A holistic approach to aged care

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Summary

This is a submission to the Royal Commission into Aged Care Quality and Safety, made on behalf of consumers.

Gray QC has said that a holistic approach to aged care is needed. Principles suggested here for such an approach are

- Quality of care should be measured automatically, allowing prompt intervention
- Quality of life should be measured by annual surveys with large sample sizes
- Action in response to unacceptable quality levels should be prompt and decisive
- All quality and financial data should be publicly available
- Provider subsidies should be set at levels allowing reasonable profits in all regions
- Automated time records could help determine mandated staff levels
- Providers must have financial structures which allow assessment of their financial position
- Regulators should have a range of options to deal with unsatisfactory profitability, liquidity or capital adequacy
- Aged care regulation needs to be underpinned by ongoing research.

To help meet its terms of reference, the Commission could

- Seek evidence on the effectiveness and cost of automated quality of care measurements
- Seek data from the Department of Health on the effectiveness of its financial monitoring and interventions
- Obtain analyses of the relationships between quality and financial data
- Obtain analyses of residential care services changing ownership or ceasing operation
- Obtain case studies of providers with complex financial structures
- Obtain estimates of the subsidies per person needed to provide good care in all regions
- Draft a recommended system intended to provide good care to all
- Obtain projections of the performance and costs of its recommended system, and of the present system.

1. The need for a holistic approach

1.1 Fragmentation and siloed approaches in the Australian Public Service

The Independent Review of the Australian Public Service (Thodey 2019 p50) noted that only 31% of people trust the APS, dropping to 26% in outer regional areas. The review said

"*The APS lacks a clear unified purpose. Fragmentation and siloed approaches have negative impacts*…".

1.2 A case study of siloed approaches to quality and financial issues

In summing up the evidence given in Brisbane to the Royal Commission, Gray QC described facts that had emerged about Earle Haven

- Failure to address complaints about service and staffing levels
- Failure to address communication issues between People Care and HelpStreet
- Failure to obtain prudential compliance information
- Non-response to alarming use of chemical and physical restraints.

"It appears that these four facts were not considered holistically by the Commonwealth regulators at any time before the abrupt cessation of services on 11 July 2019 and that they had no contingency plan to secure the welfare of care recipients at Earle Haven and, in the end, it was left to state emergency services to deal with that event." (9 August 2019 p4799).

1.3 The need for a holistic approach

The Department of Health, and the Aged Care Quality and Safety Commission, have many different responsibilities in aged care, including

- Measuring quality of care and quality of life
- Issuing notices of non-compliance and sanctions where standards are not met
- Removing approved provider status where lesser actions fail
- Determining the structure and level of provider subsidies
- Allocating available places in Aged Care Allocation Rounds
- Obtaining financial information from providers
- Assessing the profitability and financial viability of providers
- Dealing with providers with unsatisfactory financial viability
- Finding alternative places for residents of failing homes
- Making data available to consumers, providers and researchers
- Recommending legislation to the government.

Most of these responsibilities have been treated in isolation, sometimes with poor results for consumers, providers and government finances. A holistic approach, concerned with the whole system rather than individual parts, is needed.

1.4 What would a holistic approach to aged care look like?

- Ensuring good quality of care for all would remain the primary goal

- Reliable data on the quality of care from individual providers would be automatically available, allowing rapid responses to emerging problems
- Government staff with aged care responsibilities would work together
- Data would be shared between government staff, and with the public
- All available data would be used, and better data obtained as feasible
- Ongoing research would improve care and help ensure good use of government funds.

1.5 Why has it taken so long to address known problems?

In his closing submission on 9 August 2019, Gray QC said

"Government has been unable to deal with the challenge posed by the need for reform or at least to do so promptly. Critical reform tasks have been outsourced to consultants and appear to be mired in protracted and multi-staged industry consultation processes." (p4798)

There are major failings in the Department of Health's use of consultants, and in its consultation processes. But an underlying problem has been the lack of useful data about quality of care, and about the finances of providers. This has had grave consequences for the Department's ability to control individual providers. Staff morale has suffered as a result. The lack of data also greatly hampers the Department's ability to give useful advice to government.

1.6 Using the data now available

This submission suggests new ways to automatically collect and analyse data on quality of care. This will take time and capital investment, and new data may only become available progressively. In the meantime, all the financial and quality data now held by the Department should be analysed and used. Ways to do this are suggested at the end of this submission.

2. Quality of care should be measured automatically

2.1 Existing quality measures

Notices of non-compliance per provider have been about 1.8 times higher for for-profit providers compared with not-for-profit. Sanctions per provider have been about 2.8 times higher. Complaint numbers per place from for-profit prover have been about 1.8 times higher those from not-for profit providers (Cumpston & Bail 2019). For-profit residents are about 17% less likely to report positive responses to consumer experience surveys (Cumpston 2019).

While all this suggests that many for-profit providers are providing low quality of care, there is no current way to prove unacceptable quality of care by any one provider. Without such a way, ensuring acceptable quality of care by every provider is impossible.

Three quality of care measures became mandatory on 1 July 2019, but have been criticized as costly, vulnerable to fraud and of little value (Cumpston, Sarjeant and Service 2019).

2.2 Use of automated quality measures to help residents and regulators

Inquiries to ACSA and LASA, and to several suppliers of equipment to aged care homes, suggest that there is little use of automated quality of care measurements by Australian aged care homes. There are however many monitoring devices which could be adapted for aged care monitoring and quality reporting.

