Submission to the Senate Inquiry into Residential Aged Care in Australia

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1. INTRODUCTION

We thank you for this belated opportunity to provide a submission to the Senate Inquiry into Residential Aged Care in Australia.

KGA Consulting Group is a small boutique organisation established in late 2004 to provide business consulting support to aged and community care providers, primarily in Western Australia. Prior to setting this business up, I was Director, Corporate Services with Brightwater Care Group which, prior to my departure was the largest provider of residential aged care within Western Australia and widely recognised as an innovative service provider.

With a background in accounting, my natural focus was to help guide providers to achieve their strategies through the identification of best practice in formulating development strategies, application of sound business development methodologies and application of efficiency improvement processes to identify and move Providers closer to achieving good financial performance.

To this end we have worked with the benchmark data provided by Stewart Brown, as being the best we feel available to the sector, together with data assimilated from our own client base with the view of identifying where a facility should be performing and the actions required to move them to that level.

The difference between our approach and that of the Accounting Firms is that we work at Facility Level and with Facility staff and often uncover performance issues and improvement opportunities that cannot be gleaned from the numbers alone. The opportunity for this improvement is often unknown by the Providers themselves who do not always get down to this level of detail and therefore assume, given what is being said across the sector that it is a general malaise that is affecting their performance rather than a series of issues many of which can be addressed by the Providers themselves.

I have been told by some CEOs that I am a lone voice in this regard and by one that no-one wants to hear what I have to say, I think primarily because of the general view it is an industry wide funding problem that Government needs to address

It is the reliance of many who have submitted to the Inquiry on this benchmark data that has prompted me to prepare this late submission. This is not to say, however, that there are not issues in the planning and funding of aged care that need to be recognised and addressed but these are specific not general in nature.

2. BENCHMARK ANALYSIS

Our view on assessing benchmark data is that it is a guide to performance improvement and many who submit their data for benchmark purposes do so as they believe there are opportunities to improve their own performance. The performance of those assessed in the various benchmark processes is not, therefore entirely representative of the overall performance of the sector.

Currently there are around 175,000 residential care beds throughout Australia with Stewart Brown sampling 23,748 (13.6%) beds across 375 facilities, an average size of 63.3 beds per facility, while Grant Thornton's Report sampled 686 facilities so, on a similar ratio might have covered 43,433 beds (24.8%).

From this data, in particular that produced by Stewart Brown, 63 of the 282 facilities (22.3%) were achieving a negative earnings figure (EBITDA) while 162 of the 282

facilities were achieving an Operating Loss (57.4%) indicating many were using their capital income, from Accommodation Bonds and Accommodation Charges as well as Concessional Income to support their operations.

Certainly this figure has been deteriorating over the years. To address this, we believe consideration has to be given to the care model required in residential care facilities and the efficiency of Providers when delivering this care. Thus we will identify where the true issues in funding residential aged care lie.

3. RESIDENTIAL CARE MODELS

3.1 The Australian Residential Care Model

Residential Aged Care has developed since the early 1990s in a way that has de-institutionalised Australian care facilities and resulted in the introduction of more homelike environments for residents. Newer facilities have been developed with much better facilities and furnishing than the older hospital based model although, arguably, as they grow in size, they tend to be losing that homeliness that was a distinct feature of the 1990s "cluster" design.

Most providers who have developed the newer accommodation have done so to meet the changing expectation of resident's families who wanted a facility they would feel happy to put their mum or dad in. This development, while creating an expectation in the eyes of the client was not supported by additional funding from either client or Commonwealth.

In developing the future "Care Model" for residential aged care in Australia, one must first consider whether this model developed over time is still appropriate and if so determine the level of care that should be provided within these facilities. There are, not surprisingly, differing points of view.

In de-institutionalising the physical infrastructure, we have failed to de-institutionalise the mindset of many working within aged care and, as a result, the clinical models from the hospital era are still prevalent in many of our facilities and indeed across organisations.

The Americans developed a concept called the Eden Alternative which went some way to soften the concept of facility design but failed to address this clinical (institutional) regime. This process, in Australia, is known as Eden in Oz and while a number of Providers are members, the concepts have been adopted by many.

A new program, stemming from the same Gerontologist, called the Green House Project, has moved to address this institutional culture, and attempt to create a carer driven culture as would be found in the home, by separating the clinical role from personal care. Carers have far more say in the wellbeing of residents and clinical staff ensuring quality of care and clinical activities are provided on a "consultancy" basis. Clinical results from this program indicate greater client and staff satisfaction without a drop in client care. Changes in Nurses Board legislation in some States make this a distinct option for Australia.

