ACSA Submission

National Commission of Audit

22 November 2013

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ABOUT THE ACSA FEDERATION

Aged and Community Services Australia (ACSA) is the leading national peak body for aged and community care providers and represents church, charitable and community-based organisations providing housing, residential and community care and home support services to older people, younger people with a disability and their carers.

About 700,000 older Australians depend on care and support provided by ACSA members in the metropolitan, regional, rural and remote regions across Australia.

ACSA operates within a federated structure of state associations which are independently incorporated and to whom mission-based providers belong as members. The state associations are members of the ACSA national body.

The ACSA Federation is made up of the following members:

- Aged and Community Services Association of NSW & ACT (ACS NSW&ACT)
- Aged and Community Services SA & NT (ACS SA&NT)
- Aged and Community Services Tasmania (ACS Tas)
- Aged and Community Services Western Australia (ACS WA)
- Aged and Community Services Australia Victoria (ACSA Vic)
- Aged and Community Services Australia Queensland (ACSA Qld)

ACSA provides direct representation for providers in Queensland and Victoria through Board membership and the ACSA National Policy Forum and Council.

INTRODUCTION

Mission-based and not-for-profit (NFP) aged care organisations are charged with responsibility for providing services to those most in need. They deliver about 65 per cent of aged care services and about 85 per cent of all community aged care in Australia. These organisations are visible and highly accessible in the community resulting in the public relying on NFPs for service, support and care. The public has an expectation that NFPs will provide for them.

As a result NFPs have the confidence of the community at large and trust derived from that accessibility. There is also an ever increasing expectation by governments that the NFP sector will deliver programs and services on their behalf as a means of maximising efficiencies.

As the population continues to age, ACSA recognises the need to make the aged care system more responsive, flexible and affordable by creating a balance between individual responsibility for aged care services, affordability for taxpayers and a safety net for those who require such services.

With the growth in the numbers of ageing Australians and the requirement for a far greater number of services required to provide care and support, ACSA argues that the aged care sector should be quarantined from the National Commission of Audit. To offset this, in this submission we have proposed some areas of red tape reduction which would result in cost reductions to Government and aged care providers.

ACSA welcomes the opportunity to make this Submission to the National Commission of Audit.

EXECUTIVE SUMMARY

Australia has an ageing population, and as people become frailer in older age many will require care and support in the community or in a nursing home.

Currently there are about 182,000 aged care beds[1] and about 1 million older people who use community care services in Australia. By 2020 we will need 82,000 new aged care beds and over 1.4 million will be utilising community care so the service system will need to gear up to accommodate this growth. To put this in context, to meet the demand for aged care beds there will need to be 2.25 new 100-bed residential aged care facilities opened each and every week over the next seven years.

Recent financial analysis, prepared for the Aged Care Financing Authority (ACFA) by KPMG, reports that only 70 per cent of providers were making a surplus in 2011-12, and 16 per cent had a negative EBITDA. That indicates that 30 of aged care providers per cent made a loss or just broke even. Of particular concern are the small stand-alone services and those in regional, rural and remote areas which are predominantly provided by not-for-profits.

Current federal government funding of residential aged care is about $122 per bed per day to provide a vast array of services, in comparison a hospital bed in the acute sector which is funded at about $1500 a day.

In order for not-for-profit aged care providers to be able to provide care and support and deliver on their mission they need to make surpluses so they have funding for capital expenditure to develop the services frail older Australians will require into the future and in locations that are not financially viable for for-profit providers.

To compound the impending problem, the proportion of working age people is projected to fall, with only 2.7 people of working age to support each Australian aged 65 years and over by 2050 (compared to 5 working aged people per aged person today and 7.5 in 1970). Population growth is projected to slow to an average annual rate of 1.2 per cent over the next 40 years, slightly lower than the 1.4 per cent average annual rate of growth in the previous 40 years.[2]

This means there will be fewer people paying taxes to fund aged care, and less people in the working population to provide the care and support services required. These demographic changes are also borne out in a Productivity Commission Research Paper, *An Ageing Australia: Preparing for the future*, released on 21 November 2013.

