national AGED CARE alliance

National Aged Care Alliance
Discussion Paper

Capital Creation in Residential Aged Care Facilities

March 2004

Introduction

This Discussion Paper has been released by the National Aged Care Aliance (the Alliance) to stimulate debate and discussion, and does not represent an Alliance policy position. The focus of the Discussion Paper is on short to medium term issues around capital creation and possible options to secure sufficient capital to meet the immediate and short to medium term needs of the aged care sector to provide quality buildings. Options for the long term are the subject of a previous Alliance Discussion Paper *Options for financing long-term care for older people in Australia* (2002), available at www.naca.asn.au.

The Discussion Paper raises the capital creation options of:

- daily rent, or
- lump sum, or
- government grant or supplement, or
- purchase of a place in advance, or
- incorporation of a capital component in federal government subsidies to the aged care sector.

The National Aged Care Alliance is a body representing peak national organisations in aged care including consumer groups, providers, unions, and health professionals, working together to determine a more positive future for the aged care sector (see Attachment B).

The current funding system for residential aged care is an inadequate base on which to provide quality care. The demand for aged care services for older people in Australia will increase because of the rising number of older people in our population. While the overall population will increase by 30% by 2030, the population of people aged 80 or more will increase by over 200%.[1] Among this population will be greatly increased numbers of people with dementia.

The Alliance recognises that, while the Federal Government has largely withdrawn from providing capital funds for aged care facilities, providers are increasingly unable to fund the capital costs.

[1] Commonwealth Productivity Commission. 2000. *Long Term Aged Care*. Research Paper. Canberra.

Without adequate capital support, facilities will not be built to take up the increasing demand for high care places, and some existing facilities will close as they are no longer economically viable: the capital cost of restructuring and rebuilding is not sustainable (see Attachment C).

A better funding environment, which is acceptable to the Australian community, must be available, from a mix of sources, including government, to ensure access to quality aged care for those who need it.

The Alliance's vision for aged care in Australia is that:

> *All older people in Australia have access to planned and properly resourced integrated quality aged care services that are flexible, equitable, that recognise diversity and promote choice and respect for users and workers.*

Summary of key points

- Under the Aged Care Act 1997, approved providers are responsible for achieving adequate capital income to meet capital generation requirements for approved residential aged care services within the policy parameters set by the Act.
- Residents entering high care (nursing homes) may be eligible to pay a daily accommodation charge of up to a maximum of $13.91 per day which only generates an income of $5,077.15 per annum.
- Residents entering low care (hostels) may be eligible to pay an accommodation bond. The annual income, which could be used for capital purposes, flowing from an average bond of $98,775.00, is between $9,000.00 and $12,000.00.
- The income stream from government for residents unable to pay an accommodation bond or charge is up to a maximum of $4,923.85 per annum.
- Facility construction cost is in the range of $80,000.00 to $120,000.00 per bed (not including land and many fit out costs).
- Most operators of high care facilities have made the decision that there is an insufficient income stream in the current financial framework to support the outlays required for new buildings and upgrades.
- Almost 90 per cent of residents in aged care facilities are pensioners. This means that they generally have a relatively low income, although many, but not all, usually have assets in the form of housing.

Background

With the introduction of the Aged Care Act on 1 October 1997, responsibility for achieving adequate capital income to meet capital generation costs of approved residential aged care services was almost fully transferred to approved providers. The Commonwealth only provided a small capital grants program to assist some rural and remote services and special needs groups.

Prior to the introduction of the 1997 Act, different programs and the different dependency levels of residents resulted in different policy approaches being adopted for residents in high and low care facilities. Policy in low care facilities was broadly based on welfare/housing needs, whilst policy in high care facilities reflected health policy.

In low care facilities[2], residents could be asked to make entry contributions. The low care facility was able to set the amount of the entry contribution providing the payment left the resident with assets of no less than 2.5 times the annual rate of the single age pension.[3]

Professor Gregory estimated in his 1994 report[4], that some 69% of all low care facilities were charging entry contributions from around 54% of their residents. An estimated 38% of all residents in low care facilities paid entry contributions. High care facilities[5] on the other hand, were not permitted to charge entry contributions. This resulted in a rundown of high care facility capital stock as they had limited access to a source of capital income.

When hostels and nursing homes were effectively combined under the 1997 Aged Care Act as residential aged care facilities, it was considered necessary to allow all approved services, regardless of whether they were former hostels (low care) or nursing homes (high care) to charge entry contributions called accommodation bonds. This was meant to achieve a uniformity of building stock improvement and building stock creation over the ten years 1997 to 2008.

