likely for extra service status under the current legislation. This ‘exaggeration’ highlights the full potential of accommodation bonds as a method of capital funding.

The key assumptions used are set out below. They are not intended as predictors of prices, interest rates, economic growth rates, inflation rates or any other factors determined by market forces.

Key assumptions

Project building costs	Land already owned and funded by shareholder funds	$5m
	Construction excl GST (standard level compliant buildings)	$12m
	Consultants - pre-construction and QS	$200,000
	Project management fees	$500,000
	Authority fees	$300,000
	Contingency - 5%	$750,000
	Fit out - rooms	$1.5m
	Fit out- common areas, kitchens etc	$1.5m
	Total	$21.75m
Construction timeline	New development and building approval, commence construction - year one	
	Construction complete - End of year one	
	Occupation ready - Start of year two	
Construction finance	Land - shareholders equity	$5m
	Building works to occupancy	$16.75m
	Total funding	$21. 75m
	Total external borrowing	$16.75m
	Interest capitalised - construction phase	8.5%
Post construction finance	Interest only bank finance on residual bank debt	
	Come and go overdraft to support trading requirements	
	Progressive lump sum reductions from accommodation bonds - if available	
	Re-draw facility to support Prudential Accommodation bond Liquidity compliance	
	Interest rate	8.5%
Accommodation bond payments	Average accommodation bond $250,000 per place	
	Uplift in Accommodation bonds achievable from 2014	
	Timing of collection of accommodation bonds over three month cycle	
	Standard retentions on Accommodation bonds	
ACFI/Revenue	60 low care beds - assume 3 x 20 of each ACFI category except NNN	
	40 high care beds - assume one of each category except NHL, NNM, NNH	
	95% occupancy rate	
	Uptake schedule over two years from 1 July 2012	
	Accommodation charges are applicable in Model A	
Expenses	Operating expenses are estimated on a per bed day basis	
	Wages are benchmarked as a percentage of care related income	
	Wages on costs are a function of wages	
General	Bed licences - valuation on commissioning not recognised	
	Management fees - assume $150,000 per annum to head office	
	Interest rate on Bank debt - 8.5% pa through out	
	Inflation	3%
	Capital growth	3%
	Marketing	$100,000
	Interest revenue	4%

Consistencies

For the purposes of isolating the impact of accommodation bonds being available across all places in the models, it is useful to first highlight the financial consistencies between the two scenarios.

- The financial projections of the construction phase which take place in year one are the same for both scenarios, namely:
    - the land for the project has been acquired from capital contributions by the shareholders of $5m; and
    - construction finance of $16.75m is assumed from bank sources, on which $498,871 of interest is incurred during the year and capitalised into the construction loan, the balance of which is $17,248,871 at the end of the build.
- The EBITDA and EBIT calculations across all years are comparable for both scenarios, the only difference being the inclusion of accommodation charge revenue in the Model A scenario, with no accommodation bond retention revenue. Conversely in the Model B scenario, accommodation charge revenue is not earned due to the fully accommodation bonded situation, in which case the retention income is therefore included.
- The operating expense projections are the same for both models, being the same underlying facility and resident mix.

The stabilisation and eventual reduction in expenses in both models is attributable to the cessation of certain start up expenses and extra staffing and resources during the trade up phase to full capacity. As the resident population and workforce become established, normalised levels of expenditure are projected.

This is where the consistencies in the financial outcomes between the two models end, with the differing results entirely attributable to accommodation bonds being available for all places in the Model B case, as opposed to no accommodation bonds being available in Model A.

Income statement

A review of the income statements shows that Model A is not financially viable. Despite the higher EBITDA from accommodation charge income after depreciation and interest, the proposed facility is not profitable.

There is no ability to pay interest on borrowings during the trade up period without additional debt or shareholder funding. Overall the level of borrowings accessible for the funding being generated from operations is approximately half of that required to undertake construction. There is no potential for return on investment to shareholders.

In contrast, the financial viability demonstrated by the ramp up of net profitability of Model B is the direct result of reduced interest charges and interest revenue achieved from the retirement of bank debt and accumulation of invested cash from accommodation bonds.

