
# Issues facing aged care services in rural and remote Australia

Richard Baldwin, Marguerita Stephens, Daniel Sharp and John Kelly

December 2013

# Contents

## Tables

## Table of Figures



## Table of Acronyms

**Table 1 List of acronyms used in this paper and their full expression**

| Acronym | Full expression |
|---|---|
| **ACFA** | Aged Care Financing Authority |
| **ACSA** | Aged and Community Services Australia |
| **AIHW** | Australian Institute of Health and Welfare |
| **CACP** | Community aged care package |
| **CBO** | Community benefit organisation (religious, charitable or community based) |
| **CDC** | Consumer directed care |
| **DAP** | Daily accommodation payment |
| **DoHA**[1] | Australian Government Department of Health and Ageing |
| **DVA** | Department of Veterans' Affairs |
| **EACH** | Extended aged care at home package |
| **EACHD** | Extended aged care at home dementia package |
| **EBITDA** | Earnings before interest, tax, depreciation and amortisation |
| **FP** | For-profit |
| **LLLB** | Living Longer Living Better |
| **NFP** | Not-for-profit |
| **PC** | Productivity Commission |
| **RAC** | Residential aged care |
| **RAD** | Refundable accommodation deposit |

[1] Portfolio responsibility for aged care has moved from DoHA to the Department of Social Services under the recent change of government.

## Definition of commonly used terms

**Table 2 Definition of terms used in this paper**

| Terms used | Definition |
|---|---|
| Care recipient | These are consumers in receipt of care and the term is used to distinguish them from other consumers, such as family members receiving respite services, but who is not a care recipient. |
| Charitable | An organisation that intends social value or utility to the general community or an appreciable section of the public, and that is not established primarily to provide profit, gain or benefit to its individual owners or members.[2] |
| Community based | An organisation formed for a particular common purpose by members of an identifiable community based on locality, ethnicity or some other identifiable affiliation, whose activities' may be carried out for the benefit of its members but which does not provide financial profit or gain to its individual owners or members[1]. |
| Community Benefit Organisation | Collectively, these are community based, religious and charitable organisations that do not seek to make a profit from their activities, previously referred to as not-for-profit (NFP[3]) organisations. |
| Consumer | A consumer of services may be a person receiving formal care, the carer of a person receiving formal or informal care or a person making an enquiry about the receipt of care |
| Consumer Directed Care | 'CDC is a way of delivering services that allows consumers to have greater control over their own lives by allowing them to make choices about the types of care they access and the delivery of those services, including who will deliver the services and when. Under a CDC approach, consumers are encouraged to identify goals, which could include independence, wellness and re-ablement. These will form the basis of the Home Care Agreement and care plan' (Australian Government Department of Health and Ageing 2013c, p. 8). |
| Daily Accommodation Payment | An amount paid by a care recipient towards their accommodation costs in a residential aged care facility calculated on a daily basis (Aged Care Financing Authority 2013). |
| Formal or paid care | This is care provided by a person who is paid to provide that care generally by an organisation in receipt of government funding but the person may also be paid directly by the person receiving care or their carer |
| For-profit | A for-profit organisation is one which operates primarily for the financial profit or gain of its owners, members or shareholders. For-profit organisations include private incorporated bodies that are registered by the ASIC or publicly listed companies that are listed on the Australian Stock Exchange[1] |
| Informal care | This is care provided to a care recipient by a person who is not paid to provide that care and generally includes family, friends and neighbours of the person receiving care |

[2] The definitions of local and state governments, not for profit, for-profit, religious, community based and charitable were sourced from the DoHA (Australian Government Department of Health and Ageing 2009).
[3] The term not-for-profit, or NFP, is used in this paper where there is a direct quote from the original source which used this term or the context requires that this terminology is used.

| Terms used | Definition |
|---|---|
| Living Longer Living Better | LLLB is the name given to the Australian Government's Aged Care Reform Package announced in April 2012 in response to the Productivity Commission's Report - Caring for Older Australians. |
| Local government | A body established for the purposes of local government by or under a law of a State or Territory[1]. |
| Not-for-Profit | A not-for-profit organisation is one which does not distribute operating surpluses for the profit or gain of its individual owners or members; whether these gains would have been direct or indirect. This applies both while the organisation is operating and when it winds up. The Australian Taxation Office accepts an organisation as not-for-profit where its constituent or governing documents prevent it from distributing profits or assets for the benefit of particular people[1]. |
| Refundable Accommodation Deposit | An amount paid as a lump sum by a care recipient for their accommodation costs in a residential aged care facility (Aged Care Financing Authority 2013). |
| Religious | An organisation whose objectives and activities reflect its character as a body instituted for the promotion of religious objectives and the beliefs and practices of whose members constitute a religion[1]. |
| Resident | The term resident refers to a person who permanently or temporarily resides in a residential aged care facility |
| Service provider | This is the organisation that is providing an aged care service and who receives a payment either from the government, another funder or the care recipient or carer to provide care. Service providers in receipt of government funding must be approved or meet certification or standards before being funded. |
| State/Territory government | Includes State or Territory Government authorities, instrumentalities and local health authorities established under State or Territory legislation[1]. |
| Sustainability | Sustainability is the combined viability of aged care services within the sector, or parts of the sector, to the level that the numbers of providers continuing to operate are sufficient to enable the sector to continue functioning to a level that will achieve social and financial objectives that are acceptable to the community or have been agreed. |
| Viability | Viability refers is the financial capacity of an organisation to provide sufficient financial return to satisfy the requirements of the operators to the extent that the owners or operators of the organisation are prepared to continue to operate the service both in the short and long term. The determination of the viability of an organisation may be based on its current operational performance measured by its EBITDA or its project return on investment. |

# Executive summary

The ongoing reforms of aged care in light of the Productivity Commission and the Living Longer Living Better initiatives has created potential opportunities and challenges for rural and remote aged care providers. These changes relate to viability and the funding mix but the changes also tap into fundamental issues of service delivery.

Approximately 11.3% of Australians aged 70 and over live in outer regional, remote and very remote areas.

Residential aged care facilities in outer regional, remote and very remote areas are generally small in size. The facilities lack the economies of scale and economies of scope which are found in more urban areas. Aged care costs more per patient in these settings on a 'like for like' basis while the aged care system provides only minor opportunities for operators to recoup these above average costs. There is little evidence to suggest that extra funding such as the viability supplement is an effective offset against these increased costs.

Many aged care facilities in rural and remote areas operate on the cusp of viability. These facilities will, from 1 July 2014, be particularly sensitive to the changing payment settings of residential care. Residents will pay for accommodation costs through a refundable accommodation deposit or a non-refundable daily accommodation payment or a combination of both.

# Introduction

This paper has been prepared by ACSA to explore issues facing aged care services, funded under the Aged Care Program, in regional, rural and remote Australia. This includes a response to the Living Longer Living Better (LLLB) reforms which are progressively being introduced by the Australian Government, but also canvasses many wider and long standing issues for rural and remote Australia for which we have a long history of sub optimal responses.

The aged care sector is anticipating a period of substantial growth due to the increased demand for services from the cohort of people born in the decades following the end of the Second World War. Because of the large size of this cohort of citizens compared to the previous generation there will need to be an increase in the capacity of the system over the next few decades to meet the demand. The Australian government has identified a need to expand both home aged care services and residential care. The Aged Care Financing Authority (ACFA), (2013, p. 10) in their inaugural report, estimate that over the next decade 74,000 additional beds will need to be built to meet the targets identified in the Living Longer Living Better (LLLB) targeted reforms. They claim that this investment, together with the need to upgrade and replace existing residential facilities, will require an investment of about $25 billion over ten years. A proportion of these new beds will be needed outside of densely populated parts of Australia. The ACFA (2013, p. 44)also predicts that the total number of home aged care packages will be 144,000 by 2021-22; an increase of approximately 9,000 packages per year. Based on the current financial and structural frameworks within which this sector operates, finding the management skills, workforce and funding for this expansion and investment will present challenges to the current and future providers of residential and home aged care services in these less populated parts of Australia and the ACSA is concerned that inadequate attention has been paid to the challenges and issues facing the rural and remote sectors during the current reform process.

This expansion will be characterised by changing patterns of demand regarding choice, quality of care and quality of life. Many analysts have commented that the next generation of aged care consumers will demand services that will not necessarily be met by providers continuing to deliver service in the same way as they have in the past. In addition, the changed financial and regulatory framework being introduced by the Australian Government may require management and structural changes in many services if they are to remain viable. It is important for the stability of the sector that the issues that arise from the current changes and future demand continue to be debated within the sector and the wider community.

The first section of this paper describes the size and shape of the sector in terms of the distribution of services by location, size and ownership type and highlights the differences between services in the sparsely populated and more densely populated parts of Australia. This is followed by a short summary of the current reforms both recently introduced and those that are to follow over the coming year. The paper then explores the impact of these reforms on services in rural and remote Australia for both residential and home care services. A number of issues are flagged throughout the paper.

The paper has been prepared based on reports from the Australian Government, by analysts commissioned by government and by the sector, and from the ACSA's own research.

The paper, in its current form, makes no recommendations. Following the receipt of comments and the opportunities for debate around the issues within the Association the paper will be revised and released as a position paper of the Association.

# Aged care services across Australia

This section describes the distribution of residential aged care (RAC) and home aged care (HAC) services funded under the Aged Care Act 1997 across Australia to provide a perspective on the structural characteristics of services located in regional, rural and remote areas of Australia.