On this basis, ACSA argues that there should be no reduction on any budgetary programmes in the aged care sector. However, we offer up as suggested areas of savings for Government, a number of burdensome regulatory processes that duplicate other mechanisms already in place or do not add value for aged care stakeholders or Government. These would provide cost savings for government and aged care providers.

To provide vital aged care services now and into the future we need a community debate to determine how we best fund and meet the needs of those who require aged care services and their families in a sustainable manner for the aged care sector and government.

[1] *2011-12 Report on the Operation of the Aged Care Act 1997, DoHA, p.35.*
[2] Intergenerational Report, 2010, Australia to 2050: Future Challenges, Jan 2010, p.viii.

FINANCIAL PERFORMANCE OF THE AGED CARE SECTOR

The Aged Care Financing Authority (ACFA) recently presented the former Government with the Inaugural Report on the funding and financing of the Aged Care Sector.[3]

ACFA's role is to provide independent advice to Government on financing and funding issues in the aged care sector, examining issues of concern and advising Government as appropriate. ACFA's recommendations are considered in the context of maintaining a sustainable aged care sector balancing the needs of care recipients, funders, providers, workforce and financiers.

Consistent with the remit of ACFA's operating framework the Inaugural Report looks at the impact of aged care financing arrangements on sector viability, access to quality care, the aged care workforce and sustainability.

Residential Aged Care

Sector overview

Currently there are about 182,000 aged care beds[4] and about 1 million older people who use community care services in Australia. By 2020 we will need 82,000 new aged care beds and over 1.4 million older people will be utilising community care so the service system will need to gear up to accommodate this growth.

To put this in context, to meet the demand for aged care beds there will need to be 2.25 new 100-bed residential aged care facilities opened each and every week over the next seven years.

Not only is the number of people requiring aged care services going to grow significantly, their needs will be more complex. For example - an estimated 269,000 Australians currently live with dementia and this is expected to grow by about another 120,000 by 2020 (115,700) and to 1.3 million by 2050.

The Inaugural Report points out that there are 1,054 residential aged care providers operating a total of 2,716 aged care services (homes) providing a total of 182,663 aged care places (beds):

- of the 2,716 homes 74 per cent are high care, 24 per cent mixed care and 2 per cent low care;
- of the 182,663 places 77 per cent are high care, 22 per cent mixed care and 1 per cent low care;
- 60 per cent of services are run by not-for-profit organisations, 30 per cent by for-profit and 10 per cent by state government;
- 58 per cent of providers are city based, 38 per cent are regional based and 4 per cent are in both city and regional areas; and
- 63 per cent of providers operate single homes, 29 per cent between 2 and 6 homes, 8 per cent operate 7 or more homes.[5]

[3] http://www.livinglongerlivingbetter.gov.au/internet/living/publishing.nsf/Content/acfa-inaugural-report-fund-financing-june2013

[4] *2011-12 Report on the Operation of the Aged Care Act 1997, DoHA, p.35.*

[5] Inaugural Report on the funding and financing of the Aged Care Sector - 30 June 2013, p.8.

Funding and Financing

The Inaugural Report states that the Federal Government provides about 71 per cent of total funding to residential aged care providers. This is made up predominantly of funding through the Aged Care Funding Instrument (ACFI) (almost 80 per cent) and additional funding through various supplements.

The next most significant funding source is resident care fees making up 25 per cent of total funding, followed by revenue from accommodation payments (regular accommodation payments and retention amounts drawn down from accommodation bonds) at about 4 per cent of total funding.

Lump sum accommodation bonds (now Refundable Accommodation Deposits – RADs) are not recorded as revenue funding, but play a significant role in the financial arrangements of the sector. Providers can earn interest from these RADs (offsetting interest on borrowings) or use them as a source of capital financing.

Capital financing for the sector comes from equity investment and borrowing including accommodation bonds and retained profits. The Federal Government also contributes with capital grants and zero real interest loans available to a small number of providers.

