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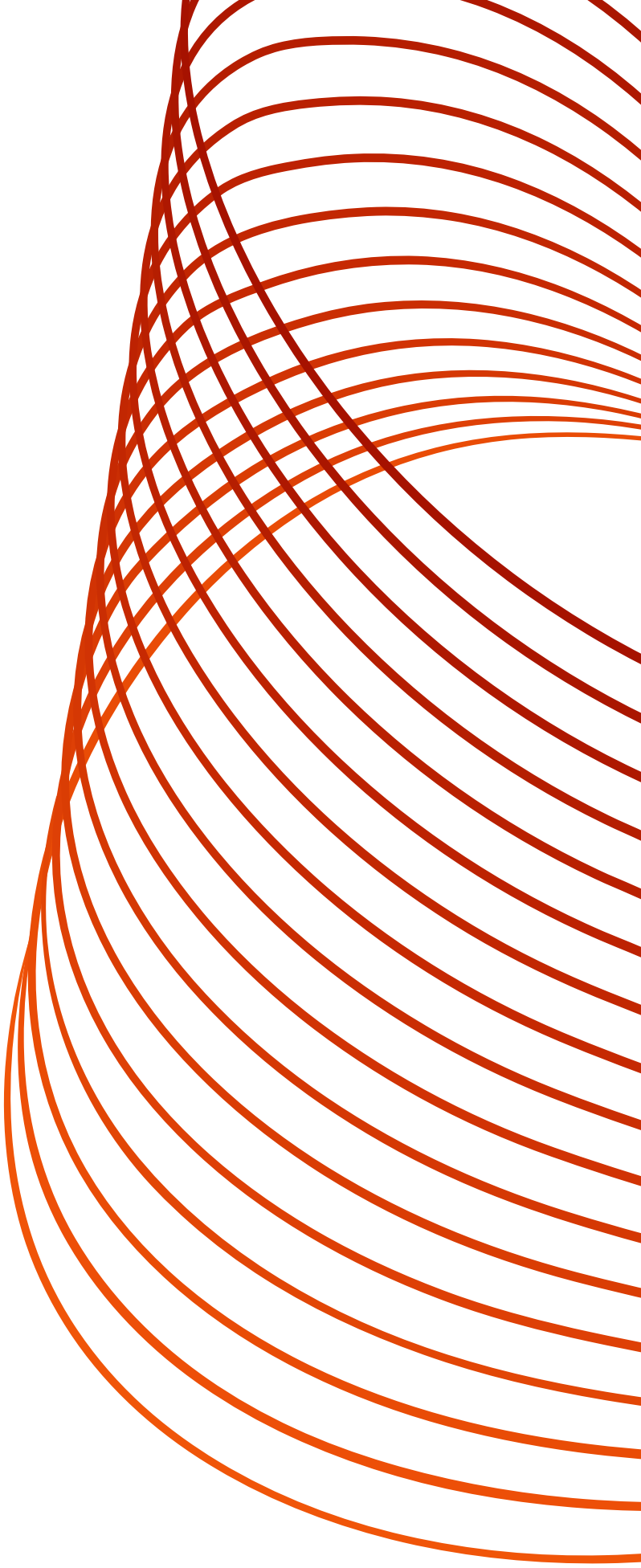
Aged Care Accommodation and Services Strategy

Prepared for Shire of Boddington

20 September 2021



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Executive Summary

Project Context

The Shire of Boddington wishes to facilitate or to establish an aged care accommodation facility. The purpose of this initiative is to provide residential care to older persons with complex care needs from the Shire of Boddington and surrounding areas.

To progress this initiative, the Shire of Boddington engaged Verso Consulting to undertake a review of non-traditional models of residential aged for their suitability to Boddington, including analysis of the financial and licence implications and pathways to implementation.

The review is intended to provide a recommendation that includes a suitable model, its expected viability (and assumptions) with an implementation pathway to scan the marketplace for approved providers with whom a delivery partnership may be possible.

Demand

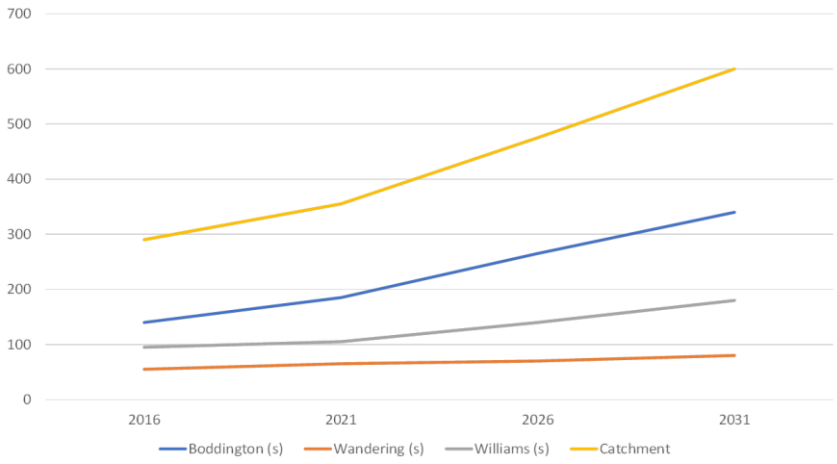
Service Catchment

The catchment for residential aged care based in Boddington includes Williams and Wandering. Community forums and broader supply and demand evidences supports the validity of the catchment.

Population 70+ years

Between the 2011 and 2016 census periods, the population aged 70+ grew in both the catchment (+39.2%) and in Boddington Local Government Area (LGA) (+39.8%). In this period, the overall population declined in both the catchment (-8.5%) and in Boddington LGA (-17.1%). The other two LGAs in the catchment experienced a small overall growth in population.

The 2016 census detailed that there were 330 persons aged 70+ in the catchment, with 151 residing within Boddington LGA. WA Tomorrow population projections demonstrate that by 2026 there are estimated to be 475 people aged 70+ in the catchment and 265 in Boddington LGA.



It is worth noting that in Shire of Boddington's 2012 needs study, the 70+ population was projected to be 486 for the catchment and 297 for Boddington LGA. This is similar to the WA Tomorrow projections used in the updated needs study (Appendix 1). Therefore the projections can be confidently used to support strategic planning.

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The percentage increase from 2016 to 2031 for the catchment's 70+ population using the 2016 census data and WA Tomorrow projections (+81.8%) is slightly higher than the 2012 population needs study documented (+80%), and a significant 125.2% for Boddington. Calculating high growth of the 70+ population supports recommendations related to the development of aged care services to meet complex higher care needs.

The data for populations aged 85 and older demonstrates even higher growth (based on the 2016 census and WA Tomorrow population projections) of +234.3% for the catchment +253% for the Boddington.

Demand for Residential Aged Care

The table below shows that without residential aged care being supplied in the catchment (operational places) by 2026 there will be demand for 37 places. Using WA Tomorrow projections, the unmet demand is estimated grow to 47 places in the catchment by 2031. The broader area of the Southern Wheatbelt is also delivering less aged care places than the demand estimates would justify, indicating that alternate placements are less likely in a broader Wheatbelt catchment.

LGA	70+ Population	Benchmark	Operational (2020)	Variance (+/-)
Boddington (S)	265	20.7	0	- 20.7
Wandering (S)	70	5.5	0	- 5.5
Williams (S)	140	10.9	0	- 10.9
Catchment	475	37.1	0	- 37.1
Wheatbelt South SA3*	**3,419**	**266.7**	**202**	**- 64.7**

Characteristics of residential aged care residents

The characteristics of the residents entering a residential aged care facility supports an understanding of the model of care required and the form of building design that will be most appropriate. This also provides insight into the workforce skills and expertise required to deliver the service.

The *Likelihood of residential aged care use in later life*[1] report highlights the requirement for residential aged care:

- An estimated 34% to 53% of Australians will enter a residential aged care facility during their lifetime
- About 9% of people using aged care services at any one point time are in residential aged care

Key findings of the report include:

- The majority of residents entering residential aged care in the catchment are aged 80 years and older
- More than 20% of entrants will stay for less than 5 months, however about 1 in 4 residents will stay longer than four years
- 84% of residents exit the facility because they have died, pointing to the requirement to provide palliative care within residential aged care
- The people entering residential aged care have complex health care and behavioural support needs, with 54% having 5 to 8 long-term health conditions and 23% having 9 or more. 35% had 5-8 impairment types and 38% had 9 or more.

[1] [Broad JB, Ashton T, Gott M, McLeod H, Davis PB, Connolly MJ. Likelihood of residential aged care use in later life: a simple approach to estimation with international comparison. Aust N Z J Public Health. 2015;39(4):374–9].

- Dementia care is required for at least 53% of residents, with 40% also having a mental health diagnosis
- Australian Institute of Health and Welfare publications detail that 79% of residents have a mental health diagnosis (26% who are not living with dementia) although more current research suggests that 93% had a mental or behavioural disorder, including dementia 58% or depression 54%.

Residential Aged Care Viability

Summary of changes over the last 15 years

Over the last 15 years residential aged care has changed significantly. The big picture trends have been:

- The abolition of the low care (hostel) and high care (nursing home) divide
- Increased capacity of providers to seek residential aged care deposits (RADs) or Daily Accommodation Payments (DAPs) from all persons entering a residential aged care facility. Previously bonds could only be secured from older people entering a low care facility
- Consolidation of ownership of residential aged care into increasingly fewer providers including listed companies
- The diminishing role of local community organisations, local government and health services
- The central role of dementia care in residential aged care
- Increasingly complex care needs of older persons entering residential aged care
- Significant reduction of smaller sized facilities

Size and financial viability

A range of operational issues impact financial viability relative to a residential aged care facility's size:

- Administrative and management functions including compliance requirements are the same regardless of size
- Larger facilities can assign the functions to specialised staff improving efficiencies and can support these functions with lower cost clerical staff
- As a portion of the overall size of the facility, vacancies and refurbishments can be managed more readily within the business model, e.g. One vacant bed offline for two weeks to be refurbished after a resident exits in a 100 bed facility is a loss of 1%, whereas in a 30 bed facility this represents 3.3%.
- Rostering of staff can be more easily flexed to match the actual load as occupancy levels change in large facilities
- Overnight staffing ratios can be more easily managed in a large facility than in a small facility, particularly registered nurse costs
- Increased scale can improve a range of options for specialist inputs such as dementia specialist, allied health and clinical nurse practitioners
- Larger facilities located in areas with strong property markets can increase their earnings from non-operational property investment strategies. These are often not available to smaller aged care facilities located in rural townships without the same capital gain opportunities.

Royal Commission statement on funding

The following statements by the Royal Commission into Aged Care Quality and Safety[2] provide a perspective on the current status of the aged care system and the impact felt in places such as Boddington. The Commissioners reported:

"Funding for aged care is insufficient, insecure and subject to the fiscal priorities and wide-ranging responsibilities of the Australian Government. This affects access to, and the quality and safety of, care."

"The aged care system has been affected by piecemeal approaches and policy compromises that detract from quality care. For several decades, one of the priorities for governments dealing with the aged care system has been to restrain the growth in aged care expenditure. This priority has been pursued irrespective of the level of need, and without sufficient regard to whether the funding is adequate to deliver quality care. This has occurred through limiting expenditure without accounting for the actual cost of delivering services, rationing access to services, and neglecting reform of the funding model."

"These should not be thought of as inadvertent errors in the design of the aged care system in Australia. These are design features."

The overall operating model for residential aged care

Providers of residential aged care seek to generate value in two ways:

1. By delivering services for which the Commonwealth Government pays subsidies and residents pay fees

2. Property investment which is currently the strongest driver for generating value

The Stewart Brown (aged care specialist accountants) survey of 44% of residential aged care facilities was published in their annual Aged Care Financial Performance Survey. The December 2020 quarter report provides the most up-to-date data on the status of residential aged care operations and financial performance. Key insights include:

- The average result is a deficit of $6.10 per bed per day
- A decline in occupancy over the year of 1.3% in the past 12 months for all facilities
- If the special funding for COVID-19 and a rural and remote viability supplement had not been provided, the situation would have been worse
- The situation in rural and remote aged care is worse, with average per bed day operating loss of $10.54

Figure 1: Overview of the operational issues

Source: Stewart Brown Aged Care Aged Care Financial Performance Survey December 2020

[2] Royal Commission into Aged Care Quality and Safety Final Report Volume 2 page 188

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Summary of current residential aged care viability

Residential aged care is not operationally viable primarily due to government failures that have focused on restraining expenditure by design with no regard for the impact on the safety and quality of care provided to older people. The worsening situation has been a long-term trend.

Currently the viability of residential aged care is further disproportionately and negatively impacted by:

- The degree of rurality
- Size of the aged care facility

The larger for-profit providers represent a small group of approved providers (3%) but hold 36% of funded places. Their business models are primarily driven by the non-operational activities of property investment.

Models of residential aged care

There are three basic concepts that support small scale or homelike residential aged care. The models have been developed to address viability and/or to deliver safe high quality care related to the contemporary care needs of people entering residential aged care. The three broad models reviewed for application in Boddington are:

- Small scale residential aged care designed to address viability using either a place based (multi service) model, federated model, hub and spoke model or the multi-purpose service (MPS) model
- Small scale and or homelike models that are part of a larger campus focused on superior dementia/mental health care/maintenance of wellbeing
- Housing based alternatives providing the equivalent to residential aged care using home care packages to fund and provide care

Selection Principles

Principles and threshold issues used for determining the right/best option(s) must be able to respond to:

- The quantum of need, bearing in mind that the facility might have a 40 year life
- Care and safety issues
- The requirement to attract and retain the leadership and staff required to deliver the care safely
- Viability issues and the capacity to return a surplus to enable reinvestment of funds into service improvement and capital replacement/refurbishment
- The preferred position of the Shire of Boddington to attract or facilitate the involvement of an approved provider

Option Selection

A workshop was conducted with the Shire of Boddington project committee to consider the best options.

Residential aged care required in Boddington

The committee reaffirmed the resolute view from the community forums that residential aged care is required in Boddington. The foundational principle is that it is a human right to be able to age in the community of choice. The

negative impact on residents, carers, partners and families when older persons have to leave their community go to residential aged care some distance away is considered unacceptable.

The committee's preferred options are:

Option 1: A small sized residential aged care facility operating under current business rules achieving enhanced viability through delivering a multiplicity of service types. Within this model, the committee is not discounting that there may be opportunities to develop a 'federated model'. The committee also appreciate the care model and design exemplified in the Green House Project, and similar models should be incorporated into the facility design and operations. The committee considers that co-locating the facility adjacent to the hospital would be particularly beneficial. In this model a close and effective relationship with Western Australia Country Health Service (WACHS) will be desirable.

Sector feedback indicates attracting an approved provider in the current operational environment is unlikely due to COVID-19 restrictions and effects, negative operational results, major reforms and associated uncertainties, restrained property investment opportunities in Boddington, increased regulation, and current occupancy rates. The committee accepts that to achieve the vision for high quality residential aged care and the outcomes achieved in models such as the Greenhouse Project, a local community organisation may have to be developed to operate the facility and the mix of other services.

Option 2: Work with WACHS to have the Boddington Hospital reclassified as a MPS, with WACHS as the provider delivering residential aged care in the manner discussed in the care models in this section. The community would seek for this model to be a genuine partnership between the Commonwealth, the State and the local community.

This option will require significant collaboration and a shared vision with WACHS.

Business Case – Option 1

Key enabling factors

There is current and growing demand for residential aged care in Boddington driven by the population characteristics.

Financial viability can be enhanced in a small scale facility through delivering a range of complimentary services such as (but not limited to): home care packages, post-acute care, disability services, Veterans Home Care, respite, older persons housing or even child care. Good business leadership has found to be a vital factor using this approach.

There is an opportunity to develop partnerships and collaborations into the future with other similar rural aged care services that could support the development of shared capability and economies of scale.

The cost and complexity of care can be reduced by adopting international best practices in the care model and the building design.

A package of capital and land may provide incentives to support an existing approved provider to undertake a feasibility study (this report could help support the business plan).

Key limiting factors

The scale of demand (35-45 beds) is low when compared to contemporary residential aged care. Smaller sized facilities have generally been unviable. Residential aged care providers derive value from operations and property investment. The operations side of the equation is unviable because of scale and the overall government funding model. The property investment (enabled by RADs) is not likely to be a commercially attractive proposition in Boddington. The implication is that providers are unlikely to be attracted to Boddington to deliver residential aged care under the current operating conditions.

The current operational business model may limit opportunities to attract the capital required to construct and develop the facility – at $330,000 per place, the capital required would be between $11.6m to $14.9m.

There is uncertainty regarding the future of residential aged care due to the recommendations of the Royal Commission into Aged Care Quality and Safety and the Federal Government's response.

Customers

Demand for residential aged care is being driven by a growing number of people aged 85+ and a lack of supply. Key care needs are dementia care and mental health; however, the group of people requiring residential aged care typically have 5 to 8 comorbidities with the implication that current and future residents will need a high degree of technical nursing care. The demand is drawn from a catchment that includes Wandering, Williams, and Boddington.

Partners

Potential partners may include Shire of Boddington, WACHS, an approved provider of residential aged care, local health providers, the local governments of Wandering and Williams, Development Commissions and the Federal Government.

Budget

Capital

Capital development cost for the residential aged care facility: $11.6m to 14.9m

Standalone residential aged care facility operating result

The expected operational loss for a standalone facility is using current industry average results:

- $10.54 per bed day x 365 x 35 places = $134,649
- $10.54 per bed day x 365 x 45 places =$173,120

A 20 year operational shortfall based on current business rules and funding model = $2.7m to $3.5m.

New Mandated increased care hours: Flowing from the Royal Commission the Commonwealth has mandated care staff and registered nurses hours. This will increase the care cost hours. UPA has advised for its small facilities that this will add to operational losses by $4.00 per person per bed day even after increased subsidies have been applied. The mandated care cost are estimated to have the following impact:

- 35 places projected additional operational shortfall = $51,100
- 45 places projected additional operational shortfall = $65,700

The overall operational result is estimated at:

- 35 places projected additional operational shortfall = $186,149
- 45 places projected additional operational shortfall = $238,820

A 20 year operational shortfall based on current business rules and the additional cost impost = $3.7M to $4.8M

Mix of other services operational result

The estimated operating results for a mix of additional services is:

- 2 Short Term Restorative Care places operational result = $21,152 p.a.

- 15 home care packages (revenue $386,152) operating result: $5.67 per client per day x 365 x 15 = $31,043
- A range of basic care services (CHSP equivalent) at $300,000 at 8.75% margin = $26,250 (for full calculation see Appendix 2)
- NDIS service provision at 25 hrs per day x 365 x $58.80 = revenue of $536,550; margin 3.14% = $16,848 (for full calculation see Appendix 2)
- Potential saving by spreading administration, quality, IT, HR etc across multiple services = $20,000

Positive results from a broader suite of services = $115,293 p.a. or $2.3m over 20 years.

Operating result combining residential aged care and a mix of other services

In a mixed model of residential aged care and other aged and disability services, the negative operating result may be between: $70,856 and $123,527 p.a. or a result over 20 years of $1.4m and $2.5 m.

Non-operating result

Non-operating income is impacted by the RADs. Estimating the result is based on 60% of places (21 to 27) attracting a RAD of $300,000. Potentially, there would be between $6.3m and $8.1m from which the organisation could earn income from term deposits or investments, e.g. older persons housing. Even on a conservative estimate of 2.5% return, the result could be between $157,500 and $202,500. Over 20 years, non-operational income could exceed $3.2m or $4.1m.

20 year outlook operating and non-operational result

With the addition of a mixed model and non-operating revenue, the result over 20 years may be between $1.8m (35 places) and $1.6M (45 places).

Investors

Notwithstanding previous comments made regarding the likelihood of attracting an approved provider, the option should be incentivised and all options exhausted prior to considering other alternatives. The investment options may be dependent on the following:

- Securing an in-principle agreement with an approved provider who is willing and able to deliver the services in a manner consistent with the community vision and best practice
- Securing an approved provider may require:

- The provision of land on a peppercorn lease over 99 years
- A capital grant

This would enable the provider to build out a detailed business case benefiting from non-operational results to justify anticipated negative operational results.