## Measures of location

The broad classification system used by the Australian Government Department of Health and Aging (DoHA) to describe the location of aged care services in Australia is the Australian Standard Geographical Classification (ASGC) (Australian Bureau for Statistics 2010)[4]. The ASGC has five classifications:

- Major cities—for example, Sydney
- Inner regional—for example, Hobart
- Outer regional—for example, Darwin
- Remote—for example, Charleville
- Very remote—for example, Tennant Creek.

The Australian Institute of Health and Welfare (AIHW) (2012b) reported that at 30 June 2011 there were 2,163,500 Australians aged 70 and over and that,

- 66% lived in major cities,
- 23% lived in Inner regional locations
- 10% lived in outer regional locations
- 1% lived in remote areas
- 0.3% lived in very remote areas.

The distribution of RAC places across Australia mirrors this population distribution but with a slightly lower percentage of services in Major Cities (61%) and slightly higher percentage distribution in all other locations. As would be expected, and as

[4] The ABS is progressively moving its data collection to a revised version, the Australian Statistical Geographical Standard, (ASGS) from 2011 and its first release of data on disability and ageing survey will commence in late 2013.

Table 3 indicates, the distribution of RAC services in some states and territories reflects the distribution of the population of that state or territory (especially Northern Territory, Tasmania and Queensland) and differs from the national distribution.

Table 3 Distribution of residential aged care facilities, by state/territory and ASGC classification 30 June 2011

| | Major Cities | Inner regional | Outer Regional | Remote | Very Remote | All regions |
|---|---|---|---|---|---|---|
| | | | Number | | | |
| **NSW** | 559 | 235 | 87 | 7 | 0 | 888 |
| **Vic** | 475 | 215 | 67 | 4 | .. | 761 |
| **Qld** | 260 | 131 | 74 | 10 | 8 | 483 |
| **WA** | 183 | 28 | 24 | 4 | 6 | 245 |
| **SA** | 181 | 35 | 44 | 3 | 0 | 263 |
| **Tas** | .. | 47 | 26 | 3 | 3 | 79 |
| **ACT** | 26 | 0 | .. | .. | .. | 26 |
| **NT** | .. | .. | 6 | 5 | 4 | 15 |
| Australia | **1,684** | **691** | **328** | **36** | **21** | **2,760** |
| | | | Per cent | | | |
| **NSW** | 63.0% | 26.5% | 9.8% | 0.8% | 0.0% | 100% |
| **Vic** | 62.4% | 28.3% | 8.8% | 0.5% | - | 100% |
| **Qld** | 53.8% | 27.1% | 15.3% | 2.1% | 1.7% | 100% |
| **WA** | 74.7% | 11.4% | 9.8% | 1.6% | 2.4% | 100% |
| **SA** | 68.8% | 13.3% | 16.7% | 1.1% | 0.0% | 100% |
| **Tas** | - | 59.5% | 32.9% | 3.8% | 3.8% | 100% |
| **ACT** | 100.0% | - | - | - | - | 100% |
| **NT** | - | - | 40.0% | 33.3% | 26.7% | 100% |
| Australia | 61.0% | 25.0% | 11.9% | 1.3% | 0.8% | 100% |

Source: (Australian Institute of Health and Welfare 2012c Table A1.2)

## Size of Residential Aged Care Services

The size and ownership type of RAC services in regional and remote locations differs from the profile of services in major cities. Table 4 illustrates that while only 1.4% of services in major cities and 8.5% for inner regional locations have 20 beds or fewer, 47.2% of services in remote locations and 76.2% of services in very remote locations have 20 beds or fewer. Across the country 27.6% of all facilities are over 80 beds, however, there are no services in very remote locations with more than 60 beds, only 1 service in a remote location with more than 80 beds and services with more than 80 beds are only 10.6% of all services in outer regional locations.

Table 4 Size of aged care facilities in Australia, by remoteness, 30 June 2011

| | Major Cities | Inner regional | Outer Regional | Remote | Very Remote | All regions |
|---|---|---|---|---|---|---|
| **size** | | | **Number** | | | |
| **1<=20** | 23 | 59 | 57 | 17 | 16 | 172 |
| **21-40** | 259 | 178 | 114 | 9 | 4 | 564 |
| **41-60** | 494 | 191 | 87 | 6 | 1 | 779 |
| **61-80** | 328 | 121 | 35 | 3 | 0 | 487 |
| **81-100** | 223 | 72 | 23 | 1 | 0 | 319 |
| **101-120** | 166 | 32 | 5 | 0 | 0 | 203 |
| **121+** | 191 | 38 | 7 | 0 | 0 | 236 |
| **All services** | 1,684 | 691 | 328 | 36 | 21 | 2,760 |
| | | | **Per cent** | | | |
| **1<=20** | 1.4 | 8.5 | 17.4 | 47.2 | 76.2 | 6.2 |
| **21-40** | 15.4 | 25.8 | 34.8 | 25.0 | 19.0 | 20.4 |
| **41-60** | 29.3 | 27.6 | 26.5 | 16.7 | 4.8 | 28.2 |
| **61-80** | 19.5 | 17.5 | 10.7 | 8.3 | 0.0 | 17.6 |
| **81-100** | 13.2 | 10.4 | 7.0 | 2.8 | 0.0 | 11.6 |
| **101-120** | 9.9 | 4.6 | 1.5 | 0.0 | 0.0 | 7.4 |
| **121+** | 11.3 | 5.5 | 2.1 | 0.0 | 0.0 | 8.6 |
| **All services** | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

Source (Australian Institute of Health and Welfare 2012c Table A1.5)

The predominance of small services in outer regional, remote and very remote locations impacts on their capacity to remain viable over the long term. Small services can have greater challenges in recruiting and retaining staff because of matters such as limited training, promotional opportunities and the lack of desire from employees to reside in rural and remote locations. Providers may incur greater costs in recruiting and retaining employees in the form of 457 visas, fly-in fly-out arrangements, employment agency costs as well as higher wages. Small services are also likely to face greater financial challenges within a funding and regulatory system that is geared to the economies of scale of the majority of services, which are larger and located in major cities and inner regional locations. Furthermore, the challenge of staff turnover and its impact on leadership, culture, quality consistency, corporate knowledge, plus their size invariably means they have less sophisticated business systems which can be consistently applied.

## Providers of Residential Aged Care Services

Providers of aged care services are classified by as not-for-profit *(referred to as Community Based Organisations (CBOs) in this paper),* Government or for profit (FP). The proportion of services in outer regional, remote and very remote locations operated by the different RAC provider types differs from the pattern of providers in major cities and inner regional locations. As Table 5 illustrates although FP providers operated 816 services (40% of all services) across Australia in 2011 these included only 4 services in very remote locations, none in remote locations and only 30 in outer regional locations. That is, only 4.1% operated by FP providers are located outside of major cities and inner regional locations. In contrast 34.5% (103 of 296 services) of all government operated services and 15% (249 of 1,648) of all CBO owned services are located in outer regional, remote and very remote locations. 14% of all services are located in outer regional, remote and very remote locations, of which the vast majority (91.2%) are provided by CBOs or Government operated providers. With regard to services provided in outer regional, remote and very remote locations, there is significant diversity with regard to viability and the challenges at hand.

It is noteworthy that some FP providers do offer services in outer regional locations whereas FP providers are more scarce in rural areas. It is also noteworthy that government providers often operate as multi-purpose services. It would appear that the demands of rural and regional areas tend towards different models of service delivery.

**Table 5 Number of residential aged care facilities, by provider type and remoteness, 30 June 2011**

| | Major Cities | Inner regional | Outer Regional | Remote | Very Remote | All regions |
|---|---|---|---|---|---|---|
| | | | | **Number** | | |
| CBOs | | | | | | |
| **Charitable** | 295 | 107 | 52 | 2 | 2 | 458 |
| **Community Based** | 151 | 173 | 99 | 14 | 4 | 441 |
| **Religious** | 498 | 175 | 61 | 7 | 8 | 749 |
| ***Total CBOs*** | *944* | *455* | *212* | *23* | *14* | *1,648* |
| Government | | | | | | |
| **Local Government** | 21 | 11 | 20 | 4 | 0 | 56 |
| **State Government** | 45 | 117 | 66 | 9 | 3 | 240 |
| ***Total government*** | *66* | *128* | *86* | *13* | *3* | *296* |
| For Profit | | | | | | |
| ***Total FP*** | *674* | *108* | *30* | *0* | *4* | *816* |
| Total services | **1,684** | **691** | **328** | **36** | **21** | **2,760** |
| | | | | **Per cent** | | |
| CBOs | | | | | | |
| **Charitable** | 17.5 | 15.5 | 15.9 | 5.6 | 9.5 | 16.6 |
| **Community Based** | 9.0 | 25.0 | 30.2 | 38.9 | 19.0 | 16.0 |
| **Religious** | 29.6 | 25.3 | 18.6 | 19.4 | 38.1 | 27.1 |
| ***Total CBOs*** | *56.1* | *65.8* | *64.6* | *63.9* | *66.7* | *59.7* |
| Government | | | | | | |
| **Local Government** | 1.2 | 1.6 | 6.1 | 11.1 | 0.0 | 2.0 |
| **State Government** | 2.7 | 16.9 | 20.1 | 25.0 | 14.3 | 8.7 |
| ***Total government*** | *3.9* | *18.5* | *26.2* | *36.1* | *14.3* | *10.7* |
| For Profit | | | | | | |
| **Total FP** | 40.0 | 15.6 | 9.1 | 0.0 | 19.0 | 29.6 |
| Total services | **100.0** | **100.0** | **100.0** | **100.0** | **100.0** | **100.0** |

Source (Australian Institute of Health and Welfare 2012c Table A1.7)

## Services by population and locations

The current planning framework used by the Australian Government for the allocation of approved places is based on a target ratio of 113 places per 1,000 persons over the age of 70 within each planning region. This distribution is made up of 42 high care residential places, 44 low care residential places and 27 community care places (Australian Government Department of Health and Ageing 2012, p. 7). However, as Table 6 illustrates the number of combined places per 1000 persons over the age of 70 year varies across locations and within states and territories[5]. Although care is needed in interpreting these data due to the different population distributions across the states and territories, the national totals suggest that regional locations are under this target and both major cities and remote locations are over this target. There appears to be a poorer distribution of services in locations outside major cities and inner regional areas in NSW and Victoria, lower provision in inner regional areas of Western Australian and in remote locations in South Australia. On the other hand the number of places per 1000 persons over 70 and indigenous persons aged 50 to 69 years in the Northern Territory is much higher (219) than the national total (114). This higher result for the Northern Territory reflects the much higher allocation of community aged care packages (CACP) per 1000 persons over the age of 70 in that territory compared with other jurisdictions.