Expenses are predominantly staff related, with staff expenses making up approximately 64 per cent of total expenses. In 2013/14 some providers in some states are reporting staff expenses higher that 75 per cent of total expenditure.

Financial Performance

The Inaugural Report states that analysis of the 2011-12 financial results of the sector show that 70 per cent of providers recorded a net profit (surplus) before tax and 84 per cent have a positive Earnings Before Interest Tax, Depreciation and Amortisation (EBITDA). The average EBITDA margin for the sector is 12 per cent and the Net Profit Before Tax (NPBT) margin is 5.6 per cent.

However, the results are variable across the sector and further analysis is required to determine what key factors are common to the well performing providers, what key factors are common to those providers with less profitable or loss making operations and what can be done to improve performance. Some observations from the analysis to date include:

- Average EBITDA per resident per annum is $9,274. The top quartile has EBITDA of $21,081, the second quartile $10,394, the third quartile $5,654 and the bottom quartile negative $3,646.
- For-profit providers have higher EBITDA per resident per annum on average ($13,121) than not-for-profit providers ($8,176) and Government providers (-$1,508). For-profit providers also have a higher NPBT margin of 10.5 per cent compared to not-for-profit at 4.5 per cent.
- High care providers have higher EBITDA per resident per annum on average ($10,364) than low care providers ($2,454).
- City providers have higher EBITDA per resident per annum on average ($10,369) than regional providers ($6,663).
- Single service providers have higher EBITDA per resident per annum on average ($9,809) than providers with 2-6 homes ($8,759) and providers with 7 or more homes ($9,309).[6]

[6] Inaugural Report on the funding and financing of the Aged Care Sector - 30 June 2013, p.9.

Balance Sheet Analysis

The Inaugural Report states that the sector as a whole has assets of $28 billion, current liabilities of $12.5 billion, non-current liabilities of $5.9 billion with resulting net worth/equity of $9.6 billion. Included in the liabilities are RADs held by the sector of $12.966 billion.

Key observations from the analysis include:

- Average return on assets for the sector is 5.5 per cent and average return on equity is 15.9 per cent. In both cases the for-profit sector has higher returns than the not-for-profit sector.
- Average net worth/equity per resident is higher in the not-for-profit sector ($70,371) compared to the for-profit sector ($24,660).
- Average financing from equity is 35 per cent and debt 65 per cent. The not-for-profit sector has an average of 43 per cent of financing from equity compared to 15 per cent for the for-profit sector and accordingly has a lower reliance on debt, higher interest coverage ratio and higher average returns on equity.
- RADs are a significant source of funds and represent 48 per cent of assets for the sector (46 per cent of assets for the not-for-profit sector and 58 per cent of assets for the for-profit sector).[7]

Table 2: Provider structure by ownership type, 2010-11[1]

	Not for profit	For profit	Government owned	All providers
No. of providers	565	409	116	1,090
No. of facilities	1,664	811	297	2,772
No. of facilities per provider	2.9	2.0	2.6	2.5
EBITDA[2]	$7,656	$10,480	-$1,379	$8,036
Average bond per resident	$173,056	$214,647	$129,987	$185,689
Accommodation bonds as % of total finance	44.6%	57.2%	19.3%	47.1%
Debt as % of total finance[3]	12.9%	24.2%	5.4%	16.2%
Equity as % of total finance	43.6%	14.5%	77.7%	36.1%

1. KPMG, Scenario Analysis of selected LLLB Financial Arrangements, Interim Report, based on data from Department of Health and Ageing, May 2013, p.21.

Investment in the sector

Analysis by the Department of Health and Ageing suggests that the residential aged care sector will need to build approximately 74,000 additional places over the next decade in order to achieve the *Living Longer Living Better* (LLLB) reform provision target for residential services.

This involves an estimated investment requirement for new stock and rebuilding of existing stock in the order of $25 billion over the next decade.[8]

[7] Inaugural Report on the funding and financing of the Aged Care Sector - 30 June 2013, p.10.
[8] Inaugural Report on the funding and financing of the Aged Care Sector - 30 June 2013, p.10.

