



Aged Care Association Australia – SA Inc
Unit 5, 259 Glen Osmond Rd, Frewville, 5063
Phone: 8338 6500 Fax: 8338 6511

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Response to the Productivity Commission draft report

Caring for Older Australians

March, 2011

Our Association represents Commonwealth-approved residential aged care providers in South Australia. There are 51 residential facilities in our group, operated by 27 different providers, the majority of whom are private organisations. Our members care for around 3,300 aged residents, 85% of whom are high care.

Endorsement of ACAA Response

As a member of the federation of state-based associations which comprise ACAA, our Association endorses the response to Commission's draft made by ACAA.

Therefore, we have not wanted here to duplicate the information, views and recommendations expressed in that document, and have confined our submission to comments which express a different perspective, emphasis or view.

Regulation of Bed Supply

Draft Recommendation 1.3

The Australian Government should remove regulatory restrictions on the number of community care packages and residential bed licences over a five-year period. It should also remove the distinction between residential high care and low care places.

We remain of the view that the complete removal of restrictions on residential bed licences is not appropriate in a market where the federal government will continue to be the majority funder.

We acknowledge the Commission's point on page 106 of the Report that "limiting the supply of care places..... limits competition which in turn reduces choice for users and dampens the incentive for providers to operate efficiently and to be innovative."

However, the long term effect which unrestricted supply will have on occupancy and viability appears not to have been examined. While average national occupancy is around 90% the Department of Health and Ageing says 40% of aged care homes have occupancy rates above 98%, implying that such high rates do not offer choice.

There has been no analysis to establish the extent to which facilities with high occupancies are in areas where there is an under-supply of beds, or whether the reason they enjoy high occupancies is because of strong consumer preference. If it is latter situation, increasing bed numbers in the area will not push down the occupancy rates of these highly preferred facilities, it will simply increase the total of unoccupied beds in the area, causing considerable damage for no gain.

Complete deregulation of supply will bring other problems:

1. Supply deregulation will not deliver consumer choice to areas which investors deem financially unattractive, e.g. those where the catchment population has low incomes and low assets. In such areas the government will need to attract investment by offering construction and/or operating subsidies and the granting of such subsidies would need to be restricted to a planned number of beds.

2. In areas which investors regard as attractive, there will be an inevitable spate of new residential aged care development as providers try to position their organisations for the perceived opportunities

It is feasible that organisations who are in strong financial positions, could invest in attractive areas with a long-term view, i.e. willing to accept low occupancy levels and losses in the early years, in anticipation of high returns later.

However, the effect of such strategies on existing providers in the area could be devastating. Their occupancy levels would be driven down, and their financial viability threatened. Good providers, who had operated efficiently and with high standards of care, could be forced out of the industry, because of predatory competitive behaviour.

Even without such behaviour, deregulating supply will increase the risk profiles of providers, and therefore the required return on investment. This is acknowledged by the Commission on page 167 of the Report.

To the extent that deregulation increases losses because of declines in occupancy, providers will be financially driven to recover the capital cost of their vacant spaces by charging more for the occupied places. In other words, in the long run, unoccupied beds will have a cost to those who provide revenue to the industry, that is Australian taxpayers and aged care recipients.

The increased risk profile will also be factored in by lending institutions, forcing up interest rate margins, and of particular importance, the loan to value ratio used by lenders will decrease, and this will have a sharp and immediate effect on the availability of capital to the industry.

To the extent that daily charges are preferred over bonds by consumers, this will also heighten lender caution, providing further reduction of loan to value ratios, as well as increasing interest rate risk margins.

The cost of this additional risk will be borne by the funders of aged care, the Commonwealth as the major funder, and the care recipients themselves.

The poor rates of return being experienced in the industry will be negatively impacted for many providers by the progressive loss of bond retentions and this will tend to be replaced by higher daily charges and or bonds to recover this loss of revenue.