- A capital grant may be provided by the Commonwealth government, state government or alternatively from the Boddington Gold Mine
- Granted land could be Shire owned, state government land or Crown land
- Based on a viable business model and securing an experienced operator, banks would lend money for development, construction start up and as a long-term mortgage (up to 60% of the required capital – land and building value) or the approved provider's asset position
- A large provider could also provide a loan from their internal resources

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- An alternate approach would be to establish a community organisation to become an approved provider granting land and securing a capital grant and borrowing money to develop, construct and cover the start-up operational shortfall

Business Case – Option 2

Key enabling factors

- There is current and growing demand for residential aged care in Boddington driven by the population characteristics
- Integrated approaches to health, community care and residential aged care can produce improved outcomes for older people and improve health literacy relevant to aged care across the community
- The cost and complexity of care can be reduced by adopting international best practices in the care model and the building design
- The Commonwealth government has been developing a suite of reforms of the MPS model, and in response to the Royal Commission into Aged Care Quality and Safety, has agreed to expand the model where there has been market failure. The reforms bring the MPS model, with reference to aged care, into alignment with aged care standards in the broader system.

Key limiting factors

It is unknown how the reclassification may impact health services at Boddington Hospital and what the implications might be with reference to funding.

WACHS would need to be a willing and active partner to:

- Consider this option
- Co-design the service model with the community, including the building design (considering flexible and integrated service delivery)
- Develop a comprehensive plan to deliver community care, respite, and restorative care across the catchment (Wandering, Williams and Boddington)
- Develop a workforce with a focus on local employment where possible
- Deliver residential aged care services at the required scale

The Commonwealth would need to agree to the reclassification and provide adequate funding to support the scale of operations required.

There is uncertainty regarding reform details, timeframes and funding limitations of the MPS model and how the model intersects with consumer choice. There is also a lack of detail on how capital would be accessed for the expansion of the model.

Customers

The demand for residential aged care is being driven by a growing number of people aged 85+ and a lack of supply. Key care needs are dementia care and mental health. However, the group of people requiring residential aged care typically

have 5 to 8 comorbidities with the implication that current and future residents will need a high degree of technical nursing care as well. The demand is drawn from a catchment that includes Wandering, Williams and Boddington.

Partners

Potential partners may include Shire of Boddington, WACHS,, the local governments of Wandering and Williams, Development Commissions and the Federal Government.

Budget

The budget is to be determined within the MPS program funding and budget.

Next Steps

Immediate actions

The consultants recommend that:

- The Shire of Boddington receive the report
- Confirm the vision, the model of care and the model of viability, i.e. Option 1 or Option 2
- Consider/determine the role the Shire will play in realising the vision for residential aged care and the accompanying viability considerations e.g. advocate, facilitator, partner, investor (seeding, in kind or long-term), customer
- Build consensus with the Shires of Wandering and Williams and their communities regarding the model and their ongoing voice in realising the vision
- Identify if land is available to grant to a prospective approved provider and its suitability considering the model and what the process would be to obtain/grant the land and under what conditions
- Develop collateral to support the marketing of the opportunity and to garner investor support
- Obtain seed money to move through the project inception and realisation phase
- Maintain a project steering committee to work through the next phases of the project

Project Inception

Conduct a project inception workshop with key stakeholders:

- Confirming the vision for the development, model of care, model of community engagement and integration and integration with health
- The viability issues and how they will managed by design, integration and the risks
- The ongoing communication process
- The next steps, noting that The Commonwealth would need to agree to the reclassification and provide adequate funding to support the scale of operations required

- Identify and quantify resources (including human) required to realise the project
- Communicate with relevant State and Commonwealth politicians about the project and intended cause of action; seek their support

Project Realisation

Threshold Issues

There are two threshold issues that need to be determined first:

- Whether WACHS would be willing to partner with the community to explore the concept of establishing a MPS in Boddington to deliver 35-45 places and to also deliver other aged care services to the catchment
- Whether an approved provider organisation would establish 35 to 45 bed aged care facility in Boddington, what incentives could be offered and what would the process be for securing the incentives

Alternate Response

If an approved provider or cannot be incentivised to develop and deliver the model of care envisaged, it is recommended that the following key steps be taken:

- Support the project committee to form a legal entity to deliver aged care services and model of care and viability envisaged in the catchment that includes directors who meet the Commonwealth's requirements for key personnel under the Aged Care Act and consistent with the approved provider governance reforms recommended by the Royal Commission
- Obtain seed funding to manage the costs associated with developing policies and procedures, the organisational design, the concept design for the building and site location and support to develop the approved provider application and associated detailed business case required by the Commonwealth
- Prepare a concept design for the land and buildings
- Prepare a detailed business plan required as an attachment to the Approved Provider application
- Prepare and lodge an Approved Provider application and manage the iterative process often required to meet all of the Commonwealth's requirements
- In concert with the Approved Provider application, develop a comprehensive set of policies and procedures to manage compliance with the Aged Care Act and to enhance practice
- On approval, negotiate with the Commonwealth for licences if the Aged Care Act is still in the process of being rewritten
- Manage land grant processes, and capital grant funding applications
- Build the business case for the additional mix of services as determined in the project inception phase

Project Commencement

The project commencement activities will be dependent on:

- The response from WACHS
- Current Approved Providers

- Alternatively, forming a local organisation that meets the requirements and succeeds in the application to become an Approved Provider

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1 Context

1.1 Background and scope

The Shire of Boddington wishes to facilitate establishment of an aged care accommodation facility. The purpose of this initiative is to provide residential care to older persons with complex care needs from the Shire of Boddington and surrounding areas.

To progress this initiative, the Shire of Boddington engaged Verso Consulting to undertake a review of non-traditional models of residential aged for their suitability to Boddington, including analysis of the financial and licence implications and pathways to implementation. The review is intended to provide a recommendation that includes a suitable model, its expected viability (and assumptions) with the implementation pathway to scan the marketplace for approved providers with whom a delivery partnership may be possible.

As part of this review, Verso Consulting has therefore:

- Reviewed the Shire of Boddington's 2012 Aged Care Plan (developed with support from Verso Consulting) to assess the continued relevance of the recommendations contained therein, in light of the significant changes that have occurred in the Australian aged care system since (including the shift to consumer directed care and the Royal Commission into Aged Care)
- Liaised with industry, government and the community through stakeholder and community consultation
- Obtained data and research specific to Boddington and the catchment area
- Identified current, emerging, and future trends to guide recommendations
- Identified and analysed varying models of aged care accommodation suitable for use in Boddington

1.2 About this report

This report:

- Identifies the assets and comparative advantages, challenges and opportunities within the Shire of Boddington in relation to the provision of aged care accommodation and services
- Identifies suitable non-traditional models of residential aged care with a focus on the economics of these opportunities to develop a short list of the top 2 priority opportunities
- Identifies key limiting and enabling supply and demand factors for the short list priority opportunities
- Identifies the likely investors, partners, suppliers, and customers for each of the priority opportunities
- Provides a business case and high level budget for each priority opportunity, identifying potential funding sources and next steps to advance the priority opportunity

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2 Aged Care Needs in Boddington & Surrounds

This chapter identifies the assets and comparative advantages, challenges and opportunities within the Shire of Boddington in relation to the provision of aged care accommodation and services.

2.1 Review and Research

Verso conducted a review the Shire of Boddington's 2012 Aged Care Plan to assess the continued relevance of the recommendations contained therein. This was achieved by comparing and contrasting evidence required in the project briefing by obtaining data and research specific to Boddington, the surrounding area and a broader catchment area, including:

- Catchment rationale and evidence
- Supply across the catchment for aged care
- Contemporary understanding of WACHS and their aged care policy and practices
- Boddington Hospital services and future service plan
- Updated demographics and a comparison to the projections used in the study
- Updated demand for aged care services and older persons housing including the Boddington Seniors Village wait list and business model

2.2 Catchment Rationale and Evidence

In the community forums (conducted in Williams, Boddington and Wandering) and in other stakeholder discussions the proposed catchment was discussed to test the potential for Boddington based residential aged care to draw from the areas identified. Several factors were considered and are discussed in the following section.

Current Boddington health and related services

The degree to which Boddington's health services are accessed from persons across the catchment was reviewed. There is evidence that people access services such as medical and hospital care from across the catchment, however not exclusively. For example, there is a much stronger relationship between Narrogin and the residents in most parts of Williams. There are also residents of Boddington that may access services in Armadale due to choice, specialisation or availability.

Other Residential Aged Care Options

The capacity of other residential aged care facilities in Narrogin (in particular) or other Wheatbelt locations to meet the current and future needs were reviewed. Key insights identified a need for an alternate to the current residential options in Narrogin due to wait times for a suitable place and concerns amongst some respondents relating to the quality of care. Travel time/distance to access alternate aged care in the Wheatbelt was also identified as an issue.

Accessing Services in Mandurah and Perth

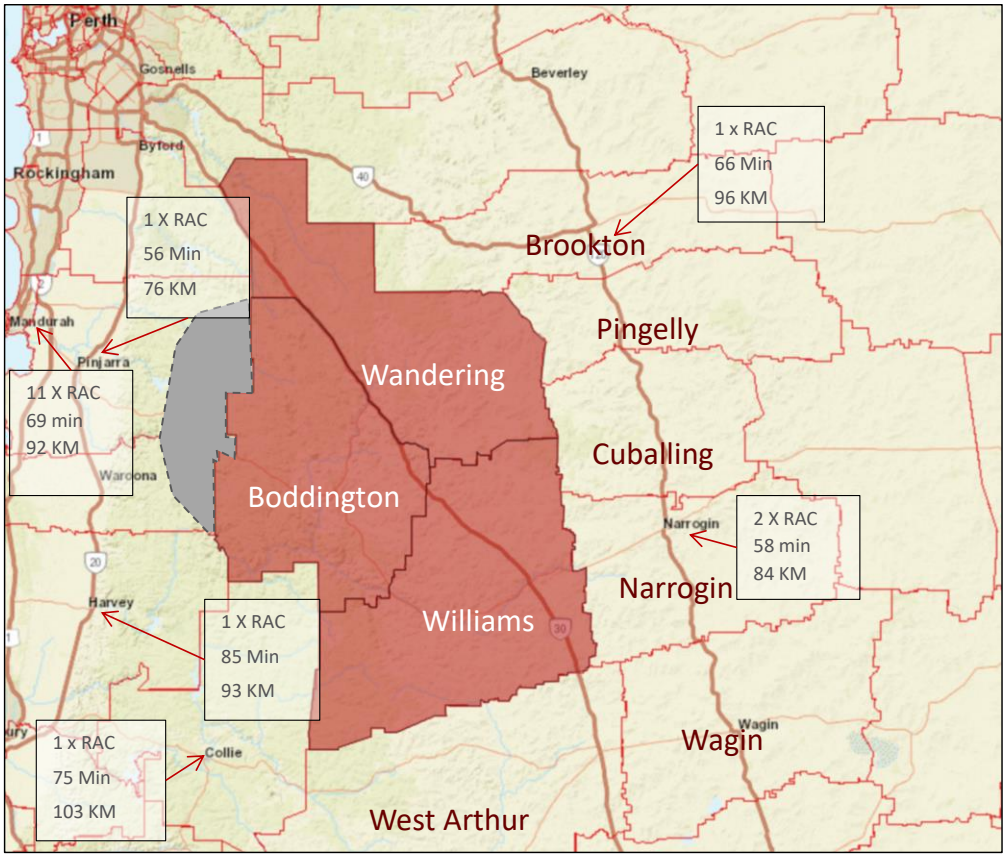
There was strong evidence that people in the catchment do not wish to access services in Mandurah, Perth's South Eastern suburbs or in towns in the Peel Region as alternatives to accessing aged care close to home. This outlook forms the basis of a shared value across the catchment communities and its local stakeholders. People see that it is their fundamental right to age in place. The example cited more than once was the placement of a Boddington resident in Albany which effectively cut the person off from their family. This example was seen as cruel and unacceptable.

The WA Country Health Service (WACHS) did not share the imperative of close-to-home ageing for Boddington residents, putting forward the alternate perspective that the travel times to multiple options in Mandurah and in the south east suburbs of Perth were reasonable. This response was provided taking into account the challenge of establishing residential aged care in Boddington due to scale and related viability, the complexity of care presented in residential aged care and scarcity of the workforce required to support the complex care needs of potential residents.

Catchment Overview

The catchment detailed in Figure 1 below forms the basis for estimating current and future demand for aged care in a Boddington-based service. The demographic profiles in the updated needs study (see Appendix 1) have been developed using population data from Wandering, Boddington and Williams. The map also demonstrates travel times and distances from Boddington to aged care facilities that may be accessed by people in the catchment. The implication of this information is that a resident's family or friends may have to undertake a round trip of 2 hours or more to visit a facility. For some older people the cost or physical exertion of the travel required to visit may be prohibitive. In planning in an urban setting, a 30 minute round trip is often considered to be the primary catchment.

Figure 2: Catchment



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2.3 Aged Care Supply from Metropolitan Perth

In the 2012 needs study (see 2.5), the capacity of Perth based residential aged care providers to offer services to residents of the Boddington catchment was discussed. At that time there was a significant service gap in the Metro South West and Metro South East regions, with a shortfall of 819 places. Consultations had identified that the suburban fringes were poorly serviced with a lack of residential aged care, home care packages and basic services.

In 2021 the capacity of Perth and Mandurah based providers to respond to the demand for residential aged care in the Boddington catchment include the following factors:

- Residential aged care deposits (RADs) sought in these services are benchmarked to real-estate values in the immediate area where the facility is located. This means that the residents in the Boddington catchment may face barriers in accessing the service of their choice due to the relationship between real estate values in the Boddington catchment and RADs sought. In postcodes 6210 (Mandurah) and 6112 (Armadale), the RADs range from $200,000 to $525,000 at an average of $384,6963.

- COVID-19 has significantly disrupted aged care services across Australia undermining consumer confidence and affecting providers' admission policies

- Falling occupancy rates in residential aged care. However, sector commentators and consultations undertaken by Verso show that some consumers struggle to find beds, with providers 'picking and choosing' their residents. This may be due to intersecting issues including health complexities, complex behaviours, financial capacity etc.

- As at June 2021, residential aged care places in Metro South East and Metro South West regions fell short of the Commonwealth's planning benchmarks by 740– in the post COVID environment this could mean that the availability of places will again retract.

Table 1: Occupancy Rates WA

Occupancy Rates in RACs	2015-16	2016-17	2017-18	2018-19	2019 20
Western Australia	94.5%	93.8%	93.2%	90.3%	89.4%
Australia	92.4%	91.8%	90.3%	89.4%	88.3%

Source: Aged Care Financing Authority Ninth report on the Funding and Financing of the Aged Care Sector

Comment

The demand for residential aged care is being impacted by the increasing availability of high care (Level 3 and 4) home care packages. The stated preference of older people is that they wish to remain independent in their own home for as long as possible.

The countering factor is that vacancy rates in residential aged care in locations such as Mandurah could provide people from the Boddington catchment with access to residential care now and into the immediate future. It is noted that this option is not considered to be acceptable to community members.

2.4 Aged Care Supply from the Wheatbelt Region

The supply of residential aged care beds in the Wheatbelt (Boddington is within the Wheatbelt aged care planning region as defined by the Commonwealth; there is no Peel region under this definition) has sharply declined due to the closure of

[3] AIHW

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low care (hostel) residential aged care beds in WACHS services. In 2013/14 residential aged care admissions for all providers across the Wheatbelt was 301 persons. In the latest comparable data, 2018/19 new admissions had fallen to 112 persons. The average age of admission had declined from an average of 84.2 to 83.3 years.

In 2012, when the first aged care needs study was completed, Boddington Hospital offered residential aged care places. These places were funded by the state government rather than the Commonwealth. These places are no longer available, although it is noted that there are instances where the hospital will provide a bed for care "while awaiting placement".

WACHS
Consultations were undertaken with WACHS as part of this project. Discussions included the Royal Commission's recommendation that in rural and remote Australia that the MPS model should be expanded. In the Commonwealth's response to the Royal Commission they have accepted this recommendation. However, WACHS has not considered this an option for Boddington Hospital at this stage. There is much more to be understood about what this recommendation means before WACHS would be able to use the MPS model as mechanism to respond to market failure in places such as Boddington. WACHS expressed interest in this study and would like to be informed on key findings are and related recommendations.

The profile of alternate residential aged care relatively close to the Boddington catchment includes:

- Narrogin (58 minutes' drive away);
- Residency by Dillons Narrogin 50 places (some shared rooms) with RADs of $220,000 and $330,000
- Karinya Residential Care 50 places with RADs of $350,000
- Brookton (66 minutes' drive away)
- Kalkarni Residency Baptistcare 43 places (some shared rooms) with RADs of $300,000 to $400,000

Implications
There is limited availability in alternate residential aged care options for people living in the catchment. Several respondents consulted as part of the background research for project also stated that the there was a need for better quality of care than currently offered in Narrogin.

There is a total of 576 residential aged care beds in the Wheatbelt (provided by WACHS and other providers). The Commonwealth benchmark of 78 places per 1,000 persons aged 70+ years would equate to 898 places; therefore, there is a calculated shortfall of 322 places.

In 2012, consultations with Boddington District Hospital revealed that people are moving into the area and bringing their elderly parents with them to maintain close access to the hospital and medical centre. It can be surmised that this dynamic will continue to increase with the expansion of the Boddington mine and other economic drivers that will feed population growth.

Consultations showed that "CACP (now Level 2 home care packages) are well used and often 'topped up' by staff so people do not need to move away". There are no Level 3 or 4 home care package providers in the area so people who need a higher level of care often enter a residential care facility which may be as far away as Albany. Feedback from consultations undertaken in 2021 demonstrate that the situation has deteriorated due to closures of aged care beds in the Boddington Hospital and a lack of Boddington-based home care service provision. A key insight from the consultations is that there is significant inconsistency in the quality of home care service provision and the quantum of care is not meeting demand.

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2.5 Needs Study Findings

In 2012 Verso Consulting prepared a needs study for the Shire of Boddington. As part of this project we have reviewed and assessed the continued relevance of the recommendations contained therein.

To achieve this assessment, catchment assumptions were examined and validated and demographic and other service data was updated. Consultations were undertaken to provide further information regarding unmet need and service gaps and the implications for the community. The full updated 2021 needs study is attached (Appendix 1).

In this section we have provided a summary of highlights and implications from the study and reviewed the relevance of the 2012 recommendations.

2.5.1 Aged Population

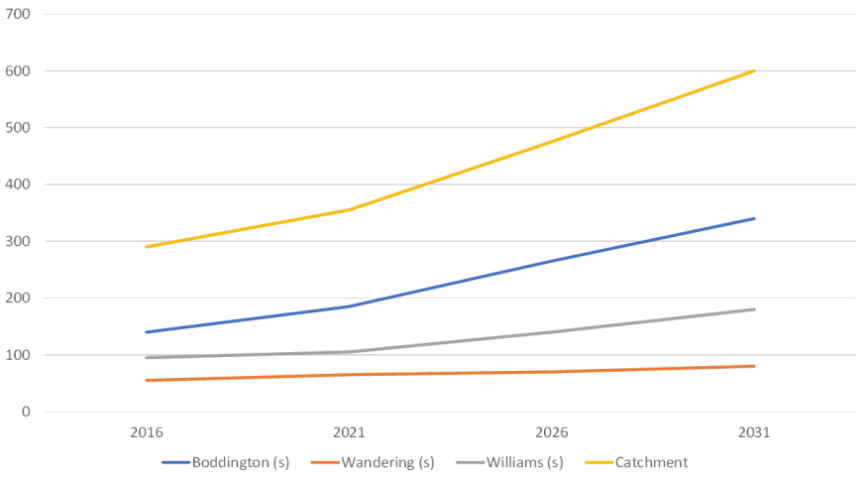
An examination of the 70+ population was undertaken, as this population is used as the basis by the Commonwealth for aged care planning including as an estimate of demand for funded service types including residential aged care, transition care, short term restorative care and home care packages.