Living Longer Living Better reforms

The Inaugural Report points out that the LLLB reforms can be expected to impact on sector viability in a number of ways. Particular reforms of relevance include:

- Reforms to the accommodation payments system incorporating:
    - Changes to the pricing system – with the harmonisation of high care and low care through the removal of the capping of daily payments in high care and allowing lump sums to be paid in high care; and
    - Changes to the mode of payment – with full choice of payment type (lump sum versus periodic) resting with the resident and applying across high care and low care.
- The more than a 50 per cent increase in the accommodation supplement being paid for residents with low means in new or significantly refurbished homes.

KPMG modelling and analysis commissioned by ACFA indicates a positive impact on the sector at the aggregate level. Positive impacts are likely to arise from the removal of regulatory restrictions on charging for accommodation in high care places (lump sum accommodation payments will be allowed and caps on periodic payments removed) and the increase in the accommodation supplement for new or significantly refurbished homes.

However, ACFA advises that the impacts will need to be closely monitored as they will vary between providers dependent on their business models, operating and capital structures and other factors. For example, low care providers and those more dependent on lump sum bonds may find the transition to the new system more challenging than others.[9]

Home Care[10]

Sector overview

Home care is provided through packaged care (community or home care packages) or through the Home and Community Care (HACC) program. Not-for-profit providers are the major providers of home care providing 84 per cent of packages with 9 per cent from government providers and 7 per cent from for-profit providers.[11]

Funding

Funding for home care package providers is sourced primarily from Federal Government payments ($1.1 billion) with some care fees ($80 million) also paid by care recipients. There are 59,201 packages in total. Community Aged Care Packages account for 55 per cent of the funding and 79 per cent of the packages. Extended Aged Care at Home packages account for 15 per cent of funding and 14 per cent of packages and Extended Aged Care at Home Dementia packages account for 30 per cent of funding and 7 per cent of packages.

The Federal Government provides funding of $1 billion to the Commonwealth HACC program and contributes $462 million to the jointly funded programs in Victoria and Western Australia (with total funding in those States of $769 million). The Commonwealth HACC program provides services to approximately 480,000 older clients and the joint programs in Victoria and Western Australia provide services to approximately 350,000 clients of all ages. In most cases, HACC fees paid by clients are generally minimal relative to total funding and vary across State and Territories.

[9] Inaugural Report on the funding and financing of the Aged Care Sector - 30 June 2013, p.11.
[10] As part of the LLLB reforms from 1 August 2013 existing community care services will be replaced with home care services.
[11] Inaugural Report on the funding and financing of the Aged Care Sector - 30 June 2013, p.11.

Other independent financial analysis

Stewart Brown Aged Care Financial Performance Survey[12] - *YEAR TO JUNE 2013*

The year 2012/13 saw Aged Care Funding Instrument (ACFI) subsidy rates frozen at 2011/12 levels which increased hardship for many aged care providers attempting to provide quality care under changing and somewhat challenging economic conditions.

This year the StewartBrown Aged Care Financial Performance Survey contains data from 710 Residential Aged Care facilities (comprising in excess of 29.5% of Australian RAC beds), 236 CACP programs, 150 EACH programs and 128 EACHD programs.

Results in Summary

- On average the results for the year are worse than for the same period in 2012.
- Average Facility Result was $5.29 per bed day (June 2012: $8.24 per bed day)
- The average facility EBITDA was $6,573 per bed per annum (June 2012: $7,621 per bed per annum)
- Overall EBITDA with the inclusion of investment, fundraising and other income averaged $6,884 per bed per annum (June 2012: $7,994 per bed per annum)
- Facility income averaged $201.48 per bed day (June 2012: $193.65 per bed day)
- The facility result represents a return on income of only 2.6% per annum (June 2012: 4.25% per annum)

Bentleys National Aged Care Survey[13]

Bentleys undertake an annual National Aged Care Survey to allow aged care providers undertake benchmarking for the costs of delivering services. Some findings are outlined below.