**Table 6 Residential aged care, CACP, EACH, EACH D and TCP places per 1,000 persons aged 70 years and over, by state/territory and remoteness,(a) 30 June 2011**

| State/ territory | Major cities | Inner regional | Outer regional | Remote | Very remote | Total (70+) | Total (70+ population and Indigenous population aged 50–69 years) |
|---|---|---|---|---|---|---|---|
| | | | | Ratio | | | |
| | | | | Combined residential and community places | | | |
| **NSW** | 115.3 | 114.3 | 96.4 | 89.4 | 53.3 | 113.4 | 110.4 |
| **Vic** | 115.2 | 109.6 | 93.0 | 22.9 | 0.0 | 112.5 | 111.6 |
| **Qld** | 116.4 | 103.1 | 110.9 | 117.5 | 155.7 | 112.6 | 110.4 |
| **WA** | 122.2 | 92.3 | 115.1 | 118.8 | 128.9 | 116.7 | 111.8 |
| **SA** | 120.1 | 110.8 | 102.6 | 91.0 | 233.3 | 116.6 | 115.6 |
| **Tas** | .. | 128.5 | 80.2 | 125.0 | 126.7 | 112.5 | 110.2 |
| **ACT** | 122.2 | 0.0 | .. | .. | .. | 121.7 | 119.6 |
| **NT** | .. | .. | 144.8 | 282.7 | 484.0 | 219.6 | 107.7 |
| Australia | **116.7** | **110.3** | **101.4** | **118.5** | **195.5** | **114.1** | **111.4** |

Source: (Australian Institute of Health and Welfare 2012c Table A1.9)

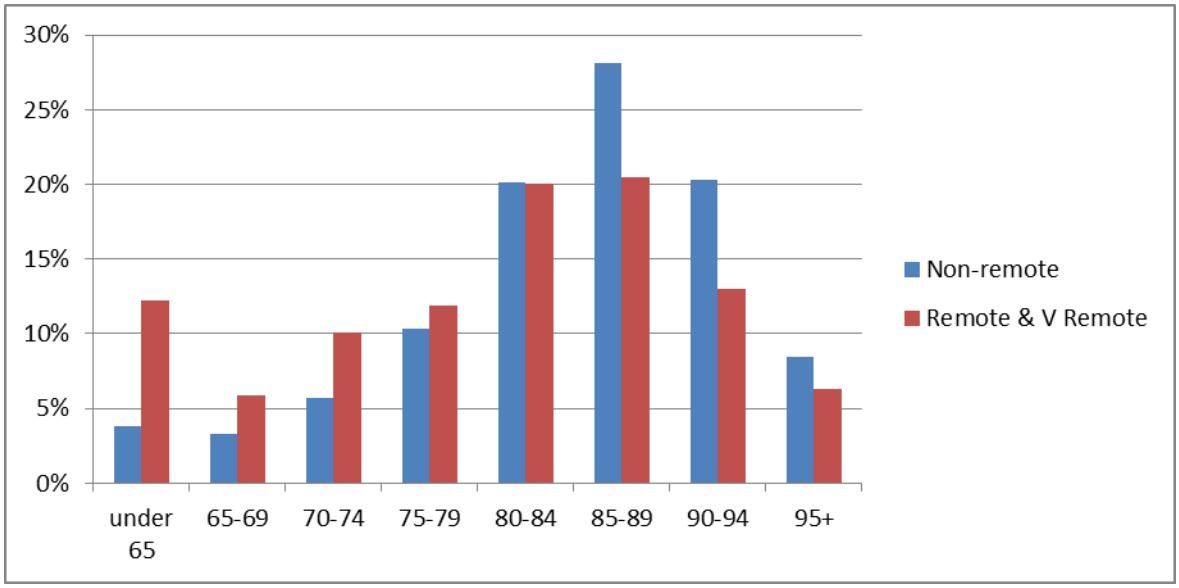
[5] The full details of the tables on the distribution of services by type and jurisdiction across Australia is provided in Appendix 1.

## Distribution of residents in RAC across Australia

For the purposes of this discussion it is valuable to examine any differences in the distribution of residents in RAC by locality across Australia. Of interest is the distribution of high care and low care residents, the dependency level of residents in RAC in different locations and the age of residents. A difference in the distribution of high and low care residents will have a bearing on the capacity of the sector to generate income in the future from RADs (see discussion below in relation to the predicted changes in the payment of RADs and DAPs). A difference in the distribution of residents by dependency level may indicate a need for different staffing profiles between different locations.

Figure 1 illustrates the age difference across Australia between services in non-remote locations (major cities, inner and outer regional locations) and service in remote and very remote locations. This figure illustrates that a greater proportion of residents less than 80 years old in remote and very remote locations and a greater proportion of residents more than 85 years old in non-remote locations. The AIHW concludes that the presence of Indigenous residents results in the sharp contrast in representation at younger age groups in homes in remote and very remote locations.

**Figure 1 Age Distribution of permanent residents**



## Summary

The predominant profile of services in outer regional, remote and very remote locations is that of small facilities provided by CBOs or by state or local government providers. This profile is different to that of the profile of all services across Australia. This may mean that a financial and regulatory framework that is based on the structural characteristics of the majority of services may not provide for the sustainable operation of services in outer regional, remote and very remote locations. It is therefore important that the current reform process creates a long term framework for the viability of services in these more sparsely populated locations.

The challenges of rural and remote aged care should not be seen as a 'bricks and mortar' issue but very much an issue about human capital as well. Rural and remote areas do not ordinarily have the same labour force or balance of skills which can be found in more populated places. These areas are often even under represented with regard to highly educated and qualified people such as doctors and dentists. These areas do not generally have training facilities and prestige. To refer to dentists as an example, the accreditation standards suggest that all residents should be seen by a dentist at a minimum of twice yearly. There are very few dentists in many rural and remote communities and the costs of travelling to a centre with a service, usually with accompanying staff, is not appropriately accounted for in government subsidies.

There are often a myriad of issues with getting these vital professionals into these communities where they are needed. For example, it would seem that speech pathologists from the local State service are sometimes told not to attend to nursing home residents due to the fact they are privately run and Commonwealth funded. There appear to be an option to bring in a private speech pathologist that may be in towns hundreds of kilometres away. There is often urgent patient need for these services which is unmet.

Should the financial and regulatory framework not take account of the challenges of operating services in outer regional, remote and very remote areas then residential and home care services in these regions will close, or not be opened in response to emerging need. A consequence of this would be to force clients out of their community into residential care in larger population centres, creating a need for greater capital investment in those centres.

However, if the financial and regulatory framework is adjusted to make allowances for the realities of operating services in outer regional, remote and very remote communities, then sustainable services will remain and grow to meet emerging needs. This desirable outcome can be achieved if government can enhance matters as ARIA and the viability supplement, which shall be canvassed further on in this paper.

# LLLB reforms of significance to RRR services

This section summarises the changes that have been or will be introduced as a result of the reforms announced by the Australian Government under the Living Longer Living Better package of reforms. Many of these changes have a particular impact on providers in remote areas. For example, greater consumer preferences for ongoing payments for care rather than bonds may further accentuate the existing challenges faced by rural and remote providers in attracting capital investment.