While some Providers are starting to implement this type of model partly to address resource shortages and partly to reduce costs, this approach goes against the views of others who see residential aged care being far more medically or clinically based with personal care being delivered in the community. Indeed the AMA have stated that residents in aged care facilities are missing out on the levels of medical input required

yet this is something clients would not necessarily receive were they to be cared for in their own homes rather than in ours.

The fundamental question in developing a long term funding model for residential aged care is clarifying what the anticipated purpose of the care facility will be in the spectrum of services available to the elderly. What kind of model of care do we anticipate being delivered in these facilities and what should it actually cost?

3.2. The Change in Residential Care Provision

The expectations of service provision in Residential Aged Care have changed significantly since the current Aged Care Act and associated RCS Funding Tool were introduced in 1997.

3.2.1 High or Low Dependency

When this Act came in there were two broad categories of aged care split over eight levels:

i) High Care, covered by RCS Levels 1 to 4, and

ii) Low Care, covered by RCS Levels 5 to 8

Low Care facilities were called Hostels and residents had quite low care levels often admitted to gain structure in their routines and provide some companionship. High Care facilities were called Nursing Homes, were registered with the State Government and were very heavily dominated by Registered and Enrolled Nurses. When a resident's acuity increased from low care to high care they moved from the Hostel to a Nursing Home.

Since that time, many traditional hostel residents have "dropped out" of the care system and no alternative model has been developed to replace the accommodation options required for this group of people.

Low care models have become much more personal care orientated and Providers have targeted the high end of low care with residents moving quickly to the lower levels of high care to manage financially. This concept of "ageing in place" has created a "low dependency" concept where residents can stay in one facility for as long as physically possible and, in some instances, beyond that facility's capability, both physically and financially, to accommodate their needs.

High Care, on the other hand, became far more high dependency orientated with over 92% of residents in many facilities in either Level 1 or Level 2 RCS categories. This allowed the high care unit to achieve a sufficient funding level to cover the cost of the additional staff required within the high care environment.

However, the distinction between "Low Dependency" and "High Dependency" is blurred at the edges and unless a facility physically prevents "ageing in place", many retain residents far beyond the financial viability these residents accord in a low care environment.

3.2.2. Ageing in Place

"Ageing in place" has "crept in" over the past 10 years as a concept where residents can be kept in a facility even when their acuity levels increase. Like the de-institutionalisation of facilities, "ageing in place" has evolved without any clear guidelines

or protocols neither from Government nor with additional funding to address the higher service delivery costs per client of a few high care residents in a low care environment rather than a dedicated high care unit.

The additional cost per resident of high dependency clients "ageing in place" is significantly higher than the additional income a facility might receive for their higher acuity levels and, in reality, for ageing in place to work, there does need to be a point where a facility moves a resident from a facility whose cost base is primarily low care to one that is predominantly high care so there are sufficient numbers to cover the far higher staffing levels required in high care facilities.

When their care needs can no longer be met by the physical design of the facility or the capacity of the facility to manage those residents within their current staff structures as their needs increase there should be clear expectations these residents move on or sufficient capacity in the funding tool to differentiate for the higher "unit cost" to that facility.

Some Providers manage this process well, particularly if they have both high and low dependency areas within the same facility. Residents are kept in the low dependency (low care) areas until their care needs are too high and are then moved to the high dependency (high care) areas where the staffing levels are sufficient to meet their care needs.

Not all residents that need the high cost input require high dependency support, normally defined as when needing two people transfers, one on one feeding support or difficult behaviours. Some residents, however, might have the need for a two person transfer to get them out of bed or to toilet them but they are reasonably independent once up and their personal care needs do not warrant a high enough additional level of funding to cover the extra staff time required during a very short time period. This creates a "middle dependency" that requires higher staffing levels in a low care facility yet does not warrant high dependency care levels which could be addressed by an "ageing in place" supplement to offset the higher unit cost of this level of service provision.

At facility level, many Facility Managers and Care Managers are unsure how best to manage this process.

3.3 Secure Dementia

The income profile of residents in secure dementia units is not as high as a mainstream high dependency unit yet the level of staff to residents required is the same because of safety, rather than heavy care needs.

ACFI, when being proposed, was meant to address this issue but has not and, as a result, facilities operating a Secure Dementia Facility will perform at a significantly lower level than those without one.

