5th April 2011

Mr Mike Woods
Deputy Chairman
Productivity Commission
GPO Box 1428
Canberra City ACT 2601

Email: mwoods@pc.gov.au

Dear Mike,

Re: Follow up letter to Productivity Commission Hearing, Regis presentation by CEO Ross Johnston on Monday 21 March 2011

We appreciated the opportunity to present to the hearing a couple of weeks ago.

It became apparent through the course of the questions and answers that Regis had assumed that the commission's intended direction to cap accommodation bonds was only for the "standard accommodation" with competition prevailing above this level. It is clear now that you are recommending that all accommodation bonds are capped or linked to the cost of the room at a pre determined rate (or by some other mechanism that is not apparent).

Regis would not be opposed to a policy of effectively capping accommodation bonds provided the policy is linked with the following two outcomes.

1. Adequate alternative sources of funding
    - Future alternative sources of funding will need to be adequate to encourage sufficient investment in this essential infrastructure to meet current and future demands
2. Appropriate transition period
    - Existing approved providers in the market will require adequate time to adjust their existing accommodation bond pools on their balance sheets to reflect any changes to the capital funding mechanism.

To assist in the understanding our position, we have elaborated further on these two points and provide a worked example with additional commentary.

Regis Group Pty Ltd
ABN 17 084 720 561

National Office
Level 2
615 Dandenong Road
Armadale VIC 3143

Mail
PO Box 8373
Armadale VIC 3143

Tel: 03 8573 0444
Fax: 03 8573 0422
Email: regis@regis.com.au
www.regis.com.au

Adequate alternative sources of funding

As you are aware, most approved providers utilise accommodation bond cash flows to acquire facilities, construct new facilities and/or retire debt related to these. The accommodation bond concept allows non interest bearing debt to replace interest bearing debt. This is important because:

- Existing capital funding of a recurrent nature (ie accommodation charge, retentions etc) is inadequate to support the funding costs associated with development activity if the capital outlays are not considerably offset by accommodation bonds

- The capital structure (level and mix of debt and equity) required to fund future development would be negatively impacted thereby placing a further constraint on future development.

The implementation of an effective cap on individual accommodation bonds in isolation would inevitably have a negative impact on development funding and therefore society's ability to cope with future demand. To meet future demand, the impact of such a policy change would need to be more than offset by the benefits of some other source of funding.

It is important to note that while there are situations where Regis does charge individual accommodation bonds greater than the unit cost of the associated room, Regis only charges an accommodation bond to approximately 40% of all its residents. The other 60% contribute nothing to the cost of capital development or only pay the accommodation charge which is a grossly inadequate amount to justify development and an adequate return on investment.

Alternative sources of funding could be obtained by a broadening of the accommodation bond paying resident base from current levels and / or an increase in recurrent capital charges.

It is a fact that in recent years there has been very limited development of high care beds, which is where the demand exists. It is also a fact that greenfield development timeframes are 5-7 years given the ACAR process and planning consents required. To meet future demand for residential high care the benefits of alternative funding sources will need to significantly exceed the negative impact of a policy that caps individual accommodation bonds.

Appropriate transition period

The cash outflow from any isolated policy capping accommodation bonds runs the risk of placing significant financial stress on all providers holding accommodation bonds. This will be the case particularly for the smaller, less diversified approved providers that have a higher percentage of bonded residents or higher average bond levels. Debt financing arrangements rarely exceed four years and existing financing arrangements are, naturally, based on the current funding model. While prudent liquidity management strategies should be in place for all approved providers the stress testing would need to be re-evaluated for an isolated policy change capping accommodation bonds.

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Given the increasing acuity of residents, the cash outflows over the short term may be significantly higher than previously expected. Approved providers that are financially less sophisticated may underestimate the impact of these changes if they are not carefully modelled and implemented.

Without an offsetting capital funding policy change, we estimate that in 18-24 months valuations would move materially downward causing many approved providers extreme duress in finding this additional cash flow to maintain their balance sheets and source appropriate future debt and equity funding

Given the "Prudential Compliance" legislation regarding the use of accommodation bond cash flows is about to be released mid year any change would have to be implemented to allow approved providers time to achieve the obligations outlined therein.

Worked example and additional commentary

In relation to alternative funding sources should accommodation bonds be capped, we provide the following worked example to assist the commission in their considerations. We have outlined in our submission the level of return required to achieve this in order to build and or acquire new facilities which are generally debt funded due to the cash flow support required.

We have recommended a 14% WACC[1] be adopted to offset the reduction in bond cash flows, this would have to be applied to a "valuation of a facility" in order for it not to unfairly prejudice approved providers with more invested in better quality facilities. This provides for a 45% debt funded and 55% equity funded model.

We have attached our worked example calculations for your information (see Attachment 1).

Additionally, this change would be viewed by lenders as a material denigration of current cash flows for approved providers in the industry. Similarly, we believe there would be a significant impact on valuations from this change in funding as we have outlined above. Reduction in bond cash flows are assessed as a $1 for $1 reduction in the value of a facility by valuers. We firmly believe that bond cash flows are a surrogate for debt in terms of an approved providers cash flows and therefore are quite an effective tool for residents, government and approved providers.

Debt is in order of 8% p.a. whilst a reasonable return on weighted average capital deployed is in the order of 14% p.a. by any measure this is an efficient system. The lack of current stock coming to market we believe is a function of the uncertainty around availability of licenses and extra service places not a sign that the current system is not working efficiently.

We have outlined our position on both of these well in the report.

[1] Weighted Average Cost of Capital

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Similarly the escalation that is applied to this formula should be in line with movements in the median house price, currently accommodation bonds track this metric across the industry. Any metrics lower than these will constrain lending to the sector and will again in a few short years amount to a form of price control, we are not sure how this sits with a competitive market environment as outlined repeatedly throughout the commissions report.

If bond escalation were to be capped at CPI, this would be the only form of residential accommodation artificially capped in this way and disparity would soon occur with the residential market. Land and built form prices fluctuate principally through supply and demand metrics, not CPI. With Australia's supply side constraints on land, new development in aged care will very quickly become uneconomic through land price escalation over and above CPI.

Additionally residential aged care facilities require constant capital to achieve the level of presentation and compliance necessary to compete in the market. Any movement away from the median house price metric would have to see the base used for establishing the return adjusted up to accommodate this capital expenditure.

An average facility we would expect would undergo the following in its life cycle.

- minor renovation every five years; 5% of capital cost
- major renovation every ten years; 25% of capital cost

Please feel free to call me to discuss any of the above in more detail.

Yours Sincerely,

Ross Johnston
Chief Executive Officer
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Attachment 1

Worked Example

1. Single Bed Ensuited Room return required

Cost to develop	$302,400.00
Return PA @ 14% (WACC)	$42,336.00
Funding per day	$115.99
Current accommodation charge for non supported resident	$30.55
Increase in funding required	**$85.44 per day**

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21st March 2010

Inquiry into Caring for Older Australians
Productivity Commission
GPO Box 1428
Canberra City ACT 2601

Via Email: agedcare@pc.gov.au
Via Fax: Jill Irvine 02 6240 3311

Dear Sir/Madam,

RE: Productivity Commission Draft Report (Jan 2011) – caring for Older Australians

As five of Australia's leading aged care organisations we would like the opportunity to communicate to the Productivity Commission our views on the key recommendations contained within the draft report.

Together, we represent over 10% of Australia's residential aged care facilities that provide care and services to over 18,000 elderly Australians.

Our estimates are that in the order of 40,000 beds will be required across the sector to meet increased demand by 2015[1]. It is against this backdrop of rapidly growing demand that we believe the following issues require immediate attention if we are to achieve a high quality and sustainable aged care sector in Australia:

- The impact of a shift from provider-based accommodation bonds to daily accommodation charges which we understand to be the Productivity Commissions desired output. This may result in significant cash flow reductions impacting on an operators ability to invest in meeting future growth demands;

- Greater certainty of increases in the funding instruments (Aged Care Needs Assessment Instrument replacing ACFI);

- A review of the funding to allow providers to develop new and re-develop existing facilities. The Commission has publicly acknowledged this issue and stated that further work is required to determine an appropriate solution;

- The impact of deregulation of supply, i.e. the removal of the bed licence system, which may lead to an overall reduction in occupancy increasing inefficiency in the system. Consumers may be faced with some providers closing their doors (due to non-viability) and potentially an overall reduction in quality standards that is often associated with such financial pressures. The impacts of deregulation in terms of efficiency and financial viability therefore need to be fully understood;

- The need for additional funding to support the recruitment, training and development of the health care professionals who will be caring for the growing number of aged Australians into the future;

- Recognition that the pay inequalities between the aged care and the public health care sectors need to be addressed;

Our collective belief is that there are a number of matters that need addressing urgently to safeguard the future viability of the industry and support its required growth. We would welcome the opportunity to meet representatives from the Commission to discuss these, as well as provide amplification on those addressed above, at an appropriate time in April.