Between the 2011 and 2016 census periods, the population aged 70+ grew in both the catchment (+39.2%) and in Boddington local government area (LGA) (+39.8%). In this period, the overall population declined in the catchment (-8.5%) and in Boddington LGA (-17.1%). The other two LGAs in the catchment experienced a small overall growth in population.

Population projections for 2017 were detailed in the 2012 report as 348 persons aged 70+ years for the catchment and 201 persons in Boddington. Comparatively, the 2016 census detailed the 70+ population was 330 for the catchment and 151in Boddington.

The population projections relied on in 2012 estimated that by 2027 the 70+ population would grow to 486 for the catchment and 297 for Boddington LGA. Similarly, WA Tomorrow population projections used for the updated needs study estimate the 70+ population in 2026 to grow to 475 people in the catchment and 265 in Boddington LGA. Therefore the projections can be confidently used to support strategic planning.

Figure 3: 70+ Population projections by LGA and the catchment as a whole



Source: Source: Department of Planning, Lands and Heritage, Western Australia Tomorrow population forecasts, official WA State Government forecasts to 2031, https://www.dplh.wa.gov.au/information-and-services/land-supply-and-demography/western-australia-tomorrow-population-forecasts#latest

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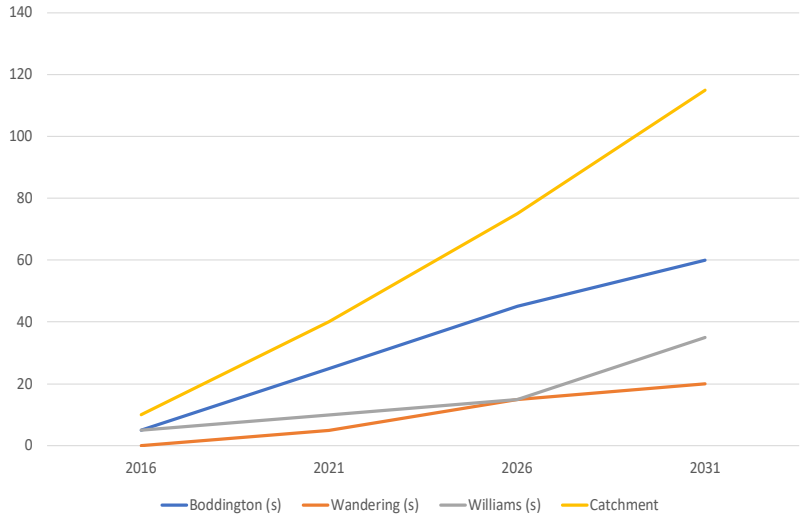
The population of persons aged 85+ was also examined. This population are the highest users of aged care services supporting complex care. For example, in the Wheatbelt the average age of entry to residential aged care is 83.3 years (84.6 in Metro South West).

The 2012 needs study identified that the population aged 85+ was projected to grow from the 2011 census of 27 persons in the catchment and 18 people in Boddington to 52 in the catchment and 25 in Boddington LGA by 2027.

The 2016 census used in the updated needs study identifies 35 people aged 85+ in the catchment and 17 in Boddington. The numbers and future projections may be somewhat constrained by the number of people who are unable to remain in the community due to the lack of high care services to support their needs.

Figure 4: 85+ Population projections by LGA and the catchment as a whole



Source: Source: Department of Planning, Lands and Heritage, Western Australia Tomorrow population forecasts, official WA State Government forecasts to 2031, https://www.dplh.wa.gov.au/information-and-services/land-supply-and-demography/western-australia-tomorrow-population-forecasts#latest

The projections based on WA Tomorrow predict high growth of the 85+population by 2026 of 75 people in the catchment and 45 in Boddington. It is noted that there is a difference between WA Tomorrow's 2016 projections as shown in the figure above (10 persons in the catchment) and the 2016 census record of 35 persons. The implication is that projections may be conservative.

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Continued relevance of the 2012 recommendations and implications

The 2012 needs study recommended that *"additional aged care services will need to be developed to support an 80% increase in the 70+ population from 2012 to 2027"*.

Using 2016 census data and WA Tomorrow projections, the percentage increase from 2016 to 2031 for the 70+ population is slightly higher at +81.8% for the catchment and a significant 125.2% for Boddington. Calculating high growth of the 70+ population supports recommendations related to the development of aged care services to meet complex care needs.

The 85+ data demonstrates even higher growth of +234.3% for the catchment +253% for the Boddington. The 85+ population projections do not consider that some may have to relocate due to a lack of access to appropriate aged care services. This data reinforces the 2012 recommendation related to service development.

2.5.2 Remoteness

Using the Modified Monash Remoteness Scale, the catchment is rated as Moderately Accessible (equivalent to an Accessibility/Remoteness Index of Australia score of 3.52 to 5.80). Areas that fall within this rating are classified as having 'significantly restricted accessibility of goods, services and opportunities for social interaction'. As a result, providers of aged care services operating in these areas can claim:

- An additional $2.42 per day per client for home care packages regardless of the level
- An additional $33.65 per residential aged care bed (this figure is calculated giving consideration to at least 50% of residents having behavioural support needs)

2.5.3 Supply and Demand in Boddington Catchment

As discussed earlier, the residential aged care options in adjoining metropolitan and Wheatbelt regions are unlikely to be able to respond to the needs of older persons in the Boddington catchment. Consultations also confirm strong desire for residents in the catchment to 'age in place' in their community close to family and friends and where they feel they belong. This choice is considered to be a fundamental right and the position is a strongly held value.

This section details the benchmark supply and demand equation. This is based on 78:1,000 places per 70+ population for 2021 through to 2031. The operational places detailed in the tables assume that no additional places will be constructed and brought online. Consultations did not provide any evidence of planned expansion of current services. Contributing factors include current operating conditions (widespread deficits), falling occupancy rates, uncertainty created by the Royal Commission and COVID-19 impacts.

The data tables demonstrate that between 2026 and 2031, a residential aged care facility with 35-45 beds located in Boddington could be justified to meet the growing need, if no other solutions were developed that impact the catchment.

Table 2: 2021 - Aged Care Planning Benchmarks (78:1000, 70+ population)

LGA	70+ Population	Benchmark	Operational (2020)	Variance (+/-)
Boddington (S)	185	14.4	0	- 14.4
Wandering (S)	65	5.1	0	- 5.1
Williams (S)	105	8.2	0	- 8.2
Catchment	355	27.7	0	- 27.7
Wheatbelt South SA3*	**2,921**	**227.8**	**202**	**- 26**

* DoH ABS Projections

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Table 3: 2026 - Aged Care Planning Benchmarks (78:1000, 70+ population)

LGA	70+ Population	Benchmark	Operational (2020)	Variance (+/-)
Boddington (S)	265	20.7	0	- 20.7
Wandering (S)	70	5.5	0	- 5.5
Williams (S)	140	10.9	0	- 10.9
Catchment	475	37.1	0	- 37.1
Wheatbelt South SA3*	**3,419**	**266.7**	**202**	**- 64.7**

* DoH ABS Projections

Table 4: 2031 - Aged Care Planning Benchmarks (78:1000, 70+ population)

LGA	70+ Population	Benchmark	Operational (2020)	Variance (+/-)
Boddington (S)	340	26.5	0	- 26.5
Wandering (S)	80	6.2	0	- 6.2
Williams (S)	180	14.0	0	- 14.0
Catchment	600	46.8	0	- 46.8
Wheatbelt South SA3*	**3,924**	**306.1**	**202**	**- 104.1**

* DoH ABS Projections

2.5.4 Older Persons Housing

Older persons housing is relevant in this discussion as the scale of any residential aged care option is predicated on the retention of older people in the community, and the feasibility and options may be further enhanced by attracting incoming retirees. The population of older people retained and attracted will also support the sustainability of vital local health services, which in turn will enhance retention and attraction.

The figure below details why older people move based on comprehensive consultations and data analysis.

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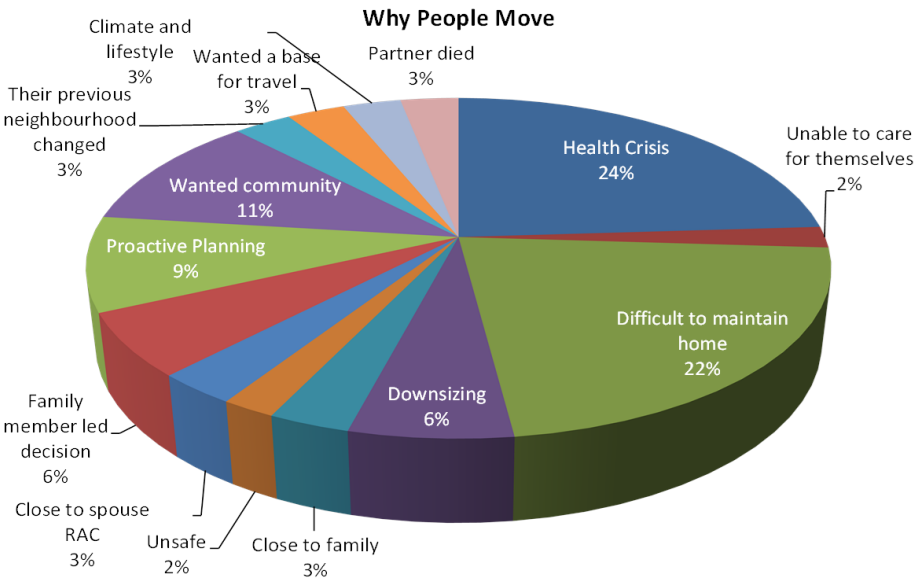
Figure 5: Why Older People Move



Source: Verso Consulting Aged Housing Research

Key Findings: Age-appropriate Housing Demand Research

The wide range of reasons cited by older people for their move to alternate housing demonstrates the complex range of factors that influence this decision. Only 6% were specifically looking for an enhanced lifestyle, which is a common retirement village marketing strategy. 94% of respondents were responding to changes relating to their age or capacity. Wider community consultations conducted by Verso reinforced the proposition that the decision to move to older persons' housing is often motivated by a strong desire to remain independent and avoid entering residential aged care.

University of NSW

Associate Professor Dr George Earl, Head of Construction Management & Real Estate at the University of NSW, describes a planning ratio (demand calculation) in *Evolution, Prospects and Challenges*[4]. As the most transparent demand estimate data, it is relied upon as the basis of this analysis. Estimates for retirement living demand are as follows: 0.2% aged 55 to 64 years, 2.0% aged 65 to 74 years, 4.0% aged 75 to 84 years and 7.0% aged 85+. It should be noted that retirement living does not encompass all the options that support changing housing needs.

Table 5: Dr Earl Projections (1.9% of 55+ population)

Area	Current Supply	2021 Projected Demand	2031 Projected Demand	Demand △ 2021-2031 (+/-)
Boddington	7	4	8	+100%
Wandering	?	3	4	+25%
Williams	?	6	6	0%
Catchment	7	13	19	

Sources: ABS Census of Population & Housing, 2016 and WA Tomorrow population projections

[4] Stinson, *The Retirement Village Industry In Australia: Evolution, Prospects and Challenges,* University of Queensland, 2002.

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Verso Demand Estimate

Structured qualitative research surveys were undertaken by Verso Consulting with 122 individuals living in retirement units in 2009. The average age of respondents was 79 years. This study is useful as it is based on actual behaviours, rather than consumer aspirations. The study collected information about numbers and reasons for housing moves in the 13 years leading up to 2009. All participants were living in their own/family home, flat or independent living unit (ILU) in 1997. Successive relocations recorded a continuum of change from larger homes to ILUs as issues of mobility and home maintenance increasingly came into play. Results are summarised in the table below.

Table 6: Results of Verso's Housing Research

Dwelling type	1997	Intermediate Move made between 1997 and 2009	Current (2009)
Own/Family Home	103	12	38
Flat/Unit	13	14	11
ILU	6	-	43
Retirement Unit	-	2	5
Aged Care Facility	-	6	25
Total	**122**	**34**	**122**

Source: Verso Consulting Aged Housing Research

This research identified that 63% of older people surveyed were prepared to move (often from the family home) to alternate accommodation if it facilitated maintenance of their independence. This willingness to relocate has been verified in further surveys undertaken by Verso with a wide range of community members across all regions of rural Western Australia (n650+). This research was undertaken in rural localities including the Boddington catchment. The following reasons were cited as to why older people surveyed chose to move.

Table 7: Verso Demand Estimate based on 24% of 79+ population

Area	Current Supply	2021 Projected Demand (less supply)	2031 Projected Demand	Demand △ 2021-2031 (+/-)
Boddington LGA	7*	24	50	+108%
Wandering	?	11	13	+18%
Williams	?	18	30	+67%
Catchment	7	53	93	+75%

Sources: ABS Census of Population & Housing, 2016 and WA Tomorrow projections

*Older people may be living permanently in the caravan park as an alternate ageing in place arrangement

The 2012 needs study stated:

> *Consultations undertaken to develop this proposal demonstrate that the rate of sale of retirement units and general confidence of retirees improves with the knowledge that they will have access to residential and community aged care and the expected range of health services when required. RSL WA indicates that in their Jurien Bay development that the average age of retirees is 77 years. Other data sources indicate that residents of retirement villages are in their mid to low 70's.*
>
> *Consultations also highlighted the following: 'ILUs would mean that people from out of town would be able to move closer and still be independent', 'Rents in town are very high due to the mine' and "You see these old*

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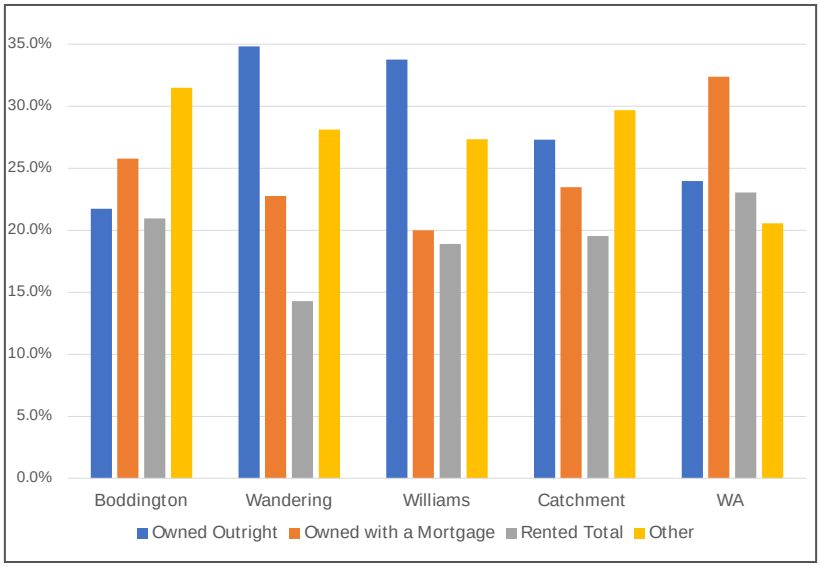
people struggling to find somewhere to live. They often end up in old farmhouses close to town which are not ideal. It breaks your heart."

Boddingtons' health and aged care services will impact on the retirement village (rate of sale, possibly the pricing, stability of the residents and capacity to age in place). The mix of housing types in the retirement village will ensure the needs of seniors across the catchment are met. There is sufficient current and future demand to develop a 40 unit retirement/ILU village.

Consultations and ongoing studies confirm that these insights are still current. The assets of the Boddington community, including health services, pharmacy, a hospital, the landscape and proximity to Perth, all act as advantages to retain current populations of older people and to support incoming migration of "tree changers". A restrictive factor in both is the supply of appropriate housing.

The figure below demonstrates the structure of housing ownership within the general populations of Boddington, Wandering and Williams LGAs, the catchment and the state as a whole.

Figure 6: Home Ownership Structure (General population - 2016)



Source: ABS 2016 Census Tenure and Landlord Type Data, viewed 04.06.21, https://auth.censusdata.abs.gov.au/webapi/jsf/tableView/tableView.xhtml

It can be concluded that an active rental market will impact rental costs. Data from realestate.com showed that in August 2021 the average rental in Boddington was $350.00. Based on current rental rates, Verso has prepared updated data on the socio-economic advantage or disadvantage detail in the table below.

Table 8: Local Government Area - Index of Relative Socio-economic Advantage and Disadvantage, 2016

LGA	Score	Rank	Min	Max
Boddington (S)	978	345	904	1068
Wandering (S)	1004	421	1004	1004
Williams (S)	1019	446	949	1070

Source: 2016 SEIFA datacubes were released on 27 March 2018, viewed https://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/ 2033.0.55.001 2016 ?OpenDocument

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Weekly Income

The table below details the median income for older persons living in the catchment. The data confirms the relative economic disadvantage of Boddington's population identified through the SEIFA compared to Wandering and Williams.

Table 9: Weekly Income 2016 population (aged 55+ and 70+)

	Income less than $500 pw		Income $500-$999		Income $1,000+ pw	
	55+	Age 70+	55+	Age 70+	55+	Age 70+
Boddington (S)	218	88	86	27	117	8
Wandering (S)	63	23	34	8	30	8
Williams (S)	125	56	76	24	99	21
Catchment Total	**403**	**168**	**198**	**64**	**243**	**35**

Source: Census of Population and Housing, 2016, TableBuilder

Continued Relevance of Recommendations

Boddington's relative disadvantage coupled with comparatively high rents and limited choice is impacting on the area's capacity to support the aged care housing needs of older persons in the catchment - in particular, the capacity to provide aged housing (ILUs) and options for older persons with limited income and assets.

In addition, the capacity to provide affordable and appropriate housing to attract and retain the health workforce is a factor that requires a positive response to both retain and attract additional older people into the community.

2.6 The Nature of Need in a Residential Facility

Understanding the characteristics of older people who need to access residential aged care provides a framework to consider the relative merits of the options to be considered by the Shire of Boddington.

The requirement for residential aged care is highlighted as follows:

- An estimated 34% to 53% of Australians will enter a residential aged care facility during their lifetime[5]
- About 9% of people using aged care services at any one point time are in residential aged care

2.6.1 Age at entry

Most residents entering residential aged care in the catchment will be aged 80 years and older. The majority of Indigenous entrants into residential aged care in Metro South West were younger than 80 years, with 38% being less than 70 years of age.

In the Wheatbelt region there was a 62.8% decline in entrants into permanent residential aged care between 2013/14 and 2018/19. A major factor was the closure of hostels/low care in WACHS facilities (mainly MPS) thereby reducing the number of beds available across the Wheatbelt.

[5] [Broad JB, Ashton T, Gott M, McLeod H, Davis PB, Connolly MJ. Likelihood of residential aged care use in later life: a simple approach to estimation with international comparison. Aust N Z J Public Health. 2015;39(4):374–9].

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Table 10: Entry into Permanent Residential Aged Care 2018/19

Location	< 65	65 to 79	80 to 89	90+
Wheatbelt	0.9%	32.1%	42.9%	24.1%
South West Metro	2.6%	22.1%	46.3%	28.9%

Source: AIHW GEN Data Admissions into aged care 2018/19

In the period 2013/14 to 2018/19 there was an increase in the number of entrants into residential respite of 32.5%.

Table 11: Entry into Residential Respite 2018/19

Location	< 65	65 to 79	80 to 89	90+
Wheatbelt	2.8%	35.8%	45.3%	16.0%
South West Metro	2.6%	25.1%	45.4%	26.9%

Source: AIHW GEN Data Admissions into aged care 2018/19

It is worth noting that in the period 2013/14 to 2018/19 there was strong growth in new entrants into home care packages in the Wheatbelt of 68.3%. That number of entrants is expected to rise sharply as the Commonwealth government releases 80,000 additional home care packages between June 2021 and June 2023 - an increase of 41%.

Length of life

Life expectancy changes over the course of a person's life, because as they survive the periods of birth, childhood and adolescence, their chances of reaching older age increase. The life expectancy at different ages can be presented as the number of additional years a person can expect to live, or their expected age at death in years.