The modelling shows that the reduction in earnings from operations

(at EBITDA level) is more than compensated in the interest revenue achieved and interest savings made from the utilisation of the accommodation bond pool. The trading losses incurred in the trade up period are sustainable due to the availability of cash or are able to be funded by way of bank debt, because of the availability of accommodation bonds applied in reduction of debt. There is potential to reinvest profits and for raising and servicing debt for future expansion. There is also potential for return on investment to shareholders.

Balance sheet

The improved financial position in Model B clearly demonstrates the benefits of lump sum accommodation payments being charged for all permanent residential aged care places.

While a short trade up over two year period is assumed for this model's purposes, with the majority of residents in place by the end of year two, the ramp up of the accommodation bond liability pool in Model B demonstrates the potential for extinguishment of bank debt and the accumulation of cash to meet prudential liquidity requirements in a full accommodation bond situation.

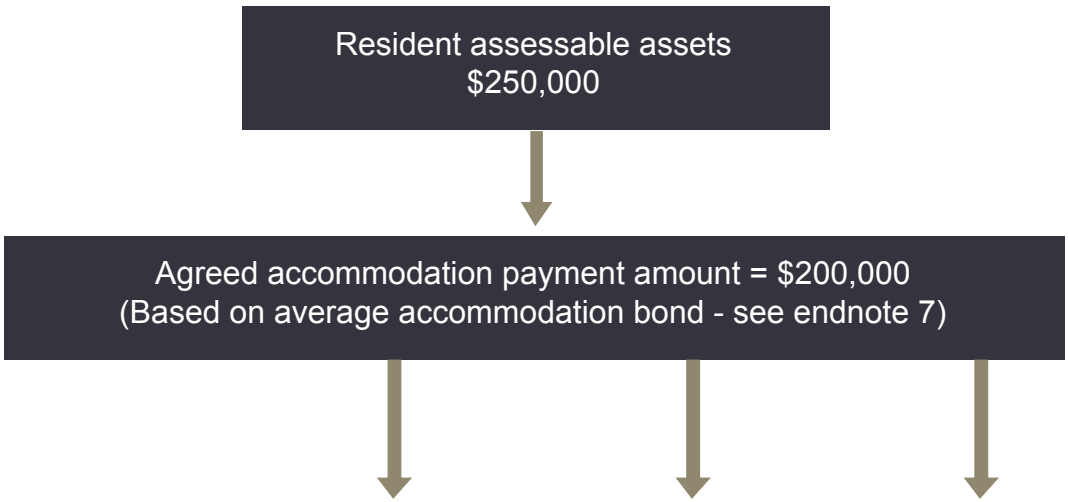
Model B still requires the availability of a loan re-draw facility in year two to the extent of around $3m to satisfy a cash over accommodation bond ratio of say 20%, but by this time, due to the availability of the extended accommodation bond pool, bank debt is retired and the facility would only be utilised temporarily, as the accommodation bond cash pool continues to accumulate.

While accounting convention requires the accommodation bond liability pool to be classified as a current liability (which causes the liquidity ratio of current assets to current liabilities to appear negative), cash over accommodation bonds continues to accumulate. The balance sheet projections in Model B also highlight the potential for a full accommodation bond model to stimulate initial investment in building stock and a return on investment to fund replacement stock.

Consequently, profitability and shareholder equity in Model B increases.

In contrast, Model A is debt ridden, has no liquidity to sustain operations and the loan to value ratio is such that further finance is unlikely to be accessible. In addition the lack of profitability completely erodes shareholders equity, even taking in to account the building revaluations imputed for this hypothetical model.

Annexure 5 - Example of accommodation payment options



	Option 1 **Lump sum payment (accommodation bond)**	**Option 2** **Daily payment**	**Option 3** **Combination of lump sum and daily payment**
Agreed accommodation payment amount	$200,000	$200,000	$200,000
Lump sum payment	$200,000	$0	$50,000
Daily payment - calculated on balance of agreed accommodation payment x interest rate (as agreed between parties eg MPIR of 8.80%) ÷ by 365 days	N/A	$\frac{\$200{,}000 \times 8.80\%}{365}$ = $48.22 per day	$\frac{\$150{,}000 \times 8.80\%}{365}$ = $36.16 per day
Retention amount - $307.50 per month, ÷ days in month (eg 31)	$9.92 per day or deduct from lump sum payment	$9.92 per day	$9.92 per day or deduct from lump sum payment
Total daily payment	**$9.92 per day** (or nil if retentions are deducted from lump sum payment)	$48.22 per day + $9.92 per day = **$58.14 per day**	$36.16 per day + $9.92 per day = **$46.08 per day** (or $36.16 if retentions are deducted from lump sum payment)