Making automated quality of care mandatory for all providers would have substantial advantages. The large numbers of sensors and monitoring systems needed would allow them to bought by the regulatory authority cost-effectively. Where the data for a resident indicated a need for help, the provider would be alerted by the monitoring system.

The very large volumes of data available from all providers would allow complex analyses and statistically valid conclusions. This would allow multi-staged interventions by the regulatory authority. If court proceedings ever became necessary, then strong evidence would exist on failings to give appropriate care to individual residents, and on the overall quality of care provided relative to that by all other providers.

The high levels of physical restraints found at Earle Haven could have been detected by automatic monitors, and the high levels of psychotropics could have been detected by an automatic recording system for all prescription drugs.

2.3 Use of weight as an example of an automated quality of care measure

Weight loss soon after entry to residential care may be a symptom of inappropriate food, poor feeding regimes or psychological distress. Weight gain after entry may also be a symptom of inappropriate food. Automatic measurement of weight each night could quickly alert providers to particular residents needing help. Automated analysis of weight data from each resident would allow regulators to identify homes with unsatisfactory food or feeding regimes.

It is not clear how best to obtain weight measures automatically. One possibility would be to fit a weight sensor to each leg of a bed, connected by a transponder to the monitoring system at the home, and then by the internet to the regulator. While this would involve capital costs, it would avoid the labour costs of manual measurement and reporting. Weight sensors would also provide measurements of activity by sleeping residents, helping detect those made comatose by excessive drug use.

Beds with weight monitors are readily available as hospital beds, but are probably not yet in use in Australian aged care homes. One supplier estimates that adding weight-monitoring and read-out facilities to a new bed might add $800 to $1000 to the bed cost. Retro-fitting weight-monitoring to existing beds might be costly, depending on the bed design.

2.4 Automated time records could help determine mandated staff levels

Requiring all residential care staff to clock on and clock off in a system recording their skill levels would allow analyses of the relationships between quality and staff levels. This would allow mandatory staff levels to be reasonably determined, taking into account resident care needs. For example, residents with dementia may need different patterns of staff skills and availability. To allow useful analyses of automated time records, the diagnoses and care needs of each resident would have to be computer recorded. This is only partially done under the present Aged Care Funding Instrument (ACFI) system for determining the

subsidies for each permanent resident, and it is not clear if it would occur under the system proposed by Edgar, McNamee, Gordon et al (2019).

2.5 Automated quality of care measurements could help determine the need for financial interventions

Given automated quality of care data, analyses could be made of the relationships between quality and financial data. These analyses would allow interventions when liquidity or capital adequacy were inadequate, and help determine legislative requirements.

2.6 Value of automated quality measurements may be restricted by privacy issues

Under the three mandated quality of care measures introduced on 1 July 2019, resident consent is required. This provides a loophole for recalcitrant providers to avoid scrutiny. Under the ACFI system, detailed information on medical conditions and care needs have been recorded for each permanent resident since March 2008.

Aged care recipients are vulnerable persons, whose needs are largely being met by Australian government funds. Should legislation allow sharing of some their data, to help provide better care to them?

3. All quality and financial data should be publicly available

3.1 Why is transparency important?

The Commission has proposed that the aged care system be transparent (Consultation Paper December 2019). For consumers, transparency is particularly important when choosing a residential care home. Moves over long distances, and payments of large sums, are often involved. If the quality of the home proves inadequate, or if it collapses financially, it may be difficult to recover bond payments and change providers.

3.2 Providers must have financial structures which allow assessment of their financial position

In a February 2019 discussion paper on managing prudential risk, the Department gave several examples of insufficient transparency in reporting. Some of the issues were outdated information, unit trusts, trustee companies and related parties. Lack of transparency makes it impossible to assess the liquidity and capital adequacy of a provider. Lack of transparency also makes it impossible to assess the true profitability of aged care operations, so that the Commonwealth cannot determine appropriate subsidies. Some structures may make it difficult to recover accommodation deposits if a provider collapses. Present structures should be examined, and structural requirements introduced if necessary.

3.3 Current limitations on public access to financial data

Access to financial data is currently limited to prospective care recipients. Under section 58 of the Fees and Payments Principles 2014, the provider of an aged care service is required to supply the most recent statement of their audited accounts, on request from a prospective residential care recipient. If the service is operated as part of a broader organisation, the

provider must supply the most recent audited accounts of the organisation's aged care component.

A request on 9 February 2018 to the 8 largest for-profit providers (excluding the 3 listed providers) showed that only one was willing to provide these audited accounts for research purposes. One provider was only willing to supply its accounts to a person already approved for residential care. The objectives of section 58 would be better met by making all provider financial data publicly available