Men aged 65 in 2017–2019 could expect to live another 20.0 years (an expected age at death of 85.0 years), and women aged 65 in 2017–2019 could expect to live another 22.7 years (an expected age at death of 87.7 years)[6].

The increase in length of life is an important consideration in relation to aged care. There is a very small increase in the years of dependency and high health costs associated with increasing length of life. People tend to need the highest levels of care in the last three years of their life.

However, there is a relationship between increased length of life and dementia. Dementia rates steadily increase until at least 90 years. The implications for a Boddington based residential aged care facility is that over the length of life of the building, people will become progressively older at entry and dementia care will become an increasingly larger portion of the service requirements.

[6] Source: AIHW Deaths in Australia updated June 25th 2021

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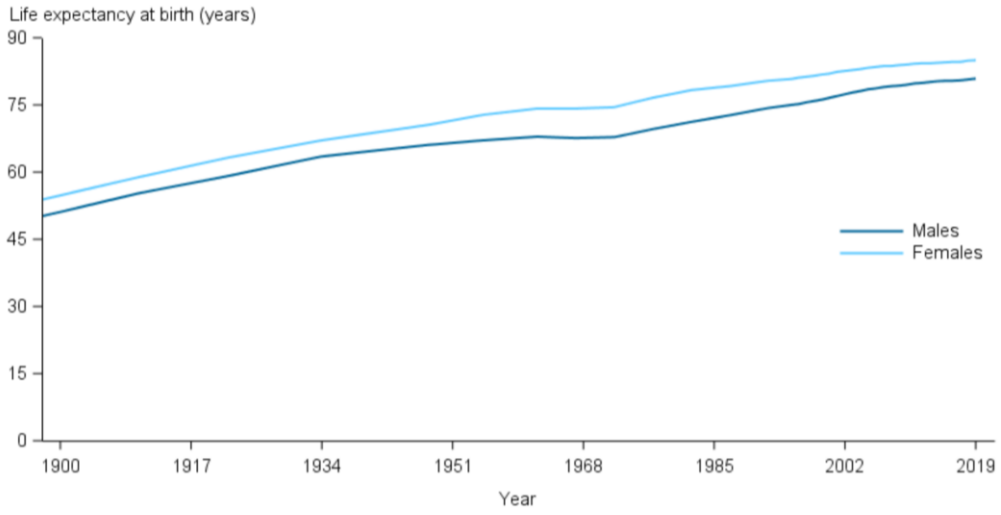
Figure 7 Life Expectancy (years) at Birth by sex, 1891-1900 to 2017-2019



Sources: ABS 2014a; ABS 2014b; ABS 2015; ABS 2016; ABS 2017; ABS 2018a; ABS 2019; ABS 2020 (Table S6.1).

2.6.2 Length of stay

Reviewing the data for length of stay in a residential facility demonstrates that there is high 'churn' for people entering and staying for a comparatively short period of time. The overwhelming majority of exits (84%[7]) from residential aged care occur because the resident died. A decreasing number of residents are going to hospital for palliative care.

Table 12: Length of Stay Permanent Residential Aged Care

Months	0 to 5	6 to 11	12 to 29	30 to 47	48+
National Length of Stay	22.8%	11.2%	24.1%	16.2%	25.7%

2.6.3 Complexity of care and support needs

To document the expected complexity of residents of an aged care facility in Boddington, the latest available data for Aged Care Funding Instrument (ACFI) claims in permanent residential aged care have been compared across two time points. The following table demonstrates how the complexity and related high care needs have changed significantly in the period 2009 to 2019. The ACFI scale scores are Nil, Low, Medium and High.

Table 13: The portion of people that measure a high rating on the ACFI

ACFI Domain	2009	2015	2019	+/- Change %
ADLs	33	51	60	+81.8%
Cognition and Behaviour	37	59	64	+73.0%
Complex Health Care	4	27	31	+675.0%

[7] https://www.gen-agedcaredata.gov.au/Topics/People-leaving-aged-care

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Health Conditions

This section details research published in the Australian Health Review[8] which provides insight into comorbidities and the mitigation and management requirements required to support residents in residential aged care. Key findings include:

- 93% of residents had some form of circulatory disease, with hypertension the most common (62%)
- Most residents (93%) had a mental or behavioural disorder, including dementia (58%) or depression (54%)
- For most conditions, EHR data identified approximately twice the number of people with the condition compared to aged care funding assessments. Agreement between data sources was highest for multiple sclerosis, Huntington's disease, and dementia.
- Cluster analysis identified seven groups with distinct combinations of health conditions and demographic characteristics and found that the most complex cluster represented a group of residents that had on average the longest lengths of stay in residential care.

In 2018 the ABS reported selected disability and health characteristics of people 65+ living in permanent residential aged care. The table below details the findings.

Table 14: Health conditions and impairments of residential aged care residents

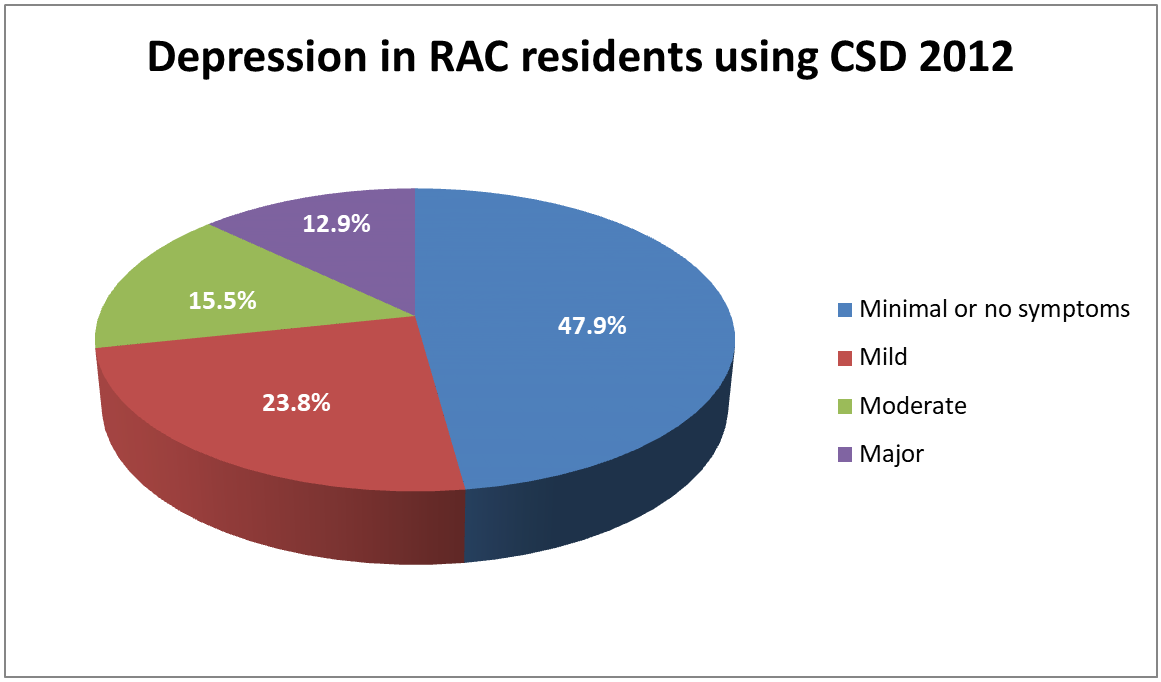
Disability or health characteristic	% of people
Disability Group	
Sensory and Speech	62%
Intellectual	54%
Physical restriction	88%
Psychosocial	73%
Uses aids or equipment for:	
Managing incontinence	73%
Eating	33%
Getting in and out of bed or a chair	58%
Moving about the place of residence	76%
Managing health conditions using medical aids	39%
Number of long-term health conditions	
5 to 8	54%
9 or more	23%
Number of impairment types	
5 to 8	35%
9 or more	38%

[8] Who uses residential aged care now, how has it changed and what does it mean for the future? Diane Gibson Australian Health Review, 2020, doi:10.1071/AH20040

Depression

Identifying depression in residents living in residential aged care is achieved by completing the Modified Cornell Scale for Depression (CSD). This assessment forma part of the ACFI assessments undertaken by clinical staff in residential aged care. The latest published outcomes of the assessments were as part of a major report in 2012 developed by the AIHW[9] and are detailed in the following figure.

Figure 8: Depression in RAC residents



Source AIHW Australian Institute of Health and Welfare 2013. Depression in residential aged care 2008–2012

Residents with symptoms of depression had higher care needs, with 73% classified as high care residents, in contrast to 53% of those without symptoms. The AIHW report demonstrates that care needs increased with the severity of depression symptoms. The increase is mirrored in each ACFI domain. A key finding of the report was a 139% higher rate of behaviours impacting on care needs for people with depression than those without.

It is now widely recognised that depression is associated with premature morbidity and mortality (Stek, 2014; Zivin, 2014; Peters, 2010), but depression among the elderly also has an impact on quality of life (Adams-Fryatt, 2010; AIHW, 2013). The dramatic effect of even mild depression on a person's wellbeing was dramatically exhibited in the recent Danish population research into depression (Ellvivk, 2014). The report details that there was an initial decline of 57.5% in wellbeing from even mild depression.

Notwithstanding the AIHW report, it is recognised that depression is under reported and under treated in Australian residential aged care facilities (Snowdon, 2008; Davison, 2007), in part because of the lack of training and awareness by aged care staff (McCabe, 2008; Davison, 2009).

Currently the use of antidepressant medication (ADM) represents the current standard approach for the treatment of depression within residential care facilities and there is little or no use of non-pharmacological interventions (Davison, 2012). However, a recent meta-analysis of randomised placebo-controlled trials of the effects of ADM suggest that while they are of benefit to people with severe depression, the effects "may be minimal or non-existent, on average, in patients with mild or moderate symptoms." (Fournier, 2010).

[9] Australian Institute of Health and Welfare 2013. Depression in residential aged care 2008–2012. Aged care statistics series No. 39. Cat. no. AGE 73. Canberra: AIHW

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Comment
This finding is important background relating to developing innovative alternatives to the current residential aged care built form and operations such as 'home-like' residential aged care.

Dementia

Dementia is a term used to describe a group of conditions characterised by the gradual impairment of brain function. It is commonly associated with memory loss, but can affect speech, cognition (thought), behaviour and mobility. An individual's personality may also change, and health and functional ability decline as the condition progresses.

While there are many forms of dementia, the best known is Alzheimer's disease - a degenerative brain disease caused by nerve cell death resulting in shrinkage of the brain. The boundaries between different forms of dementia are indistinct and it is possible for a person to have multiple (mixed) types of dementia at the same time. Although dementia can affect younger people, it is increasingly common with advancing age and mainly occurs among those aged 65 and over but is not a normal part of ageing. Dementia is a major cause of disability and dependency among older people. It not only affects individuals with the condition, but also has a substantial impact on their families and carers, as people with dementia eventually become dependent on their care providers in most, if not all, areas of daily living.

The exact number of people with dementia in Australia is currently not known. It is estimated that in 2020 there are between 400,000 and 459,000 Australians with dementia (AIHW 2018; DA 2020), with Alzheimer's disease accounting for up to 70% of diagnosed cases (DA 2018).

Aged care services are an important resource for both people with dementia and their carers. At 30 June 2019, about 183,000 people were in permanent residential aged care, and just over half (53%) had been diagnosed with dementia. The care needs of people in permanent residential care are assessed through the ACFI across 3 domains of care: activities of daily living, cognition and behaviour, and complex health care. The care needs in each domain are allocated a rating of nil, low, medium, or high. In 2019, people with dementia had higher care needs ratings than people without dementia on the activities of daily living and cognition and behaviour care domains; the differences were largest for the cognition and behaviour domain, where nearly twice as many people with dementia (80%) had high care needs compared with people without dementia (46%). A similar proportion of people with and without dementia had high care needs in the complex health care domain (AIHW 2020a, 2020b).

Dementia Australia provide the following information[10]:

- Dementia is the second leading cause of death of Australians
- Dementia is the leading cause of death for women
- In 2021, there are an estimated 472,000 Australians living with dementia. Without a medical breakthrough, the number of people with dementia is expected to increase to almost 1.1 million by 2058
- In 2021, there were an estimated 28,300 people with younger onset dementia, expected to rise to 29,350 people by 2028 and 41,250 people by 2058. This can include people in their 30s, 40s and 50s
- In 2021, it is estimated that almost 1.6 million people in Australia are involved in the care of someone living with dementia.
- Approximately 70% of people with dementia live in the community
- More than two-thirds (68.1%) of aged care residents have moderate to severe cognitive impairment

The figure below details dementia rates by age and demonstrates that prevalence rates rise sharply as people age.

[10] https://www.dementia.org.au/statistics

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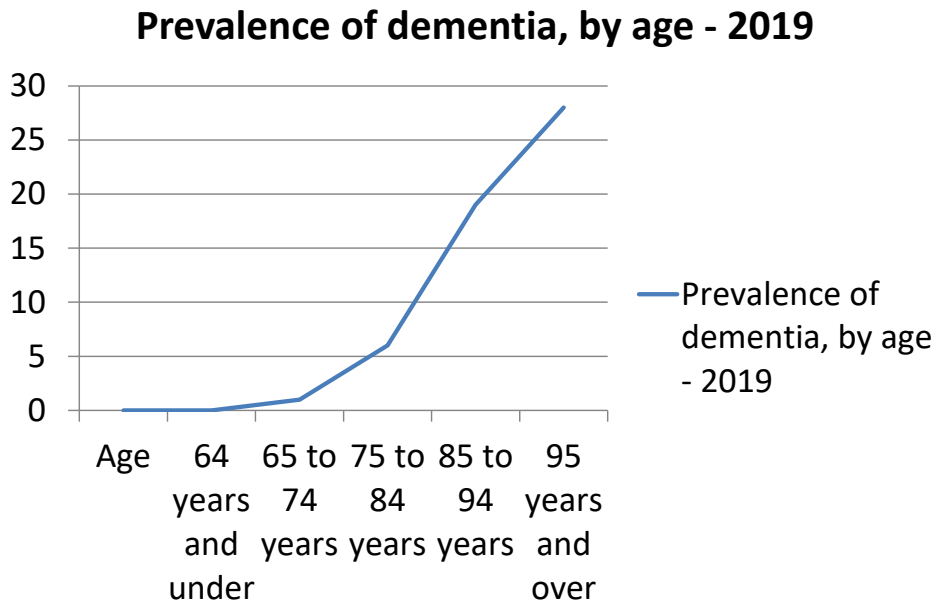
Figure 9: Dementia prevalence rates by age



Mental Health

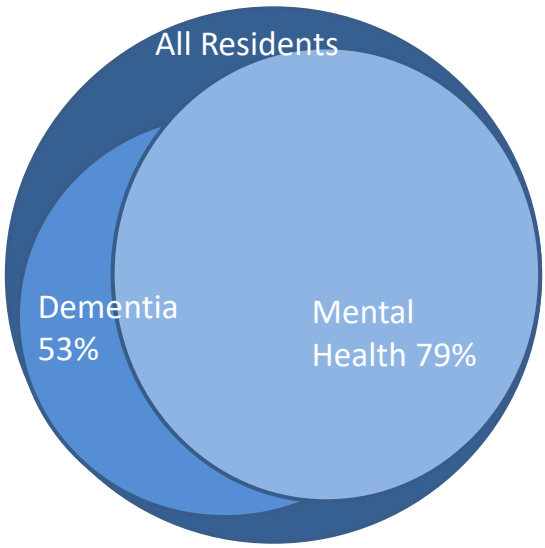
The diagram at right demonstrates the importance of behaviour support and skilled mental health and dementia care.

At 30 June 2011 (AIHW), 79% of residential aged care residents across Australia were reported to have a mental illness.

At the 30th June 2019 53% of permanent residents with an ACFI appraisal had a diagnosis of dementia recorded.

The 2011 report indicated that 40% of residents with dementia also had a diagnosis of a mental illness. A further 26% of residents had a diagnosis of mental illness without a diagnosis of dementia. Sane Australia's 2017 research report highlights mental illnesses common to older adults, including anxiety disorders, mood disorders such as depression and bipolar disorder, psychotic illness such as schizophrenia, and personality disorders.

Figure 10: Prevalence Dementia and Mental Health



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3 Viability of Residential Aged Care

3.1 Overview

3.1.1 15 years of structural changes

Over the last 15 years residential aged care has changed significantly. The big picture trends have been:

- The abolition of the low care (hostel) and high care (nursing home) divide
- Increased capacity of providers to seek residential aged care deposits (RADs) or Daily Accommodation Payments (DAPs) from all persons entering a residential aged care facility. Previously bonds could only be secured from older people entering a low care facility
- Consolidation of ownership of residential aged care into increasingly fewer providers including listed companies
- The diminishing role of local community organisations, local government and health services
- The central role of dementia care in residential aged care
- Increasingly complex care needs of older persons entering residential aged care
- Significant reduction of smaller sized facilities

3.2 Scale

3.2.1 Reduction of very small facilities

The following analysis of small scale residential aged care facilities is provided as Boddington's current and future demand for residential aged care services would justify development of a small facility.

In 2005 there were 571 residential aged care of 30 beds or less in Australia. By June 2020 there were just 265 facilities of 30 beds or less. (This analysis excludes multiple small services located on a single aged care campus.)

The reduction in the number of facilities with 30 or less beds represents the market response to the negative impact of scale on viability. State government health services in Victoria supplement the cost of care. This is of particular importance as Victorian government residential aged care represents 83% of services of state government operated facilities with 30 beds or less. Verso's research suggests that even with government subsidies, these services are commonly operating at a loss.

In the 15 years covered by this analysis, there has been an overall reduction of very small facilities of 54% as illustrated in the following figures.

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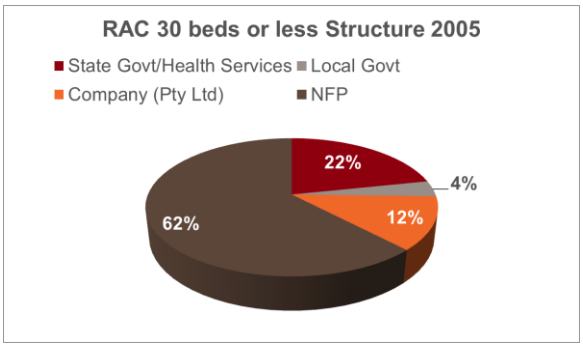
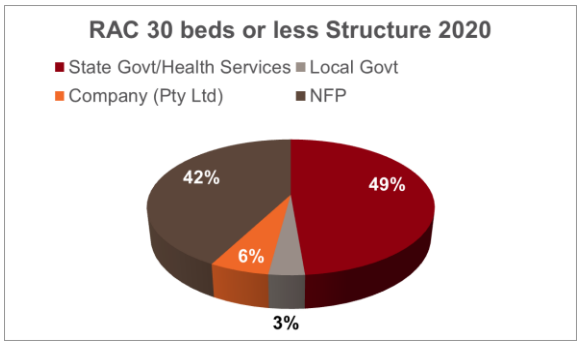
Figure 11: Ownership structure of RACs <30 2005



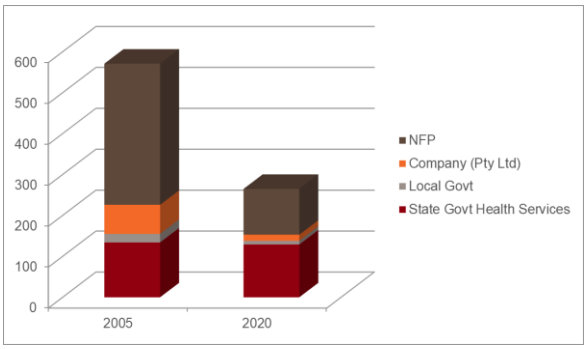
Aged Care Service List 2005 Department of Health; Verso Analysis

Figure 12: Number of ownership structure of RACs 30 beds or less 2015



Aged Care Service List 2020 Department of Health (AIHW GEN Data); Verso Analysis

Figure 13: Reduction in the number of very small RACs



Aged Care Service Lists 2005 and 2020 Department of Health (AIHW GEN Data); Verso Analysis

3.2.2 Increasing size of facilities

Between 2002 and 2013, the proportion of facilities with more than 60 beds doubled to 48.6%. Financial viability rather than quality of care drove the increase in size.