We look forward to the final report

Yours sincerely,

Ross Johnston
Chief Executive Officer
Regis Group

Paul Gregersen
Managing Director
Bupa Care Services

Gary Barnier
Acting Managing Director
Domain Principal

Andrew Sudholz
Chief Executive Officer
Japara Holdings

Paul Walsh
Managing Director
Lend Lease – Aged Care

[1] A 2010 report commissioned from LEK on the aged care industry where it was projected that an additional 40,000 new places will be required by 2015 and 76,000 by 2019.

Productivity Commission

Inquiry into Caring for Older Australians

Submitted by: **Regis Group**

Date: **21 March 2011**

Contact: **Mr Ross Johnston, CEO**

Attachments: Joint Response letter (Regis, Bupa, Japara, Domain Principal, Primelife)

Regis Response to Productivity Commission Report

Regis Group Pty Ltd
ABN 17 084 720 561

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Regis Response to Productivity Commission Report

1. Introduction

About Regis

The current Regis Group ("Regis") was formed through the merger of the residential aged care assets of Regis Aged Care with the aged care assets of Macquarie Capital Alliance Group in 2007. Regis has nearly 4000 residents in over 40 facilities and is represented in all mainland states of Australia, cared for by a workforce of over 4000 full time equivalent employees, of which many are part time and casual.

Regis has been at the forefront of bringing new and improved facilities to residents in the market having completed over 550 new beds over the last four years, with a further 200 beds to come online in the next financial year. Over the same period we have employed over 700 new staff.

Regis is also committed to improving care, safety and operating efficiency in our business and has made substantial investment towards this in the form of new technology and new equipment, for example an electronic Care Management System ($ 2.5 million investment over 2 years) and an electric bed program ($ 3 million over 2 years).

Regis shareholders have been investing in the industry for over 18 years and are committed to the sector. We see ourselves as one of the leaders in the space.

The Regis business is broad in terms of our exposure to the issues facing the industry that are identified and discussed in the Commission's Draft Report:

- Our resident care profile includes High Care and Low care, giving us significant exposure to the impact of the increasing acuity of residents, shorter tenure and the impact on the entry to residential care of the increased Community Care sector
- The economic profile of our residents includes fully supported, bonded, accommodation charge and Extra Service, giving us a good understanding of the customer's view towards bond payments, accommodation standards and service choice
- The geographical spread of our business covers all mainland states and both metropolitan areas and regional towns, exposing us to a broad range of labour issues and cost variations
- Our building portfolio ranges from brand new with predominantly single ensuited rooms to some older facilities with multiple bed rooms that are difficult to fill based on resident preferences and nearing the end of their economic life.

The Regis business, whilst having a small degree of Community Care and Independent Living Units, is predominantly Residential Aged Care and this is the focus of our response.

Purpose of the Regis Response to the Commission's Draft Report

The stated purpose of the Commission's Inquiry is:

> *To undertake a broad-ranging inquiry with the aim of developing detailed options for redesigning Australia's aged care system to ensure that it can meet the challenges facing it in coming decades.*[1]

Regis supports the initial findings of the Productivity Commission in most areas. Our submission seeks to

- support the Commission's report with evidence from our experience
- identify which issues have the most significant impact from a provider's perspective, and to explain the business impact
- identify the implementation priorities from our perspective, and provide discussion on the proposed implementation stages where relevant.

Our response follows the format of the Commission's recommendations. For clarity as to the section that the discussion relates to, quotations from the Commission's report are made throughout this response, illustrated in blue boxes.

Where we do not provide comment on a recommendation, it means that we support this recommendation and the implementation plan relating to it, or else it does not directly impact the Regis business.

Short Term Implementation priorities

We have outlined what we believe are a series of measures that government can act on which will "keep the industry moving" in terms of keeping a supply of new beds to the market.

[1] PC Draft Report, About the Inquiry, p3

2. Consumer Directed Care

Opening up the supply of care and accommodation to enhance choice

As part of the consumer-directed arrangements, the Commission is proposing the progressive relaxation and eventual removal of supply-side limits on bed licences[2]

Between 2008 and 2010 the number of new beds brought on line by the industry has fallen sharply.

The time required to bring on green field beds via new Residential Aged Care services is in the order of five to seven years depending on planning and site constraints. This includes consolidation of a site, planning, construction and mobilisation. Brownfield beds (ie new beds at existing services) can be brought on line in as short a timeframe as two years, again dependant on planning constraints.

If the industry is to meet forecast demand the principal issue is to commence the freeing up of capital constraints to stimulate supply. Regis supports the Commission's recommendations around the opening up of supply, however the implementation timeframe will of reforming the system over the next 3-5 years will exacerbate the present supply problem when recognising the required lead time for new developments.

The implementation plan needs to take into account that if the market is opened up to competition depending on the "basic standard" of accommodation configuration there are a great number of three and four bed rooms in the market today. The impact of the ultimate replacement of these older facilities will need to be considered while these beds are removed from the market for a period of up to three years.

Additionally over 50% of the industries facilities have less than 50 beds. In our experience, given the current funding structure, these facilities are not economically viable and will need to be reconstructed over the next 5-10 years. This adds an additional impost to delivering the beds required to meet the forecast industry demand.

Regis sees a number of issues in terms of the Commissions' recommendations and Implementation Plan, as detailed below. The proposed Implementation Priorities that we recommend be considered to address these issues are also outlined.

Introduction of competition, providing a level playing field

Regis supports the introduction of competition into the market but it must be recognised that the legislation, funding structure and government infrastructure (AACRC, DoHA, etc) needs to be fully in place before this occurs so that existing providers can adjust their business models to the new environment with knowledge and certainty during the implementation of the Commission's recommendation.

This will be a small adjustment for some providers and a significant adjustment for others. These may range from a restructuring of a groups balance sheet to account for changes in accommodation bond cash flows, reconstruction of facilities, financing arrangements or a simple adjustment in staffing and service delivery.

Residential Aged Care providers are discouraged to improve their service offering under the current funding mechanism and are constrained from doing so under the current framework of rules and regulations.

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[2] PC Draft Report, Overview p XXX

As with deregulation of the greater economy, freeing up the ability of the client to negotiate the standard of service they want would encourage providers to deliver a better range and level of services and would drive quick long lasting improvements.

Examples of what the future Aged Care consumer will be looking for include:

- Internet access
- A much expanded Allied Health and health services offering
- Greater care to resident ratios
- Expanded activities programs including one on one minders on trips outside the facility
- Contemporary hospitality, food and beverage offers
- Quicker and better access to subacute services and care

The issue here is the Implementation timeline.

It is essential that deregulation of the supply of Places, and the removal of High, Low, and ES categories go hand in hand with the deregulation of price controls. To defer price deregulation until 10% or 20% oversupply of Places (refer Box 14.3) occurs will create further distortions in supply similar to that of the High Care bond issue.

Capacity for a resident to choose the level of service they want

The Commission is proposing that the distinction between ordinary and extra-service status be removed.[3]

With the impending wave of baby boomers set to retire and transition to aged care, expectation of service delivery and options of service will be far greater and more diverse than at present, as will their capacity to pay.

Our experience is that there is already strong demand in the market from residents who have wealth in assets and are willing to draw down on those assets to pay for a premium level of service.

The current Extra Service framework is far too rigid to adapt to these demands. The proposed recommendation will enable providers to tailor their services to consumer demand, and the requirement to publish information about services will be a critical part of marketing.

The constraint of current Extra Service places to 15 % at a regional level as a measure is meaningless, and providers are unable to offer the level of choice that is being demanded by many more than 15 % of those residents presently allowed within the current ES ceiling.