Over the last eight years (since 2003/04 to 2011/12):

- the average merged high/low provider's profitability increased from an average EBITDA (earnings before tax, depreciation and interest) of $3.88 per resident per day) to $21.98 per resident per day (as a result of the ACFI rising)
- Wages for care staff have moved from an average of $42.70 prpd to $78.07 prpd (85.6% increase)
- Electricity, light and power costs have increased from an average of $2.37 prpd to $3.60 prpd (51.9% increase)
- Care staff hours (RNs, ANs, ENs, Therapists etc) have increased from 33.84 hours per fortnight per resident to 39.08 hours on average.
- The average accommodation bond collected has increased from $101k on average to $191k on average

In FY2012 Administration costs accounted for on average $23.62 prpd - 12.4% of the $198.35 prpd received by a provider from the Government and Consumers. The top 25% of performers on average spent $21.67 prpd (11.39%). Extrapolated over 135,000 residents this $1.95 prpd differential in performance identifies a potential $96M efficiency saving

[12] *http://www.stewartbrown.com.au/asset/cms/Financial_Benchmarking_Reports/ACFPS_Report_June_2013_-_Executive_Summary.pdf*

[13] http://www.agedcaresurvey.com.au/

There still remains a significant gap between Consumer contributions to personal services and accommodation; and the cost of providing these services. In FY2012 Income excluding Government subsidies) was on average $56.50 prpd compared to average costs of $62.76 prpd (Accommodation = $28.35 prpd; Services $34.41 prpd)

From a Balance Sheet perspective – provider's bond repayment capacity has increased from 85.64% when Bentleys completed the second year of Industry wide CAP financial ratio analysis on behalf of the Department of Health and Ageing to 98.35% in Fy12 (a positive sign consumer capital contributions to providers are well protected against provider failure; and admin/red tape in this area can be eased up)

During that same time (FY2006 to Fy2012)

- Employee expenses increased from 56.06% to 67.32% of total expenses
- Return on Assets decreased by 12.5% from 2.95% to 2.58% on average. Both of these are critically low, even when risk adjusted for the fact that revenues currently flow directly from Government to provider (rather than via consumer)

The average provider's return on equity (assets less liabilities) as at 30 June 2012 was 6.57% - also well short of the 11.6% (for profit) to 12.6% (not for profit) calculated by Bentleys (2013)

THE PRODUCTIVITY COMMISSION REPORT: CARING FOR OLDER AUSTRALIANS

ACSA considers that the Productivity Commission's (PC's) Report, *Caring for Older Australians,*[14] presented a comprehensive blueprint which, with some refinement, would improve access by older Australians and their families to better quality and more responsive aged care services.

Importantly, the PC's recommendations provide the basis for making the aged care system more affordable for the community by striking a balance between individual responsibility for aged care services, affordability for taxpayers and a safety net for those who need it.

ACSA also advocates for standards in accommodation and service that are the same level for all, with the ability for users to purchase more services according to their own personal requirements.

To ensure that community and residential aged care services are sustainable into the future, ACSA has also outlined below potential cost savings focusing particularly on regulation in regards to service rationing and workforce.

POTENTIAL COST SAVINGS

It is acknowledged that the community demands protections in an aged care system that cares for a vulnerable segment of our community. We would not envisage any significant reduction in a regulatory framework that focused on the maintenance of standards and the monitoring of quality of care indicators within community and residential aged care.

The two main areas where the regulatory burden needs to be decreased are regulation around service rationing and workforce issues. While supply continues to be regulated, the levels of compliance necessary to ensure accountability for access to supply and subsequent funding is unnecessarily burdensome.

Moving to an entitlement based community and residential aged care system where the consumer has far greater flexibility and say in how they may make choices to access the system goes a long way in freeing up that regulatory burden. It enables providers to utilise market forces that embrace competitive principles as well as consumer demands to determine where resources will be allocated and what a particular market will pay for those services.

Of course, government will still need to support from a funding perspective those individuals who cannot afford to access services - these might be financial or geographical in nature.