By June 2020, 31.5% of residential aged care beds were provided in facilities with 120 or more beds. Similarly, facilities with between 80 and 119 places accounted for another 31.5% of beds. In in the 2018/19 Aged Care Approvals Round, the average new facility size allocation was 108 beds.

Once larger facilities become the norm, it will be difficult to undo. Capital infrastructure is built to have an average 40-year life, which will lock in the institutional model of aged care. All of this means that many older Australians are living out their last days in an institutional environment.

3.2.3 Size and financial viability overview

A range of operational issues impact financial viability relative to a residential aged care facility's size:

- Administrative and management functions including compliance requirements are the same regardless of size

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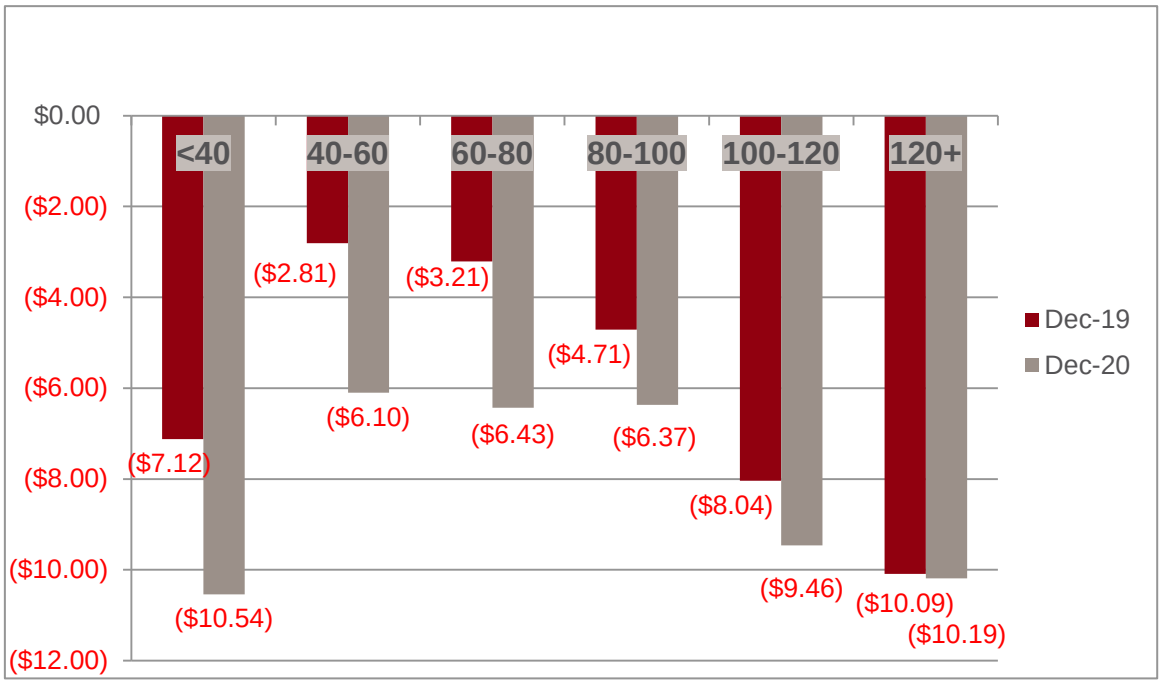
- Larger facilities can assign the functions to specialised staff improving efficiencies and can support these functions with lower cost clerical staff
- As a portion of the overall size of the facility, vacancies and refurbishments can be managed more readily within the business model, e.g. One vacant bed offline for two weeks to be refurbished after a resident exits in a 100 bed facility is a loss of 1%, whereas in a 30 bed facility this represents 3.3%.
- Rostering of staff can be more easily flexed to match the actual load as occupancy levels change in large facilities
- Overnight staffing ratios can be more easily managed in a large facility than in a small facility, particularly registered nurse costs
- Increased scale can improve a range of options for specialist inputs such as dementia specialist, allied health and clinical nurse practitioners
- Larger facilities located in areas with strong property markets can increase their earnings from non-operational property investment strategies. These are often not available to smaller aged care facilities located in rural townships without the same capital gain opportunities.

Figure 14: Stewart Brown Survey of RAC's by size 2019/20



Source: Stewart Brown Aged Care Aged Care Financial Performance Survey December 2020

3.3 Ownership Structure – Change over Time

The ownership structure of residential aged care is reviewed in this section, providing insight into the role that a small number of Approved Providers play in relation to the places they manage. As evidenced, these large scale providers (the number of places and facilities that they manage) are progressively increasing in relation to the overall market. If the growth trend was to continue over the next 10 years these providers may end up managing more than 60% of all places.

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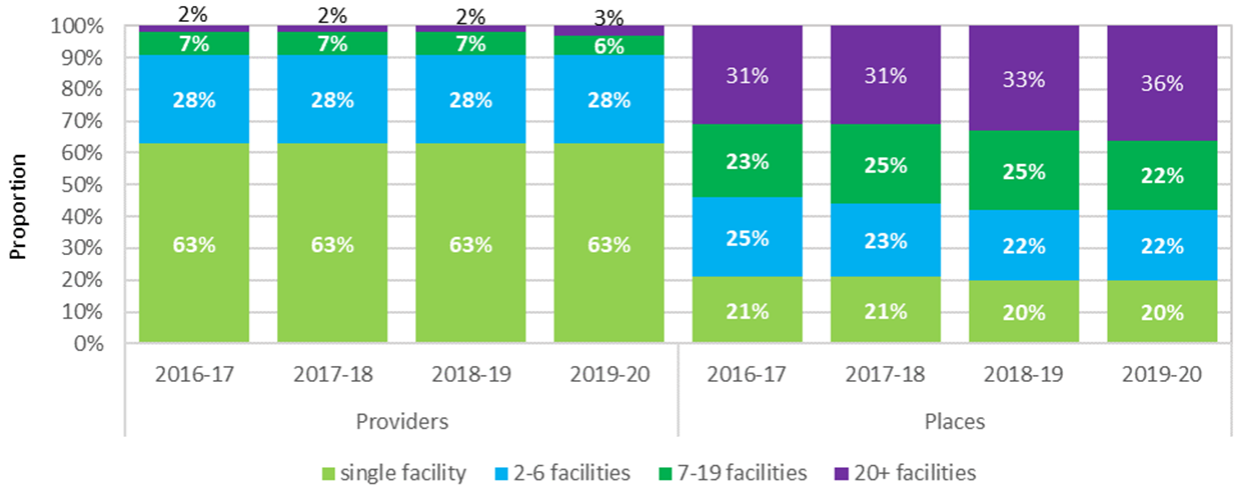
In the following section we discuss the role that property investment plays in the financial model of residential aged care. The incentive to become larger in terms of the number of facilities, the RADs held and increasing value of real-estate held is driving this growth. For example, if a provider manages 30 facilities with 100 beds per facility, they have 3,000 places. 70% of places may attract a RAD of $450,000, giving the provider access to $945m in interest free funds, of which $756m would be a non-current liability. The provider may lend the money to related entities as it sees fit.

It could be argued that the model and growth will not drive improved quality and safety, as the primary activity (focus) of the provider is property investment.

Figure 15: Provider Scale and Places Held



Source: Aged Care Financing Authority, Ninth report on the Funding and Financing of the Aged Care Sector, June 2021

The following extract of an article in The Guardian (Sept 16th 2021) provides additional insight into the corporate behaviour of not for profits who are substantially relying on property investment to maintain viability. Verso has observed that the provider's status as a not-for-profit is not necessarily a protective factor.

"Wayne Prosser remembers the day the closure of his father's nursing home was announced in the small town of Harden on the south-west slopes of New South Wales. "It was horrendous," he says. "They called a meeting…and said we're closing within six weeks." Prosser, a lifetime farmer like his father, Rusty, says the distress around the room at the St Lawrence Residential Aged Care nursing home quickly spilled into the community. "Staff were crying … my dad's eyes were boggling. He just said ... 'What now?'

The decision by the not-for-profit Southern Cross Care to close the home in January blindsided the town and the local council. "The way they dealt with it … it was just inhumane," Prosser says.

The 35 residents were offered a place in nearby homes owned by SCC including Cootamundra or Young. Most took up the offer while a small number, including Rusty, managed to find a bed at the local hospital. Others made their own arrangements. SCC told residents the home would not close until all had found alternative accommodation.

The chief executive of Southern Cross Care (NSW & ACT), Helen Emmerson, apologised to the community for not fully explaining the reasoning behind the sudden announcement, saying: "Our process for communication was unsuitable, especially for a close-knit community like Harden." But she went on to say numerous factors had led to the decision. "There was no option to responsibly keep it open in the long term," Emmerson said. "Inadequate funding, staff shortages, occupancy challenges, limited allied health services and a lack of after-hours support services, including pharmacy and GP access, made it challenging to maintain the quality of care, safety and support necessary at St Lawrence"."

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3.4 Financial Performance (RACs)

3.4.1 The Royal Commission's Perspective

The following statements by the Royal Commission into Aged Care Quality and Safety[11] provide a perspective on the current status of the aged care system and the impact felt in places such as Boddington. The Commissioners reported:

"Funding for aged care is insufficient, insecure and subject to the fiscal priorities and wide-ranging responsibilities of the Australian Government. This affects access to, and the quality and safety of, care."

"The aged care system has been affected by piecemeal approaches and policy compromises that detract from quality care. For several decades, one of the priorities for governments dealing with the aged care system has been to restrain the growth in aged care expenditure. This priority has been pursued irrespective of the level of need, and without sufficient regard to whether the funding is adequate to deliver quality care. This has occurred through limiting expenditure without accounting for the actual cost of delivering services, rationing access to services, and neglecting reform of the funding model."

"These should not be thought of as inadvertent errors in the design of the aged care system in Australia. These are design features."

3.4.2 The overall operating model for Residential Aged Care

Providers of residential aged care seek to generate value in two ways:

1. By delivering services for which the Commonwealth Government pays subsidies and residents pay fees - operating results are discussed in detail in this chapter

2. Property investment which is currently the strongest driver for generating value - an overview of property investment is provided in this section

Property Investment

A primary enabler of property investment is the fees or deposit paid by residents.

The two primary mechanisms used to leverage the equivalent of rent are the Refundable Accommodation Deposit (RAD) and Daily Accommodation Payment (DAP). The cost is determined by the provider based on the quality, location and features of the accommodation. This may vary from room to room in the same facility.

The provider sets the price within controls established under the Aged Care Act. For example, if a facility wants to charge more than $550,000 for their RAD, they need to seek approval from the Aged Care Pricing Commissioner. The RADs requested from Narrogin's two aged care facilities range from $230,000 to $350,000. The RAD is fully refundable (in effect it is a no interest loan to offset rent) when the resident leaves the aged care facility, however there is no capital gain or interest.

The DAP is calculated by multiplying the RAD that has been determined by the provider for the particular room by the current government interest rate (4.01 % p.a.at the 1st October 2021) and divided by the number of days in a year. The DAP has a lifetime cap, however it is a much more costly option for the resident.

Having a RAD or a DAP often means that the person and or their family can exercise choice regarding the quality of care and amenities available. There are concessional places in every facility (that don't attract a RAD or DAP) which are focused on people with low means.

[11] Royal Commission into Aged Care Quality and Safety Final Report Volume 2 page 188

In describing the property investment dynamic Binder Dijker Otte (BDO Accountants and Tax Auditors)[12] provide the following overview:

“The providers may invest capital to build and maintain property (a facility) for the purpose of housing care recipients (or residents). The Government and care recipients pay for use of that facility (effectively rent). The care recipients can pay their portion of rent as either a daily fee or as a lump sum deposit to be held as a bond by the service provider. This is known as a Refundable Accommodation Deposit (RAD) and is fully refunded to the recipient or their estate upon exit. No interest is payable on the lump sum while the resident is in care. The full amount is underwritten by the Australian Government”.

Within this property investment paradigm, residential aged care providers can use the lump sum deposits paid by residents for a range of permitted uses, including offsetting the debt on the property investment (albeit only after the property is constructed), generating an interest saving on the debt, or generating returns by investing the deposits elsewhere.

Providers may use group structures to maximise their returns and minimise risks. For example, a provider may transfer RADs received from clients to another entity in the form of a related party loan and that entity may use the funds to buy property or other investments. Approved providers are not required to have priority over secured creditors or employees on this related party loan. Group structures can also be leveraged to optimise operational activities within a group. In such instances, related entities may be used to provide services to the provider at a fee (e.g. management fees). These mechanisms are more likely to be used by large for-profit providers who may also structure the investments and management fees to minimise the tax that may otherwise be required.

If the incentive is profit, the aged care provider will seek to build more properties or acquire other providers’ property portfolios while the long-term property market outlook remains positive. The retention of stable and high occupancy levels is critical to this business strategy. Within this business model there is an assumption that 80% of RADs should be treated as non-current liabilities. However, this business model has risks, as described in the Sydney Morning Herald on September 6, 2020: “One of the largest operators, ASX-listed Regis Healthcare, reported in its full-year results last year that it held $1 billion in refundable accommodation deposits and just $27 million in cash.”

The buoyant and positively growing property markets tend to be in large population centres. Therefore, residential aged care providers are more likely to develop in these markets as they are likely to have a long-term positive growth outlook. As the non-operating activities are currently the strongest driver for providers to generate value, locations such as Boddington are not likely to be attractive to providers and indeed Boddington may present as being a business risk even if there is a strong service demand and unmet need.

While non-operational property development and other related investments are the primary way providers generate value, there is significant risk that operational focus will be compromised. The design of the system has removed incentive from a focus on the value delivered to residents, including responding to unmet needs and service gaps, and resident quality and safety.

[12] Report on the profitability and viability of the Australian aged care industry Research Paper 12 September 2020; The Royal Commission into Aged Care Quality and Satey

3.4.3 Current RAC Operating Results - Overview

The Stewart Brown (aged care specialist accountants) survey of 44% of residential aged care facilities was published in their annual Aged Care Financial Performance Survey. The December 2020 quarter report provides the most up-to-date data on the status of residential aged care operations and financial performance. Key insights include:

- The average result is a deficit of $6.10 per bed per day
- A decline in occupancy over the year of 1.3% in the past 12 months for all facilities
- If the special funding for COVID-19 and a rural and remote viability supplement had not been provided, the situation would have been worse
- The situation in rural and remote aged care is worse, with average per bed day operating loss of $10.54

Figure 16: Overview of the operational issues

Source: Stewart Brown Aged Care Aged Care Financial Performance Survey December 2020

3.4.4 Operating Results RACs

Aged Care Financing Authority

The Aged Care Financing Authorities 9th Report on the operation of the aged care system provides detail of the overall financial and operational picture of Australia's aged care system. The table below summarises the overall financial performance of residential care providers since 2014-15. As shown the profit of the sector has been declining significantly since 2017-18 and was negative $736 million in 201- 20, dropping below zero for the first time. The average earnings before interest depreciation amortisation (EBITDA) per resident has also been declining since 2017-18 and dropped again from $8,523 in 2018-19 to $6,445 in 2019-20.

The results published by the Aged Care Financing Authority are unlikely to include the results of the 3% of providers who control 36% of residential aged care places across Australia.

Table 15 Summary of financial performance of residential care providers, 2014-15 to 2019-20

	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
Revenue ($m)	$15,810	$17,172	$17,757	$18,066	$19,032	$20,536
Expenses ($m)	$14,903	$16,109	$16,751	$17,631	$19,037	$21,273
Net Profit Before Tax(es) (NPBT)	$907	$1,063	$1,006	$435	$264	($736)
NPBT margin	5.7%	6.2%	5.7%	2.4%	1.4%	-3.6%
Earnings Before Interest Depreciation Amortisation (EBITA)	$1,776	$1,985	$2,072	$1,591	$1,590	$1,222
Average EBITDA per resident per annum	$10,222	$11,134	$11,481	$8,746	$8,523	$6,445
EBITDA margin	11.2%	11.6%	11.7%	8.8%	8.2%	6.0%

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Source: Aged Care Financing Authority, Ninth report on the Funding and Financing of the Aged Care Sector, June 2021

Royal Commission's Independent Financial Assessment

The Royal Commission's analysis of residential aged care operations was based on 2018 data and was examined by Binder Dijker Otte (BDO Accountants and Tax Audits). As detailed in this report, the situation has deteriorated significantly since the analysis was undertaken, however there are some useful insights.

When examining residential aged care operations in isolation from other activities (such as home care) that a provider may also operate, it was concluded that:

- 25 of the for-profits (8.7%) are 'not profitable', representing $140m (1.9%) of the total for-profit income in residential aged care. A further 32 providers (11.1%), representing $1.4b (19.0%) of the total for profit income, are assessed as 'may not be profitable'.

- 34 of the not-for-profit providers (6.9%) are 'not profitable'. These comprise $331m (3.4%) of the total not-for-profit income. A further 54 providers (11.0%) are 'may not be profitable'. These equate to $1.1b (10.6%) of the total not-for-profit income in residential aged care.

- 47 government entities (49.5%) are 'not profitable', representing $444m (49.7%) of the total government income in residential aged care. A further 5 government providers (14%) are deemed 'may not be profitable'. These account for $26m (2.9%) of the total government income in residential aged care.

The table blow provides information regarding viability (vs profitability). The ATO states that a business is viable where:

1. It is returning a profit that is sufficient to provide a return to the business owner while also meeting its commitments to business creditors, or

2. It has sufficient cash resources to sustain itself through a period when it is not returning a profit

Table 16: Viability of RACs by ownership type

		For Profits	Not For Profits	Government	Total
80% of RADs treated as Non-Current Assets	Viable	119 (41%)	303 (62%)	29 (31%)	451 (51%)
	May be viable	126 (44%)	160 (32%)	55 (57%)	341 (39%)
	Not viable	44 (15%)	30 (6%)	11 (12%)	376 (43%)

Source: Report on the profitability and viability of the Australian aged care industry 21 July 2020 The Royal Commission into Quality and Safety Research paper 12 September 2020.

BOD provided modelling in their research paper (part of the Royal Commission into Aged Care) demonstrating that if 40% of RADs were treated as non-current assets then the total providers that could be considered viable would fall to 34%.

The Australian Aged Care Financing Commission report suggests that operational results have deteriorated by 26% since 2018. Stewart Brown comment that the situation has deteriorated further in the six months since the 2019/20 results were published by Australian Aged Care Financing Commission.

Operational business cost and revenue breakdown

The Stewart Brown survey of 1,200 aged care homes (97,056 beds/places), representing 44% of all aged care facilities, provides insight into where revenue is not keeping pace with costs and the overall financial metrics of a residential aged care facility. The results in the table are below averaged across all providers/facilities and are expressed in the cost per resident per day, comparing the December quarter 2019 to the December quarter 2020. The revenue from everyday living costs is not keeping pace with costs.