3.4 Facility Analysis

When we review facilities, we classify them as high dependency, low dependency or secure dementia, targeting the average income profiles of these three areas and matching the rosters to the demand levels of the client base,

We now classify facilities or areas of facilities either "high dependency" or "low dependency" when undertaking performance reviews with an average income per bed

day target set for both categories, offset by appropriately costed rosters for each unit depending on size and physical configuration.

3.5 Aged Care Funding Instrument

Since the introduction of the ACFI assessment tool in March 2008, the 8 RCS Levels have moved to 64 ACFI Levels with a further 7 funded RCS protected levels for existing residents whose ACFI scores are lower than their current RCS Levels.

Providing 71 funding levels, we believe ACFI has added little if any value to residential aged care other than make the funding process far more complex than the value it brings and making it far harder to target a specific facility in terms of its optimum income levels.

From our experience, we target facilities to achieve an average of $132.60 per resident per day for "high dependency" beds, $74.83 per resident per day for "low dependency" and $91.25 per resident per day for a secure dementia unit which is usually a mixture of high and low care residents.

The high and low care ACFI definitions and the split between Activities of Daily Living, Behaviour and Complex Health all add needless noise to a process that could be much simpler in its delivery.

3.6 Targeting Facility Income

The practical process of targeting the levels of care income available to a facility has also become much more difficult.

With the RCS process, Facility and Clinical Managers could pre-assess a resident and gauge quite accurately where they would sit on the RCS Scale. The facility profile was an aggregate RCS Score, for example 1.94, made up of a number of residents in each category and managers had the capacity to admit clients based on their needs against this RCS Profile.

This has been lost with ACFI as the number of levels make it too complex to guestimate and smarter facilities either are or are being advised to engage an ACFI Co-ordinator, normally an EN, whose sole purpose is to manage the ACFI assessment process, both for existing residents and for new admissions so facilities are capable of managing their income profiles.

By assuming a High Care bed has an average "value" of $132.60 per day, these co-ordinators, with the right tools, can assess new and existing residents to "manage" the facility income level around this target figure.

3.7 Performance Assessment

From our experience, facilities who manage their income profiles can meet or indeed exceed these income "benchmarks" and raise income levels over a relatively short period of time.

Facility Managers do not have the time in many facilities nor know how to go about maximising their income but our experience has shown across a number of groups in Western Australia that this process adds significant value to a facility's bottom line, particularly when that facility is operating at a loss.

There are exceptions, of course and we have found facilities in rural areas and some metropolitan areas do not have the ability to choose residents or have waiting lists and therefore find they achieve lower income levels even though they incur the same costs.

Furthermore, older facilities, in our experience also suffer as they have a lesser ability to be selective in the level of residents they can admit and, despite the view that facilities with multiple bedded rooms perform better financially, our experience is that facilities themselves find it extremely difficult to fill multiple bedded rooms as they need to find a compatible resident, for example a male to share, and often operate with beds in the shared rooms empty. This is particularly the case where there is competition from newer facilities in the surrounding area.

4. FACILITY ANALYSIS

Broadly speaking, residential aged care in Australia comprises of three activities:

i) The delivery of care
ii) Provision of room and board
iii) Long term provision of a physical infrastructure from which service delivery can take place

In the work we do, we split residential aged care into three component parts and assess the performance of each part:

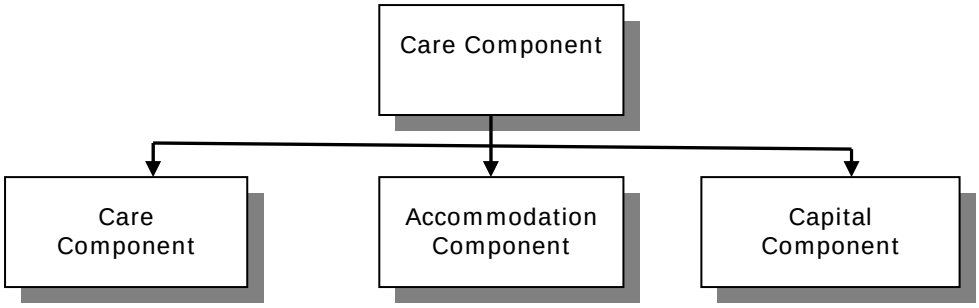

Fig 1 – Residential Care Model

This approach supports the view that care and accommodation could be split, a point other commentators have already made. In addition, by isolating the care component, there is an argument this can be bundled up separately and delivered in any location whether it's is owned by a Provider, a client or a third party.