Many providers are waiting until they have Extra Service places in hand prior to proceeding with developments given the low levels of Extra Service places allocated in the 2009-10 ACAR round. This is a major disincentive to build new buildings.

Approved "basic standard of accommodation"

The Commission proposes a two room shared bathroom as the standard accommodation type. To do this without defining the intended use is not consistent with opening the market up to competition and allowing residents a choice to meet their accommodation preferences.

[3] PC Draft Report, Overview p XXX

If the "standard accommodation" option outlined in the report is to be adopted then Regis believes this is appropriate only for a fully supported high care resident and not every other customer. In today's market we have difficulty in selling these shared rooms (even brand new accommodation) to residents meeting some level of the funding themselves. The Regis experience is that the "baby boomers" are demanding single rooms with ensuite. Both low and high care residents paying a bond will always choose a single room en suite configuration. The larger the bond and services payments, the more space and amenity they are looking for. There is little difference in a regional setting except for price point.

This difference in preference for those with the capacity to fund accommodation needs to be accounted for in the definition of the standard of accommodation.

Respite care

The Commission is proposing the establishment of an Australian Seniors Gateway Agency which would be responsible for maintaining the national aged care information base and for delivering assessment and care coordination services.[4]

With the Government's release of an increasing amount of community based care packages and increased reliance on the informal workforce, respite should be promoted as the safe vehicle to encourage the transfer to residential aged care and to promote choice through demonstrating the levels of service available. Our experience is that respite residents often choose to become permanent residents and if their assessment does not allow for this the process can be complex, costly and stressful for the resident.

Currently the Aged Care Assessment Teams will not provide a respite ACAS if the resident intends to use it as a "try before they buy" option. This is deterring sometimes traumatised residents who have been forced to confront going into Residential Aged Care from availing themselves of the best option going forward.

Regis recommend that the new Assessment and Referral process give consideration to a process by which the assessments increase flexibility for residents in terms of choice of short term or long term accommodation. This will also support the increase in demand for respite care that will arise from the implementation of the gateway approach proposed by the Commission in Recommendation 11.1.

Introduction of Regional quotas for supported residents

To ensure sufficient provision of the approved basic standard of accommodation for those with limited financial means, providers should continue to be obliged to make available a proportion of their accommodation to supported residents. The Australian Government should set the level of the obligation on a regional basis…….After five years, the Australian Government should consider the introduction of a competitive tendering arrangement to cover the ongoing provision of accommodation to supported residents.[5]

Regis supports the introduction of Regional quotas for supported residents. This is similar to the system of supplements for supported (or concessional) residents that operates today.

[4] PC Draft Report, Overview p XXVII

[5] PC Draft Report, Draft Recommendations p XLVII

We do not support the tendering of these places and fail to see how this would work in practice. To supply residential aged care services on a periodic basis subject to re tender is a difficult concept to embrace as it adds an additional level of risk of business continuity to providers, and could potentially reduce competition and supply of residential places.

Whilst a tendering process exists in Residential Aged Care today for acute providers seeking the suppliers for Transitional Care Programs the concept outlined in the report takes this to another level.

We see a critical issue is how the Provider is impacted for the loss of a contract and how this is handled, as it would impact resident tenure, occupancy, resident relocation, staff and provider finance arrangements (including valuation, profitability, bonds).

The remobilisation of a facility is a slow and financially expensive process that can take a provider up to two years, depending on market condition and local issues.

Implementation Priorities

Based on the issues described above, Regis proposes the following in relation to the Commission's recommendations around opening up the supply of care and accommodation:

- Immediately increase the "cap" on extra service places to 30% and enable these to be allocated through "out of round" (ie; outside ACAR) applications to avoid year's of delay in the supply of future places for residents (this will also give some certainty to providers to encourage future investment). It will also provide for a more seamless entry to removal of ES category which may occur within the next 2 years.
- Allow an accommodation bond to be taken for any care level, based on resident's income level rather than low care or high care assessment. This will also ease the transition.
- Establish clear parameters around the funding for the "Basic standard of accommodation" through independent evaluation.
- Implement a minimum price point for accommodation charges and bonds based on this (allow the industry to compete above this price point, this will enable providers to cater for individual resident needs)
- Progressively open the market up to competition by removing the current impediments to flexibility around the provision of pricing, places, care and services to residents/providers enabling residents to choose the level of care/accommodation they require and providers to achieve a reasonable return on their investment and compete on their reputation
- Ensure that assessments allow a resident to choose between permanent or respite accommodation to ease the transition into residential care

Other Implementation Issues

- Reconsider the concept of putting regional places for supported residents to competitive tender after 5 years (recommendation 1.5)

3. Funding Residential Aged Care

Provider's concerns with funding arrangements were centred on the residential high care accommodation charge and the indexation rates applying to care payments. They claimed that the former no longer provides and adequate return on capital.[6]

ACFI has gone a long way to addressing the traditional disparity between the actual cost of delivery of care and that which is funded for high care across the sector.

In our view however, this is of short term benefit when the true cost of health inflation is taken into account.

In our view the Commission needs to look at the following when assessing the adequacy of funding and the true cost of care.

- Measurement of health inflation across sector
- Increased levels of acuity and increasingly complex care levels (impacting labour costs, consumables and medical expenses)
- A diagnosis of dementia should be a key trigger for an elevated level of care based funding
- Increased levels of challenging behaviours psycho geriatric
- Above parity of staffing costs with acute sector
- A mechanism whereby qualifications of nursing staff should attract incremental increases in the care funding. This will allow better nurses to provide better care across resident populations.
- The high cost of compliance
- Accommodation costs need to be covered by accommodation bonds, the present high care accommodation charge is substantially insufficient to fund new High Care Facilities.

Regis agrees with the split of accommodation costs from that of care and also agrees that an independent body should set the cost of basic care that is to be provided by the provider, however the costs of care should be expanded to include those points laid out above.

Details have been provided in this section.

Increasing acuity

There is a high and unmet demand for the limited number of community care packages, a decline in demand for residential low care and a deferral of entry into residential high care until people reach greater frailty.[7]

It is clear that residents coming into Residential Care are of a higher acuity level than historically. The number of low care resident coming into care had reduced by approximately 20% in July 2009 to July 2010.

As a residential aged care operator with both low care and high care places, Regis recognises the significant increase in "ageing in place" in our facilities over the last five years.

[6] PC Draft report, Overview p XXXI

[7] PC Draft Report, Overview p XXX

The table below illustrates the current Regis mix of beds and residents:

Occupied Beds as at 31st Jan 2011	Low Care	High Care
Bed Licences	1,432	2,185
Resident Care Level at Entry	37%	62%
Resident Care Level, Current	18%	81%

The table illustrates that, whilst we still have a substantial number of residents entering care at a level classified as low care, that most residents are rapidly reclassified as high care as their care requirements accelerate.

The Commission's report has a focus on Consumer Directed Care, and identifying a model that best provides a flexible model of care to meet individual needs. Whilst Regis strongly supports this view, we are concerned that the inquiry does not explicitly address the increasing care requirements of residents in residential care by residential care employees in the form of any direct recommendations.

The strategy focuses on a gateway service to using a building block approach to develop the right care solution to meet individual's needs. Whilst we support this strategy, it is focussed on consumer demand and does not directly recognise the supply side issues – ie that Residential Aged care providers are already finding meeting the specialised care needs a challenge on a number of fronts, including:

- Appropriate number of staff with the right skill levels
- Appropriate accommodation facilities and equipment
- Appropriate range and level of medical consumables eg. Complex wound dressings/specialised nursing care equipment.

Recommendation 8.5 discusses in-reach services:

The Australian state and territory governments should, subject to further evaluation, promote the expanded use of in-reach services to residential aged care facilities and the development of regionally or locally-based visiting multidisplinary health care teams.[8]

This concept has merit and should fulfil its goal of greater integration between residential care and acute care, but needs to be coupled with a review of the scope of ACFI funding to ensure that the in-reach programs are implemented to efficiently cover areas that are outside the scope of residential care.

Mapping the processes in terms of the delineation of responsibility between the in-reach teams and residential accommodation providers from a compliance perspective will also be complex.