Annexure 6 - Common indirect care delivery costs

Description of service	Legislative/Policy reference	Description of service	Legislative/Policy reference
Administration	Item 1.1 of SCAS	Continuous improvement	Item 4.1 of AS
Maintenance of business and grounds	Item1.2 of SCAS	Regulatory compliance	Item 4.2 of AS
Accommodation	Item 1.3 of SCAS	Education and staff development	Item 4.3 of AS
Furnishings	Item 1.4 of SCAS	Living environment	Item 4.4 of AS
Bedding	Item 1.5 of SCAS	Occupational health and safety	Item 4.5 of AS
Cleaning services	Item 1.6 of SCAS	Fire, security and other emergencies	Item 4.6 of AS
Waste disposal	Item 1.7 of SCAS	Infection control	Item 4.7 of AS
General laundry	Item 1.8 of SCAS	Compulsory reporting	Section 63 - 1AA of the Act
Toiletry goods	Item 1.9 of SCAS	Police checks	Section 1.19 of the AP
Continuous improvement	Item 1.1 of AS	Compulsory reporting of missing residents	Section 1.14A of the AP
Regulatory compliance	Item 1.2 of AS	Accreditation audits	Section 3.3 of the AGP
Education and staff development	Item 1.3 of AS	Certification	Part 2.6 of the Act
Comments and complaints	Item 1.4 of AS	Comments and complaints	Section 56-7 of the Act
Planning and leadership	Item 1.5 of AS	Mandatory food safety programs and licenses	Item 4.2 of AS
Human resource management	Item 1.6 of AS	Gastroenteritis reporting	Item 4.7 of AS
Inventory and equipment	Item 1.7 of AS	Workers compensation regulations	Item 4.5 of AS
Information systems	Item 1.8 of AS	Vehicle maintenance	Item 1.11 of the SCAS
External services	Item 1.9 of AS	Insurance	Item 4.2 of AS

SCAS - Specified Care and Services outlined in Schedule 1 of the *Quality of Care Principles 1997* (Cth)

AS - Accreditation Standards outlined in Schedule 2 of *Quality of Care Principles 1997* (Cth)

AP - *Accountability Principles 1998* (Cth)

AGP - *Accreditation Grant Principles 1999* (Cth)