In relation to workforce issues, there needs to be a correction in terms of the balance between what an employer may be able to negotiate and agree with its employees and what is prescribed by government in funding contracts. This may or may not involve assistance from a trade union. It certainly should not be predicated on an EBA as the basis for employer/employee relations.

The *Aged Care Act 1997* (and Principles) is as large and as complex as the laws governing corporations. Ultimately though, until greater market forces operate to enable the supply side to respond to consumer demands and workforce relationships are allowed to be more flexible, it will be difficult to reduce too much of the regulatory burden in aged care as a substantial part of the Act (and Principles) deals with the control of supply.

[14] *http://www.pc.gov.au/projects/inquiry/aged-care*

Aged Care Red Tape reduction

1. Abolish the rationing; introduce entitlement (for those assessed as meeting a defined need)

Subsidised aged care services are rationed according to a population-based target ratios. This rationing requires regulations, red tape and bureaucracy to:

- administer the allocation of places to approved service providers and their transfer between providers and regions,
- plan the types of services to be offered, and the quantities and location of each service type,
- ensure that conditions attaching to allocated places are fulfilled,
- ensure available services are distributed equitably across Australia,
- support price and other controls to counter local market power, and
- be the primary instrument for supporting the quality of aged care services in the absence of competition, the primary driver relied upon in the economy to drive quality and efficiency ie excessive reliance on costly regulated sanction and compliance activity. As far as safety and quality is concerned, prevention is less costly that treatment/cure.

Rationing adds to administrative overheads, and constrains service flexibility and responsiveness to individual preferences. It limits competition and incentives for innovation and more efficient service delivery.

The regulatory consequences of the current rationed system of aged care were recognized by the Productivity Commission in its report *Review of Regulatory Burdens: Social and Economic Infrastructure Services 2009,* when it concluded:

> *"The aged care industry is characterized by centralized planning processes which result in heavy regulatory burden on aged care providers in order to maintain quality of care. Without tackling the underlying policy framework that constrains supply, it is unlikely that the regulatory burden can be substantially reduced."*

The PC provided Parliament with an integrated package of reforms which would address regulatory burdens, as well as improve the quality and sustainability of aged care services for older Australians.

Ideally, the rationing would be done away with and a new entitlement for those assessed as in need established.

If we significantly streamline the funding and subsidy process that currently occurs under ACFI, then there could be a significant reduction in staff required to undertake this task at an aged care provider level and at the Department of Health and Ageing (DoHA, now DSS).

2. Consolidate multiple community care provider contracts into a single contract

A significant number of aged care providers have multiple contracts/agreements with DoHA (now DSS) for delivery of the same service types. An actual illustration is a provider who has 19 CACP agreements, 8 EACH, 6 EACH D, 4 CDCL, 4 CDCH and 4 CDCHD. In some cases these agreements are for the delivery of a single package. Each of these agreements has the same activity and financial reporting requirements, audit requirements and subsidy claim process. All are replicated on a varying basis, some monthly, some annually. This represents a significant duplication of effort. Consolidation of package care agreements is strongly recommended.

3. Reduce the 39 page place transfer application process to a single page

When a provider decides to transfer approved places to a different approved provider, a 39 page application process is required. Ideally, an approved provider should be simply able to advise the Department that a transfer of places was to be made to another approved provider.

4. Establish a "Key Personnel" licence that allows police/finance checks to be transportable

Providers are required to undertake a criminal history and bankruptcy check on all persons that are classified under the *Aged Care Act 1997* as Key Personnel. As each new Key Personnel (KP) individual joins the provider, the provider is required to complete an 11 page 'Add' form. If they cease to be a KP a four-page 'Cease' form is completed. If the KP moves from one KP position to another KP position with the approved provider a four-page 'Change' form is required.

It is not clear in what way DOHA makes use of this information other than maintaining a database on KP which requires constant updating and is continually out of date.

Ideally, once a person has obtained a criminal history and satisfied bankruptcy requirements, those details could be made transportable, and that a provider need only advise the Department when a person holding a "licence" commences or ceases employment.