There is also potential to review the responsibility for delivery of the in-reach teams. It may be as logical for experienced Aged Care providers to be funded to operate these teams as it is for the acute sector to run them. Regis is currently trialling a roving nurse program for a group of Melbourne based facilities and is finding it an effective means of the delivery of some services. A competitive tender process is encouraged to ensure innovative delivery proposals are received from the market.

[8] PC Draft Report, Draft Recommendation 8.5, Draft Recommendations p L

Complex Care

Older Australians may also increasingly require specialised care such as for wound management and other health and nursing care, dementia and challenging behaviour, incontinence, palliative and end-of-life care and restoration and rehabilitation including transitional and sub-actuate care[9]

The following is a reflection of what that acute care needs are currently being experienced in the Regis facilities:

- IV Fluids including (PIC lines) and high maintenance Intravenous lines
- Subcutaneous fluid/hydration
- Blood transfusions
- Cytotoxic treatments
- Syringe drivers
- Cannulation procedures for blood tests
- Complex tracheotomy and suprapubic catheter care and changes
- Post acute care – following fracture of MI
- HIV (active) and multi resistant disease processes

Currently the flexibility to take on residents with complex care needs requires careful consideration as the costs related to these residents can be significant and demanding off nursing time. The cost associated with management of medical supplies for these residents is high and not subsidised. As an example, Regis currently has 3 residents in Qld facilities requiring care for a tracheostomy. There has been demand from more residents who require this service however we have not been able to accept them because even high care facilities do not necessarily have this level of specialised nursing available at present.

Dementia and Psycho Geriatric Behaviours

We believe that the behaviour domain in ACFI requires a significant uplift to deal with the growth of Dementia in our resident population. To be adequately managed adequate dementia care requires a significant uplift in the ACFI ADL and behaviour domains to cater for staff expenses, lifestyle programs and to provide a food service more appropriate to these residents needs.

The current ACFI funding is not sufficient to meet psycho geriatric or severe dementia management – particularly constant repetitive behaviour that is intrusive and disruptive to the peace and dignity of other resident with whom they reside. Accommodation and care models need to be restructured to accommodate the increased number of residents displaying these behaviours.

To support these we have seen a 30% increase in resident to staff incidents over the last two years. Staff need to be rewarded for working in these environments and are entitled to go home in the same condition as they arrived for their shift

Critical and crises management for psychotic episodes require one on one care - this can only be provided if there is consultation and agreement with family.

[9] PC Draft Report, Overview p XXXIX

Issues around security of tenure make it difficult for providers to encourage families to seek alternative accommodation when care is not appropriate to either long or short term need.

This is a funding issue. A review of the extent to which these requirements are addressed under ACFI would assist providers in restructuring their businesses to cater to the higher and more complex levels of care required.

Palliative and end of life care

The Australian Government should ensure that, through the Independent Hospital Pricing Authority, residential and community care providers receive appropriate case mix payments for delivering palliative and end-of-life care.[10]

Regis supports this proposal. Our experience is that based on residents entering at a higher level of acuity, resident turnover is higher and the care model needs to support residents' palliative care needs and end of life choices.

From a residential providers' perspective the market will segment itself into two principal areas of care. This will be a high level of residential care and an end stage high care offer – which will most likely include a large service offering on dementia care. Any funding structure going forward needs to be structured in line with this. The challenge for the industry is to reposition the existing accommodation to meet the new demand metrics. This will take time to effect as refurbishment or upgrade of a building will be required.

Funding Indexation - ACFI

As per the commitment by our last Minister, the Hon. Justine Elliot, Minister for Aged Care to introduce a revised indexation instrument for the 2012 financial year, we support the introduction of this as soon as possible. For the last three years we have seen real annual funding increases lag our expense increases in the order of 3% per annum. Since the suspension of the CAP profitability has been eroded during a period of significant cost increases in most expense categories.

Any new indexation instrument should use staff expense movements as 70% of the base and the other principal inputs to care being food, medical supplies, utilities and medical equipment.

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Increasing acuity – Impact on accommodation costs

As acuity increases, so do the costs of accommodation and provision of care. A high care accommodation facility is subjected to higher resident turnover, from a care perspective it requires the use of more resources to deliver care (labour, fixed and loose furniture, equipment, medical devices and consumables). This combines and results in the facility requiring a more rigorous capital and expenditure program to maintain it in the standard residents and their families expect.

These things present themselves as;

- Refurbishment every 10 years
- Higher levels of maintenance
- More frequent replacement of furniture, equipment and medical devices.
- Higher levels of cleaning
- Higher expenses as a facility ages

[10] PC Draft Report, Draft Recommendation 8.3, Draft Recommendations p L

Lastly, facilities need to be tailored to be suitable for residents with Dementia. We believe this capital cost equates to circa $ 1,700 per room.

Getting paid for services rendered

An additional issue not addressed by the Commission is that, as acuity increases the average length of resident stay decreases, giving rise to a higher level of late payments and bad debts, which need to be managed with extreme sensitivity. Regis has seen an increased frequency of residents passing away before an accommodation bond or charges have been paid.

In order to support providers in managing this situation without undue stress to those involved, the industry requires support in terms of:

- The requirement for a Resident Agreement to be signed
- The ability to require deposits for Accommodation bonds
- A more equitable financial arrangement within the provider/ resident relationship

This will help mitigate the cost of debt collection impacting on the cost of delivering Aged Care and enabling the focus of a facility to remain on care delivery

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Staff Expenses and Compliance

The Commission is proposing that scheduled care prices take into account the need to pay competitive wages to nursing and other care staff.[11]

Over the last 5 years the ratio of low care residents to high care residents at our Facilities has significantly changed. To meet these changes in acuity of care has necessitated the uplift in personnel rostered to work. This in turn has driven up our staff costs in supporting functions such as recruitment, compliance, training, orientation, supervision and management oversight.

To meet our compliance obligations we have had to invest significantly in Training. To meet solely our mandatory training obligations alone costs 1.4% of our salaries budget. This does not include other associated training such as; dementia, wound management, aggressive behaviour management, falls prevention, oral health, pain management, to on boarding, buddy shifts and orientation of staff substantially add to our staff costs with a further 2.2% of wages costs. This is an environment where staff turnover is up to 25% per annum.

Additionally the changes in the ethnicity of staff which has seen a substantial increase in the numbers of staff borne outside Australia working for Regis has seen a need to develop training that addresses cultural issues, English language skills to enable effective communication with our residents, written communication development to enable correct documentation has also added to our training costs.

Over the past 3 years our COPO funding increases of 2.3%, 1.9% and 1.7% respectively have not kept pace with increased staff expenses for Training and Development. This increased cost is outside Enterprise Agreements for wages.

[11] PC Draft Report, Overview p XL and Draft Recommendation 11.2

Additionally the ever increasing focus on compliance has necessitated the introduction of a Corporate Compliance team solely responsible for ensuring Regis facilities remain compliant with the Aged Care Legislation, accreditation standards and dealing with responses to complaints. This is a team of 8 senior staff employed to achieve this objective at an overall cost of in excess $1.5M per annum.

Accommodation funding adequacy/structure

Under the Commission's recommendations regarding accommodation bonds, there looks to be no defined measure of inclusions for the determining of the amount of Bond payable.

In essence Regis believes the accommodation bond should include:

- Cost of land
- Cost of development and other regulatory applications
- Nominal cost of capital required over the application period
- Indexation for land and building costs in the area of the facility
- Building costs
- A mechanism to revalue the building, land and fixtures over its lifetime
- Furniture, Fixtures and Equipment to fully fit out the building to full functionality.

Under the Commission's proposed framework, bonds will become the second or third most attractive option for entry residents. Regis believes accommodation bonds have served the industry extremely well and have produced a capital environment for the industry with minimal non compliance of providers. Under the Commission's recommendations, Approved Providers will now be burdened by having to provide for several different funding avenues adding complexity and consumer risk.

The impact of reducing access to bond capital should be taken very carefully. Unless a guaranteed alternative cash stream to build new aged care facilities is offered, Regis believes Bonds should be retained as the number one source of capital across the industry and re-ranked within the framework of the other options in the Report.

The average bond paid by new residents has risen from $58,000 in 1997-98 to over $230,000 in 2009-10. The average bond exceeds the cost of new construction for basic residential accommodation[12].