This is a relatively arbitrary split as there are no clear definitions about what each funding element is meant to cover but logically it can be split into the provision of "Care", provision of 24 hour accommodation, and provision of capital infrastructure from which the care and accommodation can be delivered.

In this model, "Care" is funded by ACFI/RCS; Accommodation by the Resident Fees and Capital by the Capital Income Receipts from Accommodation Bonds, Accommodation Charges and Concessional Income.

We believe if each segment is examined separately we can identify where the true problems in residential care funding can be found.

4.1 Care Component

The management of the care component is determinant on two key factors:

i) Managing income
ii) Managing staff rosters

Management of consumables is also important but the dollar value is significantly less so is less of a determinate in facility performance.

4.1.1 Care Income

Our experience has shown that the former can be managed, in most cases, through the establishment of targets and the empowerment of staff within facilities to achieve these targets. We have seen improvements of between $200,000 and $900,000 per annum in 100 bed facilities operating at a loss when the approach outlined in Section 3.6 is applied by that facility.

Ideally facilities should be earning an average of $132.60 per resident per day for "high dependency" beds, $74.83 per resident per day for "low dependency" and $91.25 per resident per day for a secure dementia unit. (See Section 3.5)

4.1.2 Care Expenditure

The management of staffing rosters is a more complex issue and is determinate on the design, rather than the size of the facility.

Some providers are moving to outline the specific duties of their Registered Nurses and identify when these duties need to take place. Traditionally nursing cover has been provided 24/7 but the actual tasks required of an RN are primarily undertaken during the day. At night, RNs are an expensive "insurance" guarantee and because of the shortage of RNs, many providers have an EN or carers working at night without RN supervision for at least part of the fortnightly roster without particular incident. They may have an RN on call and a protocol to follow should staff need to talk to an RN but the amount of times an RN is called out in these circumstances is practically negligible.

Much of an RN's time is spent supervising personal care staff yet legislation allows personal care staff to hold a number of competencies, like medication, that were traditionally the domain of the RN. Some RN's in aged care find it difficult to let go of this control and, as a consequence, are one of the key blockages in the improvement of efficiency within the residential aged care setting.

Much of what RNs traditionally do in residential aged care can be performed by competent carers or Enrolled Nurses and we believe the RN role should be specifically focused on the clinical tasks that need to be undertaken and ensuring they provide consultancy support to the carers to ensure they can do their jobs effectively.

Care supervisors or ENs should report directly to the Facility Manager, as should the Clinical Team and, for a facility to be effective, the Facility Manager needs to manage the facility, not focus specifically on the day to day care provision which should be delegated to the clinical team.

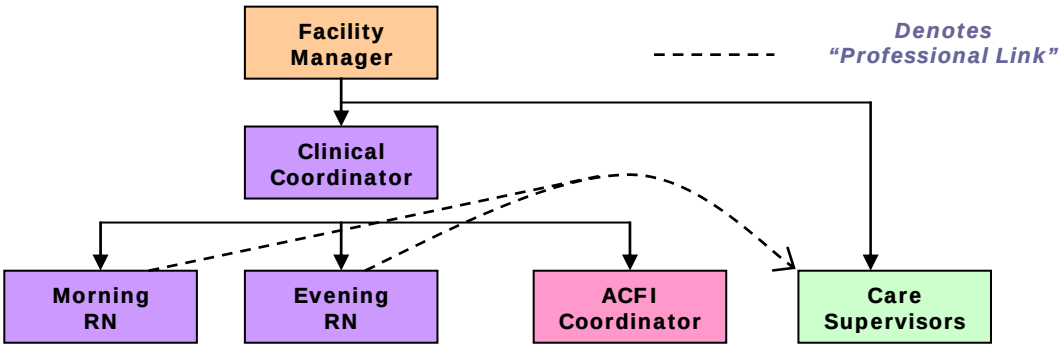

Fig 2 – Residential Facility Management Model

Care staff work on the basis of resident to carer ratios with the ideal being 2 carers to 12 residents for high dependency residents and 1 carer to 10 residents for low dependency residents at the peak morning period when residents are getting up, showered and toileted. These ratios do not change as the number of beds increase but the average length of shifts reduces as staff numbers increase.

If the facility were designed efficiently and staffed according to these ratios, then we believe there is sufficient funding in care to meet the costs of this service delivery.