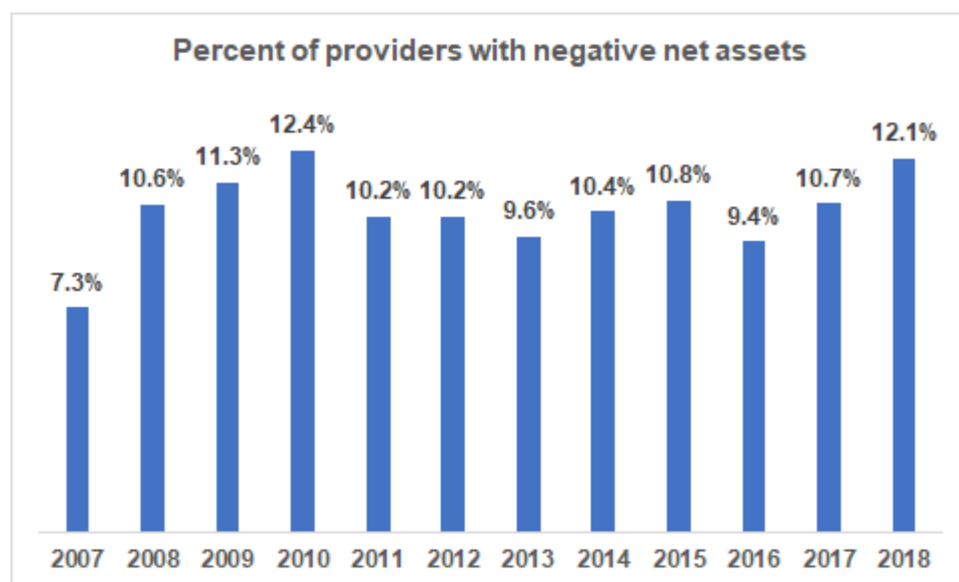
3.4 Making provider information available to the public

The financial information the Department receives from each provider is not available to the public. This contrast strongly with life and general insurance, where the Australian Prudential Regulatory Authority publishes quarterly financial data for each insurer, together with the extent that the insurer meets capital adequacy requirements. Financial data and adequacy ratios for each aged care provider should be published on MyAgedCare, together with details of financial structures. The same information should be available on the aged care website of the Australian Institute of Health and Welfare, to help independent research.

Consumers selecting an aged care provider are making an important choice, and should have all the financial and quality information available. The slow disintegration of the Cambridge Aged Care Group (see 8.5) was one case where the Department did not act promptly to correct problems. Consumers, especially those with well-informed advisors, may be able to make good choices even if the Department has not yet acted.

4. Financial health of residential aged care providers

4.1 Providers with negative net assets



Confidentialised general purpose financial report data for each provider, and aged care financial reports, were published by the Department from 2006-07 to 2014-15, and for 2015-

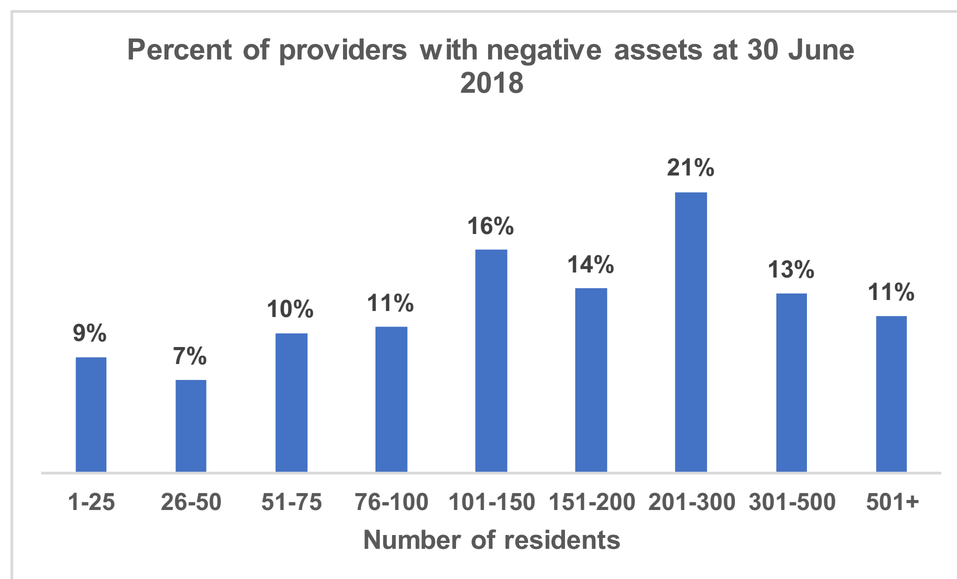
16 to 2017-18 were obtained through Freedom of Information requests. The numbers in the above chart were calculated from aged care financial reports.

The chart shows the percentages of providers with negative net assets in their aged care financial report balance sheets. The percent with negative net assets rose from 7.3% at 30 June 2007 to 12.4% at 30 June 2010, and remained at about 10% from 2011 from 2017. The rise to 12.1% at 30 June 2018 may reflect the increasing financial pressures providers have been reporting.

About 12% of residential care providers had negative net assets at 30 June 2018. Overall, for-profit providers have much higher ratios of debts to net assets than not-for-profits. Reserve Bank of Australia research shows that failure risks increase strongly as debts to net assets increase.

