LASA
LEADING AGE SERVICES AUSTRALIA
The voice of aged care

Improving Choice in Residential Aged Care – ACAR Discontinuation Discussion Paper

LASA submission

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About LASA

Who We Are

LASA is the national association for all providers of age services across residential care, home care and retirement living/seniors housing.

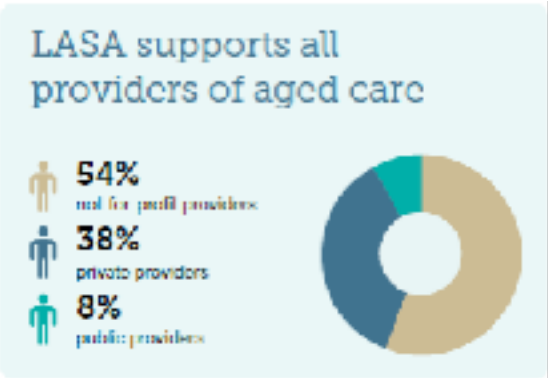
Our Purpose

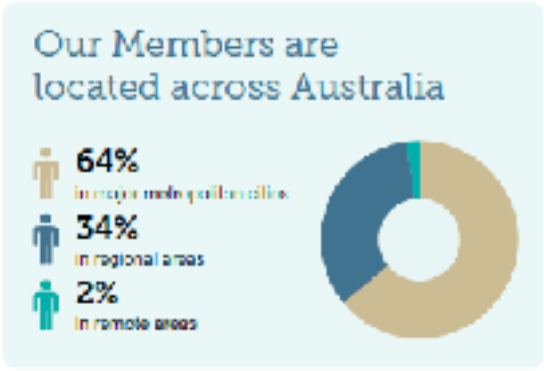
Our purpose is to enable high performing, respected and sustainable age services that support older Australians to age well by providing care, support and accommodation with quality, safety and compassion—always.

Our Members

We represent providers of age services of all types and sizes located across Australia's metropolitan, regional and remote areas. We are dedicated to meeting the needs of LASA Members by providing

- a strong and influential voice leading the agenda on issues of importance;
- access to valuable and value-adding information, advice, services and support; and
- value for money by delivering our services and support efficiently and effectively.





Our Affiliates

LASA Affiliates are proud supporters of the critical role played by the age services industry in caring for older Australians. Their value-adding products and services help age services providers apply innovative solutions that improve the provision of efficient and quality care.

Our Strategic Objectives

1. Be the credible and authoritative voice of aged care representing the views of our Members for the benefit of older Australians.
2. Build sector capability and sustainability by delivering valued services and support to Members
3. Lead continuous improvement by promoting and celebrating excellence and innovation in age services
4. Deliver value for money for Members and Affiliates.
5. Be a high performing, respected and sustainable association that cares for our purpose, our Members and our people.

Contents

Key points

LASA broadly supports the proposals outlined in this paper to the discontinuation of ACAR. However, there are number of key points and concerns that need to be addressed.

1. Under the proposed transitional arrangements, places would be available on a non-competitive basis until ACAR formally ends. This helps address Member concerns about uncertainty. But it also appears to effectively bring forward the end of ACAR, unless these places can only be used post July 2024.
2. The paper discusses the issue of local supply issues (including for special needs groups) but LASA is concerned that the planned approach seems relatively ad hoc – in line with the Royal Commission we recommend clearly articulated expectations for access and a robust policy framework for guaranteeing that access standards are met.
3. The paper acknowledges that informed choice will be crucial to the success of more market-based arrangements, but we do not believe that the approach to quality indicators and star ratings that has so far been articulated will actually provide the information needed to make informed choices.
4. Consideration needs to be given to growing concerns about the role of commissions and placement agencies in a more competitive market.
5. The paper proposes the end of extra services – but this would be premature in our view given there has been no resolution of the issues with additional services that LASA has previously raised with government. An alternative would be to implement the Tune Review recommendation on the basic daily fee.
6. A further significant issue with the end of extra services is the effect this may have on the supported resident ratio of extra services facilities – acting effectively as a retrospective change to the capacity of these services to cover their capital costs. Any change to extra services should allow for grandfathering with respect to the supported residents ratio.

Responses to individual questions are provided below.