Annexure 7 - Endnotes

1. Productivity Commission, *Annual Review of the Regulatory Burdens on Business: Social and Economic Infrastructure Services*, (2009) 23.
2. Senate Standing Committee on Finance and Public Administration, *Inquiry into residential and community aged care in Australia*, (2009) 58.
3. The Government's $300 million zero real interest loans scheme targets the building or expansion of residential aged care and respite facilities in areas of high need. The loans are designed to enable providers to establish aged care services in areas where they were previously unlikely to invest. The loans are not interest free, the CPI is applied for the first two of the maximum 12 year loan period. Two years after the loan commences repayment of the principle will be required at 10% of the original loan amount plus interest.
4. The maximum retention amount set by the Department as at 1 July 2010.
5. Supported residents were formerly referred to as concessional and assisted residents.
6. *Residential Care Subsidy Principles 1997* (Cth) s 21.11b.
7. Based on the average bond listed in the Department's *Report on the Operation of the Aged Care Act 1997 – 1 July 2008 to 30 June 2009* in 2008-09 being $200,000 and generating $16,320 from investments when applying the MPIR of 8.16% and $3,588 in retentions. Less the maximum accommodation contribution of $7,062 annually based on the average accommodation charge of $19.35 listed in the *Report on the Operation of the Aged Care Act 1997 – 1 July 2008 to 30 June 2009* xiv.
8. Figures based on the estimated annual shortfall and the estimated building costs outlined in the UnitingCare Queensland Position Paper referenced in endnote 9.
9. UnitingCare Queensland, *Position paper*: *Crunch time for residential aged care funding* (2010) [7], <http://www.bluecare.org.au/NewsAndEvents/Papers/Crunch%20time%20for%20aged%20care.pdf>, at 27 May 2010.
10. Senate Finance and Public Administration Committee, above n 2, 106.
11. Australian Institute of Health and Welfare, *Residential aged care in Australia 2007-08: A statistical overview*, (June 2009) 18.
12. Senate Finance and Public Administration Committee, above n 2, 8.
13. Adele Horin, *High care bond ban criticized*, http://www.smh.com.au/national/high-care-bond-ban-criticised-20090317-910b.html> (2009), at 18 March 2009.
14. Senate Finance and Public Administration Committee, above n 2, 55.
15. Department of Health and Ageing, *Report on the Operation of the Aged Care Act 1997 – 1 July 2008 to 30 June 2009*, (2010) 49.
16. The Hon. Justine Elliot, Minister for Ageing, '*Better Health for Older Australians: Aged Care in the Rudd Government's Reform of Australian Health*, (2010)' <www.health.gov.au/internet/ministers/publishing.nsf/Content/sp-yr10-je-jesp200510.htm?OpenDocument&yr=2010&mth=5>, at 27 May 2010.
17. *Residential Care Subsidy Principles 1997* (Cth) sch 1, s 1.3, s 1.4.
18. Senate Finance and Public Administration Committee, above n 2, 54.
19. Bankwest, *Bankwest Inherited Housing Report*, (2010) 1.
20. Productivity Commission, *Trends in Aged Care Services: some implications*, (2008) XVIII.
21. Productivity Commission, above n 1, xxxv and 162.
22. Department of Finance and Deregulation, *Australian Government Response to the Productivity Commission Annual Review of Regulatory Burdens on Business: Social and Economic Infrastructure Services* (2010), <www.finance.gov.au/publications/response-to-the-pc-annual-review-of-regulatory-burdens-on-business/index.html>, at 7 June 2010.
23. Professor Warren Hogan, *Pricing Review of Residential Aged Care*, (2004) 152.
24. Medicare Australia, *Aged Care Funding Instrument (ACFI) - Rates 2009-10* (2010), <http://www.

medicareaustralia.gov.au/provider/aged-care/files/acfi-rates-table-2009-2010.pdf> at 30 June 2010.

25. The BDCF is indexed by the Department quarterly. The rate of $38.65 is current as at 1 July 2010.
26. Department of Health and Ageing, above n 15, 39.
27. Aged Care Industry Council, *2010-2011 Federal Budget Submission* (2010) [9],<www.agedcare.org.au/POLICIES-&-POSITION/Submissions/ACIC-Federal-Budget-Submission-2010.pdf>, at 4 June 2010.
28. Senate Finance and Public Administration Committee, above n 2, 60.
29. Minister for Ageing, *$140 Million Funding Boost for Aged Care Services* (2010), <www.health.gov.au/internet/ministers/publishing.nsf/Content/MediaReleases-JE-1>, at 28 May 2010.
30. Aged & Community Services Australia, *ACSA National Report*, (2010) [1-2] <www.agedcare.org.au/AGED-CARE-NEWS/Nat-report-pdfs/Issue232_10Jun10.pdf>, at 10 June 2010.
31. See Annexure 6 - Common and indirect care delivery costs.
32. Aged Care Industry Council, *2010-2011 Federal Budget Submission* (2010) [4], <http://www.agedcare.org.au/POLICIES-&-POSITION/Submissions/ACIC-Federal-Budget-Submission-2010.pdf >, at 4 June 2010.
33. Senate Finance and Public Administration Committee, above n 2, ix and-xi.
34. Productivity Commission, above n 1, 88-89.
35. Productivity Commission, above n 20, 100.
36. Grant Thornton, *Aged Care Survey 2008*: Second Report, (2009) 3.
37. The Hon. Justine Elliot, Minister for Ageing, '*Better Health for Older Australians: Aged Care in the Rudd Government's Reform of Australian Health'* (2010), <www.health.gov.au/internet/ministers/publishing.nsf/Content/sp-yr10-je-jesp200510.htm?OpenDocument&yr=2010&mth=5>, at 27 May 2010.
38. Productivity Commission, above n 20, 30.
39. Productivity Commission, above n 1, 23.
40. Productivity Commission, above n 1, 40.
41. ACAA and Hynes Lawyers Survey results show only 34% of approved providers agree the demographics should be increased from 70 to 75 years of age and 47% of approved providers were supportive of increasing the demographics from 70 to 80 years of age - see Annexure 2.
42. Senate Finance and Public Administration Committee, above n 2, 135.
43. Productivity Commission, above n 1, 40.
44. Department of Health and Ageing, *Final report: Evaluation of the impact of accreditation on the delivery of quality of care and quality of life to residents in Australian Government subsidies residential aged care homes*, (2007) 71.
45. Productivity Commission, above n 1, 53.
46. Productivity Commission, above n 1, 54.
47. ACAA and Hynes Lawyers Survey results show 62% of approved providers surveyed stated audits and support contacts are effective for monitoring compliance - see Annexure 2.
48. ACAA and Hynes Lawyers Survey results show 69% state the Agency alone should not have the powers to review accreditation decisions - see Annexure 2.
49. Department of Health and Ageing, *Discussion Paper: Review of the Accreditation Process for Residential Aged Care Homes*, (May 2009) 11.
50. ACAA and Hynes Lawyers Survey results show 77% of approved providers state that agency accreditation assessment team should always include a registered nurse - see Annexure 2.
51. Associate Professor Merrilyn Walton, *Review of the Aged Care Complaints Investigation Scheme*, (2009) 11-16.
52. Associate Professor Merrilyn Walton, above n 51, 15.
53. Associate Professor Merrilyn Walton, above n 51, 49.
54. Associate Professor Merrilyn Walton, above n 51, 48.