## Proposed accommodation payments for RAC

From 1 July 2014, subject to any further changes by the new Australian Government, the proposed model for accommodation payments for RAC will introduce the following arrangements (Australian Government Department of Health and Ageing 2013a):

- residents will pay for accommodation costs through a refundable accommodation deposit (RAD) or a non-refundable daily accommodation payment (DAP) or a combination of both
- the amount of the DAP will be derived from the preferred RAD price using the 'maximum permissible interest rate' (MPIR)
- RADs will be subject to a minimum permissible asset value test, prudential requirements, restrictions on the use of these funds and regulations regarding refunds
- accommodation prices are to be set taking into consideration the privacy of the room, quality of the room and facility, and other factors including location, design and services (other than care services and services charged for through an extra service fee)
- providers must publish the level of RADs and DAP they charge creating greater transparency in relation to accommodation costs to residents, prospective residents and other stakeholders
- accommodation payments will be one of three levels

**Table 7 residential accommodation payment levels from 1 July 2014** ***(current as of 20 November Press Release from Senator Fifield)***

| Level | Description |
|---|---|
| **Level 1** | From $0 to the amount of the maximum government accommodation supplement, equivalent to $50 per day from 1 July 2014, or an equivalent RAD of approximately $200,000 *and paid in part or full by the Government accommodation supplement for residents with 'low means'* |
| **Level 2** | From the maximum government accommodation supplement of approximately $120 per day or an equivalent lump sum of $550,000 *(which will be set by providers and published from 19 May 2014 on the My Aged Care website and the provider's own publications)* |
| **Level 3** | Amounts greater than $120 per day (or the lump sum equivalent) will need to be pre-approved by the Aged Care Pricing Commissioner. This approval process will affect approximately 5% of proposed prices. |

Source: (Australian Government Department of Health and Ageing 2013a)

- providers will be able to charge, an 'additional amenity fee' for amenities and services that are not included in basic services, the accommodation charge or 'extra service' charge, and the resident can agree to pay these on an 'op-in opt-out' basis
- providers will no longer be allowed to deduct regular 'retention amounts' from the RAD but will be able to deduct amounts as payment for DAPs or to top up the DAP (following agreement with the resident)
- providers will retain any interest earned on the RAD and this income may be used for any purpose approved under the prudential compliance safeguards

These reforms to the payment for accommodation in residential aged care will allow residents to choose between RAD and DAPS or a combination of both. KPMG (2013b, p. 44) have estimated that the number of RADS that will be switched over to DAPs is more likely at the lower end of the value of the RADs, that is, less than $200,000 with the average at $113,000. However they caution that their estimates may be an overestimate and comment that 'although most residents would prefer to pay a DAP based on their estimated wealth, in the majority of cases the estimated income earned from renting out the home will not be enough to cover the estimated DAP' (KPMG 2013b, p. 43). This is likely to be particularly true for homes in those part or rural and remote Australia where the mining boom is not impacting on domestic accommodation and where rents and demand are not high.

***ISSUE 1***

- Is further work required by the Aged Care Financing Authority on the likely impact on small residential aged care providers in rural and remote locations prior to the introduction of the change to accommodation payments from 1 July 2014 to enable the sector to adequately prepare for the likely impact of these changes?

### Structural changes to home care services

Major structural changes for community and home care services for the aged are being implemented as part of the LLLB suite of reforms and these may have a significant bearing on future operational income and expenditure for regional and remote providers. The following changes to home care provided under the Aged Care Act 1997 (as amended) came into effect on 1 August 2013:

- the Home Care Packages Program now has four levels of home care
    1. Basic care package
    2. Low level care package
    3. Intermediate care package
    4. High level care package
- all new packages must be delivered on a Consumer Directed Care (CDC) basis[6] and will be progressively introduced over two years (Australian Government Department of Health and Ageing 2013c)
- the following possible supplements will increase payments to providers
    - dementia supplement
    - veterans supplement
    - oxygen supplement
    - homeless supplement
    - enteral feeding supplement
    - viability supplement

[6] CDC will involve the care recipient (or carer/guardian) identifying the goals they seek from care, signing a Home Care Agreement and agreeing a care plan, and some level of involvement with managing of their care; and care may involve 'innovative ways to meet the consumer's goals and care needs' within the overall value of the package (Australian Government Department of Health and Ageing 2013c, p. 27).

Future reforms are likely to include:

- a reduction in the government subsidy from 1 July 2014 according to the 'income tested fee payable' and the amount of consumer fee charged by the home care provider (Australian Government Department of Health and Ageing 2013c, p. 55)
- a new Commonwealth Home Support Program is planned to commence from 1 July 2015 which will incorporate the existing Commonwealth HACC Program, the National Respite for Carers Program (NRCP), the Day Therapy Centres (DTC) Program, and the Assistance with Care and Housing for the Aged (ACHA) Program
- new levels of interface between the Home Support Program and the Home Care Packages Program (Australian Government Department of Health and Ageing 2013c) that may impact on existing service provision.

# Financial viability of rural and remote residential aged care services

Measure of financial viability of residential aged care services are determined by

- returns from operations, generally measured as earnings before income tax depreciation and amortisation (EBITDA)
- the capacity to generate capital and return sufficient income to cover the cost of investment.

## Operational income for RAC in outer regional, remote and very remote locations

### EBITDA

Benchmarking results prepared by Stewart Brown consistently show that residential aged care facilities with fewer than 40 beds have the lowest levels of EBITDA per bed day of all size categories. Facilities with fewer than 40 beds constitute 52% of all services in outer regional locations, 72% of all facilities in remote locations and 95% of all facilities in very remote locations. For this size category EBIDTA of $6,557 per annum was reported for the nine month period to March 2013 in survey of 585 facilities (Stewart Brown 2013). This income compares with $8,392 for facilities with 40 to 60 places and $7,982 for facilities with 60 to 80 places. This suggests that, based on size, the majority of residential aged care facilities in outer regional, remote and very remote locations are in the lowest income category. The Stewart Brown survey does not distinguish financial performance by location.

By contrast the Aged Care Funding Authority accepted the findings from the KPMG report into the viability of the residential aged care system and reported that the average EBITDA for the sector in 2011-12 was $9,274. They also reported that the top quartile of operators in terms of financial performance had an annual average EBITDA of $21,081[7] (2013, p. 26). Despite this more favourable picture of the profitability of the sector by KPMG than by Stewart Brown, if the average income reported by Stewart Brown, based on facility size, is applied to the KPMG findings it would also suggest that the majority of services outer regional, remote and very remote locations are functioning in the bottom two quartiles of the KPMG range.

ACFA (2013) also reported financial performance based on EBITDA for different locations. However they only separate providers into ‘city’ and ‘regional’; where ‘city’ means the ASGC definition of ‘major city’ and ‘regional’ includes all services in the ASGC locations classifications of ‘inner regional’, ‘outer regional’, ‘remote’ and ‘very remote’. They reported that average EBITDA of $10,369 for ‘city’ based providers and $6,663 for ‘regional’ based providers. The ‘regional’ result is only 64% of the ‘city’ performance; this is despite the addition of the viability supplement to a number of ‘regional’ providers. This inclusion of all four non-major city providers in the one category may not provide a useful picture of the situation in outer regional, remote and very remote locations. As

[7] Care is needed in comparing the EBITDA results from these two reports as the KPMG data is based on approved providers overall financial data and the Stewart Brown data is based on individual facilities.

Table 3 shows the number of residential facilities in 'inner regional' locations is more than twice the number in the other three categories and therefore, the results from these inner regional facilities are likely to skew the findings in the direction of facilities in this area where facilities tend to be larger in size.

The lack of granularity in this reporting of performance in relation to location indicate a substantial lack of information as to the true nature of the financial performance of services in outer regional, remote and very remote locations. While care is needed in interpreting these data, as there may be other differences between city and regional providers that account for performance other than location, in the absence of other data, location would appear to be a significant factor in financial performance.

***ISSUE 2***

- Should ACFA provide more granular reports on financial performance to enable the true assessment of the challenges facing small services in 'outer regional', 'remote' and 'very remote' locations?

## Viability supplements for residential care

The viability supplement is paid to residential aged care services in recognition of the higher cost of providing care in relatively remote locations, by small services and those caring for residents with special needs. The scheme was introduced in 1997 and modified in 2001 and 2005. The 2005 scheme provides a daily payment per resident of between $3.67 (*remoteness score of 50*) and $40.32 (*remoteness score of 100*)[8] depending on the score that the facility receives. Points are awarded for relative remoteness, number of occupied beds and percentage of special needs residents. These payments for mainstream residential services were increased by 30% in 2010-11 and by 37% in 2011-12 and total expenditure by the Australian Government to residential aged care providers for the viability supplement for mainstream services and flexible aged care program in 2011-12 are shown in Table 8 (Australian Government Department of Health and Ageing 2012, p. 40).

**Table 8 Australian Government expenditure for residential viability supplement, and the number of aged care homes receiving residential viability supplement, during 2011–12, by state and territory**

| | Mainstream Residential Care Services | | NATSI Flexible Aged Care Program | | Multi-Purpose Services | |
|---|---|---|---|---|---|---|
| | Services | $'000 | Services | $'000 | Services | $'000 |
| NSW | 104 | 6,660.9 | 2 | 0.5 | 54 | 3,604.0 |
| VIC | 92 | 5,751.8 | 0 | 0.0 | 7 | 824.9 |
| QLD | 97 | 7,308.1 | 3 | 405.1 | 28 | 2,649.9 |
| WA | 31 | 3,350.0 | 1 | 228.6 | 30 | 2,766.6 |
| SA | 50 | 2,441.1 | 4 | 707.2 | 14 | 2,566.1 |
| TAS | 24 | 1,168.6 | 0 | 0.0 | 3 | 216.6 |
| ACT | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| NT | 11 | 1,688.1 | 9 | 1,815.12 | 1 | 54.9 |
| **Aust.** | **409** | **28,368.6** | **19** | **3,207.9** | **137** | **12,682.9** |

Source: (Australian Government Department of Health and Ageing 2012, p. 44)

[8] These rates apply from 1 July 2013 to 30 June 2014.

The $28.4 million in viability supplement for mainstream services is paid to 409 facilities (out of a total of 2,760 across Australia at 30 June 2011 (Australian Institute of Health and Welfare 2012b, p. 16)). The value of the viability supplement represents 0.3% of the overall government funding for aged care of $8,738.4 million for 2011-12 (Australian Government Department of Health and Ageing 2012, p. 40). While estimating an average payment per year to services is a very crude measure, as actual payments depend on the remoteness score and number of places in each service, the crude average provides some perspective on the contribution the viability supplement makes to the total income of the service. The crude average payments per service per year in 2011-12 were:

- $69,000 for mainstream services
- $168,000 for NATSI flexible care program and
- $92,000 for Multi-purpose Services.