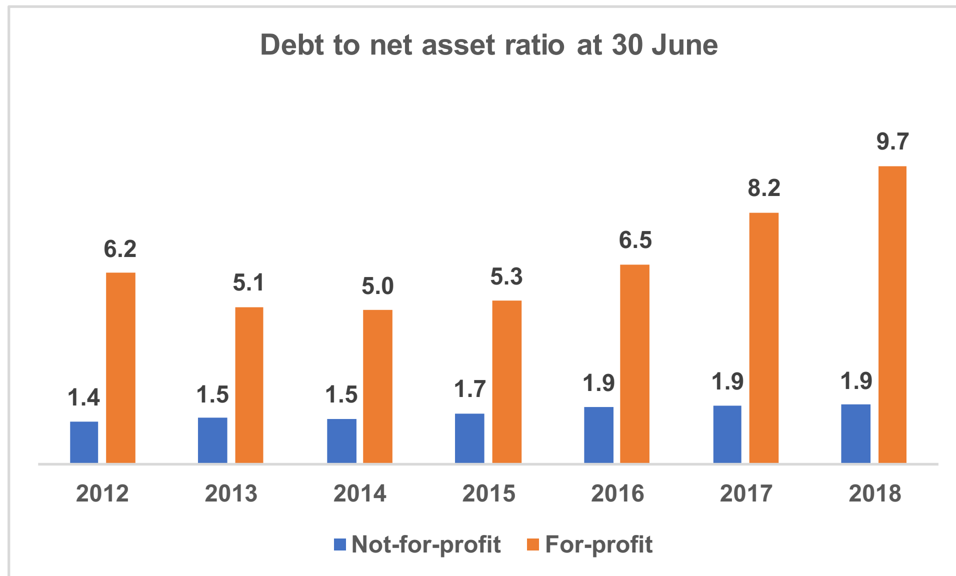
It is not clear how providers with negative net assets were able to continue operating. Were they not-for-profit or government, with the Department of Health willing to accept a guarantee from a parent organisation? Was the Department aware of significant undervaluation resulting from the use of historic asset values? Did the Department consider that some of these providers were providing services that would not otherwise be available to their communities?

4.2 Small providers are least likely to have negative assets



One suggestion is that the Department imposes less strict financial requirements on providers in regional and remote areas, taking into account the important of aged care services in these areas. But the above table shows that at 30 June 2018 it was the medium sided providers (100 to 300 residents) who most often had negative assets. Providers with up to 50 residents were least likely to have negative assets, and 68% of these are classed by Health as “regional”.

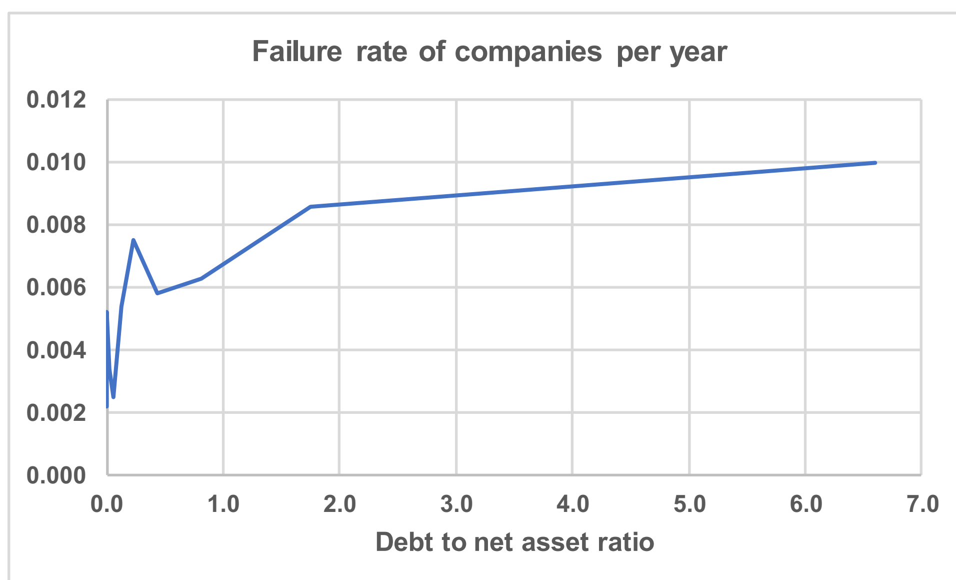
4.3 Debt to net asset ratios at 30 June



The above ratios are from data published by the Aged Care Financing Authority in its annual reports on the funding and financing of the aged care industry (ACFA 2019). The debt to net asset ratio of for-profit providers has risen sharply, from 5.0 at 30 June 2014 to 9.7 at 2018. The ratio for not-for-profit providers (excluding government) has also risen, from 1.5 to 1.9.

The rapidly rising debt to net assets ratios of for-profit providers are alarming, as they suggest there are increasing risks that a large provider will fail. Evidence to the Senate committee hearing on the tax practices of for-profit providers showed that some of the largest providers have complex structures, often involving overseas bodies, and are thinly capitalized (Ward 2018).

4.4 Failure rates of companies



The above failure rates were estimated from data for Australian companies from 2000 to 2015, from Kenny, La Cava and Rodgers [11]. They suggest that not-for-profit providers, with a debt to net asset ratio of 1.9, may have a failure rate of about 0.8% a year. For-profit providers, with a ratio of 9.7, may have a failure rate of about 1.1% a year.

5. Financial risk assessments of providers

5.1 Risk assessments by the Department of Health

A 2017 report by the Aged Care Financing Authority (p43-44) shows that the Department of Health has been undertaking financial risk assessments of approved providers since September 2010.

The Department uses General Purpose Financial Report data to identify providers that are at the highest risk of financial failure or potentially under financial distress. and to prioritise its risk management and compliance investigation activity. Some of the data taken into account are

- Profit margin
- Equity per place
- Ratio of short-term assets to short-term liabilities
- Ratio of shareholder assets to refundable deposit liability
- Longitudinal tracking of approved provider's performance year-to-year.

"The Department works with both its central and State offices in managing identified risks. This can include further detailed assessment and analysis in conjunction with regular meetings with the approved provider to address and remedy the situation."