Following political lobbying about the appropriateness of incoming residents to high care facilities being placed in a position where they may have to sell their family home to pay a bond, the Federal Government overturned the payment of accommodation bonds by residents in high care and replaced it with an accommodation charge as of 6 November 1997.

The accommodation charge has now been in place for over five years and has resulted in a capital creation stream to residential high care facilities that is less than half of the value of capital created in the low care sector.[6]

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[2] Low care facilities were formerly called hostels

[3] Gray (2001) *Two Year Review of Aged Care Reforms*, Commonwealth of Australia

[4] Gregory R (1994) *Review of the Structure of Nursing Home Funding Arrangements, Stage 2*. Department of Human Services and Health. Aged and Community Care Division Service Development and Evaluation Reports, AGPS, Canberra

[5] High care facilities were formerly called nursing homes

[6] Gray (2001) ibid.

Department of Health and Ageing analysis of the 2001/2002 financial year annual survey of aged care services for the report on the Aged Care Act tabled in Federal Parliament, showed that $2.4 billion was raised from accommodation bonds for the purpose of capital creation in low care facilities, whilst only $345 million was raised from the accommodation charge which could be used for creating capital for high care facilities.[7]

Two thirds of residents in residential aged care are categorised as high care[8] and are thus not required to pay an accommodation bond (see Attachment A). Even allowing for the fact that some residents now requiring high care may have entered residential care only requiring low care and thus paid an accommodation bond, there is an obvious disparity between the capital creation capabilities of the two sub sectors. This is a major problem for the industry, specifically relating to the capacity and capability of high care facilities to continue to build stock at the required rate and required quality to meet both future demand and 2008 regulatory requirements.

Relevant issues

Length of stay

During 2001–2002 178,111 people received permanent residential care in 144,139 operational places. Twenty seven per cent of permanent residents left within six months whilst 38 per cent left within 12 months. Only 5.6 per cent of these residents left to go to another facility whilst 77 per cent died. Nineteen per cent stayed over five years. Average length of stay was 2.8 years.[9]

These statistics are important when considering the way the current capital income structure operates and when considering possible changes to it. The current five-year cap on the payment of the accommodation charge and retention draw down from accommodation bonds means that residents staying over five years are not making the same capital contribution as those with a shorter length of stay.

Longer staying residents are those mainly with dementia and most are classed as high care. One of the consequences of overturning the payment of accommodation bonds in high care has been a deferral or cancellation of the construction of dementia specific buildings to the detriment of this category of resident.

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[7] Unpublished data prepared by Department of Health and Ageing from 2001–02 Census of approved residential aged care services

[8] Department of Health and Ageing RCS Statistics Update, September 2003

[9] AIHW (2003) *Residential Aged Care in Australia 2001–02: A Statistical Overview*. Aged Care Statistics Series No. 13

On the figures available only 6% of all residential aged care places are dementia specific. Alzheimer's Australia estimates that the figure should be at least 10%, both to provide better care for those with special needs and to reduce disturbance to other residents.[10]

An Aged Care Assessment Team (ACAT) must complete an assessment before a person can be admitted to an approved residential aged care service as a Federal Government funded resident. The ACAT may identify that some approved care recipients require a secure dementia service.

The question is how to provide for residents with dementia who need a safe and secure environment when they can no longer be supported at home and who need different care than that which can be provided in a mainstream high or low care facility? Historically, dementia specific hostels in the late 1980s and 1990s were developed for this group to meet their environmental and long-term nursing and personal care needs.

Concerns about access to specialised and secure accommodation for dementia care were highlighted in the Government's two year review of the aged care reforms.

As a result of the changes introduced in the 1997 Act, high care residents with dementia are restricted from being admitted to a post 1 October 1997 approved low care bed (which may have the right environment for a person with dementia), and are therefore not eligible to make an accommodation bond payment, which providers need to construct dementia specific facilities[11].

Certification requirements

The current Australian Government Building Certification requirements for residential aged care buildings stipulate that new buildings must have no more than an average of 1.5 residents per bedroom and three per toilet and four per shower. Existing buildings must meet, by the year 2008, privacy and space requirements of an average of two persons per bedroom, six per toilet and seven per shower.

These requirements drive construction costs. Residents do not pay a differential cost based on the standard of accommodation supplied. In practice, they may also have little choice but to accept the accommodation that is available when they need a place.