The consumer journey

Aged care assessments

Question 1: Should aged care assessments consider the person's urgency for care?

Yes. The government is proposing that urgency be assessed, but not grant priority.

Urgency will generally be clear to the provider as part of their own due diligence. Having the ACAR assessors indicate urgency may be of some assistance to the provider in forming a view.

Even though there would be no formal priority granted to urgent cases, it is likely that this will create expectations for providers to accommodate them more quickly, potentially ahead of people who may have been waiting for a place in a particular facility for longer. However, this pressure likely exists regardless of the assessment rating formalising it.

Formalising urgent cases will also help track access to residential aged care. Currently the period between assessment and placement is not a good indication of waiting times, because many people seek an early approval and then delay entry as a choice.

Overall, LASA agrees with the proposal that urgency be assessed, but not grant priority.

Question 2: Should aged care assessments consider whether a person is from a special needs group or has additional cultural or other special needs?

Yes. Government is proposing that information on whether a person is from a special needs group be collected in the assessment.

LASA supports this as it will be helpful in tracking outcomes for these groups, as well as determining whether there may be a need for additional specialist services.

Other issues

Further discussion is needed on the relationship between the eligibility assessment and AN-ACC assessments.

The period of time that a person waits between requesting an assessment and being assessed should be tracked, with a clearly articulated maximum wait time.

Assignment of places

Question 3: What should be considered when assigning residential aged care places? Should time or location restrictions be introduced?

No. LASA supports the Government's proposal that places be assigned without time limits or limits to particular regions.

However, arrangements should be made to track the location of a person when approval is granted, and the location of the service where that place is ultimately used.

Question 4: Could the assignment system be designed to mitigate localised supply issues?

No.

As noted in response to question one, LASA does not support the assessment of urgency or special need status being used to grant priority access to aged care. There is a stronger argument for such a system in a region where supply is constrained. However, lack of supply is a broader issue, that needs a more comprehensive policy response.

Whether local prioritisation will be necessary depends on other policy arrangements to avoid this situation.

The paper refers to broader structural adjustment assistance and capital grants. However, the Government's approach to addressing potential supply issues needs to be addressed more comprehensively.

Other issues

The paper states that:

> The national supply of residential aged care places is expected to be above demand until at least 2040. As such, there are no plans to ration the assignment of places at a national level, and no intention to make people wait on a national or regional queue prior to receiving a residential care place (supply and demand is discussed in further detail below).

The Government should clarify whether this reflects a formal decision to remove the cap on residential care places – or simply a prediction that demand is unlikely to exceed the supply that government.

Support for informed decisions

Question 5: Are any additional measures or information needed to support informed choice?

Quality indicators

In the context of market driven allocation of places, information about quality becomes even more essential. There is good evidence internationally that simple star ratings can play a significant role in driving choice of provider. In particular, star ratings can help people short-list providers for more thorough investigation.

There are currently no published quality indicators. Government has committed to introducing star ratings by the end of 2023. However, we need to get the implementation right as there is a real risk that the indicators that sit behind these ratings will give a misleading view of quality. Poorly designed quality indicators also create risks such as 'cherry picking' of residents, a narrowing of focus from overall care and wellbeing to maximising specific indicators (e.g., discouraging movement to limit falls). These sorts of risks are well evidenced in the literate regarding clinical indicators in hospital settings.

We will make a separate submission on these issues.

Placement services

In the context of fewer restrictions on supply the role of placement services in the market is likely to further increase. Currently, some placement services are paid directly by the resident (or family etc). However, there are an increasing number of placement services that charge commissions to care homes. In some cases, these placements cost thousands of dollars.

The nature of residential care price regulation makes it impossible for the provider to pass these costs on to the resident using the placement service – consequently the resident using the placement service has little reason to care how much the service is charged. These costs are then borne collectively by the residents of the service in the form of an increased share of resources devoted to administration.

A further concern is that the services most willing to pay these high placement fees are those having difficulty filling their beds. In some cases, because of old accommodation stock or poor reputation.

As multiple placement agencies compete, there may emerge an incentive to pay for more extensive advertising and business development to attract more clients to refer.

This is a classic market failure that results from externalities and asymmetric information. Similar problems have occurred in a range of other markets such as credit card rewards, commissions for financial advice, travel and food delivery websites (usually as a result of market power rather than regulation).