5.2 Actions taken when a provider may trigger the guarantee scheme

If the Department becomes aware that a provider has an elevated risk of insolvency, a series of coordinated actions involving both its central and State office-based teams follow. Those actions involve a mix of formal notices such as the Notice of Non-Compliance, and meetings to fully appraise a provider of their responsibilities. [ACFA 2017, p51-52]

"Where necessary, the Department will assist the provider to source alternate care for residents. The Department may also identify other providers that may be interested in acquisition and facilitate discussions between the parties."

6. Claims on the guarantee scheme

6.1 Guarantee scheme refunds

The Accommodation Payment Guarantee Scheme has existed since 2006 to refund accommodation bonds to residents of homes in liquidation. About $44m has been paid to date, resulting from the failure of 11 small for-profit providers. A claim resulting from the failure of a for-profit provider with $130m of bonds seems likely, along with at least one claim from the failure of smaller providers. Failure of a large provider could involve 7,000 residents and bonds of $1,000m. The greater availability of home care since 2017 may be increasing the risks of large claims on the guarantee scheme.

6.2 Provider failures leading to guarantee scheme refunds

Provider	Entered liquidation	Places	Location	State	Amount refunded $m	Modified Monash Code
Lifestyle Care Providers Pty Ltd	14/1/008	38	Carrara	Qld	0.6	1
Vitality Care Commissioning Pty Ltd	5/11/08	102	Roxburgh Park	Vic	8.4	1
Kendalle Pty Ltd	11/6/09	62	Ringwood North	Vic	9.8	1
Drysdale Aged Care Hostel Pty Ltd	25/11/09	50	Drysdale	Vic	2.8	2
Hirange Management Pty Ltd	24/12/09	38	Berwick	Vic	2.9	1
Viva Care Pty Ltd	27/11/13	60	Essendon	Vic	5.1	1
De Ryan Pty Ltd	14/11/13	60	Brunswick West	Vic	2.3	1
Nepean Hospitals Pty Ltd	11/4/14	46	Bendigo	Vic	3.5	2
Nepean Hospitals Pty Ltd	11/4/14	125	Safety Beach	Vic	7.3	1
Kalinda Craft Pty Ltd	3/2/16	60	Greensborough	Vic	0.1	1
D&R Community Services Pty Ltd	7//6/16	12	Collinsville	Qld	0.2	6
Total		**653**			**43.0**	

The above details are from the Aged Care Financing Authority (2017 p57-58). It is not clear if there have been any claims on the guarantee scheme, other than those in the table. All the 10 provider failures were of for-profit providers, and 9 of the 11 homes were in Victoria.

Note 27 of the Department of Health's annual report for 2018-19 says

"*Since the Guarantee Scheme was introduced, it has been activated 11 times, requiring payment of $43.6m.*" (2019c p250)

This suggests that another small provider has activated the scheme since the above table was published. Note 27 continues

"The Guarantee Scheme was not activated during the period ended 30 June 2019; however, the Department is aware of the potential for it to be activated in respect of one provider currently in administration. The quantum of potential refunds cannot be estimated at this stage, but the total value of accommodation bonds held by the affected provider is estimated as $130m."

Claims on the guarantee scheme may result from the move into voluntary administration on 4 July 2019 of Berrington Care, a for-profit group with 211 approved places (see 8.9). Claims may also result from the closure on 10 February 2020 of a home operated by Murchison Community Care Inc, a not-for-profit with 30 beds and about $3m in deposits (see 8.8).

The Secretariat of the Aged Care Financing Authority advised on February 10 2020 that the closure of Earle Haven in July 2019 is unlikely to result in any claims on the guarantee scheme.

6.3 Prompt repayments of bonds and residential accommodation deposits

"…in the event that a consumer has difficulty in recovering a lump sum accommodation deposit, they have rights to undertake legal proceedings against the provider to recover those funds … The options available … may include bringing an action against the provider under contract law…Where the provider is a corporation ... the consumer could issue a

statutory demand to the provider … Exercising this kind of recourse may impose a cost on the consumer in terms of legal advice and fees.” (ACFA 2017 p43)

If a provider is determined to delay a refund, the consumer may not be able to afford a court battle. A resident may need the refund urgently, to help move to a resident care facility better moving their needs.

“There may be a considerable interval during which the resident, estate or government seek retrieval of the funds before a formal insolvency event … ACFA recognises that in some cases there may be protracted delay in the refund of an accommodation payment” (ACFA 2017 p59)

“The legally prescribed conditions for the triggering of the refund scheme were not adequate to address a case where a rogue operator resisted declaration of insolvency. This resulted in a situation where residents and their families were in a stressful state of uncertainty for several months until one of them, independently of the Department, brought on a successful insolvency action through the courts.” (Council on the Ageing ACT 2017 p10)

A system is needed to help residents obtain overdue refunds, well before the guarantee scheme is formally triggered. This would involve the Department paying all refunds overdue for more than a short period, and seeking repayments and penalties from the providers. This would help the Department monitor the performance of providers, and take prompt corrective action. It would also help identify legislative gaps. For example, where a deposit has been paid by persons other than the resident, can this be refunded directly to the payers when the resident dies?

To allow the Department to ensure that all deposits are promptly repaid, providers should be required to notify the Department immediately of any deposit payments, notices of departure, departures, probate or letters of administration, and deposit repayments.