In recognising the additional costs of operating small services in rural and remote locations the Productivity Commission made the following comments:

> 'The Commission recognises that being able to choose between competing providers is not always feasible. In some situations, the pricing recommendations of the proposed AACC would include supplements (or block funding) to providers of specialised services (such as specific aged care services for homeless people) and to those operating in rural and remote areas (including Indigenous-specific flexible aged care services). The report provides commentary on testing the further use of market-based instruments, block funding and multipurpose services in thin markets (2011, p.XXXIV).
>
> Many aged care services in rural and remote locations, particularly residential services, are cross-subsidised from other activities (either in urban centres and/or community care and/or income from other sources including philanthropy). To ensure that the aged care system operates efficiently, services delivered in rural and remote areas should be funded at a level which has regard to the additional costs incurred in supplying the services — this ensures that funding is sustainable and predictable to provide adequate incentives for providers to invest. The Commission considers that the AACC[9] would be the appropriate body to undertake an independent study to recommend to Government the appropriate subsidies (including supplements) for providing sustainable aged care services in rural and remote locations (2011, p. 267).
>
> Alternative funding mechanisms may be warranted in circumstances where the ACFI and supplementary funding does not cover the costs of service provision. These funding mechanisms could be used for targeted development programs, such as building accommodation for staff or staff education and training' (2011, p. 267).

In its response to the recommendations of the Productivity Commission the Australian Government included a commitment that

> 'the new Aged Care Financing Authority will take into account the higher costs of delivering aged care services in rural and remote areas and to Indigenous Australians when making recommendations to the Government on appropriate subsidy levels in relation to these services. For example, the additional funding could be paid through the viability supplement arrangements' (Australian Government 2012, p. 28).

[9] The Australian Government decided to establish the Aged Care Funding Authority (ACFA) rather than the Australian Aged Care Commission (AACC) as recommended by the Productivity Commission.

The Aged Care Financing Authority has indicated that as part of its future plan of work they will, from 1 July 2014 provide

> 'Advice on the impacts of LLLB reforms on the sector, including the impact of accommodation payment arrangements, choice of payments, means testing, transitional advisory services, and in particular the impact on rural, regional and remote providers' (Aged Care Financing Authority 2013, p. 17).

However this commitment by the Australian government in 2012 does not seem to have been given a priority by the ACFA. The ACFA has published its future program of work between 2013 and 2017 (2013, p. 17) and a review of the viability supplement is not specifically included. The only mention of rural and remote services funding is in relation to the impact of the LLLB reforms, which arguably does not include the viability supplements as they predated this initiative.

***ISSUE 3***

- Is the viability supplement for small residential services in rural and remote locations sufficient to cover the additional cost of providing care in these locations and does the sliding scale or payment based on relative remoteness accurately reflect the relative costs of care in different locations? How should the supplement be determined? Should the supplement consider matters such as travel costs for long distances?

## Investment sustainability for RAC in outer regional, remote and very remote locations

### Daily accommodation Payments

The three levels of DAPs and the introduction of the capacity to charge an 'amenity fee' provide the opportunity for all RAC providers to increase their accommodation related income. The challenge for providers outside major cities and inner regional areas is the practicality of charging residents a high daily charge. Arguably a lower percentage of residents in these locations have the capacity to generate a stream of payment above the level 1 daily charge or pay any additional amenity fee. In addition. RAC facilities in outer regional, remote and very remote location may be disadvantaged by their lack of capacity to charge higher amenity fees due to the incapacity of the residents to afford an additional charge.

### Capacity to attract RADs

Services in regional and remote locations have in the past collected bonds of a lower value than those services in major cities or regional locations. As

Table 9 indicates 87% of all bonds collected in 2011-12 by services in remote locations and 83% collected by services with fewer than 20 beds were less than $250,000. By contrast 61% of bonds collected by services in major cities and 50% of bonds collected in services with more than 50 beds were greater than $250,000. These findings suggest a much greater capacity to attract larger average bonds per bed for larger facilities and service in major cities than in small services in smaller communities.

Table 9 Distribution of new bonds– by location and size *(No. of beds)* of facility Australia 2011-12

| | *Under $250,000 %* | *$250,000 - $499,999 %* | *$500,000 - $749,999 %* | *$750,000 $999,999 %* | *> $1,000,000 %* | TOTAL % |
|---|---|---|---|---|---|---|
| Geographical location | | | | | | |
| **Major City** | 39.3 | 50.3 | 9.2 | 0.9 | 0.4 | 100 |
| **Regional Areas** | 69.4 | 28.5 | 1.9 | 0.3 | 0.0 | 100 |
| **Remote Areas** | 87.4 | 10.9 | 1.7 | 0.0 | 0.0 | 100 |
| **TOTAL** | **47.9** | **44.0** | **7.1** | **0.7** | **0.3** | 100 |
| Number of beds | | | | | | |
| **1 to 19** | 82.9 | 15.7 | 1.4 | 0.0 | 0.0 | 100 |
| **21 to 49** | 64.8 | 31.4 | 3.5 | 0.3 | 0.0 | 100 |
| **50 to 99** | 49.8 | 43.0 | 6.5 | 0.7 | 0.1 | 100 |
| **> 100** | 38.5 | 50.7 | 9.3 | 1.0 | 0.5 | 100 |
| **TOTAL** | **47.9** | **44.0** | **7.1** | **0.7** | **0.3** | **100** |

Source: (Aged Care Financing Authority 2013, p. 36 & 7)

A key question for this paper is whether the new arrangements for charging for accommodation will create a level of return on investment sufficient to create a sustainable sector in outer regional, remote and very remote locations, and ideally improve the capacity of services in outer regional and remote locations to generate income to match capital investment costs. The impact of the reforms to accommodation payments beginning in July 2014 has been examined by KPMG (KPMG 2013a, 2013b). Following a review of these papers the following conclusions were reached by the ACFA (2013):

- Increased price transparency and consumer choice of payment method may result in some residents choosing to pay a DAP when they would have previously paid a RAD. Modelling suggest this will reduce the value of new RADs from low care and extra service residents but at the same time will increase the income to providers of high care RAC from the opportunity to charge RADs on high care residents
    - However
        - Low care providers, small providers, regional and rural providers, and providers with a high proportion of supported residents will not significantly benefit from these changes (KPMG 2013a, p. 12)
        - the potential of a shift from RADs to DAPs will largely depend on whether the unsold family home can generate rental income sufficient to cover the daily payments
    - The removal of the ability of providers to deduct monthly retention payments from the RADs may reduce income from low care and extra service residents, however, providers are permitted to increase the price of accommodation (RADs and DAPs) to new residents to compensate for this loss of income from reduced RAD balances, where residents have the capacity to pay
- Across the sector the increase in incomes from high care entrants is more than enough to offset predicted losses from transfers from RADs to DAPs in low and extra service residents (KPMG 2013b, p. 47)

- There will be a significant increase in persons paying accommodation charges above the maximum government accommodation subsidy of $52.84 from virtually no one to about 36% (p. 48)

- Level 2 pricing threshold for accommodation payments may hold down accommodation prices when the ACPC does not grant permission for a price above that threshold to be applied based on the 'value of the room'

- Net increase in value of new RADs from 2014-15 will support greater investment activity, but this will differ according to individual provider circumstances (p.13)

Overall, the ACFA predicts positive investment into the sector in general, driven by strong demand for care places and increased funding directed to the sector through the LLLB reforms but different segments will be differently attractive to investors (Aged Care Financing Authority 2013, p. 67).

### Impact of accommodation payment reforms

The findings of the ACFA and KPMG reports are clear:

- Small outer regional, remote and very remote providers attract smaller RADs than larger inner regional and major city based providers
- Small outer regional, remote and very remote providers will not significantly benefit from the new accommodation payment arrangements
- The size of the RAD and correspondingly the size of the DAP will depend on the value of potential residents family home, which for outer regional, remote and very remote providers is likely to be far less than for major city and inner regional providers
- As the demand for houses in many outer regional and remote locations (with the exception of those communities near major mining businesses) are lower than in major cities and inner regional areas these services are less likely to be able to demand that resident pay a DAP at level 2 or above
- Providers in outer regional, remote and very remote locations have little capacity to increase the price of accommodation through either RADs or DAPs to cover the loss of income from the removal of the monthly retention income on RADs
- While the KPMG report suggests that across the sector, the increase in incomes from high care entrants paying RADs is enough to offset the losses from transfers from RADs to DAPs by low care residents this in not necessarily the case outside inner regional areas and major cities an further work needs to be done to specifically address the impact on services in these locations
- KPMG predict that 36% of residents will pay an accommodation charge above the maximum government accommodation level of $5284, however this is an average estimate may not hold true for small outer regional, remote and very remote locations
- They predict that there will be a ‘net increase in the value of RADs in 2014-15’ and that this will support increased investment activity, however again it is not clear that this finding applies equally across all locations in Australia or how they justify this conclusion
- The ACFA admits that ‘different segments will be differently attractive to investors’ but does not indicate what those segments of the sector should do to acquire investment income.

***ISSUE 4***

- Most remote and very remote facilities report difficulties in accessing RAD from resident due to low real estate prices. Also sales can be slow. RADs can indeed be complex in rural areas. For example, farming communities will often structure there affairs so that a retiree may have minimal assets but there will be an understanding that the retiring farmer 'will be looked after.' Residents in these locations will be forced to pay a DAP for their care. Will providers and residents in these locations be worse off financially because they are paid in DAPs and RAD by virtue of their location under the proposed reforms? Will the accommodation subsidies be sufficient for the sector's viability?