Whilst the Commission's numbers are consistent with the Regis experience, we do not agree that the average bond exceeds the cost of construction once all costs are accounted for.

In order for residents to exercise informed choice when deciding on their residential care provider, the structure of the funding for accommodation must be flexible enough to enable providers to offer a range of accommodation options in response to market demand.

For the funding structure to encourage and allow the provision of the full range of accommodation options, the key components should include;

- The provision of funding based on a minimum acceptable standard of accommodation for supported residents, and
- The ability for providers to charge an accommodation payment for all non-supported residential care places, which reflects both the cost of providing accommodation as well as the desirability of the accommodation.

[12] PC Draft Report, Overview p XXXI

This bond amount should not be capped artificially by linking it to the supported resident payment, but rather set by the market.

Supported Residents

For supported residents, the minimum acceptable standard has been proposed at a two bed room with shared ensuite. The cost of this accommodation will be affected by a number of variables:

- Regional influences on price
- Cyclical movements in the construction industry pricing
- Overall size of the facility
- Whether the facility is built entirely for supported residents or in combination with non supported residents

Based on Regis experience in developing residential aged care facilities, the following table illustrates the range in capital cost possible. The funding for this accommodation charge should reflect this cost base.

Regis total cost of construction per room for various accommodation types

Cost Item	Type 1	Type 2	Type 3
Construction	180,000	142,000	180,000
Design & Documentation	16,200	12,780	16,200
Authority Fees	1,700	1,700	2,500
Furniture Fittings and Equipment	15,500	15,500	15,500
Medical Equipment	2,500	2,500	2,500
Land	40,000	32,000	32,000
Rates and Land Tax	3,000	2,250	3,750
Interest	35,000	28,500	11,400
Mobilisation	3,500	3,500	10,000
Local Authority Headworks	5,000	5,000	5,000
Total	**$ 302,400**	**$ 245,730**	**$ 278,850**

Type 1 is based on a 120 bed single room with ensuite facility

Type 2 is based on a 120 bed two bed room with ensuite facility

Type 3 is based on a 40 bed two bed room with ensuite facility

There will also be an additional regional cost of delivery which can add up to as much as 20% in some areas, ie Perth.

In addition to the upfront capital costs, the lifecycle cost of maintaining the standard of the building is a further $1800 per bed per annum, for which capital funding is required.

When the above capital costs are annualised into an annual accommodation cost for supported residents, the accommodation payment would need to be between $34,400 and $50,800 (WACC[13] assumed at 14%), depending on location, scale of facility and configuration. Refer to the Attachment for details on the calculations for these figures.

The weighted average cost of capital (WACC) has been calculated to represent the cost of funding capital works with a combination of debt and equity.

10 year Gov bond rate	5.60%	
Margin	3.25%	
Cost of debt (pre tax)	8.85%	
Tax rate	30.00%	
Cost of debt (after tax)	6.20%	
Debt funding	45.00%	
Weighted average cost of debt	2.79%	
Cost of equity	20.00%	
Equity funding	55.00%	
Weighted average cost of equity	11.00%	
WACC	**13.79%**	**Say 14%**

Non Supported Residents

For non-supported residents who will be making an accommodation payment, it is important that the price they pay is determined by the market and not capped by linking it to the supported resident payment or by linking it directly to the cost of production. The reasons for having the price set by the market are:

- Setting a price for all the different types of accommodation will not be possible, particularly once we have greater competition and consumer choice in the market
- Active competition in a non supply constrained market place will provide effective price control
- It will encourage innovation and the need to meet market demands
- It will promote investment in the rejuvenation of existing building stock
- It will enable each organisation to set its own return on investment metrics and allow flexibility to adjust risk / return judgments as the industry transitions to an open market.

[13] Weighted Average Cost of Capital

Accommodation bonds to reflect the cost of supplying, maintaining and replacing the providers accommodation

Within our report we have outlined in some detail the cost of delivering and maintaining a residential facility throughout its life. We have also outlined the impacts of increasing acuity on residential providers as shift to high care continues.

In terms of changes to the accommodation bond legislation in the act, Regis draws the Commissions attention to the following;

- We support the removal of the delineation between high and low care including the removal of Extra Services status.
- We support the removal of the bond retention amount in a deregulated market environment provided the provider is free to negotiate with the resident (or their representative) payment terms. The current period of up to six months for a resident to pay a bond or the inability for a provider to take a deposit does not work, in a high care setting the average resident turnover is circa six months, therefore a provider is unable to actually obtain the bond amount in the period of a residents stay.
- We do not support the capping of accommodation bonds; it is a significant constraint to both competition and supply.
- We do support the setting of fees and charges around a "basic standard of accommodation". This could include care, accommodation including periodic payment or bond amount. Above this level it must remain de regulated if a competitive market is to function effectively, ultimately a user pays system evolves and the industry is to meet demand in an environment where residents and their families can exercise choice at all levels.

Implementation Priorities

The Regis recommendations with regard to funding adequacy are to:

- Review the scope of ACFI to expand it to cover a broader range of complex care issues more commonly seen in Residential Aged Care
- Introduce explicit funding for care needs relating to behaviour, eg dementia
- Implement as soon as possible a new indexation instrument that takes into account the real costs to providers in the industry.
- Ensure deregulation of supply and price commences when bed type differentiation is removed(HC/LC/ES).

4. Care delivery by the informal and formal workforce

It is anticipated that the workforce will need to almost triple by 2050, at a time when the overall employment to population ratio will be declining. Aged care employers will be under pressure to offer terms and conditions which will attract sufficient numbers of workers.[14]

Over the past five years Regis has seen a significant change in the issues facing the workforce and impacting labour availability. These include:

- The increasing ethnicity of the workforce
- Training requirements – gaps between skill levels required and the skill level of available employees
- The increasing challenge in attracting staff to the industry in comparison to the acute sector, including:
  - The impact of the Accreditation requirements and Compliance framework
  - Employment terms and conditions
  - Provision of a career path for carers
  - The easier work environment in Home Care
- The impact of increasing Home Care places on Residential Care
- The ability of Australia to compete for Clinicians on an International basis

These issues impact both our ability to offer quality care to residents and the cost of delivering services.

Each of the major issues relating to the workforce and the impact that they have is detailed in this section. Some implementation priorities are identified to assist in identifying a pathway towards managing these issues.

The increasing ethnicity of the Aged Care workforce

The Commission has highlighted the need for workers who have a close connection with the cultural backgrounds of their clients.[15]

The Aged Care workforce has changed considerably over the last 5 years, from predominantly Anglo-Saxon to a substantial number of staff being born out of Australia.

This trend looks likely to continue with the proportion of the workforce for whom English is a second language dramatically increasing and an associated drop in (English) literacy levels.

The following table shows the shift in the makeup of the Regis workforce across a five year span (2006 – 2010). The data is consistent with industry experience.

[14] PC Draft Report, Overview p XXXIX

[15] PC Draft Report, Overview p XL

Regis Workforce 2006 to 2010 - % breakdown of employees as at 30 June

# employees	30/6/2006 1422	30/6/2010 4146
Australia	55%	30%
India / Nepal	10%	30%
China		15%
South East Asia	20%	5%
Eastern block	5%	
Pacific Islands	5%	
South Africa	5%	10%
Africa (excl. South Africa)		10%

Note – these figures are management estimates

There have also been many benefits to the aged care industry, but in summary, management needs to provide time and resources to maintain a harmonious environment in order to reap these benefits.

The changing demographic presents a raft of management challenges:

Recruitment

In addition to the communication challenges that arise when interviewing a candidate with English as a second language, a further major recruitment challenge when recruiting staff trained overseas is matching their competencies and skills to local requirements.

The skills that care staff and Registered Nurses from overseas bring are not always aligned to Australian expectations – including technical, interpersonal, record keeping and communications. Additionally, those staff who have received training in Aged Care Certificate III can require significant levels of further training and support so that they can fulfil their daily tasks of providing care to residents.

This means that the interview and evaluation process is more complex, more costly and the risk of incorrect decisions is higher.