	High Care	Low Care	Secure Dementia
No of Beds	48	60	16
Average Income Target*	$132.60	$74.83	$91.25
Clinical Staff Cost*	12.58	9.29	9.29
Personal Care Staff Cost*	77.18	39.18	78.65
Therapy Staffing*	5.93	2.96	2.96
Care Consumables*	4.68	2.60	3.10
Average Cost Target	$100.37	$54.03	$94.00
Contribution per bed day	$32.23	$20.80	($2.75)
% Contribution	24.31%	27.80%	(3.01%)

Fig 3 – Performance per Bed Day

** Taken from benchmark target data used in actual performance reviews*

Based on our experience, the efficiency indicator is the percentage of care income spent on expenditure and ideally facilities should be targeting around 75% spent in high care and around 70% in low care. This is consistent with the "Top 25%" performers in Stewart Brown's Benchmark Data (Aged Care Financial Performance Survey – June 2008).

Some facilities are, however, incurring in excess of 100% of their care income on care costs due to income levels that are well below benchmark capability or facility designs that are less than optimum in terms of ideal staffing ratios. We believe this level of expenditure is inappropriate and unsustainable.

Secure Dementia is much less lucrative as the facility has to maintain high care staffing levels with lower average income levels. This is because the funding tools do not provide effectively for the higher cost in managing residents whose behaviours may be dangerous to staff and each other. This was an issue the ACFI funding tool was meant to address but experience to date indicates this is not the case.

Providers that incorporate Secure Dementia Units within the overall structure of their facilities perform less well than those that do not, which is an issue, given this will continue to be an area of high demand in residential care in years to come.

Although we have only worked with a proportion of Providers in Western Australia, the number of facilities sampled is representative and we have not yet found a facility where their performance cannot get close to these benchmark levels and certainly their performance can be moved to the point where they achieve a positive contribution.

4.1.3 Building Design

Building structure is the key determinate in staffing efficiency and, after all this time, sadly Providers still do not seem to get this right.

From our experience, High Dependency units are ideally sized at 48 beds as this will require 8 carers in a morning and 6 in the evening and two at night with a supervisor on each shift. Staff work in teams of two. Bed clusters of 12 and 24 are ideal for this staffing to work.

Low dependency units are ideally sized at 80 beds as this will require 8 carers in a morning and 4 in the evening and 2 at night with a supervisor on each shift. Staff work individually. Bed clusters of 10 and 20 are ideal for this staffing to work.

Any alteration in the size of units leads to inefficiency in staff allocation and we continually see both existing and new facilities being built with numbers outside the optimum resident to carer ratio.

For example, a new facility in WA will have 28 high care beds which is two teams of two carers for the first 24 then potentially two more carers for the “overflow”. This facility will have difficulty performing optimally for the next 25 years!

Likewise the cluster style buildings popular in the early 1990’s can be less efficient as additional care hours need to be factored into the various houses. Some providers, however, overstaff these facilities and we found one where they could improve by $276,000 annually just in their low care clusters when overall the facility was only losing $167,000 in total.

4.1.4 Care Segment

In considering the care segment, we believe there is sufficient funding available with the current funding levels, including the Conditional Adjustment Payment (CAP), to cover the costs of providing care and to leave a contribution towards facility and central administration.

Indexation shortfalls over the years have been addressed in part by the CAP Payments and in part by the ability of some providers to adjust their facility management model to reflect the changing roles of nursing in residential care and the increasing competencies and responsibilities of the personal care staff.

4.2 Accommodation Component

The development of an Accommodation Component works on the assumption that care can be provided anywhere and should remain consistent whereas residents can either receive community care at home, where they pay for their own accommodation or they come to residential care where they pay Board and Lodgings.

In this latter scenario, the resident pays a daily Resident Fee prescribed by Government as distinct from Income Tested Fees which we consider to be a means tested contribution towards their care component.

Currently Resident Fees are set at $33.41 with a Pensioner Supplement or Transitional Accommodation Supplement of $6.83 bringing the overall income per bed day to $40.24 per resident per day. For this, the resident gets a room, use of the facility, meals and laundry services.

Based on average facility benchmark data from our clients, this income is offset with the following average costs per bed day, and again is consistent with the "Top 25%" of performers:

	Per Bed Day
Average Income Target*	**$40.24**
Catering*	**21.08**
Cleaning*	**4.51**
Laundry*	**2.09**
Property & Maintenance*	**4.01**
Utilities*	**4.99**
Other*	**2.33**
Average Accommodation Costs	**$39.01**
Contribution per bed day	**$1.23**
% Contribution	**3.05%**

Fig 4 – Performance per Bed Day

**** Taken from benchmark target data used in actual performance reviews***

Unlike care, the contribution from the provision of "room and board" is significantly lower and unlikely to fund the administrative costs associated with the provision of this service. Although facilities can operate within the average income available, a contribution of only 3% suggests the average Resident Fee and associated Supplements are insufficient to effectively cover the provision of this element of service.