***ISSUE 5***

– Will rural and remote residential aged care providers be disadvantaged by a switch to DAP from RADs and will the income from rents of rural properties be sufficient to enable residents to pay the level of DAP that is demanded by residential care operators?

***ISSUE 6***

– Will rural and remote residential aged care providers be disadvantaged by their reduced capacity for the providers of RAC in RRR to charge 'amenity fees'?

***ISSUE 7***

- Will RRR providers face a reduction in income from RADs for low care that is not matched by an increase in RAD from high care because they have fewer high care places than facilities in other locations or their amenity will not support a RAD that allows viability?

# Home Aged Care

## Distribution and provision of services across locations

The distribution of home aged care services across Australia by location is illustrated in Table 10. These data indicate that Level 2 services are by far the most numerous and relatively few level 4 services are available in remote and very remote locations.

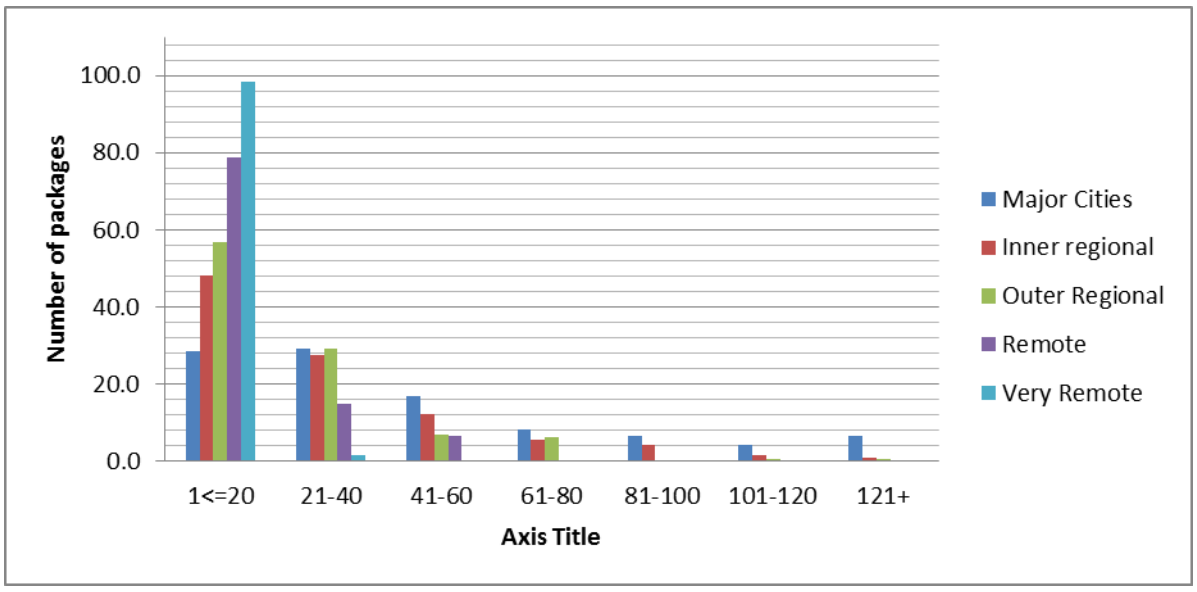
**Table 10 Distribution of home aged care services across Australia 2012**

| Indicator of remoteness | CACPs (Level 2) | EACH (Level 4) | EACHD (Level 4) | TOTAL |
|---|---|---|---|---|
| **Major Cities** | 29,112 | 5,267 | 2,342 | 36,721 |
| **Inner Regional** | 9,457 | 1,749 | 746 | 11,952 |
| **Outer Regional** | 3,303 | 649 | 278 | 4,230 |
| **Remote** | 546 | 73 | 16 | 635 |
| **Very Remote** | 417 | 19 | 1 | 437 |
| **TOTAL** | 42,835 | 7,757 | 3,383 | 53,975 |

Source (Aged Care Financing Authority 2013, p. 47 Table 4.5)

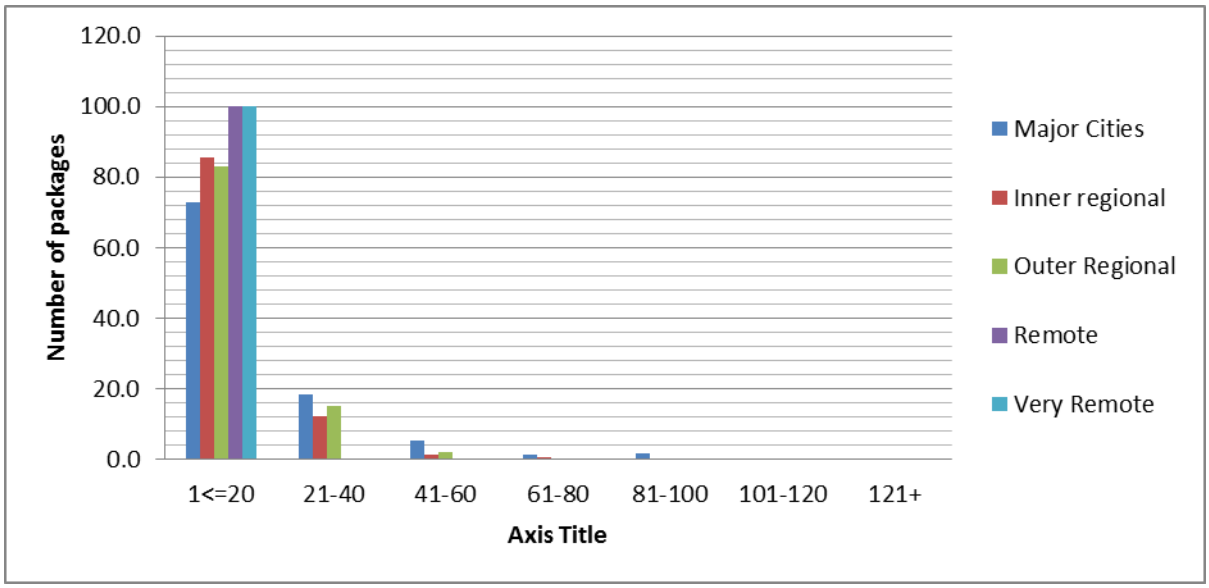
The majority of service providers with home aged care packages have fewer than 40 packages. The distribution of services by service by location for level 2 home care packages and Level 4 home care packages are illustrated in Figure 2 and Figure 3. In analysing these data the Australian Institute of Health and Welfare commented that 'the number of services offering at most 20 packages increased significantly with increasing remoteness highlighting the problem of maintaining economic viability with smaller numbers of clients' (Australian Institute of Health and Welfare 2012a Online tables: A1.1 - A1.6). Level 4 packages are less likely to be found in remote and very remote locations than in the other locations.

**Figure 2 Distribution of Level 2 packages by service size and location 2011**




Source (Australian Institute of Health and Welfare 2012a Online tables: A1.1 - A1.6)

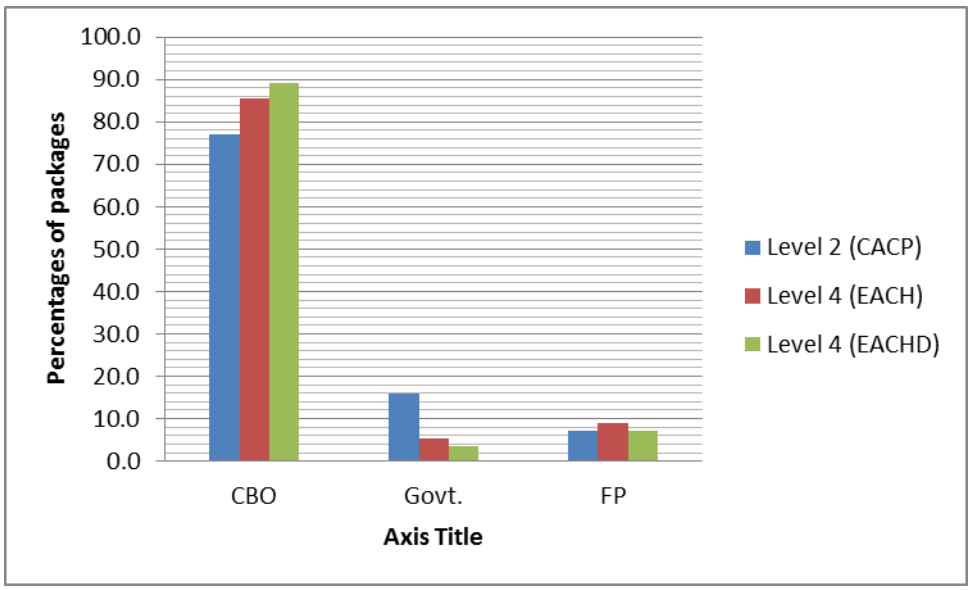
Figure 3 Distribution of Level 4 (EACH) packages by service size and location 2011




Source (Australian Institute of Health and Welfare 2012a Online tables: A1.1 - A1.6)

Figure 4 illustrates the proportional distribution of home aged care packages across Australia by provider type. It illustrates the dominance of the CBO sector as providers of home aged care. the AIHW comments that these data hide 'the involvement of the not-for-profit sector [CBOs] in smaller services necessary to reach smaller areas where there is less likelihood of acceptable profit for private operators' Source (Australian Institute of Health and Welfare 2012a Online tables: A1.1 - A1.6)

Figure 4 Proportional distribution of level 2 (CACP) and level 4 (EACH and EACHD) services by service provider type Australia 2011




Source (Australian Institute of Health and Welfare 2012a Online tables: A1.1 - A1.6)

## Additional costs of providing home care in rural and remote locations

In a recent survey of members of Aged and Community Services Australia (2012) respondents identified a number of areas of cost that they believe are higher in outer regional, remote and very remote locations than in inner regional and major city locations. These higher costs included the following:

- staffing related costs
    - higher wages to attract staff and to meet higher costs of living in some regions
    - additional costs of recruitment
    - relocation expenses and locational bonuses
    - subsidised accommodation
    - return flights to capital cities
    - higher cost for access to staff training
- transport
    - deliveries of furniture and equipment
    - higher price of fuel
    - transport cost for staff to visit care recipients living long distances from town
    - need to purchase four wheel drive vehicles in some locations
- health care related costs
    - transporting care recipients to heath care services
- support costs
    - repairs and maintenance in remote locations where tradesperson must be compensated for travel time and cost
    - audits and inspections where inspectors and auditors must be compensated for travel time and cost.