Table 17: Stewart Brown Survey Results Dec Quarter 2019 & 2020

	Dec 2020	Dec 2019
ACFI*		
ACFI Revenue	$187.79	$180.30
Expenditure ACFI		
• Labour Costs	$!51.48	$145.90
• Other Direct Costs	$9.50	$8.57
• Administration	$13.87	$13.53
Total ACFI Expenditure	$174.85	$168.01
ACFI Result (A)	**$12.94**	**$12.30**
Every Day Living		
Revenue	$54,58	$53.29
Expenditure		
• Catering	$32.50	$30.76
• Cleaning	$9.14	$8.48
• Laundry	$4.16	$4.02
• Payroll Tax – Hotel Services	$0.12	$0.11
• Overhead Allocation (WorkCover & Education)	$0.71	$0.65
• Utilities	$7.09	$7.02
• Routine maintenance & Vehicles	$9.98	$10.37
• Administration	$12.61	$12.29
Total Every Day Expenditure	$76.29	$73.71
Every Day Living Result (B)	**($21.71)**	**($20.42)**
Care Results [A + B] = (C)	**($8.77)**	**($8.13)**
Accommodation		
Revenue Accommodation		
• Residents	$13.04	$13.63
• Government	$19.49	$18.88
Total Revenue Accommodation	$32.53	$32,51
Expenditure Accommodation		
• Depreciation	$18.73	$18.11
• Property rental	$1.05	$0.67

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	Dec 2020	Dec 2019
• Other	$1.10	$1.30
• Administration	$11.02	$10.47
Total Expenditure Accommodation	$31.90	$30.81
Accommodation Result (D)	**$0.63**	**$1.70**
Operating Result (C + D)	**($8.14)**	**($6.43)**
Operating Result ($ per bed day per annum)	**($2,746)**	**($2,210)**
Earnings before Interest, Tax, Depreciation, Amortization, and Restructuring or Rent costs	**$3,924**	**$4,245**

Source: Stewart Brown Aged Care Survey Dec 2020 Quarter Results

*ACFI is the aged care funding instrument which is the tool used to classify the resident's acuity across three domains; activity of daily living (ADL), cognition and complex health care.

3.4.5 The impact of rurality on financial performance

The table below enables a comparison to be made between the critical metrics affecting residential aged care financial performance in major cities, inner regional and rural and remote areas (i.e. Boddington). With increasing rurality, the results worsen. Factors include socioeconomic status, occupancy levels, increased costs, and a lower average RAD.

Table 18 Summary Results by Region

	Major Cities	Inner Regional	Rural and Remote
Operating Results ($pbd)	($7.84)	($8.28)	($10.54)
Operating Results ($pbda)	($2,648)	($2,799)	($3,484)
EBITDAR	$4,195	$3,532	$2,682
Average Occupancy	92.5%	92.6%	90.6%
Average ACFI $pbd	$189.74	$182.93	$185.43
Direct hours per resident per day	3.32	3.22	3.31
ACFI Service costs as a % of ACFI	85.7%	85.6%	86.6%
Supported Ratio (No RAD or DAP)	45.7%	47.6%	51.0%
Av Full RAD Held	$430,382	$320,052	$293,296
Av Full RAD taken in the period	$471,016	$365,471	$339,237

Source: Stewart Brown Aged Care Survey Dec 2020 Quarter Results

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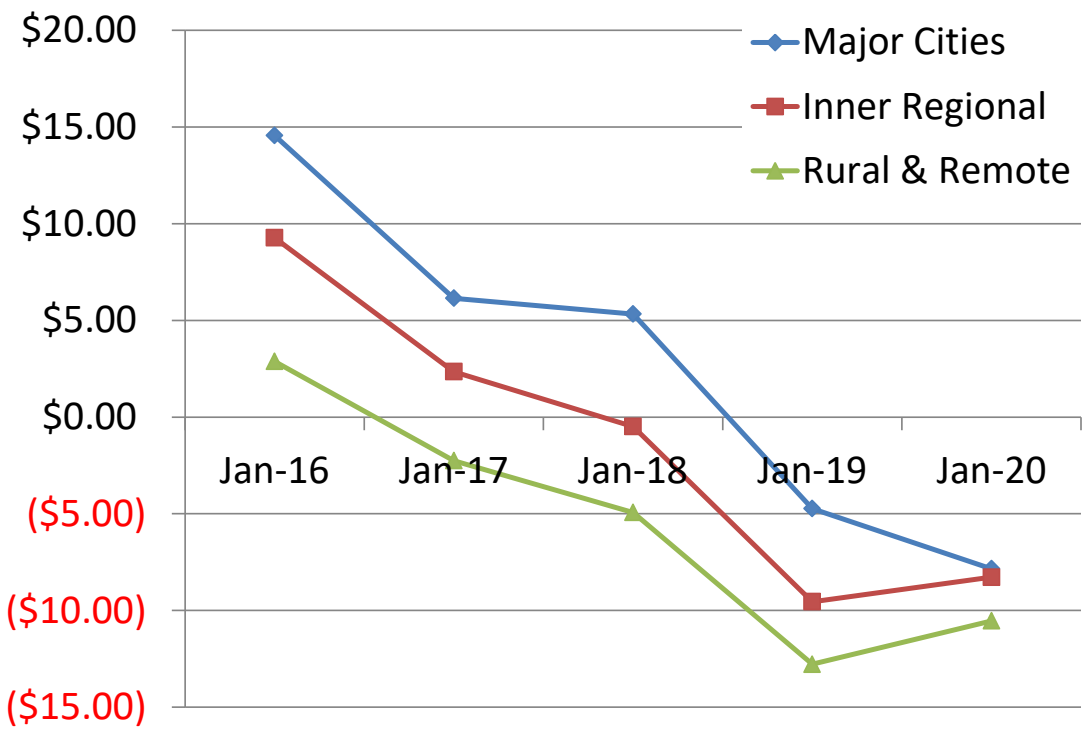
The following figure demonstrates that, due to COVID payments and the Commonwealth's viability supplement, rural providers have arrested the rate of loss making.

Viability supplement

The viability supplement is an additional payment made by the Commonwealth that aims to improve the financial position of smaller rural and remote residential care facilities that incur additional costs due to their location and are constrained in their ability to realise economies of scale due to smaller numbers of beds. In addition, the viability supplement also supports providers who specialise in aged care services for Indigenous people, or for people who are homeless or at risk of becoming homeless, in recognition of the often higher costs associated with providing these services.

At 30 June 2020, 455 residential services were receiving the viability supplement on behalf of 13,659 residents. During 2019-20, $82.3 million in viability supplements was paid to providers. A temporary 30% COVID-related increase applied from March 2020 to June 2021.

Figure 17: Operational results by rurality



3.4.6 Summary

Residential aged care is not viable primarily due to Government failures that have focused on restraining expenditure by design with no regard for the impact on the safety and quality of care provided to older people. The worsening situation has been a long-term trend.

Currently the viability of residential aged care is further disproportionately and negatively impacted by the degree of rurality, and size of the aged care facility.

The larger for profit providers represent a small group of approved providers (3%) but (36%) of places. Their business model is primarily driven by the non-operational activities of property investment.

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4 Alternate Models of Aged Care Accommodation & Services

4.1 Context

As part of this project, the Shire of Boddington sought the identification of non-traditional models of residential aged care (such as the Green House model). This chapter provides insight into existing and emerging non-traditional models of residential aged care. This includes global trends that are potentially relevant to the local context and changes within the Australian aged care sector that are expected or those that have been foreshadowed by the Commonwealth following the Royal Commission.

4.2 Overview of Models

There are three basic concepts that support small scale or homelike residential aged care. The models have been developed to address viability and/or to deliver safe high quality care related to the contemporary care needs of people entering residential aged care. The three broad models reviewed for application in Boddington are:

- Small scale residential aged care designed to address viability using either a place based (multi service) model, federated model, hub and spoke model or the multi-purpose service (MPS) model
- Small scale and or homelike models that are part of a larger campus focused on superior dementia/mental health care/maintenance of wellbeing
- Housing based alternatives providing the equivalent to residential aged care using home care packages to fund and provide care

4.3 Achieving Viability in Small Scale Residential Aged Care

4.3.1 Multiple Service Types including Residential Aged Care

This model may be imagined as a community and services hub (see the figure below) delivering multiple and integrated services. This model aids viability through multiple funding streams and therefore increased capacity to recruit, train and retain governance, management and clinical staff. The multiple funding streams also promote opportunities for efficient and effective business processes.

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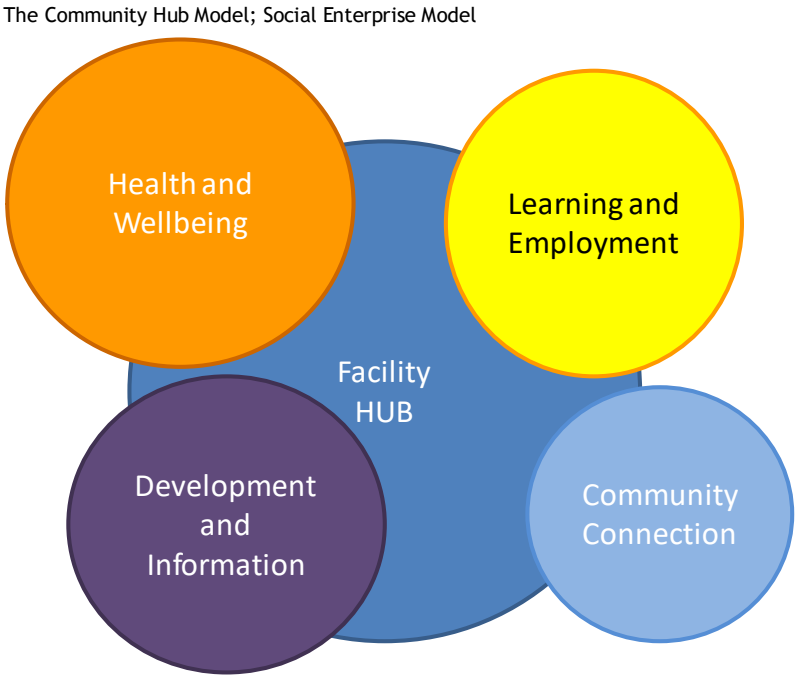
Figure 18: Facility as a hub



Source: An Alternate Model of Aged Care for Rural and Remote Australia Dept of Health 2011 (Faircloth D Verso Consulting Pty Ltd)

Examples of providers delivering multiple services that include residential aged care:

- Tandara Lodge in Sheffield Tasmania. In this service the provider delivers the Commonwealth Home Support Program services, home care packages, residential aged care, primary health services and community wellbeing services, using a single governance and administration function. These responses require strong, entrepreneurial and competent leadership.
- Yeoval aged care facility operated by the United Protestant Association of NSW (17 places)

4.3.2 Hub and Spoke Model

The hub and spoke model typically includes a range of service offerings as described in the Tandara Lodge example above. An example of the hub and spoke model is operated by the United Protestant Association of NSW (UPA) in the Riverina Murray District. Murray Vale Shalem has 60 places in the suburb of Lavington and operates as a hub, supporting smaller facilities in:

1. Holbrook (21 places) - co-located with a state government operated health service
2. Jindera (21 places)
3. Howlong (21 places)
4. Henty (20 places)

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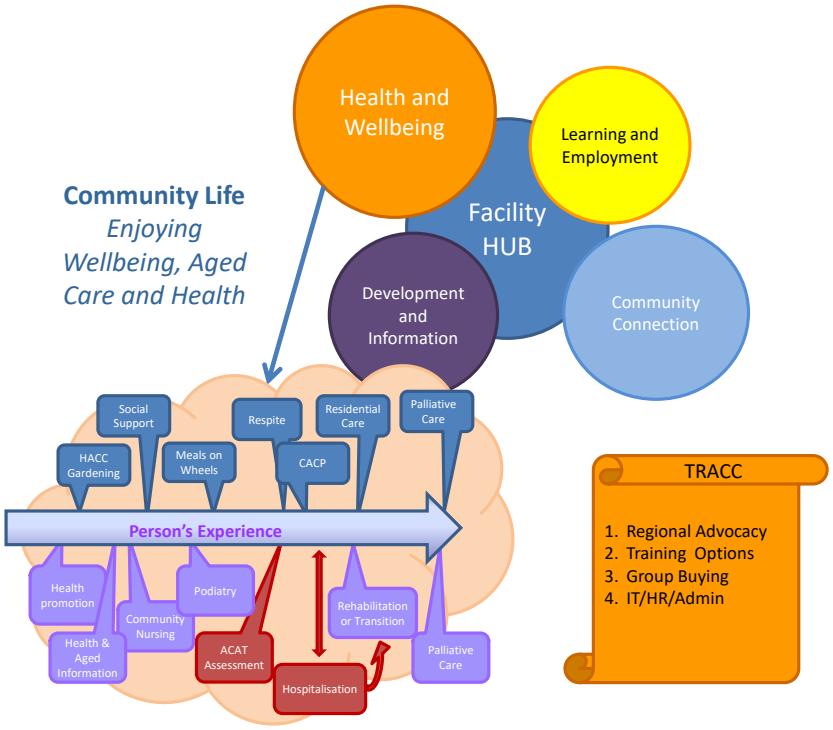
4.3.3 Federated Model

Tasmanian Residential Aged Care Collective

This model uses the principles of the hub and spoke model and supports multiple providers to share buying power, training, specialist staff and service improvements. An example of this model is the Tasmanian Residential Aged Care Collective (TRACC). The TRACC model has been in operation for 10 years. Tandara Lodge is a member of TRACC.

Figure 19: Model with a federated approach



Source: An Alternate Model of Aged Care for Rural and Remote Australia Dept of Health 2011 (Faircloth D Verso Consulting Pty Ltd)

UPA

Another example of the federated model is found within UPA. All UPA regions operate as semi-autonomous organisations, with local boards federated under the Approved Provider whose key personnel are representatives of each region. This model ensures that the corporate activities/benefits - which include legal, quality management, clinical governance, HR, training, marketing, IT and financial management (including sophisticated investment and land banking) - benefit the mainly small rural services.

4.3.4 Multi-Purpose Service (MPS)

The MPS model is mainly operated as a health service (hospital) and residential aged care. This service type is funded through the Commonwealth's Flexible Service funding stream. The Multi-Purpose Services (MPS) program provides integrated health and aged care services to regional and remote communities in areas that cannot support both a separate aged care home and hospital. The program is operated by WACHS in WA. Verso notes that the Royal Commission has called for an expansion of the model to respond to needs of rural and remote Australia.

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A detailed review of the model was undertaken in 2019 with 12 recommendations to improve aged care delivery through the model. The Commonwealth accepted (or accepted in principle) all 12 recommendations.[13] A summary of the recommendations and the Commonwealth's response is attached (Appendix 1).

Multi-Purpose Service – Government Response to Royal Commission Recommendation 55
The Government will provide additional funding from July 2022 to uplift and broadly align the funding for Multi-Purpose Services with mainstream aged care. This funding will reflect the changing number and acuity of people receiving care and ensure senior Australians accessing aged care from Multi-Purpose Services are subject to the same eligibility and needs assessments as people accessing other Government-subsidised aged care services. Multi-Purpose Services will also be given better access to other aged care funding programs, including new capital grant funding (see the response to recommendation 46). The Government will also consult with state and territory governments to develop and implement a co-contribution model for aged care capital projects to establish new Multi-Purpose Services.

Note: In light of these foreshadowed activities, there may be an opportunity in Boddington to showcase new responses in collaboration with WACHS.

The underlying principle in the models detailed in this section is that to overcome the inherent viability issues in small scale residential aged care facilities (<50 places), multiple services need to be developed from a single campus or connected campuses.

4.4 Small Scale and/or Home-like Models

Models such as the Green House Project that deliver small scale or home like models are commonly part of a larger campus or are 'houses' within a larger facility. These models focus on superior dementia/mental health care/maintenance and promote wellbeing. The efficacy of this approach and the financial impact is discussed in a research paper (Dyer S. et al) developed within the Australian system and context[14]. The research concludes that clustered domestic models of residential care are associated with better quality of life and fewer hospitalisations for residents without increasing whole of system costs.

The Aged Care Royal Commission into Quality and Safety[15] noted that:

"Good design in residential aged care, particularly for people living with dementia, usually involves smaller, lower-density congregate living arrangements rather than larger, more institutional settings. Smaller, lower-density congregate living arrangements generally promote better quality of life for everyone. Large, noisy institutional environments can worsen the adverse consequences of dementia."

"Creating 'familiar households' facilitates the provision of person-centred care. We have heard that for residential aged care, there is significant benefit to a domestic setting instead of a traditional institutional model. Small household models usually involve housing eight to 10 people receiving aged care services, and sometimes up to 16 people, within a home-like environment. Common features include 'a focus on domestic, homelike, familiar or normalised environment with medical equipment hidden'. Regular staff are employed and they do not wear uniforms. Without wishing to limit innovation, we consider that the small household model is one way in which residential aged care can adopt dementia-friendly and accessible design principles."

[13] Commonwealth Government Response to the Multi-Purpose Services Program Review Dept of Health

[14] Suzanne M Dyer, Enwu Liu, Emmanuel S Gnanamanickham, Rachel Mitte, Tiffany Easton, Stephanie L Harrison, Claire E Bradley Julie Ratcliffe, Maria Crotty; Clustered domestic residential aged care in Australia: fewer hospitalisations and better quality of life MJA 208 June 2018

[15] The Aged Care Royal Commission into Safety and Quality Exec Summary page 105

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4.4.1 The Green House Project

The Green House Project has come into particular focus in Australia, as it was referred to by the Royal Commission into Aged Care Quality and Safety. Commissioner Briggs visited the Leonard Florence Centre For Living site in Chelsea, Massachusetts (in the United States of America) which was the first to adopt the Green House Model of care in an urban setting.

The Green House Project locates a home within a cluster of homes on the same campus (effectively part of a much larger service). The homes provide high levels of care for individuals who do not wish to be in a traditional aged care setting. Instead of a residential aged care facility, a Green House Project community consists of clusters of smaller homes with six to ten residents.

The Green House Project has been developed as an alternative to the traditional American nursing home in an effort to 'de-institutionalise' and invigorate the long-term care environment by providing specially designed homes in which older persons can live with dignity, comfort and companionship.[16]

Residents have their own room and ensuite, are free from scheduling and able to access social and shared areas of the house at any time, making it truly feel like home. Private areas open to central dining, kitchen and living facilities with flexible seating and other arrangements based on individual preferences.

Figure 20: Green House Floor Plan

There are many other Australian and international examples that have a similar care goals and quality outcomes using home like models with a larger complex, including:

- Life Care Aldinga Beach (SA)
- Korongee Village (Hobart, Tasmania)
- Adards Tasmania (now Regis)

[16] https://propertycouncil.com.au/Web/Content/News/NSW/2015/The_Greenhouse_Project___A_Residential_Model_for_Aged_Care.aspx

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- Zorgkwadrant Fryslan Oost - Friesland Province (The Netherlands)
- Dagmarsminde Carehome (Græsted, Denmark)
- Tönebön am See (Hamelin, Germany)

The Royal Commission's focus on safety and quality resulted in resonation with these models, as they have a profound impact on dementia care, mental health care, reduction in behaviours of concern, reduction in the use of medications to manage behaviours and reduction of depression.

It is worth noting that the home-like and small scale references were not discussed by the Commission to resolve scale and market failure issues in rural and remote Australia. Models such as the Green House are developed within a larger cluster of houses on a single campus or under a single roof. The scale enablers providers to resource the built form and workforce that are essential elements of the model.

4.5 Housing-based Alternatives

Housing-based alternatives provide the opportunity to deliver 24/7 care equivalent to residential aged care on a very small scale. These alternatives provide the opportunity to manage wellbeing, high quality and safe care with the outcomes noted in the previous section.

4.5.1 Group Homes Australia (GHA)

GHA offers care for 6-10 residents living in a traditional home, on a traditional street. There are currently ten group homes of this model located in Sydney's suburbs.

There is an emphasis on blending a socially inclusive home with best practice clinical care. The GHA approach focuses on getting residents involved in day-to-day life activities that bring them purpose and meaning.

Care costs are subsidised through home care packages; therefore this model is not regulated as a residential aged care facility.