Internal staff training and education

The range of skills nursing staff require has expanded significantly, in response to the increasing level of acuity of our residents. The Department of Health and Ageing publication "National Aged Care Nursing roundtable; Final Report" provides details of this[16], noting that essential skills include:

- High level clinical assessment, problem solving and clinical reason & leadership skills including palliative care, wound management, dementia care and complex behaviour management

[16] Department of Health and Ageing – National Aged Care Nursing Round Table, p8, Table 1.

- Assessment skills to analyse and use data
- Importance of management and awareness of the opportunities to manage / nurture / lead in aged care
- Communication, liaison, negotiation and advocacy skills; counselling, mediation and conflict resolution
- Knowledge of ageing and gerontology issues
- Knowledge of evidence based practice and role of research in their practise

Accordingly, so too has the necessary quantity, quality and complexity of general and specialist training and provided to nursing staff. Literacy and/or language barriers mean that day to day communication with residents and on the job training together with mandatory training programs take longer to deliver the required learning outcomes. Great effort must be taken to simplify text, activities, examples, data and instructions without compromising content. Additional supervision and buddy shifts are necessary.

Quite simply, these measures mean that:

1. it takes much longer to train staff from other countries / cultures, and
2. corporate support teams are resource-heavy to supplement the expertise necessary at our facilities

Cultural alignment

Older people from culturally and linguistically diverse backgrounds can have difficulty in communicating their care needs or having their preferences and cultural needs respected. These circumstances can negatively affect the wellbeing of the older person receiving care.[17]

The relationship between our residents (and families) and their care givers is one based on trust. Older Australians often place great value upon Australian traditions and may have survived major historical events such as world wars. Carers new to Australia will behave within their own value framework until they are able to recognise and appreciate Australian expectations and cultural norms. It takes considerable on the job supervision, training and management oversight to ensure that the care provided by staff is culturally appropriate to older Australians and meets the expectations of their families.

However, it is our experience that despite our best efforts, some older Australians are reluctant to have caregivers from certain countries (against whom Australia went to war). In fact, often racial discrimination - from the resident to some carers - is evident.

Communications and risk management

Internal communication and procedures:

The way Regis communicates company policies, standards, procedures and day to day information has changed dramatically over the past years, the change underpinned by language and literacy issues. To ensure that our quality systems are robust and that our residents are not put at risk, communications have been overhauled to include effective but resource-hungry process such as face to face staff briefings, and structured demonstrations and buddy systems.

The quality of documentation from some foreign born staff leads to more time spent reviewing documentation on a constant basis by management.

[17] PC Draft Report, Summary of Draft Proposals, "Current Problem – Caring for special needs groups" p LX1

Communications with residents and their families:

Where there is increased risk of residents being aggressive towards their carers due (eg some dementia residents), language barriers create a new layer of complexity. Additional training is necessary but comes at a cost – both in terms of additional administrative support, direct financial costs and decreased workforce flexibility.

Further, day to day communications with older Australians and their families are a critical factor in providing optimal care. Liaison, negotiation and advocacy skills, mediation and conflict resolution are made more difficult due to language difficulties.

Increased Training requirements - formal & on the job

The Australian Government should promote skill development through an expansion of courses to provide aged care workers at all levels with the skills they need, including advanced clinical courses for nurses to become nurse practitioners, Management courses for health care workers entering management roles.[18]

Registered nurses within aged care are required to exercise the full range of generalist clinical nursing assessment and analytical skills as well as specialized areas of expertise such as wound management, dementia and continence (reference: National Aged Care Nursing Roundtable – final report). No longer is working within aged care the 'easy option'.

The search for professionally trained carers who want to move to and stay in the aged care sector is becomingly increasingly hard, and labour availability is low.

For those who do join the sector, expectations of care levels and legal compliance are high and expected to further increase in coming years.

In parallel with the expanded demands upon the workforce and a reduced employment pool, staff turnover rates are particularly concerning. Turnover rates are described here:

Position:	Care staff	Registered nurses	Clinical and facility management
Turnover rates, per annum	25%	31%	27%

Employing and retaining suitably qualified and experienced staff is one of Regis' biggest challenges. The pool of candidates is small.

Once recruited there is an ongoing requirement for staff to complete initial on-boarding orientation training, buddy shifts and then mandatory training programs, to ensure that skill levels are adequate for the increasing demands of all care roles.

Regis has recently devised an induction program and Onboarding with a minimum five days provided for a Registered Nurse. Without this type of training many nurses are just not equipped to care for our resident population's growing acuity and the complex regulatory environment.

[18] PC Draft Report, Draft Recommendation 11.3, p L111

Initiatives such as the retraining of nursing staff, provision of competency based activities require a huge amount of money from Providers budgets to stay compliant with regulators demands.

The Commission's recognition of this challenge and recommendation is supported.

Pre employment training deficits

The Australian Government, in conjunction with universities and providers, should fund the expansion of "teaching aged care services" to promote the sector among medical, nursing and allied health students.[19]

Limited staff availability has led to employing talent and further developing it 'in house'.

Employees can upgrade entry level qualifications with the support of Regis and partnering RTO's, together with government funded Better Skills, Better Care programmes. With the industry's high turnover and each provider's variable polices and producers, the solution is additional training. While an effective strategy it does require a significant tier of corporate administration overlay and direct facility support such as on the job training, buddy skills, rostering flexibility and skills coaching.

Regis has invested a comprehensive training program to help build skills, covering mandatory topics (Fire Safety, OHS, Infection Control, Compulsory Reporting, Customer Service, Manual Handling) as well as a raft of clinical modules (pain management, wound care etc). These training courses are available in a number of formats: face to face, self-directed learning packages and online learning.

We have launched a 7-month leadership development program to build our next tier of facility manager and senior nursing staff.

It should be noted that nursing graduates new to Australia can require a substantial volume of additional training and support (cultural, interpersonal and communication skills) before they are able to fulfil their duties.

Any additional training available externally at tertiary level will help to ease the cost of training on providers, and increase the potential available pool of staff to the industry.

Attraction of Staff to Aged Care versus the acute sector

Attracting and retaining qualified nursing staff is extremely difficult, due to the national shortage of nurses, coupled with the extensive and direct competition from the acute and other health sector employers. These sectors offer better; wages, working conditions through less resident/patients ratios, less administration associated with compliance and overall better allowances and conditions of employment.

Regis sees wage parity is the primary challenge in attracting employees, but others include:

- The comparative complexity of the regulatory framework (discussed in detail in the section addressing the Regulatory framework)
- Staffing to resident ratios
- The increase in caring for residents with challenging behaviours (eg dementia)

[19] PC Draft Report, Recommendation 11.4, p L111

Due to the non financial issues, Regis believe that wages need to be favourable to the acute sector in order to attract sufficient staffing numbers into the industry.

Improved employment terms and conditions are the foundation for building a larger supply of workers in the aged care sector. The most notable shortcoming is the long standing disparity between the wages paid to nurses in the sector compared to those in the public acute sector.[20]

Our Personal Care Workers are not paid a competitive wage and as a result leave the industry all together at a time of real growth in the industry to pursue roles in unskilled industries such as manufacturing, labouring or other low skilled industries.

When negotiating our Enterprise Agreements (with the Nurses Unions) we are faced with aggressive and skilled union negotiators demanding we provide at least comparable % salary increase secured in acute and health sectors. Yet our funding increases in no way match these levels of increase provided. Over the last 3 years we have had to provide between 3.25% and 6.5% per annum wage increases to be competitive with other health sectors, as well as introduction of additional allowances. During this same 3 year period our COPO funding has increased by 2.3%, 1.9% and 1.7% respectively.

For profit providers have the extra burden of the fact they cannot offer their workforce tax effective salary packaging.

Younger staff have more options, are more salary savvy and demand flexible work conditions as seen with the introduction of paid parental leave etc.

Also with the advent of paid parental leave and a predominantly female workforce, providers will be forced to pay for benefits such as child care etc to attract younger and more mobile staff.

The adoption of the Commission's recommendation is critical to the supply of employees into the industry.

Additional factors impacting the Aged Care Workforce

Impacts of increasing Home Care places on Residential Care

In an industry that has scarce resources and cannot compete with acute providers, the continual growth of home care provides an additional resourcing burden on the industry.

We accept at many older Australians wish to stay at home as long as possible and this is not the issue here. The issue is that, as the provision of home care increases, the drain on the human resource pool available to deliver the service becomes even greater.