It could be argued that the Federal Government is requiring an unnecessarily high standard of accommodation when residents may prefer to have a choice of facilities with a lower standard of accommodation at a lower cost.

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[10] Access Economics for Alzheimer's Australia (2003) *The Dementia Epidemic: Economic Impact and Positive Solutions for Australia*

[11] Since 1 October 1997, no high care resident can be admitted to a low care facility. All high care residents in low care facilities are those who have aged in place.

Who should pay?

How the capital cost of the buildings and environments are funded and by whom is another question. There are a range of options. If residents have to bear the cost, apart from those without the financial capacity to do so (concessional residents), how should this be accomplished equitably and fairly? Should residents have a choice of accommodation standards within an agreed range with the accommodation cost being their responsibility?

Current system not working

In the 2002 aged care approvals round, of the 2,206 high care beds and 3,373 low care beds allocated to providers, only six new high care 'stand alone' facilities were approved. This highlights the extremely poor number of applications received from operators for 'stand alone' facilities across the sector.

This outcome rings alarm bells for future access to residential high care, both in the context of meeting the demand for the growing aged care population and in the context of meeting the needs of an increasingly more dependent and frail older segment of the aged care population needing specialised nursing care.

Low care

Because operators of low care facilities have an accommodation bond stream and the associated income, they are in a far more favourable position to achieve capital creation whilst maintaining a stronger balance sheet and surplus/profit outcome than the high care sector.

In 2002–2003 an estimated 68.6% of all homes derived income from accommodation bonds, with the average amount of each bond being $98,775.[12] Most providers are now charging around $113,500. The pensioner supplement cuts out above this amount.

With an annual retention amount of $3,054 and interest saved or earned on an accommodation bond of somewhere between 6% and 9%, depending on the investment strategies employed, the annual income flowing from an average accommodation bond of $98,775 is between $9,000 and $12,000 and between $9,800 and $13,300 on a bond of $113,500.

High care

On the other hand, the income available to the operator of a high care facility is currently set at a maximum of $13.91 per day for new residents, which is only $5,077.15 per annum. The current average is about $11.00 per day. This could result in residents in low care with lower income and assets subsidising the capital payments of residents in high care with possibly higher income and assets.

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[12] Department of Health and Ageing (2003), *Report on the Operation of the Aged Care Act 1997, 1 July 2002 to 30 June 2003*

Where fewer than 40% of residents in the facility are concessional, the income stream for a concessional resident is a maximum of $2,872.55 per annum. Where more than 40% of residents are concessional, the income per concessional resident is $4,923.85 per annum. Both of these amounts are significantly below the required income stream to build high care facilities with a construction cost in the range of $80,000 to $120,000 per bed.

It is now very evident that most operators of high care facilities have made the decision that there is an insufficient income stream in the current financial framework to support the outlays required for new buildings and upgrades. Until additional income streams are available, more work will be done on facilities which can be used for either high or low care, rather than in the high care sector on 'stand alone' high care facilities.

Also in geographic areas of Australia where house values are low or large numbers of the community are non-homeowners, the current capital income arrangements do not provide sufficient income for capital construction of new facilities or major refurbishment of existing buildings. These same areas are often higher construction cost locations with the extra cost not necessarily being offset by lower land values.

Options and key areas to be addressed

Possible payment options to approved providers are:

1. a daily rent or charge (periodic payment, equivalent to an accommodation charge), or
2. a lump sum (equivalent to an accommodation bond), or
3. a combination of a) and b) and conversion from one to the other, or
4. government capital grant or supplement, or
5. purchase of a place in advance for an advertised price, or
6. incorporation of a capital component in the federal government subsidies to the sector.

The questions that arise are:

1. On what basis should the daily rent, lump sum and purchase in advance be calculated?
Possible solution: The capital value of the place amortised over the 20 year expected life of the place and calculated as a daily, weekly, monthly or annual imputed rental. The amortisation method will need to create sufficient reserve for future replacement or upgrade. This reserve would need to represent the net present value of construction in 20 years time. The capital components need to be identified in setting the capital value. Examples of some cost components that could be included are: land, site works, building fabric construction, furniture fittings and equipment and consultants' fees.

2. From what point should daily rent or lump sum apply? Should it be from date of admission?
Possible solution: From the date of admission, with the consumer choosing which option they prefer.