Not all respondents to this survey in rural and remote locations experienced all these higher costs and there was variation in the estimate of the extent of these additional costs. However, there is sufficient consistency in the responses to reach a reasonable conclusion that these services do experience significantly higher costs. The responses of this survey also raises concerns about the lack of data on the extent to which these extra costs add to the cost of care for people in rural and remote locations, and the impact these additional costs has on a reduction in the amount of care received by care recipients of the non-urban services.

## Home Care Viability Supplement

To address the higher cost of providing home aged care services in rural and remote locations the Home Care Viability Supplement was introduced in 2006-07 as an additional daily payment for providers of home aged care packages where the care recipient lived in a location with an ARIA[10] score of 3.52[11] or higher. Providers of MPS and ATSI Flexible Care services receive the supplement based on the location of their service. The supplement is in recognition of the '*the higher costs associated with attracting and retaining staff as well as other resource implications faced in providing home care services in rural and remote areas'* (Australian Government Department of Health and Ageing 2013b) and increases based on relative remoteness. The supplement has been indexed since first introduced. In 2006-07 the value of the lowest supplement was $2.66 (now $4.21) and the highest supplement was $9.03 per day (now $14.27).

The value of the new Home Care Packages and the current viability supplement is detailed in Table 11. This table illustrates that although the value of the home care package increases with the level of care required by the care recipient the viability supplement remains constant and in fact declines as a percentage of the value of the package. For example, a home care provider with an ARIA score of between 3.52 (the minimum score) and 4.66, which are locations within Outer Regional areas, will receive a daily viability supplement of $4.21 irrespective of whether the package is Level 1 or Level 4. While this is an additional 20% for a Level 1 package it is only an additional 3% for a level 4 package.

**Table 11 Home Care Packages and viability supplement as a percentage of the value of the package 2012-13**

| | | Level 1 | Level 2 | Level 3 | Level 4 |
|---|---|---|---|---|---|
| **Home Care Package Subsidy Rate** | | $20.55 | $37.38 | $82.20 | $124.95 |
| **ARIA Score** | Viability Supplement | Supplement as a % of Home Care Package Level | | | |
| **ARIA Score 0 to 3.51 inclusive** | $0.00 | 0% | 0% | 0% | 0% |
| **ARIA Score 3.52 to 4.66 inclusive** | $4.21 | 20% | 11% | 5% | 3% |
| **ARIA Score 4.67 to 5.80 inclusive** | $5.06 | 25% | 14% | 6% | 4% |
| **ARIA Score 5.81 to 7.44 inclusive** | $7.08 | 34% | 19% | 9% | 6% |
| **ARIA Score 7.45 to 9.08 inclusive** | $8.50 | 41% | 23% | 10% | 7% |
| **ARIA Score 9.09 to 10.54 inclusive** | $11.89 | 58% | 32% | 14% | 10% |
| **ARIA Score 10.55 to 12.00 inclusive** | $14.27 | 69% | 38% | 17% | 11% |

Source: Australian Government Department of Health and Ageing, accessed 10 September 2013, http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-subs-supp-current.htm

The method of payment of the viability supplement is based on a distribution formula and not on an estimation of the actual cost of delivering care. This is due to the nature of the Australian Government budgeting system, which allocated a fixed sum to be 'appropriately' distributed. The Department has adopted a distribution mechanism that is administratively efficient for both the

[10] ARIA is the Australian Department of Health and Ageing's system of allocating a score for each geographical location in Australia based on relative access to a major population centre (Australian Government Department of Health and Ageing 2001).

[11] Examples of locations in this category are: Albany (WA), Atherton (Qld), Bega Valley (NSW), Central Highlands (Tas), Gayndah (Qld), Glamorgan/Spring Bay (Tas), Guyra (NSW), East Gippsland (part) (Vic), Karoonda East Murray (SA), Kojonup (WA), Litchfield (NT), Maryborough (Qld), Mildura (part) (Vic), Naracoorte (SA), Renmark (SA), Swan Hill – Robinvale (Vic).

Department and the service providers. Under the existing system the service does not need to claim as the payment is based on the care recipient's (or service providers) location and this is information the Department already holds. However only 10% of respondents to the recent survey (Aged and Community Services Australia 2012) reported that the viability supplement covered the full additional cost of care arising from location. About one quarter of respondents reported that the supplement covered between 50 and 75% of the additional cost, another quarter that it covered less than 50% of the additional costs and four out of ten respondents believed that it covered less than 25% of the costs.

In its response to the recommendations of the Productivity Commission the Australian Government included a commitment that

> 'the new Aged Care Financing Authority will take into account the higher costs of delivering aged care services in rural and remote areas and to Indigenous Australians when making recommendations to the Government on appropriate subsidy levels in relation to these services. For example, the additional funding could be paid through the viability supplement arrangements' (Australian Government 2012, p. 28).

However this commitment by the Australian government in 2012 does not seem to have been given a priority by the ACFA. The ACFA has published its future program of work between 2013 and 2017 (2013, p. 17) and a review of the viability supplement is not specifically included. The only mention of rural and remote services funding is in relation to the impact of the LLLB reforms, which arguably does not include the viability supplements as they predated this initiative.

***ISSUE 8***

– Should the ACFA specifically include a review of the adequacy of the current levels of, and appropriateness of, the viability supplements for home care packages to ensure that the level of subsidy is consistent with the actual additional cost of providing care due to both the location of the care and the extent of care provided, in order to meet the Australian Government's commitment, contained in its response to the recommendations of the Productivity Commissions' recommendations, that this work would be undertaken by the ACFA?

## The impact of the introduction of Consumer-Directed Care

Although the level of cross subsidisation within home aged care services has not been empirically reported there is substantial anecdotal data to support the concern that the introduction of CDC may have negative impacts on some aspects of care in rural and remote locations. This concern arises from the perception that CDC will limit or prevent cross subsidisation. Cross subsidies occur within agencies between different locations, between different services operated by the same provider, between existing care recipients and to pay for 'unfunded packages'.

Submissions to the Productivity Commission specifically mentioned examples of cross subsidisation of rural services by providers using surpluses earned from services in other locations and these arguments appear to have been accepted by the Commission (2011, p. 267). Cross subsidisation is also important in rural and remote locations to provide care for people already assessed for community care but where the only local service provider holding home aged care packages is already 'full'. In the recent survey of rural and remote community service providers a number of them reported providing care for people in this circumstance (Aged and Community Services Australia 2012). These 'unfunded packages' are paid for by the agency from surpluses accrued from subsidies to existing clients who the agency assessed that some existing clients did not need the full level of care that the subsidy allowed thus allowing them to provide service for persons yet to formally access a package. The reported number of these unfunded places varied from 1 'unfunded package' in a service which has 10 funded places, to one 2 'unfunded packages' where the service held over 30 packages.

Cross subsidisation is also used in rural and remote locations to pay for the additional cost of travel for care recipients who live 'out of town'. Service providers frequently argue that travel costs can add up to 20% to the cost of care to pay for fuel and the additional time taken for staff to travel to distant clients. Under CDC this cost will need to be met within the overall budget allocated to the care recipient and potentially disadvantages that client over those care recipients who live closer to the agency by a reduction in the number of hours of care.

There is a strong concern that the introduction of CDC will limit cross subsidisation in the future due to the requirement for providers to provide a budget to each consumer with the opportunity for the care recipient and their family to choose their own care packages, within guidelines, up to the limit of the package. While CDC Is supported by the ACSA as a valuable reform to the home aged care sector there is a need to assess the negative consequences that may arise from the constraints CDC will place of service providers who have previously enjoyed a level of flexibility in the collective use of income across all care recipients. There would also appear to be a need to urgently review if the level of the current subsidies adequately allow for the different cost of care in rural and remote locations.

***ISSUE 9***

– Should the ACFA's commitment to review the impact of the LLLB package include, as a priority, the examination of the impact of reduced opportunities for cross subsidisation, arising from the introduction of CDC, by service providers in rural and remote between services and between care recipients, particularly in providing care for people waiting for packages but also where there is no allowance for higher costs in delivering care to some clients because of distance?

***ISSUE 10***

- Are the managers of RRR making appropriate use of available schemes such as medical transport schemes to cover costs of transfers and medical costs. For example, the Patient Assisted Transport Scheme (PATS) may not make proper allowance for the needs of an accompanying person in situations where a resident does not have an appropriate family member to support them and a staff member is required to travel with the resident. This scheme provides only limited resources to cover this circumstance.