4.5.2 Verso's Gathered Model

The Gathered Model is a further development of the model proposed by Verso within the Wheatbelt Aged Care Solution and Ageing in the Bush (State-wide Regional Aged Care Strategy). The model is described as:

- A cluster of independent living units built to platinum level disability access (minimum 8) promoting independent living with positive socialisation
- 2 bedrooms to support family and carers who want to visit and stay (or live) or for people who would prefer to live with another person to share a home
- A community facility also providing a space for an observation bed and for overnight accommodation for a staff member including a workstation
- 24-hour care using non obtrusive monitoring technologies
- An internal secure garden
- Co-located with primary health/hospital, if possible, with service agreements to support access to allied health
- As with Group Homes Australia, the model maximises the efficient delivery of home care

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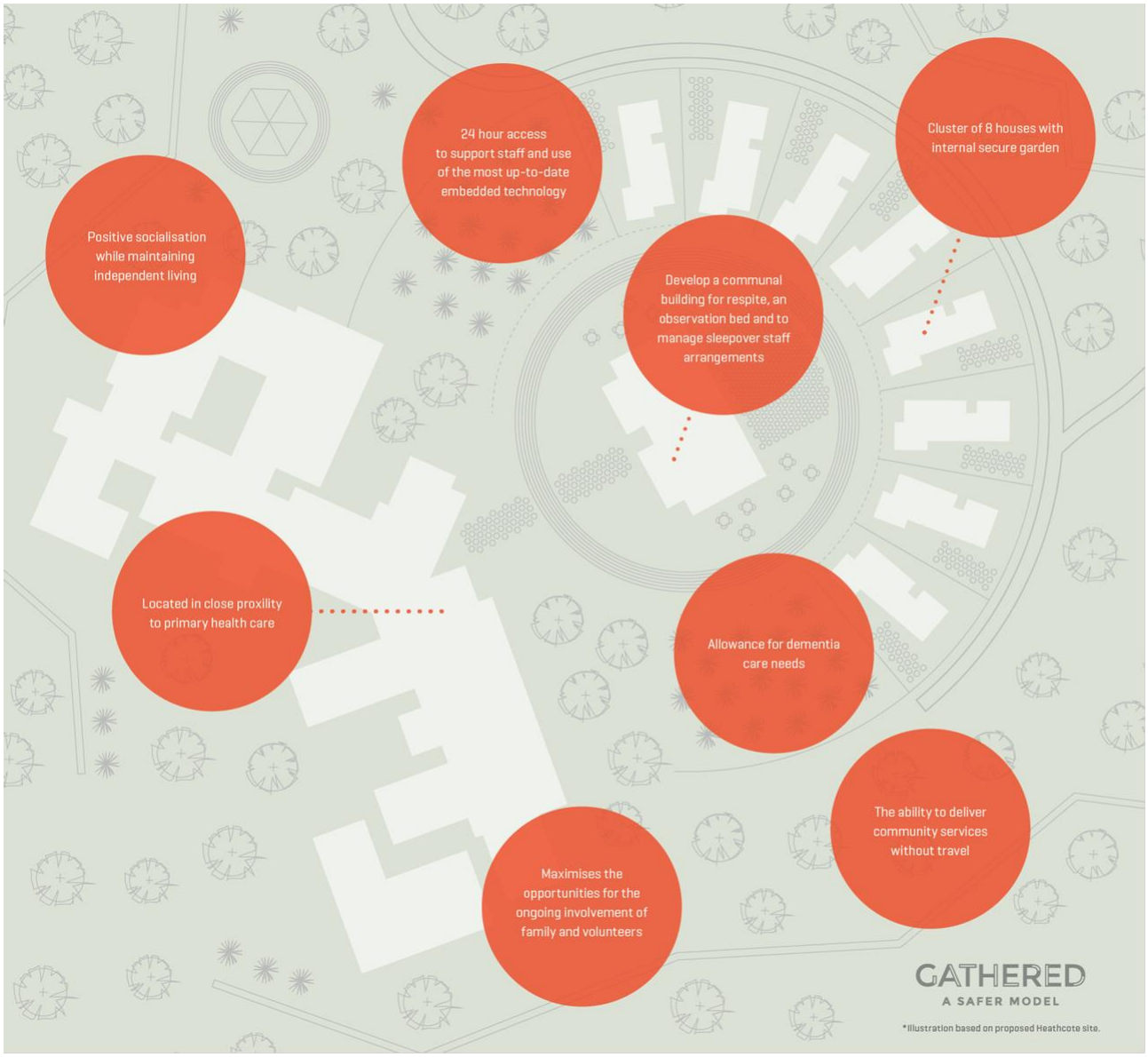
Figure 21: Verso Gathered Model



4.6 Options

4.6.1 Workshop Fact Sheets

On the evening of the 25th of August 2021, the Shire of Boddington Aged Accommodation Committee met (virtually) with Verso to develop the preferred model options. The options were developed with reference to fact sheets which summarised the information in this report. The fact sheets included:

Fact Sheet 1: Demand analysis. This analysis identifies that drawing from a catchment of Williams, Wandering and Boddington, there is demand for a residential aged care facility of up to 45 places. A 45-bed facility is very small in the broader Australian experience.

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Fact Sheet 2: Client Profile. This analysis demonstrates that entrants into residential aged care will have high level and complex care needs with dementia care and mental health care needs being dominant issues. The analysis also demonstrates that palliative care will be a feature of the care offered in the facility. The implications are that the provision of residential aged care requires high levels of clinical care and a workforce matched to care needs associated with the high acuity of residents. A residential aged care facility must meet the appropriately high standard of governance, safety and quality required under the Aged Care Act. Post-Royal Commission, the Commonwealth will be placing a greater emphasis on auditing the quality of care and safety and increasing the enforceable measures under the Act.

Fact Sheet 3: Current operational environment and dynamics of residential aged care including scale and viability. As the title suggests, the analysis considered the scale and viability of residential aged care. Given the findings from the demand analysis, the impact of scale on operating results is directly pertinent to understanding the potential viability of a residential aged care facility in Boddington. Over the last 15 years, the market has moved to larger and larger facilities and a growing portion of aged care places are operated by a very small number of providers. Current operating results for residential aged care are in the negative. Results have been trending from operational surpluses 5 years ago to the current negative results. The implication is that a new facility in Boddington is likely to be loss making.

Fact Sheet 4: Overview of alternate models. This fact sheet summarises the information detailed in this chapter.

4.6.2 Workshop Decision Making Considerations

Principles and threshold issues that were used for determining the right/best option(s) must be able to respond to:

- The quantum of need, bearing in mind that the facility might have a 40-year life
- The care and safety issues discussed in Fact Sheet 2
- The requirement to attract and retain the leadership and staff required to deliver the care safely
- The viability issues discussed in Fact Sheet 3 and the capacity to return a surplus to enable reinvestment of funds into service improvement and capital replacement/refurbishment
- The preferred position of the Shire of Boddington to attract or facilitate the involvement of an approved provider

4.6.3 Workshop Outcomes

Residential Aged Care

The committee reaffirmed the resolute view of the community forums that residential aged care is required in Boddington. The foundational principle is that it is a human right to be able to age in the community of choice. The negative impact on residents, carers, partners and families when community members have to go to residential aged care some distance away is considered unacceptable.

Residential aged care – being fully informed

The consultants considered that it was essential that they test the community's understanding of aged care. It is their experience that aged care is often understood to be residential aged care (nursing home or hostel) with little or no knowledge of community/home care options.

The impact of the knowledge gap is that the request for residential aged care has been because the benefits of the level of support offered in the community care option are not known or are confused with basic care (CHSP services - formerly HACC).

The outlook has been justified as home care package service delivery in the Wheatbelt region away from the bigger communities has been limited or compromised by the lack of a suitable workforce.

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Residential Aged Care - being fully informed (cont.)
In the community forums. community care was not seen to be able to sufficiently meet the high care needs of people requiring residential aged care. The examples cited that have shaped this position include:

- A strip of lawn is mowed to the washing line whilst the rest is let to grow out of control
- Cleaning 'only to shoulder height'
- Higher care packages not adequate with only two hours morning and night when full care is required and no care on weekends
- Disquiet about cost/value
- There is a high level of frustration regarding care levels and wait times for care
- Perception that there is a lack of packages available
- Wait times for ACAT assessments up to a year; assessment comes from Peel
- High levels of frustration at lack of co-ordination of care, communication, and transparency
- Silver Chain staff from Narrogin - lots of staff changes so continuity of care lacking

The community's poor experience with community care (including the perception that care is inadequate to meet high care needs) mean that it is not seen as a suitable substitute for residential aged care. The consultants have therefore concluded that the Shire of Boddington and its community are not lacking in knowledge or understanding of community/home care.

4.7 PESTEL

This analysis was not directly addressed in the workshop but referenced in the discussion. A PESTEL analysis addresses the impact, influence, and operational factors within a political, economic, social, technological, environmental and legal framework.

The consultants have extrapolated the general discussion and thinking of the workshop attendees to undertake the following analysis. Within the PESTEL analysis, a number of economic concepts are addressed. The consultants have considered the economic factors within the quadruple bottom line framework (sustainable prosperity) that includes[17]:

- People – Quality of Life: Quality of life for people, e.g. health, vigour, wellbeing, flourishing.
- Profit – Competitive Productivity: Competitive productivity in producing and distributing goods and services for consumption and profit with scarce resources.
- Planet – Sustainable Ecosystems: Individual, community, and ecosystems survival across lifespans and generations.
- Progress – Adaptive Innovation: Adaptive innovation in all aspects of people, profit, and planet, and innovations, e.g. adaptive learning and change; trial and error risk taking and discovery. The fourth quadrant is addressed by some authors as values, spirituality and culture.

The PESTEL analysis addresses this broader concept of economics beyond the subject line 'economics', giving consideration to the 'four Ps' within the overall analytical framework.

[17] Beech, Cambridge Leadership Development Ltd., 2013

Table 19: PESTEL Analysis

Focus	Discussion
Political	
Community concern regarding the lack of aged care services and the associated impacts on families, including incapacity to retain seniors, will create political pressure. The erosion of other health services related to the care needs of older people and their families will also create political pressures. These political pressures may also include the lost opportunity to develop Boddington through attracting 'tree changers'.	There is evidence in the tenor of the community forums that the lack of aged care services is a real concern to the community. The broader concern regarding the potential erosion of other vital services, including health services, is not as strong. However, the experience of other rural communities who have experienced the loss of vital health and community (e.g. pharmacist) would not be lost on Boddington residents. Managing the political expectations of the community may require Council to demonstrate leadership, with the goal of supporting population retention and attraction and valuing older people as vital participants in the community. The consultants recommend that mitigating the political risks will require planning and advocacy embracing: • Age friendly initiatives including access to State or Commonwealth funding supporting healthy ageing and health promotion • Continued development of older persons housing matched to current and future demand • Securing partnerships or other responses to ensure the development of a local workforce to deliver the full suite of community aged care service types and service levels (including assessments, information, respite, and way finders) • Securing partnerships or initiating a local response to establish at least 35 to 45 bed residential aged care developed to respond to contemporary standards of care and with a business model that will promote viability over the life of the building (40+ years)
Economic	
Financial sustainability is constrained by the small number of places that can be reasonably justified in Boddington (35-45). In addition, residential facilities are currently operating with a negative result. On average the current result for facilities has been trending downwards for more than 5 years. Providers report that positive results are only being achieved through non-operational factors (property values, investment earnings from RADs or other portfolios held by the provider). The Royal Commission findings and recommendations regarding viability have not been matched with an adequate response from the Commonwealth. While the Commonwealth will put more money into residential aged care, providers consider that the indicated funding levels will not cover current shortfalls, mandated and increased minutes of care per resident per day and costs associated with additional levels of compliance. A hospital, aged care services and related service infrastructure has been identified as a factor considered by older people when considering a 'tree change'. Attracting incoming ageing and older people will add to the overall economic prosperity of the Boddington community.	The framework for economic analysis may be understood to be more than financial considerations as discussed in the introductory statements. However, this section primarily addresses the financial considerations. Financial viability of a small scale residential aged care facility located in Boddington will require a development that: • Delivers residential aged care in conjunction with a suite of complimentary services that achieves economies of scale through shared administrative, management, IT, IR, HR, marketing, and governance systems, processes, and personnel • Provides a scale of operations that offer staff the opportunity to develop their skills and to be provided with a career path • Potentially uses partnerships in the Wheatbelt or other similar rural settings to enhance buying power and to spread the cost and inputs of expert clinical staff across multiple services

Focus	Discussion
Economic (cont.)	
	• Builds relationships with clients to supports their journey through the continuum of care with multiple benefits across all service types offered and with the opportunity to maintain high occupancy rates • Provides a high quality of care and enhanced wellbeing to become the residential aged care facility of choice; this will enhance the capacity to secure RADs and or DAPs that are considered by consumers to represent value • Minimises the need to raise capital through borrowing • Reduces the cost of care through design and leading international practice Overall economic outputs for the Boddington community would be enhanced by residential aged care as the facility and integrated aged care service: • Is likely to employ 70 or more people • Retains community members and, by extension, their families • Attracts incoming residents (they may be more than one or two decades away from needing complex care) • Sources local goods and services Within the overall council plan, the role of ageing and aged care should also be treated as an economic driver for community prosperity.
Social	
A major driver for creating a sustainable residential aged care facility in Boddington is the community outlook that it is a human right to age in place. It could be argued that people in rural communities are more likely to have a strong affinity to the place where they belong. For some families, their history and identity has been developed over multiple generations. Of course, for Aboriginal people, their connection to land is spiritual and cultural and extends back over many thousands of years. Distressing stories from Aboriginal people and other residents of Boddington, Williams and Wandering have been shared as part of this consultation. The impact of the current situation where people must move away from their community, family, friends and partners is profound. A residential aged care facility located in Boddington has been conceived to be vital in addressing what some have expressed to be a breach of their human rights.	The maintenance of older people in the community will have the following social benefits: • Retention of the knowledge and wisdom of the elderly • Ongoing contributions of older people to the social and civic life of Boddington • Enhanced community wellbeing with all generations part of the life of the community • Retention and maintenance of familial relationships Within the overall council plan, the role of ageing and aged care should also be treated as social factor enhancing and building community wellbeing.

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Focus	Discussion
Technological	
The application of technology to business systems and processes is a key driver to improved efficiencies that directly benefits the bottom line. Technology improves the capacity for people to age independently. A new integrated service (combining residential and home based care) in Boddington will provide the opportunity to engineer the most up-to-date technology into all aspects of the business and care services.	Current technologies with the capacity to support enhanced quality of care and safety include but are not limited to: • Telehealth, improving access to specialists (inputs from geriatricians), while reducing the cost and logistics of travel. Telehealth consultations have also been used by some specialists as an opportunity to improve the practice of clinical staff. • Care monitoring technology • Automated systems for record keeping, invoicing, care/case management, business analysis, medication management etc Emerging technology that are likely to impact positive ageing and aged care includes: • Robotics • Driverless cars • Continuing breakthroughs in telecommunications • Delivered meals Within the overall council plan, the role of technology should be factored into the capacity to deliver services that are efficient and that improve the safety and quality of care
Environmental	
Aged care services, like all aspects of business, civic and community life, should be developed by design and practiced in a manner that reduces harm to the planet. There is also emerging research that connects wellbeing and memory of people in aged care to engagement with green spaces (particularly trees and shrubs).	Government service contracts will increasingly require service providers to demonstrate how their service complies with environmental best practice, and it may become a legislated requirement. The adaption of best practice care models in Boddington can build on the significant environmental assets enjoyed by Boddington's location and amenities. Within the overall council plan, environmental design and practices should be reflected in building and development plans. Best practice and innovative care models should be explored and fostered throughout future aged care planning processes.
Legal Framework	
Aged care largely operates under the Aged Care Act 1997. The Commonwealth has indicated the development of a new Aged Care Act to facilitate part or full responses to the Royal Commission into Aged Care Quality and Safety. The Government has stated: *On 1 March 2021, the Government announced work will begin immediately on a new consumer-focused Aged Care Act. The new Act is intended to commence from 1 July 2023, subject to parliamentary processes.* *This will underpin system-wide reform of aged care and establish the legal framework for an aged care system designed to improve outcomes for senior Australians into the future.* *Drafting of the Act will be informed by consultation with senior Australians and other stakeholders, including members of the new Council of Elders and National Aged Care Advisory Council.*	The Shire of Boddington will need to be fully aware of the legal responsibilities of being an approved provider of aged care and the various enforceable undertakings as it considers the options for partnership, alternate providers and potentially facilitating/ supporting the development of a community organisation to deliver community and residential aged care. Due to the timing of this study, there is an opportunity to contribute to the reform process, including considering reforms of the MPS system. There is an opportunity to partner with WACHS with the goal of delivering residential care services that meet the quantum of need and resident acuity, in a manner consistent with leading practice.

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4.8 Preferred Options

The committee's preferred options are:

Option 1: A small sized residential aged care facility operating under current business rules, achieving enhanced viability through delivering a multiplicity of service types. Within this model, the committee is not discounting that there may be opportunities to develop a 'federated model'. The committee also appreciate the care model and design exemplified in the Green House Project, and similar models should be incorporated into the facility design and operations. The committee considers that co-locating the facility adjacent to the hospital would be particularly beneficial. In this model a close and effective relationship with WACHS will be desirable.

Sector feedback indicates attracting an approved provider in the current operational environment is unlikely due to COVID-19 impacts, negative operational results, major reforms and associated uncertainties, restrained property investment opportunities in Boddington, increased regulation, and current occupancy rates. The committee accepts that in order to achieve the vision for high quality residential aged care and the outcomes achieved in alternate models (such as the Green House Project), a local community organisation may have to be developed to operate the facility and the mix of other services.

Option 2: Work with WACHS to have the Boddington Hospital reclassified to a MPS, with WACHS as the approved provider delivering residential aged care in the manner discussed in the care models in this section. The community would seek for this model to be a genuine partnership between the Commonwealth, the State and the local community.

This option will require significant collaboration and a shared vision with WACHS.

5 Business Cases

5.1 Overview

This chapter comprises of a business case for the top two short listed priority opportunities, encompassing:

- Key limiting and enabling supply and demand factors
- Likely investors, partners, and customers
- High level budgets, potential funding sources and next steps to advance the top priority opportunity

5.2 Option 1

A small sized residential aged care facility operating under current business rules achieving enhanced viability through delivering a multiplicity of service types. Within this model, the committee is not discounting that there may be opportunities to develop a 'federated model'. The committee also appreciate the care model and design exemplified in the Green House Project and similar models should be incorporated into the facility. The committee considers that co-locating the facility adjacent to the hospital would be particularly beneficial. In this model a close and effective relationship with WACHS will be desirable.

5.2.1 Key enabling factors

There is current and growing demand for residential aged care in Boddington driven by the population characteristics.

Financial viability can be enhanced in a small scale facility through delivering a range of complimentary services such as (but not limited to): home care packages, post-acute care, disability services, Veterans Home Care, respite, older persons housing or even child care. Good business leadership has found to be a vital factor using this approach.

There is an opportunity to develop partnerships and collaborations into the future with other similar rural aged care services that could support the development of shared capability and economies of scale.

The cost and complexity of care can be reduced by adopting international best practices in the care model and the building design.

A package of capital and land may provide incentives to support an existing approved provider to undertake a feasibility study (this report could help support the business plan).

5.2.2 Key limiting factors

The scale of demand (35-45 beds) is low when compared to contemporary residential aged care. Smaller sized facilities have generally been unviable. Residential aged care providers derive value from operations and property investment. The operations side of the equation is unviable because of scale and the overall government funding model. The property investment (enabled by RADs) is not likely to be a commercially attractive proposition in Boddington. The

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implication is that providers are unlikely to be attracted to Boddington to deliver residential aged care under the current operating conditions.

The current operational business model may limit opportunities to attract the capital required to construct and develop the facility – at $330,000 per place, the capital required would be between $11.6m to $14.9m.

There is uncertainty regarding the future of residential aged care due to the recommendations of the Royal Commission into Aged Care Quality and Safety and the Federal Government's response.

5.2.3 Customers

Demand for residential aged care is being driven by a growing number of people aged 85+ and a lack of supply. Key care needs are dementia care and mental health; however, the group of people requiring residential aged care typically have 5 to 8 comorbidities with the implication that current and future residents will need a high degree of technical nursing care. The demand is drawn from a catchment that includes Wandering, Williams, and Boddington.