3. Should there be any circumstances where residents would be exempt from making an accommodation payment?
Possible solution: Exemptions should be extended prior to entry on a time limited basis to all residents or to certain categories of residents, such as those clinically assessed as needing terminal palliative care prior to entry.

4. Over what period of residency should the daily rent or lump sum apply?
Possible solution: The entire period of residency of the resident from the date of entry, subject to the resident retaining their remaining assets as stipulated in the Aged Care Act 1997.

5. How much should be retained (including interest) by the approved provider from the lump sum?
Possible solution: An amount equal to a reasonable rental charge calculated as per Question 1.

6. How would a room purchased in advance be costed and how would this option operate? Could the purchaser have priority of access?
Possible solution: The room purchased would be priced in the same way as set out in Question 1, but the purchaser would be making the purchase at an advertised price. The room could be purchased as an investment with the investor deriving a return on their investment, or it could constitute the purchase of a specific room to be eventually occupied by the purchaser. If purchased in advance, the purchaser could expect a return on their investment until they require occupancy. Purchase could be strata title, time share or through a property trust. Priority of access could be offered, however the purchaser would need to have an ACAT approval to be admitted as an approved care recipient.

7. Should the Federal Government provide low cost or interest-free loans?
Possible solution: Yes, for the same areas, as outlined in Question 8.

8. Should the Federal Government provide an increased capital grants program?
Possible solution: Yes, for geographic areas of Australia where house values are low or large numbers of the community are non-home owners, or in areas where higher construction costs are incurred as a result of the location, with the extra cost not being offset by lower land costs.

9. How should resident lump sums and purchases in advance be protected?
Possible solution: Lump sums should be treated as loans and shown on the organisations' balance sheet, with a financial arrangement guaranteeing the timely refund of lump sum balances. For purchasers, a title or time-share would be issued.

10. Should the choice of payment option be entirely a consumer one?
Possible solution: Yes, within the range of options the approved provider offers, which must include daily rent or lump sum.

11. How can residents' pensions be protected?

Possible solution: The Aged Care Act 1997 and the Social Security Act 1991 should be aligned so that the disposal of assets time frames are the same and the payment of a lump sum to an approved provider is treated in the same way as a loan 'purchase' of a retirement village unit, ie as the home of the resident.

12. How should the Concessional Resident Supplement paid by the Federal Government be calculated?

Possible solution: The maximum supplement payment should be calculated as per Question 1.

13. What should the capital income generated be spent on?

Posible solution: On areas of expenditure as set out in the Aged Care Act 1997, ie. retiring debt, meeting capital expenditure, or in the absence of these, to improving the quality of care of residents.

Sources of funds

Consumers

To fund their capital payments, consumers would have available to them the options of:

- selling their home,
- reverse mortgaging their home,
- using or converting assets,
- long term care insurance[13].

Government

Government has the options of funding their capital payments through:

- the tax system with payments from general revenue,
- a hypothecated tax,
- issuing government bonds.

Conclusion

Ensuring that there is adequate capital income available to provide quality buildings to meet the growing demand for residential aged care places is an issue that requires rational debate and discussion at both the political and community level and the generation of a range of solutions. The Alliance anticipates this Discussion Paper will stimulate such discussion, so that solutions can be agreed and implemented.

[13] Options for financing long term care for older people in Australia. A discussion paper prepared by Jan Webster of Webster Associates Pty Ltd for the National Aged Care Alliance. www.naca.asn.au

Attachment A
Accommodation Payments

There are two types of accommodation payments that may be payable in aged care facilities:

- people entering high level care can be asked to pay an accommodation charge, and
- people entering low level care or an 'extra service' place (at high or low level care) may be asked to pay an accommodation bond.

Users of respite care do not have to pay an accommodation payment.

An accommodation bond is like an interest free loan to the aged care facility and most of the bond is refunded when the resident leaves. Providers may keep up to $254.50 a month from the bond for up to five years (called the retention period).

There is no fixed amount for an accommodation bond. The amount is agreed between the resident and the service provider. Accommodation bond amounts can vary widely between residents in an aged care facility as well as between facilities even in the same locality. However, residents cannot be charged an accommodation bond that would leave them with less than two and a half times the pension ($28,500) in assets.

The ways of paying an accommodation bond are by:

- a lump sum,
- a periodic (fortnightly or monthly) payment, or
- a combination of a lump sum and periodic payment.

The resident cannot be required by the service provider to pay the lump sum during the first 6 months following entry, although they can choose to do so.