It should also not be required for people undertaking work placements or traineeships to have criminal checks done. This adds further complexity in encouraging the people to undertake a placement in aged care, and these staff are heavily supervised so they are very low risk of an offence.

5. Allow a single audited statement complying with accounting standards to acquit all reporting needs

An approved provider operating more than one Commonwealth funded program is required to lodge a number of annual acquittals that must be independently audited with a separate audit opinion for each acquittal, which is a time consuming and costly exercise. The capacity to consolidate acquittals would be a logical and sensible approach.

As a consequence of a recent legislative amendment establishing new regulations relating to prudential protection of accommodation bonds the Annual Approved Provider Statement will be required to include a separate Cash Flow Statement relating to RADs. As this will be a separate Cash Flow Statement to the one contained in the published audited accounts, it will require separate sign off by company auditors. Ideally, the lodgement with the Department of an audited statement that complies with accounting standards would satisfy all reporting requirements the Department might have.

6. Replace an annual training statement with a contract clause requiring training compliance

To comply with the conditions relating to the Conditional Adjustment Payment (CAP), the provider is required to complete an annual Training Statement as to the training made available to staff in each approved residential aged care service. Ideally, a simple contract clause requiring compliance could replace the need for a training statement to be completed and lodged.

7. Simplify the Aged Care Allocation Round (ACAR) process

Under the guise of a "competitive" application process, the ACAR requires provider applicants to identify what market research and demographic analysis has been conducted to ascertain the demand for the service. They are also required to provide documentation of the relationships with any community support for their application and to set out how the service will be delivered and how they will meet the accreditation standards.

The application also requires the provider to detail how they will fund the delivery of the places over ongoing years following the places becoming operational. The application asks how the provider will meet the needs of the residents for whom the places are targeted. The same information is needed to be provided for each separate application for places in different regions and LGAs.

The application process is principally a competition in creative writing for which the reward is the allocation of the places often after spending around $12,000 on a consultant to prepare the application. The application process is the same whether it's for four places or 400.

Assuming ACAR continues it would be of significant benefit if the ACAR was scheduled for a set time each year. It is currently random. The randomness makes it difficult to plan for and allocate resources to the ACAR. More often than not an ACAR is announced out of the blue forcing providers to "drop" other business and focus on the ACAR, sometimes to the detriment of other more important activities.

Providers are given a four to six week period to complete ACAR applications. DoHA typically takes four to six months to process applications and to announce outcomes. The lengthy turnaround time from lodgement to announcement compromises provider's capacity to plan for implementation, or to integrate potential new packages into organisation planning and budget cycles. A shorter turnaround time and a systematic approach would be advantageous.

There have been some improvements to the package care application process, however there remains duplication and repetition of information for providers seeking additional packages in multiple locations. In each application the Approved Provider needs to yet again describe who they are and what services they deliver, proving themselves to be viable businesses. All this data is currently available as part of accreditation and the annual financial statements, so this is a time consuming duplication.

Consideration should also be given to having a three to five year rolling ACAR program where it would only be necessary to make applications once every three to five years and receive up-front staged approvals for each year.

8. Examining and reducing the duplication of regulation between the local/state/territory governments and the Federal Government.

An example: *"There is a Commonwealth building certification instrument that aged care providers in NSW [and all other states in Australia] have to comply with, over and above the BCA and state authorities. If we comply with the state authority building standards, and the Department of Health and Ageing accreditation standards, we should not also be subjected to a Commonwealth Building Certification instrument. It has outlived its usefulness in correcting the very old standards. As a minimum, new buildings (like the green slip process for a car) should be exempt. This reduces holding capital costs and duplicated processes. Accreditation should pick up the older buildings still needing improvement."*

Every State has its own State based planning codes and the BCA. There is no need at all for a Commonwealth certification process, which was established to improve old building stock over a decade ago. Either it worked and therefore is no longer needed, or it failed and therefore should no longer continue. New developments are incurring significant costs in trying to match the needs of three different sets of building codes.