The highest cost associated with the provision of "room and board" is the catering cost which utilises half the funds available in this component.

Where Stewart Brown differentiates high from low care, their data suggests a $3.00 difference between high and low care catering cost as well as a difference in both cleaning and laundry.

This would suggest the need for a differential resident fee between high and low care if we were to truly reflect the cost of accommodation provision.

As with the Care Component, facilities not achieving this level of performance should be challenging their cost base to identify where their performance differs and whether they can improve either individually or as part of a group purchasing arrangement.

We know non profit facilities can access Church Resources, a large non profit buying group to achieve economies of scale and larger groups gain efficiencies through their own economies so it would not be unreasonable to assess the performance of facilities against these targets and identify where discrepancies can be managed.

For rural and remote providers there is less scope to achieve these efficiencies and the viability supplement should be sufficient to cover the discrepancy in cost between metro and rural areas.

4.3 Facility Administration

The final component of facility operational cost is administration. Based on information we have gathered from clients and that available though benchmark reporting, the contribution from care and accommodation has to be able to cover both the cost of facility administration and the costs of organisational support required to run that facility.

Based on the information available, the average cost of facility administration is around $6.97 per bed per day and can be accommodated if the other components are operating at the levels indicated.

4.4 Operational Viability

We believe that if facilities had both Care and Accommodation components in balance, there would be sufficient operational funding in the current system to make most facilities operationally viable.

We therefore cannot understand why 57.4% of providers according to the benchmark data available should be losing money when the above analysis suggests this need not be the case.

This statement is based, however, on the assumptions that:

- Care facilities can achieve the income benchmarks identified for both high and low care operating units
- Care facilities can manage their staffing in a way which focuses their clinical input to the times when this needs to be present
- Care facilities roster on the basis of optimum, and sector accepted carer to resident ratios
- That the impact of building designs be balanced with the requirement to roster to these ratios – ratios will drop as a result of ineffective design but this is less of a determinant with those providers who are prepared to work with what they've got yet be flexible where this impinges on resident care.
- Excessive variations in unit costs per bed day can be assessed and managed within the confines of efficient purchasing, i.e. providers utilise the networks and services available to them to manage their costs in line with benchmark data.

The options of smaller providers working together to achieve the economies of scale in purchasing and administration achieved by bigger provider groups can be achieved by smaller groups by moving to share resources and work in a more networked and supportive way.

Based on the information highlighted, let's look at a 124 bed facility using the numbers above:

	High Care	Low Care	Secure Dementia	Room & Board	Overall Facility
No of Beds	48	60	16	124	124
Average Care Income *	$132.60	$74.83	$91.25	40.24	$139.55
Clinical Staff Cost*	12.58	9.29	9.29		10.56
Personal Care Staff Cost*	77.18	39.18	78.65		58.98
Therapy Staffing*	5.93	2.96	2.96		4.11
Care Consumables*	4.68	2.60	3.10		3.47
Average Care Costs	$100.37	$54.03	$94.00		$77.12
Accommodation Costs				39.01	39.01
Contribution per bed day	$32.23	$20.80	($2.75)	$1.23	$23.42

Fig 5 – Facility Operational Contribution per Bed Day

Based on these real figures from residential care facilities, operationally there is no reason a facility should not be generating an average $23.42 operating contribution per bed day, based on the data and figures available to us.

Allowing for the cost of Facility Administration, $6.97, this would still leave a facility with a contribution of $16.45 towards corporate costs.

We believe there is scope for those providers whose performance is below the "Top 25%" to significantly improve their performance without additional funding certainly to the point where they are operationally viable.

4.5 Indexation

While this statement is currently true, based on the ability of facilities to maximise their performance, this has been achieved through the allocation of CAP funding which in 2007/08 was set at 8.75% of care income and provided a significant supplement to those receiving it.

In reality the CAP Funding has helped close the gap between the inadequate COPO funding levels of which 75% is based on minimum wage increases while 25% is based on CPI. While this accepts 75% of costs on average relate to salaries, it does not recognise that sector pay increases have to be much higher to compete for staff against other sectors and the public health system.

In modelling new developments, operational surpluses can quite clearly be seen turning to operating losses over the project time period based on the projection of COPO indexation to offset CPI and projected wages growth.

The current COPO Indexation calculation, we believe, is therefore insufficient to meet the future needs of the aged care sector.