Relative to residential care, the delivery of home care may be more attractive to a clinicians and carers than working in the residential care space due to:

- More flexible working hours
- Perceived greater level of one on one contact with residents
- Less regulated environment than Residential Aged Care

Our research tells us that a home care clinician has about 30% of the productivity of a residential clinician once travel time, administration etc are taken into account. This places

[20] PC Draft Report, Overview p XXXIX

enormous pressure on labour availability that is already under duress. The commission has recommended that the home care places be increased by 10-20% over the next few years. Executing this without an active comprehensive workforce strategy will impact the provision of care to older Australians materially. We provide a number of examples of the industries inability to attract clinical resources in an ever declining pool and an ever increasingly more punitive compliance environment.

Simply the only way forward is to deal with labour availability at a whole of government/industry level.

Australia's capacity to attract clinicians in a global context

Regis actively recruits from overseas and sees this as part of our strategy to secure appropriate skilled and experienced qualified nurses. Each year we send personnel across to United Kingdom and Ireland to secure suitably qualified staff at Nursing and Management level.

Australia's way of life, climate, amazing landscape and open spaces makes the migration to Australia an attractive proposition for our target market. Regretfully due to our uncompetitive wages, too often we are unable to secure candidates due to the wages we offer in Aged Care.

The retention in Aged Care of these nurses recruited from overseas after migrating is a compounding issue, as we incur the expenses of bringing them to Australia, train and orientate them to the Australian ways then they quickly move to the acute sector when they discover the wage variance. This retention issue has been further heighten by the changes to Immigration legislation relating to the 457 Visa which allows these qualified nurse to easily transfer from one employer to another. We inturn have no ability to secure any reimbursement of our substantial investment in these qualified nurses.

Implementation priorities

Based on the labour related issues and their business impact discussed in this section, Regis propose the following short term implementation priorities be considered as part of the Commission's Implementation Plan:

- Implement as soon as possible a new indexation instrument that takes into account the real labour costs facing providers in the industry
- Increase and maintain Aged Care Clinicians wages to a premium of 15% to the acute sector which is reflective of the complex nature of the role and compliance environment
- Increase funding to allow for on the job training for new employees into the industry
- Review the regulatory impacts on Aged Care industry employees
- Develop a career structure for carers in the industry
- Review government immigration policy settings to ensure they reflect the future demand requirement both domestically and internationally to allow older Australians the quality of care they deserve

This would impact providers in a positive way through:

- Enabling the provision of better quality staff
- Assisting in changing nurses' views of working in aged care as higher wages would make it a more attractive career option
- Enabling provision of higher staffing ratios
- Reducing staff turnover
- Enabling investment in modern equipment and technology enabling a safer and more efficient workplace

- Easing the prevalence of student and 457 visa based staff and encourage local staff to take up aged care as a career option.

5. Reform of the regulatory framework

The Commission is proposing the establishment of an independent regulator – the Australian Aged Care Regulation Commission (AACRC).[21]

The largest impact on delivery of care by residential aged care employees has been the increase in the regulatory regime.

Given the vulnerability of aged care residents, an effective regulatory framework is critical, but the current framework is too complex, which leads to increased costs for the provider, leads to a greater level of staff turnover and makes it more difficult to compete with both the acute and community care sectors.

There are currently approximately 12 external bodies that have access to Residential Aged Care Facilities across the country, many of these doubling up on legislative application and assessment, compliance and monitoring. Examples of this are:

- Fire standards
- Food safety
- OH&S
- Drugs and poisons

Many external auditors give conflicting advice to site staff causing confusion and resentment across the care staff and management as a whole.

When external regulators or auditors visit any one of our sites the normal care based activities take second place and residents suffer.

There has been a redirection of frontline staff from resident care to regulatory compliance.

In a recent audit, Regis Facility Manager were found to be working an additional 4 hours per week on compliance and regulatory issues. This is a significant cost when added to the direct time spent by care staff and the additional cost of the corporate team supporting these activities.

Impact of Aged Care Accreditation and Compliance on employees

In terms of improving productivity, there are opportunities to remove unnecessary and complex regulatory and administrative burdens[22]

Regis maintains a system of exit interviews across Registered Nurses and above. High on the list of reasons for leaving are:

- CIS process
- Risk of being reported to APHRA
- Too much regulatory paperwork
- Not enough time to properly care for residents

[21] PC Draft Report, Overview p XL and Draft Recommendation 12.1

[22] PC Draft Report, Overview p XXXIX

Many staff choose not to work in the Aged Care sector due to the unrelenting nature of regulation and its enforcement across the sector. In particular this impacts senior clinicians. The Regis experience is that the view of Clinicians of working in Aged Care versus the acute care sector is that:

- there is a greater need for documentation - eg long term care and socialisation, and the documentation is lengthy
- due to the audit requirements, documentation is targeted to meet the requirements of regulators rather than what are the residents' assessed needs
- external regulator contact (CIS) is onerous (eg more than one contact per week and contact time is approximately 4 hours), where staff preference is to spend time caring for residents
- CIS officers detailed investigations on site are disruptive and time consuming – more interested in the process rather than a system
- There are repetitive requests are made by external auditors from different organisations for the same policies and procedure
- There is a greater likelihood that staff may be stood down and performance managed for accidents
- There is fear of the direct power of CIS to refer Health Professionals to APHRA
- There is a view that disgruntled staff able to use the CIS as a vehicle to lodge complaints about other staff and or provider

These views make it extremely difficult to attract and retain experienced clinicians at Residential Aged care facilities.

Regis supports the Commission's recommendations and believes this more streamlined approach will reduce staff turnover and attract more clinicians to the industry.

The Cost of Compliance

The management overhead cost associated with meeting the requirements of the current framework are significant. The following is a summary of the Regis resources required to facilitate support visits and audits on a regular basis in 2010:

CIS - DoHA

- 196 contacts (more than 1 visit every second day.)
- Approximate 19,600 pages of information sent (faxed emailed and posted)
- 4.5 contacts per site per annum
- 4 hours x 196 = 785

- DoHA validations – 2 visits per site per annum = 1376 hours of staff time

ACSAA

- 120 contacts – 17 in one month
- At least 2 staff – 16 hours – x 120 = 1960
- This does not include kit submission (10) 2010 and desktop audits (9)

Other

- Food safety regulations – 1 visit per site per annum – 172 hours
- Drugs and Poisons – 1 visit per site per annum – 172 hours

- Work safe – 1 visit per site per annum –annual OH&S – 172

Whilst we recognise that an effective accreditation framework is critical in this industry and will only become more so with the advent of greater competition and the requirement for increasingly complex care needs, the current framework is too complex and takes away from resident care rather than ensuring it.

The Commission's recommendations are supported.

Ross Johnston

Chief Executive Officer

Attachment to the Regis Response to the Productivity Commission Draft Report

Accommodation Funding Adequacy / Structure

Cost Calculation for the standard unit of accommodation of twin room with ensuite.

Regis do not currently build this form of accommodation, however the cost can be extrapolated from the cost of building a single room facility on the following basis:

Establish base construction cost

- The average construction cost per bed for an all single bed ensuite facility between 80 and 120 beds is $180,000. This is based on Regis' most recent construction projects.
- The area per bed for this type of building is on average 52sqm. This is based on Regis design standards and area schedules provided.
- Based on this, the total cost for a 120 bed single room facility is $21.6m.
- The total area for this building is 6,240sqm.
- The square meter rate for construction is therefore $3,400/sqm. This rate includes all costs of construction including external works, basements, landscaping etc.

Establish cost per bed for standard unit of accommodation in 120 bed facility.

- The area per bed for this type of building is on average 42sqm. This is based on Regis design standards and area schedules (attached).
- The total area for this building is 5,040sqm.
- Based on this, the total cost for a 120 bed double room facility is $17.1m.
- The construction cost per bed is therefore $142,000.

Establish cost per bed for standard unit of accommodation in 40 bed facility.

- The area per bed for this type of building is on average 53sqm. This is based on Regis design standards and area schedules (attached).
- The total area for this building is 2,120sqm.
- Based on this, the total cost for a 40 bed double room facility is $7.2m.
- The construction cost per bed is therefore $180,000.