If reporting to Government is necessary it should occur via an annual agreement reporting process. This could be done through a three to five year overarching agreement with providers for all forms of care (residential, community, respite, day care etc) and have the specific program types attached to the agreement as principles. Accountability ought to occur yearly through Boards/legal entities against the main agreements.

ACSA recommends reducing the range of aged care provider inspections and reports. Better co-ordination between inspections with the Commonwealth to move out of state jurisdictions as much as possible to remove duplicative overlay, eg:

a. Certification visits
b. Fire inspections.
c. Council fire and food inspections.
d. Reporting around Equal Opportunity/Workplace Gender Equality, key personnel, missing persons, infectious diseases, police checks, quarterly building report etc. Boards/legal entities ought to be regarded as the responsible point of reporting and for the necessary transparency and accountability actions to occur to mitigate risk.

9. ACSA proposes **revisions to the newly instituted regulation of accommodation prices** for non-supported residents in order to reduce regulatory burden and to remove potential disincentives for attracting the financing needed to expand aged care services.

The LLLB accommodation pricing reforms included the following elements:

i. A requirement for providers to publish all accommodation prices and greater information.
ii. Removal of accommodation bond retentions.
iii. All residents will have the choice for a 28 day period after entering residential care before determining whether they will pay accommodation in the form of a Refundable Accommodation Deposits (RADs), an equivalent Daily Accommodation Payments (DAPs) or combination thereof.
iv. Prices controls in relation to RADs and DAPs.
v. The use of the maximum permissible interest rate (MPIR) as the mechanism for determining equivalence of RADs and DAPs.

ACSA is supportive of publishing of prices that will by itself significantly enhance pricing transparency and consumer choice, however, the posting of pricing is only one part of what is required to be posted. The rationale for the pricing is also required and this will entail a lot of work. ACSA questions the necessity for the level of detail that is being suggested in the draft guidelines. (i). ACSA considers the period of choice, price controls and the application of the MPIR (iii to v) will constrain new investment that will be much needed to meet demand growth for the following reasons:

- Period of choice: This represents an unprecedented restraint of trade whereby a consumer is unilaterally able to choose a mode of payment after taking possession of the property (residential aged care place). Selection of a DAP as the mode of payment may not meet the bank debt repayment obligations of a provider.

- Price controls: There is abundant evidence that virtually all bonds in residential aged care in Australia have been fairly negotiated with residents and their families. Imposing price controls which will add to the bureaucracy and red tape will not enhance consumer protection when the new publishing of prices and information disclosure rules will enable consumers to choose residential aged care places on an informed basis.
- The use of the MPIR: This is a government interest rate that inadequately reflects the market cost of equity and debt capital that will need to be sourced if the industry is to deliver the 82,000 beds ($20.5 billion investment) required to meet demand by 2020.

10. The requirement that 'missing persons' be notified to DoHA within 24 hours of notifying the police. The latter makes sense but there is no rationale for the former as it gets in the way of a focus on the search. DoHA cannot contribute anything to the process, and a review of any systemic issues that may have contributed to the person going missing can take place after the person has been found.

11. Infectious disease outbreaks and other emergency situations such as floods or fires in homes currently involve the State Health authorities, the Accreditation Agency and the Department simultaneously, who get in each other's way. It is time through COAG to establish clear responsibilities so that homes do not need to deal with multiple parties at the same time as they are trying the respond to the outbreak.

12. One of the biggest costs to government and aged care providers is the accreditation and inspection system. ACSA appreciates that a new system is being put in place. However, a change of approach from 'one size fits all' (eg each facility gets an unannounced inspection every year regardless of the quality of their organisation and their past record) to a best practice/certification process (wherein 'quality-assured' providers do not need to be constantly checked) would save the government and providers a significant amount of money.

13. Examine the possibility of greatly reducing and even out the number of ACFI pay points and potentially look to better model the broadbanding/classification of people and pay points accordingly. Classify through the Aged Care Gateway system and abolish validations.

14. Avoid the introduction of future red tape by scrutinising all new reforms/legislation against a "red tape filter".