4.6 Wage Levels

One of the biggest issues for aged care in both recruiting and retaining staff is the levels of Wages Providers are able to pay staff.

This has been further exacerbated by the fact in Western Australia that non resource based employers have had to compete with resource based employers for scarce employee resources and as a result aged care has fallen behind the public health system in terms of wages never mind the other sectors due to its inability to increase funding because of COPO Limitations.

Current wages for Personal Carers are around $17.00 per hour with the top level in WA we believe being $17.50. This for a socially important resource to care for our elderly.

Staff working on the checkout at Woolworths get paid more and they are not expected to carry out the range of duties and hold the qualifications or competencies expected of our carers.

While we believe facilities can operate within the current funding levels, this is based on paying existing salary levels. One area we believe the Government must act in terms of additional funding is to increase levels to allow Providers to pay a more appropriate hourly rate to staff that is more in line with the nature of work and level of both employment and social responsibility we expect these individuals to carry.

4.7 Infrastructure Component

If Care and Accommodation Components were in balance, Capital Income, from Accommodation Charges, Accommodation Bonds and Concessional Fees would then be available to fund depreciation, long term maintenance and contribute to any capital cost associated with the provision of the facility.

Currently many Providers class their concessional income as operational, thus using capital funding to run their day to day operations. From the information available to us, we don't believe this should be necessary, if the performance of the Care and Accommodation components could be improved to match the level of performance highlighted above.

Infrastructure income varies depending on the date of entry of residents and, in terms of Accommodation Charges and Bonds assumes a resident will remain in a facility for less than five years, which, unfortunately is not the case. We have some clients who have residents that have been in care approaching 20 years!

Residents pay an Accommodation Charge for a high care place and an Accommodation Bond for a low care place while those deemed through Centrelink to have insufficient assets pay a part bond or no bond with the balance picked up on a sliding scale by an Accommodation Supplement.

Current funding levels of $26.88 for Accommodation Supplements and $21.39 for Accommodation Charges indicate what the anticipated daily funding level should be while those paying bonds provide $292.00 per month over five years from their Accommodation Bond and interest if the bond is held for investment.

The Retention amount in low care is $9.60 per bed day, requiring a facility to make up at least $17.88 per day ($26.88 - $9.60) from interest on this bond investment. At current interest rates of, say 4.25%, this would require an average bond holding of $148,405 per bond to achieve this.

Many of our clients, particularly those that are non profit, have average bond levels well below this amount and the reduction in global financial markets has had a serious impact where bonds are held for investment purposes.

In reality, however, Providers have to use bonds to offset the cost of establishing new facilities and therefore reduce their debt levels as bonds come in. While this reduces interest costs, it also removes a sizeable income stream which has an impact on facility EBITDA. One facility we reviewed should have had annual income of $230,000 from its bond holdings but because this had been used elsewhere in the group for new projects

was not physically available to the facility and no internal adjustment made to reflect the opportunity cost of using these funds for other purposes.

5. "TOP 25% PROVIDERS

There has been much talk in the media and Senate Hansards about the "Top 25%" providers and we have explored this theme within our report.

The argument is that if 25% of providers can perform reasonably well, is this an opportunity for others to compare their own performance and try and improve their own situation?

We took this concept and applied to a client's site that was operating at a loss, projected to be $167,000 for the current year, putting it in the bottom quartile of Stewart Brown's data set. We looked at performance and developed with their facility manager a plan to improve performance against the "Top 25% benchmarks.

We were able to show a substantial improvement to the extent that it would sit in the top quartile but surprisingly not in the areas of difference to the benchmark dataset.

5.1 Benchmark Difference

The difference between this service and the benchmark for a comparable composite facility of its size was $1,200,000 per annum. In other words it would need to improve performance by this amount to achieve benchmark.

Four components were examined in terms of the main differences between facility and benchmark:

- Building Depreciation
- Central Overheads
- Direct Staff Costs
- Income Levels

5.1.1 Building Depreciation

The level of depreciation in the Top 25% averaged $4.93 for high care and $5.54 for low care. Based on a simple calculation these figures equated to $71,978 and $80,884 per bed respectively over a 40 year period. Aggregate build costs at this level have not been seen for many years

Our client facility had a Building Depreciation level of $8.88 per bed per day which equated to $129,648 per bed which approximates the construction costs of this facility when built 15 years ago.

With new building costs averaging $180,000 per bed, depreciation on buildings over 40 years would cost $12.33 per bed per day moving modern facilities well outside the Top 25% and seriously limiting their ability to get to this high level of performance.