Area schedules for a 120 bed facility

Twin Room with Ensuite Configuration

Schedule of Accommodation for 120 Beds

Residential Area

Room Name/Type	Area m²	Number	Total Area
Bedroom - 2 beds	28	60	**1680**
Ensuite	5	60	**300**
Lounge (minimum 2m² - preferred 3m² per person)	45	8	**360**
Dining (Main) 3m² per person	45	8	**360**
Dining (Private) 1 per floor	20	2	**40**
Clean Utility	6	4	**24**
Pan Room	6	8	**48**
Assisted Bath	N/A	N/A	**N/A**
Resident Toilet (assisted)	4	8	**32**
Laundry (Personal)	6	2	**12**
Cleaner	5	8	**40**
Clean Linen	1.5	8	**12**
Activities Coordinator Stores	10	1	**10**
Nurse / Clerical Workstations & Records	10	4	**40**
Stores	6	8	**48**
Soiled Linen Holding	1.5	8	**12**
Activities / Lifestyle Room	50	1	**50**
Reflection Room (Chapel)	30	1	**30**
Hairdresser / Podiatrist	16	1	**16**
Library / Internet Room	30	1	**30**
Disabled Toilet	5	1	**5**
Assisted Toilets	4	2	**8**
NET FLOOR AREA			**3157**
Add Circulation			25%
GROSS FLOOR AREA			**3946**

Schedule of Accommodation for 120 Beds

Administration Area

Room Name/Type	Area m²	Number	Total Area
Manager's Office	20	1	**20**
Secretary / Reception	14	1	**14**
Filing & Storage	8	1	**8**
Meeting Rooms	16	1	**16**
Staff Training	32	1	**32**
Activity Coordinator	16	1	**16**
Consulting Room	14	1	**14**
Residents Case Store	20	1	**20**
NET FLOOR AREA			**140**
Add Circulation			*25%*
GROSS FLOOR AREA			**175**

Schedule of Accommodation for 120 Beds

Front of House Services

Room Name/Type	Area m²	Number	Total Area
Entry / Lobby	10	1	**10**
Public Amenities	15	2	**30**
Waiting Lounge Area	30	1	**30**
NET FLOOR AREA			**70**
Add Circulation			*25%*
GROSS FLOOR AREA			**88**

Schedule of Accommodation for 120 Beds

Back of House Services

Room Name/Type	Area m²	Number	Total Area
Servery	16	4	**64**
Central Kitchen	100	1	**100**
Coolrooms & Stores	30	1	**30**
Central Laundry	40	1	**40**
Soiled Linen Holding (laundry)	4	1	**4**
Clean Linen Holding	10	1	**10**
Central Plant	60	1	**60**
Maintenance	12	1	**12**
Goods & Receiving	20	1	**20**
General Stores	30	1	**30**
Housekeeper Supplies	20	1	**20**
Staff Change & Amenities	20	1	**20**
Staff Room	15	1	**15**
Staff Toilets	4	4	**16**
Security & Communications	12	1	**12**
NET FLOOR AREA			**453**
Add Circulation			*25%*
GROSS FLOOR AREA			**566**

Schedule of Accommodation for 120 Beds

Ancillary Areas

Room Name/Type	Area m²	Number	Total Area
Stairs	16	8	128
Lifts	8	6	48
Doors & Risers	Allowance		15
NET FLOOR AREA			**191**
Add Circulation			*25%*
GROSS FLOOR AREA			**239**

Schedule of Accommodation for 120 Beds

External Areas

Room Name/Type	Area m²	Number	Total Area
Parking (1 space per 3 beds)	30	40	1200
Entry Canopy	28	1	28
Visitor Parking (at entry)	20	3	60
Roof Plant (screened)	30	4	120
Ambulance Bay	4	1	4
Secure External Area			0
Accessible External Area			0
NET FLOOR AREA			**1412**
Add Circulation			*25%*
GROSS FLOOR AREA			**1765**

Schedule of Accommodation for 120 Beds

Summary

Area	Gross Floor Area
Residential Area	3946
Administration Area	175
Front of House Services	88
Back of House Services	566
Ancillary Areas	239
TOTAL GROSS AREA	**5014**
AREA PER BED	**41.78**

Area schedules for a 40 bed facility

Twin Room with Ensuite Configuration

Schedule of Accommodation for 40 Beds

Residential Area

Room Name/Type	Area m²	Number	Total Area
Bedroom - 2 beds	28	20	**560**
Ensuite	5	20	**100**
Lounge (minimum 2m² - preferred 3m² per person)	30	4	**120**
Dining (Main) 3m² per person	30	4	**120**
Dining (Private) 1 per floor	20	1	**20**
Clean Utility	6	2	**12**
Pan Room	6	2	**12**
Assisted Bath	N/A	N/A	**N/A**
Resident Toilet (assisted)	4	2	**8**
Laundry (Personal)	6	1	**6**
Cleaner	5	2	**10**
Clean Linen	1.5	2	**3**
Activities Coordinator Stores	10	1	**10**
Nurse / Clerical Workstations & Records	10	2	**20**
Stores	6	4	**24**
Soiled Linen Holding	1.5	2	**3**
Activities / Lifestyle Room	30	1	**30**
Reflection Room (Chapel)	20	1	**20**
Hairdresser / Podiatrist	16	1	**16**
Library / Internet Room	15	1	**15**
Disabled Toilet	5	1	**5**
Assisted Toilets	4	2	**8**
NET FLOOR AREA			**1122**
Add Circulation			25%
GROSS FLOOR AREA			**1403**

Schedule of Accommodation for 40 Beds

Administration Area

Room Name/Type	Area m²	Number	Total Area
Manager's Office	20	1	**20**
Secretary / Reception	14	1	**14**
Filing & Storage	8	1	**8**
Meeting Rooms	16	1	**16**
Staff Training	15	1	**15**
Activity Coordinator	16	1	**16**
Consulting Room	14	1	**14**
Residents Case Store	20	1	**20**
NET FLOOR AREA			**123**
Add Circulation			*25%*
GROSS FLOOR AREA			**154**

Schedule of Accommodation for 40 Beds

Front of House Services

Room Name/Type	Area m²	Number	Total Area
Entry / Lobby	10	1	**10**
Public Amenities	15	2	**30**
Waiting Lounge Area	30	1	**30**
NET FLOOR AREA			**70**
Add Circulation			*25%*
GROSS FLOOR AREA			**88**

Schedule of Accommodation for 40 Beds

Back of House Services

Room Name/Type	Area m²	Number	Total Area
Servery	16	2	**32**
Central Kitchen	70	1	**70**
Coolrooms & Stores	30	1	**30**
Central Laundry	30	1	**30**
Soiled Linen Holding (laundry)	4	1	**4**
Clean Linen Holding	10	1	**10**
Central Plant	30	1	**30**
Maintenance	12	1	**12**
Goods & Receiving	20	1	**20**
General Stores	30	1	**30**
Housekeeper Supplies	20	1	**20**
Staff Change & Amenities	20	1	**20**
Staff Room	15	1	**15**
Staff Toilets	4	4	**16**
Security & Communications	12	1	**12**
NET FLOOR AREA			**351**
Add Circulation			*25%*
GROSS FLOOR AREA			**439**

Schedule of Accommodation for 40 Beds

Ancillary Areas

Room Name/Type	Area m²	Number	Total Area
Stairs	16	0	0
Lifts	8	0	0
Doors & Risers	Allowance		15
NET FLOOR AREA			**15**
Add Circulation			*25%*
GROSS FLOOR AREA			**19**

Schedule of Accommodation for 40 Beds

External Areas

Room Name/Type	Area m²	Number	Total Area
Parking (1 space per 3 beds)	30	40	1200
Entry Canopy	28	1	28
Visitor Parking (at entry)	20	3	60
Roof Plant (screened)	30	4	120
Ambulance Bay	4	1	4
Secure External Area			0
Accessible External Area			0
NET FLOOR AREA			**1412**
Add Circulation			*25%*
GROSS FLOOR AREA			**1765**

Schedule of Accommodation for 40 Beds

Summary

Area	Gross Floor Area
Residential Area	1403
Administration Area	154
Front of House Services	88
Back of House Services	439
Ancillary Areas	19
TOTAL GROSS AREA	**2101**
AREA PER BED	**52.53**