These dynamics are strengthening as average occupancy falls and are likely to further strengthen in the context of the removal of restrictions on supply.

The Government should introduce new regulatory arrangements governing the fees charged by placement agencies and the way that they are disclosed.

Transferring between providers

Question 6: How can people be supported to move between aged care homes if they want to do so?

There is likely to be very limited switching between services in residential care.

There is very little switching, even in markets were switching is relatively simple and information about differences between providers are relatively easy to understand (e.g., banking, utilities and superannuation).

In residential care, a resident considering switching providers needs to deal with the burden of moving house, breaking relationships with other residents and staff, switching care providers, and arrangements to transfer large sums of money (in the context of RADs). This occurs in the context of complex health needs and substantial functional impairments.

Where switching does occur, it is often in the context of significant issues emerging between a provider and a resident or their family. Often both the resident and their family and the aged care provider are happy for a shift in provider to occur. However, providers are often concerned about accepting residents in these circumstances, fearing that they will experience similar problems but unable to back out as a consequence of security of tenure laws.

- There may be some merit in allowing a resident that wishes to switch services access to a care finder to act on their behalf to find alternative arrangements.
- There may also be merit in reviewing security of tenure laws to address concerns that providers may have about accepting new residents where there has been a history issues with the previous provider.

Market stewardship

Ensuring quality of care

Question 7: Should the existing quality and safety functions be expanded or redesigned to address any potential gaps arising from the removal of the ACAR?

No. The current arrangements allow for sufficient oversight.

Managing the effects of competition and growth will take on increased important as part of new market dynamics. Providers will need to plan for and manage this. However, this is encapsulated within existing responsibilities around risk management, and notification to government of any matters effecting viability.

Risks at the market level should be monitored by Government using the market intelligence data referred to below.

Ensuring access to RAC

Question 8: What measures would further ensure providers cater to special needs groups and those with additional cultural needs?

Better data about special needs groups is needed to support appropriate policy making. This includes information on access and outcomes for special needs groups, as well as the cost of delivering services to them.

Funding should at least reflect measured costs for these groups, and where there is evidence of outcomes that are worse than others – there must be a transparent and robust process for deciding whether and how to allocate additional resources to improve outcomes.

Beyond ensuring that overall funding design adequately addresses diversity, there also needs to be a fund to address service gaps that are identified at a local area. The structure of this fund, and the criteria under which it can be accessed would need to be carefully considered.

Finally, there needs to be more structure and assurance around the claims that providers make about their specialisation in supporting diverse groups, both to better understand capacity within a region and to better support the choice of residents.

Market intelligence

Question 9: What information do providers need to help support decision making?

The paper raises the possibility of collecting and publishing:

- the number of people in care,
- current and future bed availability
- time in care and reasons for departure
- number of consumers approved and distribution of need
- occupancy/vacancy levels
- number of approved providers and new services

We support the collection and publication of this information.

Information on hospital bed days occupied by people ready for discharge to residential care at the LHD level.

Information on the average distance between the residential address of the person prior to entering residential care and the address of the residential care service would also be a useful indication of access levels within a region.

One critical issue is the granularity of information that is published. For most of this data, we support publication at the planning region level.

Rather than just publishing headline occupancy, variance in occupancy should also be published. This could be in the form of number of homes within an area in particular occupancy bands.

Data on the current bed numbers should continue to be published at the facility level.

Publication of future bed capacity should be published at the ACPR level linked to the point at which development approval is given.

It would be valuable to have more contemporaneous data on assessments and approvals than is currently available for residential care in line with the data currently published for home care.

Provider viability

Removal of bed licenses

Question 10: What impact will the removal of bed licences have on the sector?

Broader context

The long-term effect of removing bed licences needs to be understood in the context of broader policy and market change.

Contrary to the paper, we see very limited evidence of the substitution from residential care to home care at present.

There is research which suggests that having access to home care moderately reduces the risk of needing residential care. However, this reduction in risk only applies to the relatively small number of people who move from home care into residential care. The vast majority of admissions to residential care do not come from home care packages.

There are stories of some people choosing not to enter residential care because they are holding out for a home care package. However, the reality is that most people only enter residential care when it has become unavoidable. Therefore, relatively few have the option of holding out for 12 months or more to access a high-level home care package.