Again, as lenders review proposals, this change, no matter how desirable, will have an impact in assessing the lenders' risk and that will reflect in two key ways – increased interest margins and negative pressure on loan to value ratios, both of which combine to limit the industry's access to capital

We submit that the above factors are not conducive to stability or viability of the aged care system and will drive up the overall cost of the system. Therefore some control over bed supply needs to remain; in practical terms this control facilitates a lower risk and lower required rate of return.

However, determining the number of beds required in each area should be based on a much better system of target setting than is currently employed.

The data is available to produce a detailed profile of those people in the population currently receiving some form of aged care – HACC, CACP, EACH, EACH-D, Residential etc.

Once properly gathered and analysed, the data should be applied area by area, to Australia's population projections. This would enable reliable forecasts of the future demand for the various age care services on, say, a rolling three to five year basis.

Data from this process would be used to allocate residential bed licences, working on a three year lead time from allocation to building completion. The data would be publicly-available to assist providers in their own planning.

A branch of the proposed AACRC would be responsible for data gathering and analysis and for determining the number of beds to be made available in each area. Approved providers would compete for the allocation of licences through an open and transparent tender process.

From a policy standpoint one of the key objectives should be to ensure sufficient industry stability and viability, so that the industry can raise the capital needed to expand to meet future demand. Complete deregulation of bed supply would seem to work against this objective.

Removal of Low and High Care Distinction

Draft Implementation Plan

Stage 1: expedited measures within two years

- *remove the distinctions between low and high care, and between ordinary and extra-service status.*

Our Association supports the removal of high and low care distinctions and the consequent equality this will provide regarding how accommodation may be paid for by all people entering residential aged care.

However, we feel that to do so immediately in Stage 1 of the implementation, would be unfair to many providers. Instead, we propose that the removal of the high and low care distinction be transitioned over a five to seven year period.

This would not prevent periodic payments/bonds being allowed immediately in high care, which is the underlying intention of the proposal.

We would argue some providers who have made investment decisions under the current rules will be unfairly disadvantaged by an immediate removal of the distinction. For example, a provider who has invested in a specialized high care facility based on the local competitive environment, will become immediately exposed to competition from facilities which had chosen to invest in low care beds, but are now able to accept all residents into these beds.

Under a transitional arrangement, a facility with, say, 98 low beds would transition to having "universal" beds progressively. If the transition period was seven years, then 14 beds each year would become universal each year.

Conversely, facilities with high care beds would transition to universal beds by the same process.

This would allow all providers in a given area time to adjust to the new environment.

This proposition is about slowing the rate of change and reducing risk and volatility to providers who will already face additional competitive challenges.

Government Contribution for Supported Residents

Draft Recommendation 1.7

The Australian Government's contribution for the approved basic standard of residential care accommodation for supported residents should reflect the average cost of providing such accommodation and should be set:

- on the basis of a two-bed room with shared bathroom***
- on a regional basis where there are significant regional cost variations..***

We submit that the two-bed with shared bathroom standard is too low and does not meet the expectations of Australian aged care consumers.

“One of the greatest influences in the past decade has been the preference for privacy and personal space. Single room services are a high priority for residents” (Grant Thornton, Aged Care Survey, 2008).

One cannot imagine a reversal of this trend and, arguably, it is a trend which will become more pronounced as increasing numbers of baby-boomers' parents move into residential aged care, and as the baby-boomers themselves contemplate their own future aged care requirements.

Setting the government contribution for supported resident accommodation too low will be detrimental to the whole structure of capital raising and adequate returns.

Firstly, it will provide an inadequate return to providers who are housing supported residents, and who will continue to build single rooms anyway because this is what consumers want.

Also, the government's supported resident contribution will become the base price, a reference point from which providers will set their prices for those who can afford to pay for their own accommodation. Setting the government price too low will restrict the price at which providers set their own accommodation charge for non-supported residents, which will affect their ability to generate a reasonable rate of return.

We therefore submit that the government contribution for supported resident accommodation be based on a single room with ensuite.

Paul Carberry
Chief Executive Officer