6.4 The 20 largest providers at 30 June 2019

Type	Provider	Homes	Places
Private Incorporated Body	Bupa Aged Care Australia Pty Ltd	72	7363
Private Incorporated Body	Estia Investments Pty Ltd	68	6142
Private Incorporated Body	Regis Aged Care Pty Ltd	50	5733
Religious	The Uniting Church in Australia Property Trust (NSW)	73	5322
Private Incorporated Body	DPG Services Pty Ltd	51	5085
Religious	The Uniting Church in Australia Property Trust (Q.)	62	4556
Private Incorporated Body	Japara Aged Care Services Pty Ltd	48	4340
Private Incorporated Body	Allity Pty Ltd	45	4037
Private Incorporated Body	Arcare Pty Ltd	35	3318
Charitable	Catholic Healthcare Limited	40	2668
Charitable	Mercy Aged and Community Care Ltd	32	2615
Charitable	RSL Care RDNS Limited	26	2510
Religious	Anglican Community Services	22	2364
Community Based	RSL LifeCare Limited	27	2302
Religious	Churches of Christ in Queensland	28	2105
Community Based	Illawarra Retirement Trust	23	2000
Private Incorporated Body	McKenzie Aged Care Group Pty Ltd	17	1889
Religious	Southern Cross Care (NSW & ACT) Limited	32	1872
Private Incorporated Body	Aegis Aged Care Group Pty Ltd	19	1830
Charitable	BaptistCare NSW & ACT	17	1807
Total for 20 largest providers		787	69858
Total for all provides		2718	213397
20 largest providers as %		29%	33%

6.5 Contingency plans for residents of failing providers

At 30 June 2019 there were 16 providers with 2000 or more places, with the two largest each having about 7000 places (Regis Aged Care Pty Ltd had another 1347 places through Regis Group Pty Ltd). Larger groups tend to have higher debt-to-asset ratios and more complex structures, and may thus have higher failure rates. Assuming a 1% failure rate for these 16 providers suggests that about 16/100 will fail on average each year, so that there may be a large failure about every six years. The ready resale market for providers in city or near-city regions may have prevented a large failure to date. There needs to be a process to ensure continuing care for the residents if a group with 7000 residents collapses.

An industry consortium, formed by Mission Australia, the Benevolent Society, the Brotherhood of St Laurence and Social Ventures Australia, took over 570 ABC Learning Centres after the company went into receivership in November 2008 (Wikipedia 19/6/18). A similar industry consortium may be needed to provide continuing care when a large provider collapses.

6.6 Protracted reviews of guarantee scheme and prudential supervision

With the help of various consultants, the Department has been reviewing the guarantee scheme and prudential supervision (PwC 2016, EY 2017, StewartBrown 2017, Deloitte 2019). Only the EY report of 2017 has so far been made public, and the StewartBrown report has been obtained in redacted form. No suggestions appear to have been made about reducing repayment delays before or after providers fail. From what has been made public, no link has been made between quality and finances. No link appears to have been made between inadequate subsides and eventual failure. Little has been suggested about actions the Department can take when providers are at risk of failing.

7. Aged care regulation needs to be underpinned by ongoing research

7.1 Computer-analysable data to allow independent research

Release of financial and quality data, in computer-analysable form, would allow independent research. While the consumer experience reports are available on MyAgedCare as bar charts, it took an FOI request to obtain the data in spreadsheet form. Aged people have many different needs for care, and live in very different locations. There are continuing needs to respond to new problems, and no simple solutions. Independent research should be seen as a vital supplement to regulatory control.

7.2 Better consultation processes

The consultation processes of the Department of Health seem intended to protect the Department, rather than to seek genuine solutions. Consultations should be based on substantial research papers, describing existing problems and possible solutions. Unlike the effective consultation process of the Productivity Commission, submissions are not made public as received (the recent ACAR consultation being a welcome exception). Where published, summaries omit most the key details underling participant views.

7.3 Lack of independent review of research sponsored by the Department

Edgar, McNamee, Gordon et al (2019) made some valuable measurements of the staff times needed to care for persons in residential care. But their data were not made available for independent analysis, and the reasons for their choice of model structure were not made clear. It is possible that nursing homes will be reluctant to admit persons with conditions (such as dementia) not represented at high levels in their categorical model.

8. Case studies

8.1 List of case studies

Selected case studies, based on providers who failures have led to claims on the guarantee scheme, or which may lead to such claims, follow. They are for

- Lifestyle Care Providers Pty Ltd
- Kendalle Pty Ltd
- Hirange Management Pty Ltd
- Cambridge Aged Care Group
- De' Ryan Pty Ltd
- D&R Community Services Pty Ltd
- Murchison Community Care Inc
- Berrington Care Group Pty Ltd

Given the extreme events needed for guarantee fund claims to arise, this is a very skewed selection of cases. More representative case studies are needed.

8.2 Lifestyle Care Providers Pty Ltd

Lifestyle Care Providers Pty Ltd received a sanction on 20 July 2007 for “immediate and severe risk”. The sanction expired on 28 September 2007, and the company entered liquidation on 14 January 2008.

8.3 Kendalle Pty Ltd

Kendalle Pty Ltd received notices of non-compliance on 26 February 2009 and 6 April 2009 for Gracedale Manor, which led to 54 deposits being refunded by the guarantee scheme. Kendalle Pty Ltd also received notices on non-compliance in April 2009 for the Grandview Gardens Aged Care Facility and for Yarra West Aged Care, both of which had new operators in the 30 June 2009 service list. Kendalle Pty Ltd had also received a sanction on 4 March 2009 for “immediate and severe risk” at Grandview Gardens. Kendalle Pty Ltd entered liquidation on 11 June 2009.