5.1.2 Central Overhead

Facilities in the Top 25% benchmark incurred corporate costs of around 3.5% of total income which is significantly lower than many providers are able to achieve.

Our client had budgeted at 4.5% but was incurring additional costs. We could get back to the budget figure but the benchmark would be more difficult to achieve.

The corporate capacity of non profits seems to be far greater than comparably sized private operators with one example here in WA indicating a Private Provider has a head office staff of 21 while a comparable non profit provider has a staff of 48. We know from staff at the private provider their workload was unreasonably high but not such that you could warrant more than doubling the corporate staff levels.

Central overheads is certainly an area, we believe could be reviewed as there is a lot of duplication particularly around the deployment of systems and the replication of back office work where more commercial thinking within the industry could certainly lead to greater cost efficiencies.

5.1.3 Operational Costs

Operationally we were able to target the facility's income at the benchmark levels mentioned earlier and raise the overall income levels of the facility.

At the same time we were able to recommend reduced staffing costs by better deployment of resources in line with accepted staff to resident rosters. This specific facility had 40 high care beds to the optimum staff levels could not be achieved while its low care beds were located in a number of small separated houses which made staffing more costly for the same levels of income that would be achieved if the residents were all under one roof.

We also identified that the facility at some point in the past had converted a low care house to secure dementia and the additional cost of running this unit over a comparable open low care unit was around $273,000 per annum.

Finally we identified the facility, though holding over $5m in Accommodation Bonds was receiving no bond interest as the Provider had used the cash as part of a capital development on another site.

While this cash management is quite acceptable from a corporate perspective, it was costing this facility $230,000 per annum in "lost" income while the project got access to free capital with no opportunity cost.

Had the provider notionally charged the project for the cost of using this capital and provided the facility with its revenue stream it would have shown a far better level of performance.

5.2 Achieving "Top 25%"

All up we were able to show this facility could achieve a "Top 25%" rating through changes in practice and treatment of cash flows. Not every facility will have that degree of flexibility.

The low level of corporate overhead, 3.5% of income, and the low depreciation costs based on apparent old building stock would suggest most providers will struggle to achieve "Top 25%" performance.

However, there is significant scope for Facilities to improve performance within the four quartiles and this has to be achieved through review and development within facilities and is not immediately evident at Provider or Benchmark level.

Unlike the other contributors, I believe our experience working within provider facilities and questioning what they do against what we have found others are doing has provided

an insight where we can suggest there is scope for the sector to improve its own performance.

6. CAPITAL COSTS

So far we have focused on the Capital Income and Depreciation issues associated with capital infrastructure but recognise, with the work we have done on feasibility modelling that the capital income streams available within residential aged care are insufficient to cover the cost of building new facilities, something I have seen change in the 10 years I have worked in the sector.

There is much discussion elsewhere, both in terms of Senate representation and specific research papers, such as the recent Access Economics Report titled the "Economic Evaluation of Capital financing of high care that suggests the funding streams outside the Accommodation Bond are insufficient to cover the capital cost of building new facilities at this point in time.

Taking the view, as we do, that there are three specific components to residential care, the third component, we believe should be sufficient, not only to cover the cost of financing a new development in the longer term but also in providing sufficient cash to allow for the ongoing capital maintenance of the facility over the building's lifespan.

If any part of residential aged care funding needs to be addressed, I think we all recognise it has to be the availability of sufficient funding to allow providers to build new stock both now and into the future.

7. Conclusion

Whilst this submission has rather hurriedly been put together I hope it gives a perspective about the potential for improvement within the sector.

We believe that facilities should not be losing money and have the capacity to change their mode of operation to achieve at least a reasonable level of income if not be a star performer.

The design and function of building stock is a real impediment although there are ways to work round some of the design issues with flexible rostering without impacting on resident care. Providers and architects still do not seem to have made the connection between building design and staff rostering and therefore even new facilities must deliver less than optimal performance.

Indexation within the sector has always been an issue with COPO falling short of the inflationary creep impinging on the sector while the level of staff wages falls woefully short of the levels we should be paying for the skill levels and social importance of the role carers are expected to undertake.

Finally the cost of building in residential aged care is a significant impingement on future growth particularly for Providers who only run care facilities or those smart enough to separate projects so there is no cross subsidisation when building a care facility and a retirement village on the same site.

This is something the not for profit groups have undertaken so the village can pay the capital cost of the care facility when these projects are quite separate and should be individually assessed on their own merits.