***ISSUE 11***

- Are we headed, and/or should we be headed, for a two tier funding and regulatory system that recognises the different operating environments facing aged care services for densely populated and less densely populated parts of the country? For example, one ACSA member refers to the scarcity of Aboriginal and Torres Strait Island flexible indigenous aged care in Western Australia (there is one service) and the difficulty of rural and remote facilities to meet accreditation standards. Simply put, achieving high standards in rural and remote areas requires more resources than urbanised areas.

***ISSUE 12***

– Should CBOs in rural and remote locations be subsidised on a block grant basis in recognition that the fee for service basis for funding large providers in major cities and inner regional locations is not an appropriate and viable mode for small facilities serving low income communities

***ISSUE 13***

– How do we assist small remote services to access the management skills needed to introduce appropriate financial and operational systems and practices?

***ISSUE 14***

- Are the arguments about the additional cost of staff in RRR reasonable and is there data to support this claim?

# Appendices

## Appendix 1

**Table 12 Residential aged care, CACP, EACH, EACH D places and Transition Care Packages (TCP) per 1,000 persons aged 70 years and over, by state/territory and remoteness,(a) 30 June 2011**

| State/territory | Major cities | Inner regional | Outer regional | Remote | Very remote | Total (70+) | Total (70+ population and Indigenous population aged 50–69 years) |
|---|---|---|---|---|---|---|---|
| | **Ratio** | | | | | | |
| | **Residential places** | | | | | | |
| NSW | 88.6 | 86.5 | 77.1 | 71.8 | 3.3 | 87.1 | 84.7 |
| Vic | 87.4 | 86.6 | 75.2 | 0.0 | 0.0 | 86.4 | 85.7 |
| Qld | 87.2 | 75.1 | 81.1 | 79.5 | 78.0 | 83.1 | 81.5 |
| WA | 83.2 | 63.9 | 80.2 | 64.7 | 96.7 | 79.5 | 76.2 |
| SA | 95.7 | 78.6 | 82.9 | 72.6 | 166.7 | 91.8 | 91.0 |
| Tas | .. | 95.2 | 63.9 | 82.5 | 76.7 | 84.6 | 82.8 |
| ACT | 78.1 | 0.0 | .. | .. | .. | 77.8 | 76.5 |
| NT | .. | .. | 71.0 | 133.3 | 144.0 | 93.8 | 46.0 |
| *Australia* | 88.0 | 83.0 | 77.3 | 77.1 | 98.1 | 85.7 | 83.7 |
| | **CACP** | | | | | | |
| NSW | 20.9 | 21.3 | 14.4 | 17.6 | 50.0 | 20.5 | 20.0 |
| Vic | 21.8 | 16.7 | 14.1 | 20.0 | 0.0 | 20.1 | 20.0 |
| Qld | 20.9 | 19.1 | 21.9 | 36.4 | 69.7 | 21.2 | 20.8 |
| WA | 24.6 | 16.4 | 23.5 | 46.1 | 30.6 | 23.8 | 22.8 |
| SA | 19.4 | 26.0 | 16.3 | 15.4 | 66.7 | 20.0 | 19.8 |
| Tas | .. | 24.9 | 12.9 | 40.0 | 50.0 | 21.3 | 20.9 |
| ACT | 25.8 | 0.0 | .. | .. | .. | 25.7 | 25.3 |
| NT | .. | .. | 48.3 | 116.0 | 340.0 | 102.2 | 50.1 |
| *Australia* | 21.5 | 19.9 | 17.9 | 36.0 | 93.8 | 21.2 | 20.7 |
| | **EACH and EACH D(b)** | | | | | | |
| NSW | 4.2 | 4.5 | 3.8 | 0.0 | 0.0 | 4.2 | 4.1 |
| Vic | 4.5 | 4.5 | 3.4 | 2.9 | .. | 4.4 | 4.4 |
| Qld | 6.8 | 7.3 | 6.0 | 1.5 | 8.0 | 6.8 | 6.7 |
| WA | 12.8 | 11.4 | 9.5 | 8.0 | 1.7 | 12.0 | 11.5 |
| SA | 3.4 | 3.0 | 3.4 | 3.0 | 0.0 | 3.3 | 3.3 |
| Tas | .. | 6.4 | 2.1 | 2.5 | 0.0 | 4.9 | 4.8 |
| ACT | 16.3 | 0.0 | .. | .. | .. | 16.3 | 16.0 |
| NT | .. | .. | 21.9 | 25.3 | 0.0 | 19.6 | 9.6 |
| *Australia* | *5.7* | *5.6* | *5.0* | *4.8* | *3.6* | *5.6* | *5.5* |
| | **TCP** | | | | | | |
| NSW | 1.5 | 2.0 | 1.1 | 0.0 | 0.0 | 1.6 | 1.5 |
| Vic | 1.5 | 1.8 | 0.3 | 0.0 | .. | 1.5 | 1.5 |
| Qld | 1.5 | 1.5 | 1.9 | 0.0 | 0.0 | 1.5 | 1.5 |
| WA | 1.6 | 0.6 | 1.9 | 0.0 | 0.0 | 1.4 | 1.4 |
| SA | 1.6 | 3.2 | 0.0 | 0.0 | 0.0 | 1.5 | 1.5 |
| Tas | .. | 2.0 | 1.3 | 0.0 | 0.0 | 1.7 | 1.7 |
| ACT | 1.9 | 0.0 | .. | .. | .. | 1.9 | 1.8 |
| NT | .. | .. | 3.5 | 8.0 | 0.0 | 4.0 | 1.9 |
| *Australia* | *1.5* | *1.8* | *1.2* | *0.5* | *0.0* | *1.5* | *1.5* |

| State/territory | Major cities | Inner regional | Outer regional | Remote | Very remote | Total (70+) | Total (70+ population and Indigenous population aged 50–69 years) |
|---|---|---|---|---|---|---|---|
| | **Combined places and packages** | | | | | | |
| NSW | 115.3 | 114.3 | 96.4 | 89.4 | 53.3 | 113.4 | 110.4 |
| Vic | 115.2 | 109.6 | 93.0 | 22.9 | 0.0 | 112.5 | 111.6 |
| Qld | 116.4 | 103.1 | 110.9 | 117.5 | 155.7 | 112.6 | 110.4 |
| WA | 122.2 | 92.3 | 115.1 | 118.8 | 128.9 | 116.7 | 111.8 |
| SA | 120.1 | 110.8 | 102.6 | 91.0 | 233.3 | 116.6 | 115.6 |
| Tas | .. | 128.5 | 80.2 | 125.0 | 126.7 | 112.5 | 110.2 |
| ACT | 122.2 | 0.0 | .. | .. | .. | 121.7 | 119.6 |
| NT | .. | .. | 144.8 | 282.7 | 484.0 | 219.6 | 107.7 |
| **Australia** | **116.7** | **110.3** | **101.4** | **118.5** | **195.5** | **114.1** | **111.4** |

Source: (Australian Institute of Health and Welfare 2012c Table A1.9)

# References


Aged and Community Services Australia 2012, *The Cost of Care, Factors Affecting the Cost of Providing Aged Care in Rural Australia*, vol. unpublished document, ACSA, Canberra.

Aged Care Financing Authority 2013, *Inaugural Report on the funding and financing of the Aged Care Sector*, DoHA, Canberra.

Australian Bureau for Statistics 2010, *Australian Standard Geographical Classification (ASGC), 2009. ABS cat. no. 1216.0*, Canberra.

Australian Government 2012, *The Australian Government response to the Productivity Commission*, Canberra.

Australian Government Department of Health and Ageing 2001, *Measuring Remoteness: Accessibility/Remoteness Index of Australia (ARIA) Revised Edition. Occasional Papers: New Series Number 14*, Canberra.

Australian Government Department of Health and Ageing 2009, *Guidelines for Applicants Seeking Approval to Provide Aged Care*, Canberra, p. 20, <www.health.gov.au/in...19000F3E47/$File/GuidelinesAppSeeking.pdf - 209k pdf>.

Australian Government Department of Health and Ageing 2012, *Report on the operations of the Aged Care Act 1997 1 July 2010 to 30 June 2011*, Canberra.

Australian Government Department of Health and Ageing 2013a, *Accommodation Pricing Guidelines discussion paper*, Australian Government, Canberra.

Australian Government Department of Health and Ageing 2013b, *Home Care Packages Program Guidelines – Consultation Draft PART H – SUPPLEMENTS*, Canberra.

Australian Government Department of Health and Ageing 2013c, *Home care packages program guidelines consultation draft*, Canberra.

Australian Institute of Health and Welfare 2012a, *Aged care packages in the community 2010–11: a statistical overview. Aged care statistics series no. 37. Cat. No. AGE 69.*, AIHW, Canberra, <http://www.aihw.gov.au/publication-detail/?id=10737422820>.

Australian Institute of Health and Welfare 2012b, *Residential aged care in Australia 2010–11: a statistical overview. Aged care statistics series no. 36. Cat. no. AGE 68*, Canberra.

Australian Institute of Health and Welfare 2012c, *Residential aged care in Australia 2010–11: an overview, online tables: A1.1 - A1.9*, Canberra.

KPMG 2013a, *Report on the residential aged care sector Current state and potential impacts from LLLB financial arrangements Prepared for: Aged Care Financing Authority (ACFA)*, DoHA, Canberra.

KPMG 2013b, *Scenario analysis of selected LLLB financial arrangements; Interim report Prepared for: Aged Care Financing Authority May 2013*, Department of Health and Ageing, Canberra.

Productivity Commission 2011, *Caring for Older Australians, Report No. 53, Final Inquiry Report*, Australian Government, Canberra.

Stewart Brown 2013, *Aged Care Financial Performance Survey Report March Quarter 2013*, Stewart Brown, Sydney.