5.2.4 Partners

Potential partners may include Shire of Boddington, WACHS, an approved provider of residential aged care, local health providers, the local governments of Wandering and Williams, Development Commissions and the Federal Government.

5.2.5 Budget

Capital

Capital development cost for the residential aged care facility: $11.6m to 14.9m

Standalone residential aged care facility operating result

The expected operational loss for a standalone facility is using current industry average results:

- $10.54 per bed day x 365 x 35 places = $134,649
- $10.54 per bed day x 365 x 45 places =$173,120

A 20 year operational shortfall based on current business rules and funding model = $2.7m to $3.5m.

New Mandated increased care hours: Flowing from the Royal Commission the Commonwealth has mandated care staff and registered nurses hours. This will increase the care cost hours. UPA has advised for its small facilities that this will add to operational losses by $4.00 per person per bed day even after increased subsidies have been applied. The mandated care cost are estimated to have the following impact:

- 35 places projected additional operational shortfall = $51,100
- 45 places projected additional operational shortfall = $65,700

The overall operational result is estimated at:

- 35 places projected additional operational shortfall = $186,149
- 45 places projected additional operational shortfall = $238,820

A 20 year operational shortfall based on current business rules and the additional cost impost = $3.7M to $4.8M

Mix of other services operational result

The estimated operating results for a mix of additional services is:

- 2 Short Term Restorative Care places operational result = $21,152 p.a.
- 15 home care packages (revenue $386,152) operating result: $5.67 per client per day x 365 x 15 = $31,043
- A range of basic care services (CHSP equivalent) at $300,000 at 8.75% margin = $26,250 (for full calculation see Appendix 2)
- NDIS service provision at 25 hrs per day x 365 x $58.80 = revenue of $536,550; margin 3.14% = $16,848 (for full calculation see Appendix 2)
- Potential saving by spreading administration, quality, IT, HR etc across multiple services = $20,000

Positive results from a broader suite of services = $115,293 p.a. or $2.3m over 20 years.

Cost Comparison Unit price

The following table details the modelling for unit cost margins for NDIS and CHSP. The model builds on detailed costings held by Verso Consulting. The DSW is a Direct Support Worker Level 2 with equivalent Social, Community, Home Care and Disability Award level and EBAs from Victorian Local Government. The difference in all up costings is primarily the amount of WorkCover, overheads and administrative charges.

Table 20: Unit Cost Comparison Community Care

	NDIS Cost Model	NFP CHSP	A private Provider	A Victorian Rural Council NDIS Enterprise	Boddington community Care Organisation NDIS	Boddington community Care Organisation CHSP
	DSW 2	SCHADS 2.4	SHADS 2.4	EBA band 2 level C	SHADS 2.4	SHADS 2.4
All up cost per hour	$57.52	$62.77	$57.01	$56.00	$57.01	$57.01
Sell price	$58.86	$62.00	$61.00	$58.80	$58.80	$62.00
Margin $	$1.34	-$0.77	$3.99	$2.80	$1.79	$4.99
Margin %	2.30%	-1.23%	7.00%	5.00%	3.14%	8.75%

Operating result combining residential aged care and a mix of other services

In a mixed model of residential aged care and other aged and disability services, the negative operating result may be between: $70,856 and $123,527 p.a. or a result over 20 years of $1.4m and $2.5 m.

Non-operating result

Non-operating income is impacted by the RADs. Estimating the result is based on 60% of places (21 to 27) attracting a RAD of $300,000. Potentially, there would be between $6.3m and $8.1m from which the organisation could earn income from term deposits or investments, e.g. older persons housing. Even on a conservative estimate of 2.5% return, the result could be between $157,500 and $202,500. Over 20 years, non-operational income could exceed $3.2m or $4.1m.

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20 year outlook operating and non-operational result

With the addition of a mixed model and non-operating revenue, the result over 20 years may be between $1.8m (35 places) and $1.6M (45 places).

5.2.6 Investors

Notwithstanding previous comments made regarding the likelihood of attracting an approved provider, the option should be incentivised and all options exhausted prior to considering other alternatives. The investment options may be dependent on the following:

- Securing an in-principle agreement with an approved provider who is willing and able to deliver the services in a manner consistent with the community vision and best practice
- Securing an approved provider may require:

- The provision of land on a peppercorn lease over 99 years
- A capital grant

This would enable the provider to build out a detailed business case benefiting from non-operational results to justify anticipated negative operational results.

- A capital grant may be provided by the Commonwealth government, state government or alternatively from the Boddington Gold Mine
- Granted land could be Shire owned, state government land or Crown land
- Based on a viable business model and securing an experienced operator, banks would lend money for development, construction start up and as a long-term mortgage (up to 60% of the required capital – land and building value) or the approved provider's asset position
- A large provider could also provide a loan from their internal resources
- An alternate approach would be to establish a community organisation to become an approved provider granting land and securing a capital grant and borrowing money to develop, construct and cover the start-up operational shortfall

5.3 Option 2

Work with WACHS to have the Boddington Hospital reclassified to a MPS, with WACHS as the provider delivering residential aged care in the manner discussed in the care models in this section.

For this to be a realistic alternative, the community is seeking to be a genuine partner with the Commonwealth and the State, with an expectation that the residential aged care services would be delivered in a manner consistent with leading practice.

5.3.1 Key Enabling Factors

- There is current and growing demand for residential aged care in Boddington driven by the population characteristics

- Integrated approaches to health, community care and residential aged care can produce improved outcomes for older people and improve health literacy relevant to aged care across the community
- The cost and complexity of care can be reduced by adopting international best practices in the care model and the building design

The Commonwealth government has been developing a suite of reforms of the MPS model, and in response to the Royal Commission into Aged Care Quality and Safety, has agreed to expand the model where there has been market failure. The reforms bring the MPS model, with reference to aged care, into alignment with aged care standards in the broader system.

5.3.2 Key limiting factors

It is unknown how the reclassification may impact health services at Boddington Hospital and what the implications might be with reference to funding.

WACHS would need to be a willing and active partner to:

- Consider this option
- Co-design the service model with the community, including the building design (considering flexible and integrated service delivery)
- Develop a comprehensive plan to deliver community care, respite, and restorative care across the catchment (Wandering, Williams and Boddington)
- Develop a workforce with a focus on local employment where possible
- Deliver residential aged care services at the required scale

The Commonwealth would need to agree to the reclassification and provide adequate funding to support the scale of operations required.

There is uncertainty regarding reform details, timeframes and funding limitations of the MPS model and how the model intersects with consumer choice. There is also a lack of detail on how capital would be accessed for the expansion of the model.

5.3.3 Customers

The demand for residential aged care is being driven by a growing number of people aged 85+ and a lack of supply. Key care needs are dementia care and mental health. However, the group of people requiring residential aged care typically have 5 to 8 comorbidities with the implication that current and future residents will need a high degree of technical nursing care as well. The demand is drawn from a catchment that includes Wandering, Williams and Boddington.

5.3.4 Partners

Potential partners may include Shire of Boddington, WACHS,, the local governments of Wandering and Williams, Development Commissions and the Federal Government.

5.3.5 Budget

The budget is to be determined within the MPS program funding and budget.

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6 Next Steps

6.1 Immediate Actions

The consultants recommend that:

- The Shire of Boddington receive the report
- Confirm the vision, the model of care and the model of viability, i.e. Option 1 or Option 2
- Consider/determine the role the Shire will play in realising the vision for residential aged care and the accompanying viability considerations e.g. advocate, facilitator, partner, investor (seeding, in kind or long-term), customer
- Build consensus with the Shires of Wandering and Williams and their communities regarding the model and their ongoing voice in realising the vision
- Identify if land is available to grant to a prospective approved provider and its suitability considering the model and what the process would be to obtain/grant the land and under what conditions
- Develop collateral to support the marketing of the opportunity and to garner investor support
- Obtain seed money to move through the project inception and realisation phase
- Maintain a project steering committee to work through the next phases of the project

6.2 Project Inception

Conduct a project inception workshop with key stakeholders:

- Confirming the vision for the development, model of care, model of community engagement and integration and integration with health
- The viability issues and how they will managed by design, integration and the risks
- The ongoing communication process
- The next steps, noting that The Commonwealth would need to agree to the reclassification and provide adequate funding to support the scale of operations required
- Identify and quantify resources (including human) required to realise the project
- Communicate with relevant State and Commonwealth politicians about the project and intended cause of action; seek their support

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6.3 Project Realisation

6.3.1 Threshold Issues

There are two threshold issues that need to be determined first:

- Would WACHS be willing to partner with the community to explore the concept of establishing a MPS in Boddington to deliver 35-45 places and to also deliver other aged care services to the catchment. To explore this possibility we recommend that:

- This report and the marketing collateral is made available to WACHS senior executives, with introductory comments consistent with the consultations undertaken with WACHS in the development of this report, including the alternate options to be considered

- A briefing is provided to WACHS (if required) to provide an opportunity to interrogate the evidence and rationale in this report

- A process and timeframe is established to manage the exploration of options including ongoing stakeholder communication and participation

WACHS Innovation and MPS Exemplar
Given the planning and reform processes relating to multi-purpose services, the approach to WACHS could include the potential for a Boddington to become an exemplar of a truly contemporary aged care service. This could include active partnership with the community, a local workforce development strategy and a local service plan with particular emphasis on:

- integrating health and aged care
- integrating health literacy with an age and dementia friendly community
- developing restorative and wellbeing models
- developing a superior continuum of care from basic care to the highest levels of care including palliative care
- enhancing viability through scale achieved over a mixed service model
- creating a community and services hub
- meeting quantum of current and future demand
- contributing to a population retention and attraction strategy
- evaluating the outcomes including the economic outcomes and impacts

- Whether an approved provider organisation would establish 35 to 45 bed aged care facility in Boddington, what incentives could be offered and what would the process be for securing the incentives (Appendix 3 is collateral developed by Verso for Rural Councils Victoria to support local government to attract investment). To explore this option, we recommend that:

- A short list of Approved Providers be established based on a values alignment, their capacity and capability in delivering the services and model envisaged

- A clear communication strategy be developed to ‘promote’ the opportunity

- A direct approach to each of the Approved Providers is actioned

If neither of the two threshold issues can answered in the affirmative, the next step would be to assess the willingness, capacity and logistics required to establish a new approved provider organisation in Boddington with the following key steps:

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- Undertake a detailed business plan (this plan would include how a workforce would be recruited, trained, developed and retained). The plan would eventually form a required attachment to the Approved Provider application.
- Work with architects to develop a concept plan to be included in the business plan

6.3.2 Alternate Response

If an approved provider cannot be incentivised to develop and deliver the model of care envisaged, it is recommended that the following key steps be taken:

- Support the project committee to form a legal entity to deliver aged care services and model of care and viability envisaged in the catchment that includes directors who meet the Commonwealth's requirements for key personnel under the Aged Care Act and consistent with the approved provider governance reforms recommended by the Royal Commission
- Obtain seed funding to manage the costs associated with developing policies and procedures, the organisational design, the concept design for the building and site location and support to develop the approved provider application and associated detailed business case required by the Commonwealth
- Prepare a concept design for the land and buildings
- Prepare a detailed business plan required as an attachment to the Approved Provider application
- Prepare and lodge an Approved Provider application and manage the iterative process often required to meet all of the Commonwealth's requirements
- In concert with the Approved Provider application, develop a comprehensive set of policies and procedures to manage compliance with the Aged Care Act and to enhance practice
- On approval, negotiate with the Commonwealth for licences if the Aged Care Act is still in the process of being rewritten
- Manage land grant processes, and capital grant funding applications
- Build the business case for the additional mix of services as determined in the project inception phase

6.4 Project Commencement

The project commencement activities will be dependent on:

- The response from WACHS
- Current Approved Providers
- Alternatively, forming a local organisation that meets the requirements and succeeds in the application to become an Approved Provider

Appendix 1: Shire of Boddington Aged Care Needs Study 2021

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Appendix 2: Unit Price Model

Unit Price Calculations

The unit price calculation is the fundamental framework for calculating and billing hours for community care services. Depending on the role, there will be variables in the amount of supervision required and the hourly rate paid. All other elements will have the same impact on the margin. The sell price may be capped for competitive reasons or in response to price caps imposed by the Commonwealth or State governments.

When a community care workforce is developed, the same staff members could conceivably be delivering NDIS services, CHSP, home care packages, post-acute care, community respite, services within Short Term Restorative Care and/or privately purchased services.

Impact of Leave on the Cost per Worked Hour of a Permanent DSW

	NDIS Cost Model	
	DSW 2	**DSW 4**
Standard Hourly Rate	**$30.69**	**$38.34**
Allowance for Annual leave		
a. No. hours leave accrued in a year (hrs/yr)	152	152
b. Loading	17.50%	17.50%
c. Proportion of leave taken	100.00%	100.00%
Cost per worked hour	**$3.28**	**$4.10**
Allowance for Personal leave		
a. No. hours leave in a year (hrs/yr)	76	76
b. Loading	0.00%	0.00%
c. Proportion of leave taken	100.00%	100.00%
Cost per worked hour	**$1.39**	**$1.74**
Allowance for Public Holiday leave		
a. No. hours leave accrued in a year (hrs/yr)	76	76
b. Loading	0.00%	0.00%

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c. Proportion of leave taken	100.00%	100.00%
Cost per worked hour	**$1.39**	**$1.74**
Allowance for Long Service leave		
a. No. hours leave accrued in a year (hrs/yr)	32.93	32.93
b. Loading	0.00%	0.00%
c. Proportion of leave taken	100.00%	100.00%
	2.00%	2.00%
Cost per worked hour	**$0.60**	**$0.76**
Cumulative cost per hour, after leave costs	**$37.35**	**$46.68**
Increase from permanent standard hourly rate	21.70%	21.80%

Impact of Salary On-costs on the Cost per Worked Hour of a Permanent DSW

	NDIS	
	DSW 2	**DSW 4**
Cumulative cost per hour, before on-costs	**$37.35**	**$46.68**
Superannuation		
Superannuation Rate (%)	9.50%	9.50%
Superannuation ($)	$3.55	$4.43
Workers Compensation		
Premium Rate (%)	1.70%	1.70%
Premium Cost ($)	$0.64	$0.79
Employee Allowances		
Allowance Rate (%)	1.00%	1.00%
Allowance Cost ($)	$0.31	$0.38
Cumulative cost per hour, after on-costs	**$41.85**	**$52.28**
Cumulative increase from standard hourly rate	36.40%	36.40%

Impact of Supervision on Cost per Worked Hour of a Permanent DSW

	NDIS	
	DSW 2	**DSW 4**
Cumulative cost per hour, before supervision	**$41.85**	**$52.28**
Supervisor		
Level of supervisor (SCHADS Equivalent)	4.2	5.1
Base Salary	$36.57	$40.64
Leave Cost Proportion	21.74%	21.75%
Leave costs	$7.95	$8.84

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On Cost Proportion	11.58%	11.38%
Salary-on costs	$5.35	$5.95
Span of control		
Span of control	15	15
	7.9%	7.1%
Cost of supervision ($)	$3.32	$3.70
Cumulative cost per hour, after supervision	**$45.17**	**$55.98**
Cumulative increase from standard hourly rate	46.20%	46.00%

Impact of Casual Loading on the Cost per Worked Hour of a DSW

	NDIS	
	DSW 2	**DSW 4**
Cumulative cost per hour, at 100% permanent	**$45.17**	**$55.98**
Cumulative cost per hour, at 70% permanent	$45.71	$56.65
Effect of casual loading	**1.20%**	**1.20%**
Cumulative increase from standard hourly rate	48.90%	47.80%

Impact of Utilisation on the Cost per Billable Hour of a DSW

	NDIS	
	DSW 2	**DSW 4**
Cumulative cost per hour, before utilisation	**$ 45.71**	**$ 56.65**
Utilisation rates		
Breaks	4.17%	4.17%
Training	6.58%	7.89%
Other	0.25%	7.94%
Total Utilisation (%)	89.00%	80.00%
Cost of utilisation (%)	12.36%	25.00%
Cost of utilisation ($)	$5.65	$14.16
Cumulative cost per hour, after utilisation	**$ 51.36**	**$ 70.81**
Cumulative increase from standard hourly rate	67.40%	84.70%

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Impact of Overheads on the Cost per Billable Hour of a DSW

	NDIS	
	DSW 1	**DSW 4**
Cumulative cost per hour, before overheads	**$ 51.36**	**$70.81**
Overhead		
Overheads as a share of direct costs (%) without utilisation factored in for NFP and MAS	12.00%	12.00%
Management corporate support	0.00%	0.00%
Cost of overheads ($)	$6.16	$8.50
Cumulative cost per hour, after overheads	**$ 57.52**	**$79.31**
Cumulative increase from standard hourly rate	87.40%	106.90%

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Appendix 3: Sample Collateral

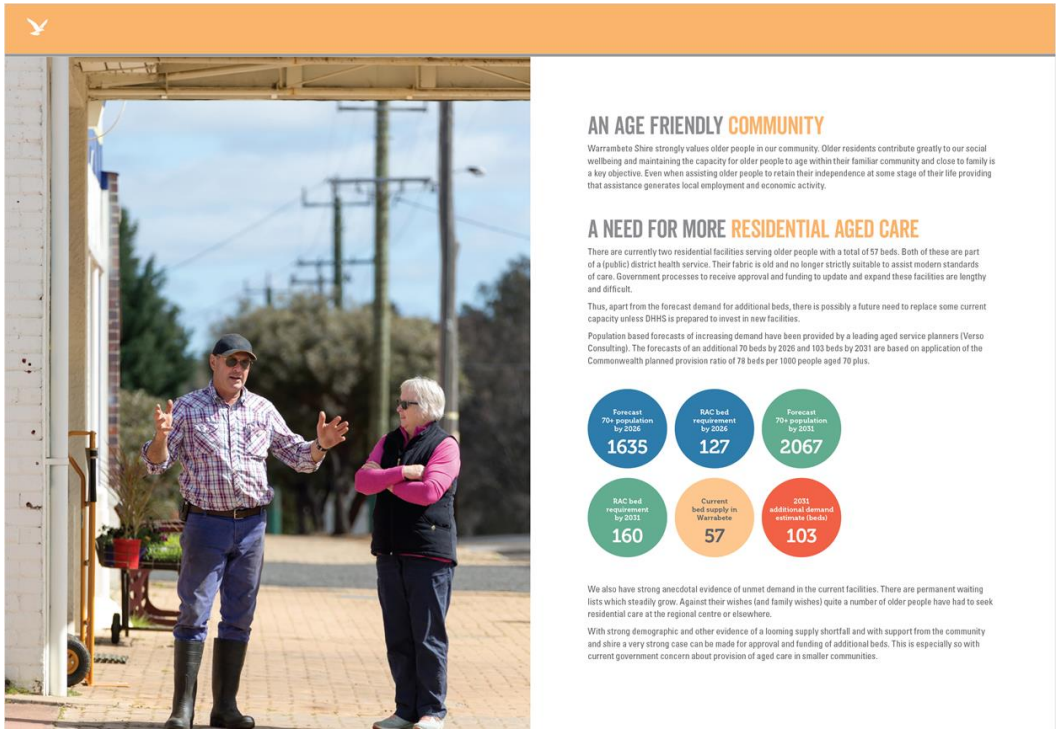
See separate PDF 'Warrambete Shire' (fictional). This exemplar has been provided as part of the 'sell' to other Approved Providers based on the Shire; accepting the report and making land available and possibly aiding the Provider to obtain a capital grant.

This type of collateral would provide the Shire with the opportunity to sell the exceptional natural features and services of Boddington to a prospective Provider/Investor. The collateral will also serve to demonstrate the professional leadership being offered by the Shire adding to the capacity to positively influence investors.

Other applications could include:

- An element of a pitch to the mine to provide them with the opportunity to provide a legacy investment
- As part of an application for a capital grant or other grants within:
  - The Development Commission's remit
  - Regional Development Australia Wheatbelt
  - Commonwealth Department of Health
- To support Advocacy – political, peak bodies and at a bureaucrat level

Figure 22: Sample of the exemplar collateral



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