8.4 Hirange Management Pty Ltd

Hirange Management Pty Ltd received a notice of non-compliance for Berwick Village Supportive Care Home on 11 November 2009, and entered into liquidation on 24 December 2012. It does not appear to have operated any other aged care homes.

8.5 Cambridge Aged Care Group

The Aged Care Financing Authority (2017 p58) noted that four of the homes which resulted in guarantee scheme refunds were operated by the Cambridge Aged Care Group, under three different provider names - Viva Care Pty Ltd, Nepean Hospitals Pty Ltd and Kalinda Craft Pty Ltd. Woodhaven Lodge, which faced collapse (Stephen Drill Herald Sun 10 February 2013), was operated by Cambridge Croydon Pty Ltd, part of the Cambridge Aged Care Group. This fifth home does not seem to have led to any guarantee scheme refunds.

An application for a winding up order of Viva Care Pty Ltd was filed on 24 October 2013 by James Yelland (a relative of a resident), and Viva Care Pty Ltd entered liquidation on 27 October 2013. Nepean Hospitals Pty Ltd entered liquidation on 11 April 2014, and Kalinda Craft Pty Ltd on 3 February 2016.

A Herald Sun article by Stephen Drill on 24 March 2013 notes that

"Westpac is suing the Berkeley Living Group and Mr Snowden for more than $7 million in unreturned money that the bank claims was taken through the electronic funds transfer scheme.

An affidavit from chartered accountant Mathew Campbell Muldoon states that his investigation into the group's financial activity found that "at least $795,167.89 of the missing funds was used to purchase … Woodhaven Lodge, located in Croydon", and "at least $2,750,000 of the missing funds … was used to purchase Rosewood Mews, located in Greensborough",

Mr Snowden was in charge of Berkeley Living Group and now owns the Cambridge Aged Care Group, which includes Woodhaven Lodge and Rosewood Mews…

The Health Department has been investigating Cambridge Aged Care Group for more than 12 months."

A Herald Sun article by Stephen Drill on 24 October 2013 notes that

"*Stephen George Snowden, 47, appeared in the Melbourne Magistrates Court on seven charges this morning.*

The charges included obtaining financial advantage by deception, providing false documents and being a disqualified person running a nursing home.

…The seven charges that were to be heard in the committal hearing relate to the Dawnsville nursing home … now closed.

…All the instances of bounced cheques or failed direct deposits occurred in November 2010.

Snowden is also accused of producing a false document to the Health Department."

8.6 De' Ryan Pty Ltd

De’ Ryan Pty Ltd received notices of non-compliance for Brunswick Manor on 11 January 2013 and 30 October 2013. They received a sanction for “immediate and severe risk” on 9 July 2013, and entered liquidation on 14 November 2013. They are shown as the operators of Brunswick Manor on service lists from 30 June 2005 to 2013.

8.7 D&R Community Services Pty Ltd

Hillside Havens Care Facility is shown on 30 June services lists as operated by Collinsville Aged Assistance Association Inc from 2003 to 2012, and by D&R Community Services Pty Ltd from 2013 to 2015. No notices of non-compliance or sanctions are recorded. D&R Community Services Pty entered liquidation on 7 June 2016. Collinsville is in the Whitsundays, 1205 kms north of Brisbane, with a population of 1501 in 2011.

8.8 Murchison Community Care Inc

Murchison Community Care Inc has operated a 30-bed nursing home since at least 2003. Murchison is beside the Goulburn River, 176 kms from Melbourne, with a population of 925 in 2016. The nursing home received a notice of non-compliance in 2009, but has had no subsequent notices or sanctions. It made a loss of $248,000 in 16-17, and a loss of $449,000 in 17-18. At 30 June 2018 there were $2.965m of bonds, and net assets of $4.216m, including $2.4m for bed licences.

After the nursing home went into liquidation in November 2019, the Commonwealth government gave a $400,000 grant to the administrators. The residents were relocated, with the home shutting its doors in February 2020 (Sarah Martin, The Guardian, 17 February 2020).

“Senator Colbeck said that the government had agreed to provide for administrators costs, estimated to be about $500,000, while negotiating with potential buyers to reopen the facility.

He said that the government recently announced a $50m Business Investment Fund to provide ‘tailored support to eligible providers grappling with financial issues in the future’.

A spokeswoman for the SV Partners insolvency firm, who took control of the property last year, told the Australian they were ‘making every effort to assist in assessing all potential avenues to maximise the likelihood of DP Jones facility reopening’.” (Geoff Chambers, The Australian, 27 February 2020).

8.9 Berrington Care Group Pty Ltd

Berrington Subiaco, at 45 Bishop Street Jolimont, has 112 beds, and was on the 2013 to 2019 service lists. Jolimont is 5 kms west of Perth. MyAgedCare shows a notice of non-compliance on 13 February 2019 for "2.10 Nutrition and Hydration", now resolved.

Berrington Como, at 30 McNabb Loop Como, has 99 beds, and was on the 2018 and 2019 service lists. Como is 9 kms south of Perth.

Barrington Subiaco charged a maximum refundable accommodation deposit of $1.25m - the most expensive in Perth. Barrington Como charged a maximum of $0.895m.

Berrington Care Group Pty Ltd and Berrington Group Pty Ltd went into voluntary administration on 4 July 2019, apparently because they were unable to repay a loan. On 5 December 2019 the two companies entered into a business agreement with the Bethanie Group for Bethanie to acquire Berrington Como and Berrington Subiaco, and take over the bond liabilities. The sale will not become effective until at least the second creditors meeting, which currently is due by 14 April 2020.