Accommodation bond lump sums are counted as non-financial assets under the Centrelink and Department of Veterans' Affairs pension asset tests, and no income is deemed from them for either the pension income test or the fees charged for aged care services. The asset value of the accommodation bond is reduced by the retention amount kept by the service provider each year (up to $254.50 a month for up to five years). The way a resident chooses to pay the accommodation bond can have quite different effects on their pension, residential daily care fees and tax liability.

The accommodation charge applies to residents entering an aged care facility to receive high level care with the following exceptions:

- people with less than $28,500 in assets,
- residents receiving care on an extra service basis (who may be asked to pay an accommodation bond even if they need high level care),
- residents who were living in a high care facility on 30 September 1997, even if they have moved to another aged care facility, and
- users of respite care.

The maximum accommodation charge that a resident can be asked to pay is $13.91 per day ($5,077.15 per year). This applies to residents with assets of $53,886 or more at the time of their entry to the facility.

People with assets between $28,500 and $53,886 at the time of their entry to the facility may pay an accommodation charge on a sliding scale, based on the margin of their assets above $28,500. For couples, half the couple's combined assets are counted.

The accommodation charge can only be applied for a maximum of five years. The accommodation charge is calculated on a daily basis and cannot be paid more than a month in advance.

The value of the former home is not counted as an asset for the accommodation bond or charge if, when entering the aged care home:

- a spouse or dependent child is living there,
- a carer eligible for an income support payment has lived there for two years, or
- a close relative who is eligible for an income support payment has been living there for at least five years.

If a resident cannot afford to pay the accommodation bond or charge they will not be asked to do so, but will still get the care they need as all providers must take at least a minimum number of concessional and assisted residents for which they receive extra government payments.

Concessional residents include means-tested pensioners who have not owned their own home in the past two years and who have assets of less than $28,500. Assisted residents must meet the same criteria as concessional residents but can have assets of more than $28,500 and less than $45,500 (http://www.ageing.health.gov.au/publicat/qcoa/16info.htm).

Attachment B
Members of the Aged Care Alliance

The National Aged Care Alliance (the Alliance) is a representative body of peak national organisations in aged care, including consumer groups, providers, unions, and health professionals, working together to determine a more positive future for aged care in Australia. The Alliance was formed in April 2000.

Members of the Alliance

Aged and Community Services Australia

Alzheimer's Australia

Anglicare Australia

Australian Association of Gerontology

Australian Divisions of General Practice

Australian Liquor, Hospitality and Miscellaneous Workers Union

Australian Medical Association

Australian Nursing Federation

Australian Nursing Homes and Extended Care Association

Australian Pensioners and Superannuants Federation

Australian Physiotherapy Association

Australian Society for Geriatric Medicine

Baptist Care Australia

Carers Australia

Catholic Health Australia

COTA National Seniors

Geriaction Inc.

Health Services Union

Lutheran Church of Australia

Pharmacy Guild of Australia

Royal Australian College of General Practitioners

Royal College of Nursing Australia

UnitingCare Australia

Attachment C
Position Statement: Quality Buildings
Endorsed November 2002

It is the position of the National Aged Care Alliance (the Alliance) that:
Quality buildings are essential for quality care.

The Alliance recognises that:

- Residential aged care facilities should be modern, efficient, safe, and sensitive to cultural factors for quality care to be ensured.
- The Government has largely withdrawn from providing capital funds for aged care facilities.
- Providers are increasingly unable to fund the capital costs of providing residential aged care.
- There have been considerable additional capital costs for both new and existing facilities to meet certification requirements.
- Without adequate capital support, facilities will not be built to take up high care places, and some existing facilities will close as they are no longer economically viable:
  the capital cost of restructuring and rebuilding is not sustainable.
- The actual cost of constructing residential aged care facilities is around $100,00–$120,000 per bed, nearly double Government estimates, and even this excludes land cost; professional fees; and loose furniture, fittings and equipment.
- The current accommodation charge and Government subsidies for high care residents do not meet the capital needs of providing and maintaining quality buildings.
- Capital funding needs for high care, dementia specific care, and care in rural areas and areas of particular socio-demographic need must be addressed.
- A better funding environment, which is acceptable to the Australian community, must be available, from a mix of sources including government, to ensure access to quality aged care for those who need it.

The Alliance recommends that:

1. A properly benchmarked care subsidy be developed which includes a capital component and which recognises the real costs of meeting building certification standards.
2. An independent analysis be commissioned by the Government to establish an accurate cost basis for investment to meet certification requirements.