Randomised control trials conducted overseas suggest that giving a person who was going to enter residential care the option of high-level home care does significantly reduce residential care admissions. But this is currently of limited relevance to Australia because of the waiting times that apply.

Looking at the data, while there has been a downward trend in use of residential care and an upward trend in home care the rate of change in these trends does not appear to be correlated. Rather what we are seeing with declining residential care usage is an expression of increasingly strong community preferences to stay at home.

Supporting this is the fact that there appears to be no negative correlation that we can see in the number of people 75+ in home care vs the number of people 75+ in residential care within a planning region. This lack of correlation holds across various different indicators, including funding and entries into care.

If our explanation for the lack of strong correlations at present is correct, then we can expect the effect of increased home care packages on residential care occupancy to greatly strengthen as wait times fall with the release of more packages.

The enhanced effect of home care substitution will add to the reputational effects of the Royal Commission and COVID related health concerns in driving down demand for residential care.

Accordingly, it is reasonable expect significantly weaker occupancy in the coming years regardless of changes to ACAR.

We note that current investment already exceeds what the Deloitte Model estimates is required. And the Deloitte model itself may be an overestimate if demand for residential care falls more sharply than the model assumes.

The market dynamics of reduced occupancy are still emerging. In markets where there are few providers, reduced demand may push facilities below minimum efficient scale – necessitating interventions to maintain supply to the region.

In markets where there are a number of different facilities, the dynamics are more complex. It is not clear to what extent the reduction in occupancy will be concentrated in unpopular services or spread more evenly across providers. Recent experience suggests that there will be a degree of concentration in reduced occupancy, mainly in the form of reduced occupancy for multi-bed rooms. However, there will be some reduction in occupancy across the board, even for services with good reputations. Occupancy may rise again if less popular services close. However, less popular services may choose to lower their prices to maintain market share, given capital costs are largely sunk and research suggests many prospective residents are price sensitive. This in turn may place pressure on the viability of even reasonably good services.

The orderly shutdown of old and unpopular services in well supplied regions is a good thing in the long-run. However, in the short-run oversupply can have problematic effects, with reduced revenue leading to cost cutting that may harm service quality. There is also increased risk of disorderly closure of services.

These issues will exist regardless of the removal of ACAR. However, it is likely that that they will be amplified by the removal of ACAR to some extent.

Effect of bed licence de-regulation

The removal of bed licences will give providers much more scope to expand, including some potential to flex capacity up and down. In the absence of the need to apply for places providers may be able to increase capacity much more quickly. These are positive changes that will facilitate improvements in the quality of services for residents.

However, there are some risk that need to be actively managed. Removing bed licenses (which restrict the allocation of capital) will tend to result in investment being concentrated in the areas of greatest financial opportunity – this usually means high income metro areas, or regional areas with attractive locations, such as warm coastal climates. As capital concentrates in those locations, there may be less interest in less attractive locations, such as regional and low-income areas.

The paper references additional funding through AN-ACC as having some scope to mitigate this – but that additional AN-ACC funding only applies to rural and remote locations. Providers in regional towns do not receive an additional subsidy because their costs were not measured to be higher, but they still perform worse financially because their revenue is substantially lower.

Existing oversupply may provide ongoing capacity in such locations, but there may be less interest in upgrading the quality of building stock. Providers currently cross-subsidising regional services may be less willing and able to continue to do so as deregulation enhances competition for their better performing services.

There is also a need to manage the risk of construction boom and bust cycles that occurs other major property asset classes such as hotels, offices and apartments. In the context of essential care, the consequence of oversupply and then a messy underwinding is much greater than it is in these other markets. However, it is the removal of ACAR may actually reduce the risk of these cycles occurring by allowing construction to occur more quickly. Demand for residential aged care may also be more predictable than demand for these other asset classes – notwithstanding the fact that for a number of years, residential aged care demand growth has substantially underperformed expectations.

Another notable effect of the removal of bed licenses may be less interest in acquisitions in the context of fewer restrictions on building new capacity. This is not strictly speaking a problem, but may create unforeseen challenges since this is the most common pathway for the orderly exit of a provider.

Question 11: Are there further measures that may help to mitigate risks arising from the removal of bed licences?