It has been suggested that this series of events will lead to payments from the guarantee fund of the order of $30m. This seems a credible estimate.

9. Steps the Commission could take to help meet its terms of reference

9.1 Seek evidence on the effectiveness and cost of automated quality of care measurements

The Commission is required to inquire into "the causes of any systemic failures, and any actions that should be taken in response".

Technology is available to automatically report (for example) weight, activity, falls, heart rates and physical restraints. Such measurements could help providers respond immediately to care recipient needs, as well as help regulators. Suppliers of such technology could be asked about feasibility in residential and home care, and about likely costs if made mandatory. Aged care researchers could be asked about any studies that have been made about effectiveness. Aged care regulators in other countries could be asked about any investigations they have made of automated quality measurements.

Prescriptions made under the Pharmaceutical Benefits Scheme are centrally recorded. Evidence could be sought on the feasibly of providing details of each care recipient's prescriptions to care providers and regulators. Evidence could be sought on automated techniques to detect inappropriate drug combinations for individuals, and on ways of using prescription data to detect over-reliance on drugs by care providers. Evidence could be sought on the availability and potential uses of pathology test results, such as the HbA1c test for diabetics.

Automated quality of care systems may require substantial capital expenditure, both for individual measuring devices and transmission to regulator and provider data systems. Data analysis systems will also require initial expenditure. The Commission is required to inquire into "how best to deliver aged care … through … increased use of technology, and investment in … capital infrastructure."

9.2 Seek data from the Department of Health on the effectiveness of its financial monitoring and interventions

There have been remarkably few provider failures leading to claims on the guarantee scheme. One possibility is that restrictions on place numbers and strong demand have resulted in many failing providers being taken over by providers with access to capital. But the Department's prudential monitoring and intervention may have been the major reason for the very low numbers of claims on the guarantee scheme.

The Department could be asked for data on its financial monitoring and interventions, including case studies where interventions have succeeded. This might be a welcome change to being cross-examined about failures.

9.3 Obtain analyses of the relationships between quality and financial data

Data for each residential care service are publicly available on sanctions since July 2002, notices of non-compliance since January 2009, and consumer experience reports since May 2017. Complaints have been computer recorded since at least July 2016, but are not available by provider. Service lists show the provider for each service each June from 2003 on.

General purpose financial reports and aged care financial reports have been required from each provider from 2006-07, but have only been made available to a few consultants advising the Department on the management of prudential risk.

The Commission should obtain all the quality data with services identified, and all the financial data with providers identified. This would allow it to obtain exploratory analyses of the relationships between quality and financial data.

Are there any significant relationships between quality and profitability, liquidity and capital adequacy? If so, this might help regulators decide when to intervene when a provider's financial position deteriorates. Any such relationships would help determine legislative requirements for solvency and capital adequacy.

9.4 Obtain analyses of residential care services changing ownership or ceasing operation

Service lists show the name of each aged care home, and the provider, at each 30 June from 2003 on. The Commission should obtain analyses of services that have changed ownership or ceased operation, and the possible reasons for the changes. Ownership changes may reflect unsatisfactory financial results or regulatory actions. Cessation of operation may also reflect obsolete premises, or more valuable uses for the land.

Such analyses could be useful background when suggesting intervention procedures. Is a buyer likely to found for services with a financially distressed provider? Can the land value of a service, and the existence of alternative services, allow it to be closed? Do the data show any recent changes, possibly reflecting the greater availability of home care?

9.5 Obtain case studies of providers with complex financial structures

Case studies should be prepared of selected for-profit and not-for-profit providers with complex financial structures. Can profitability from aged care be determined for these providers? Are there many aspects of the provider and its associated organisations which might lead to financial collapse, or make resident funds difficult to recover if collapse did occur? Should structural changes be required so that approved provider status can be retained?

9.6 Obtain estimates of the subsidies per person needed to provide reasonable care at different geographic locations

McNamee, Kobel & Rankin (2019) found that small regional homes have higher overheads per resident, and have suggested that they receive a higher subsidy per resident to compensate. Small regional facilities can be important employment centres for their communities, and meet the frequent need of residents to be close to their families. Consumer experience reports have shown higher satisfaction levels for small regional homes.

Under the present ACFI subsidy system, homes receive no extra subsidy per resident because of their size or location. The Commission should obtain estimates of the subsidy per person needed to provide reasonable care in all regions.

9.7 Draft a recommended system intended to provide reasonable care to all

The Commission's final report will presumably contain a recommended aged system, together with performance and cost projections. But well before the completion of the final report, projections should be obtained for a draft recommended system. Such estimates are likely to affect the design of the final recommended system. They are also likely to affect the performance criteria under which the final system is evaluated.

9.8 Obtain projections of the performance and costs of its recommended system, and of the present system

Performance and cost projections for the recommended system are likely to be a part of the final report. One aspect of performance could be the availability of care services in regional, rural and remote areas.

Projections should be for 15 to 20 years. A person entering residential care will on average be there for about 3 years. The average life of a residential care home may only be about 20 years. Small-area population projections are only available from the Australian Bureau of Statistics for about 15 years.

Glossary

ACFA	Aged Care Financing Authority
ACFI	Aged Care Funding Instrument
ACSA	Aged and Community Services Australia
LASA	Leading Age Services Australia

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