55. The Hon. Justine Elliot, Minister for Ageing, '*Better Health for Older Australians: Aged Care in the Rudd Government's Reform of Australian Health'* (2010), <www.health.gov.au/internet/ministers/publishing.nsf/Content/sp-yr10-je-jesp200510.htm?OpenDocument&yr=2010&mth=5>, at 27 May 2010.

56. Associate Professor Merrilyn Walton, above n 51, 33.

57. See Queensland Health Quality Complaints Commission (HQCC), New South Wales Health Care Complaints Commission (HCCC), Victorian Office of the Health Services Commissioner (OHSC) and the Commonwealth Ombudsman.

58. Health Quality and Complaints Commission Act 2006 (Qld) s 46; *Health Care Complaints Act 1993* (NSW) s 9; *Health Services (Conciliation and Review) Act 1987* (Vic) s 17; *Ombudsman Act 1976* (Cth) s 7.

59. Investigation Principles 2007 (Cth) s 16A.7(a), s 16A7(b).

60. Health Quality and Complaints Commission Act 2006 (Qld) Ch 6; *Health Care Complaints Act 1993* (NSW) Div 9; *Health Services (Conciliation and Review) Act 1987* (Vic) s 20.

61. Productivity Commission, above n 1, 49.

62. Department of Health and Ageing, above n 15, 79-80.

63. Australian Ageing Agenda, *The risky business of reform*, <www.australianageingagenda.com.au/2010/06/21/article/The-risky-business-of-reform/CSFWTJJEON.html>, (2010), at 21 June 2010.

64. Department of Finance and Deregulation, *Australian Government Response to the Productivity Commission Annual Review of Regulatory Burdens on Business: Social and Economic Infrastructure Services*, (2009).

65. Productivity Commission, *Annual Review of the Regulatory Burdens on Business: Social and Economic Infrastructure Services*, (2009) xxxv.

66. Associate Professor Merrilyn Walton, above n 51, 66.

67. Associate Professor Merrilyn Walton, above n 51, 65.

68. I*nvestigation Principles 2007* (Cth) s 16A.21.

69. Associate Professor Merrilyn Walton, above n 51, 15.

70. Section 38-3 of the Act and Part 3 *Certification Principles 1997* (Cth) allow the Secretary to have regard to relevant matters such whether the build meet the certification/licensing requirements of a state, territory or local government authority, including the Building Code of Australia Standards.

71. Department of Health and Ageing, above n 15, 71.

72. Residential Care Subsidy Principles 1997 (Cth) Schedule 1 s 1.3 and s 1.4.

73. Department of Health and Ageing, above n 15, 71.

74. Department of Finance and Deregulation, *Australian Government Response to the Productivity Commission Annual Review of Regulatory Burdens on Business: Social and Economic Infrastructure Services*, (2009).

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