Government should monitor rapid expansion or contraction of supply within regions, along with other indicators of access at a regional level.

Ongoing structural adjustment funding will likely be needed to support interventions in some cases.

Capital funding will also need to be available to support access for groups or regions where there are limitations on access.

It is important that the criteria for intervention, and expectations regarding proximity of access are clearly defined, rather than left as vague matters of judgement.

More broadly residential care funding will need to adjust to the lower level of average occupancy. This includes the role of the pricing authority in setting subsidies, accommodation pricing structures, and the basic daily fee.

Question 12: What impact will the removal of bed licences have on investment decisions?

Some providers have reported that will be a degree of increased uncertainty.

Providers that have debt covenants that are linked to balance sheet/assets (as opposed to cash flow debt covenants) will need to have discussions with their lenders. Lenders who previously could rely upon sale of bed licences in times of provider distress, now no longer can.

This will require some funders to think differently about their investment planning, and risk will be higher, meaning finance may sometimes be more expensive or not available at all in some circumstances.

On the other hand, attractive investment opportunities that are currently unavailable due to regulatory restrictions will be opened up, potentially driving increased investment.

The ultimate effect is difficult to predict, and likely depends on how broader policy changes and market dynamics in residential care and home care are resolved. For example, policy uncertainty about the future of RADs is likely having a much greater effect on investment decisions at present than the future of bed licences.

Question 13: Are there any additional issues that should be considered in relation to lending and investment decisions?

None, other than those listed in response to the previous question.

Transitional issues

Supply during the transition

Question 14: What processes could occur between now and 30 June 2024 to allocate places to providers when they are ready to deliver care immediately?

LASA notes the paper's statement that allocated places will be sufficient to meet expected demand over the period, and that providers will also be able to apply through a

non-competitive process for new places. This non-competitive allocation addresses concerns about potential delays to development.

The challenge with this approach is that it seems ACAR will effectively be over from the point at which these arrangements begin.

Provisional places

Question 15: What transitional arrangements could be in place between now and 30 June 2024 for the management of provisional places and operationalising provisional places?

LASA supports the proposal to remove reporting requirements in relation to provisional places.

Transfer and variation of places

Question 16: Are any changes needed to the arrangements to transfer or vary places?

Barriers to the transfer and variation of places should be removed wherever possible

Extra service fees and additional service fees

Question 17: Do you think that Extra Service Status arrangements should be discontinued from 1 July 2024?

Feedback to LASA has been that there is significant dissatisfaction with additional services as an alternative to extra services. This is driven by uncertainty about the circumstances in which additional services fees can be charged. We have previously raised these issues with the Department and they remain unresolved.

Extra service places should not be resolved until the broader issue of additional services and consumer contributions is more satisfactorily resolved.

An alternative to reforming additional services fees would be to implement the Tune Review recommendation to provide more flexibility in the amount that can be charged through the basic daily fee.

Effect on support residents ratio

Historically if a service has an extra services approval on beds that precludes them from being required to have the supported resident ratio apply to those beds. In other words, a full extra services facility is not required to have any supported beds onsite. This means all beds can attract RADs. Especially for more boutique smaller facilities in higher socio-economic areas where land has been more expensive, this has made these facilities more viable to build.

A retrospective change in the capital structure of these facilities is problematic and unfair, and removing 20% of the RAD pool could create viability issues for these facilities.

The other financial implications is for partly extra service approvals, the extra services places have not been included in the total number of beds to work out the supported ratio. For example, a facility with 100 beds, 50 ESS beds, only 50 beds are taken into consideration working out the supported bed ratio, so if there are 25 supported residents the ratio would be 50%, which would get the higher supported supplement, which only triggers in at over 40% supported residents on any given day. If the government removes

extra services then the same service would only achieve a 25% supported ratio. Member report this is a difference of $20 per bed per day, and would have a financial implication of $20 x 365 x 20 approximately a $150,000 for that service. Again, a retrospective change on a service that would have been built and designed on a certain funding model, which could have huge implications for the provider.

Any removal of extra services should only be considered with this issues being addressed, either there be some exceptions to organisations around the supported ratio and the exclusion of previous extra services beds to supported ratios for the purpose of working out the higher accommodation supplement or a broader change to policy regarding the supported residents ratio.