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Financial Issues Affecting Rural and Remote Aged Care Services

Minister Ley recently released the Aged Care Financing Authority's (ACFA) Report **Financial Issues Affecting Rural and Remote Aged Care Services**.

The Report was requested by the Minister following ACFA's earlier sector-wide analysis [1] which identified that location was a factor affecting the financial performance of services, and that this warranted further investigation in relation to rural and remote services.

Location is an important consideration because the only capacity for residential care providers to take the financial impact of location into account when setting prices is in relation to accommodation payments for non-supported residents. All other prices received by providers (care, living expenses and accommodation for supported residents) are set by the government and are the same Australia-wide for people with the same assessed care needs, though the proportion paid by the individual and the government within the set prices varies according to each individual's income and assets.

Similar Australia-wide pricing arrangements apply for home care packages, except that home care providers have the discretion to charge consumers a basic daily fee [2] which cannot exceed 17.5% of the single basic pension.

Policy to date has attempted to deal with the implications of this pricing 'straight jacket' through the payment of a Viability Supplement to eligible rural and remote services and the availability of capital grants under the Rural, Regional and Special Needs Building Fund to build or refurbish residential facilities in rural and remote locations.

The study's definition of rural and remote and data sources used

For the purposes of their follow-up Report, ACFA defined rural and remote services as those in areas classified as 'very remote', 'remote' and 'moderately accessible' under the Accessibility/Remoteness Index of Australia (ARIA), and which are in receipt of the Viability Supplement. Some services located in areas classified as 'accessible' were also included if they were in a town with less than 10,000 population and were in receipt of the Viability Supplement. Appendix A of the Report lists all the communities that were in scope for the study. Under this

definition, 311 residential services and 232 home care services were in scope.

To undertake this study, ACFA used financial information at the facility/service level, rather than at the approved provider level which is used for all other ACFA Reports. [3] To obtain this information, ACFA invited in-scope services to volunteer financial information for each of their facilities/services. This was supplemented by financial data from in-scope services that had participated in Stewart Brown benchmarking surveys. In total, financial data was obtained from 175 of the in-scope residential facilities and 161 of the in-scope home care services.

Limitations of the study

ACFA has identified limitations with their study, essentially around data issues. In particular, the financial data used is self-reported and unaudited, and covers data for only one year (2014-15). As a result, trend analysis was not possible and it may be that the 2014-15 findings are not necessarily representative of other years.

Findings regarding financial performance

ACFA found that residential and home care providers operating in rural and remote areas face extra challenges in their financial operations which generally results in them having higher cost pressures and lower financial returns.

This finding is not a surprise to anyone, and accounts for the fact that Viability Supplements and capital grants for rural and remote services have been around for a long time. What the ACFA Report has done for the first time is give us evidence of the extent of, and contributors to, the financial pressures.

Residential aged care

ACFA found that in 2014-15, rural and remote residential facilities achieved average operating Earnings Before Interest, Tax, Depreciation and Amortisation (EBITDA), which excludes non-operating income such as capital grants, interest and donations, of -$2,004 per resident per annum (prpa) compared with $8,840 prpa in non-rural and remote areas, [4] resulting in a difference of $10,844 prpa (or a difference of $423,000 per annum for the average 39 bed rural and remote facility).

A positive average EBITDA result is achieved when capital grants, interest and donations are factored into the calculation viz: an average EBITDA of $2,069 prpa (an improvement of $4,073 prpa) compared with $9,267 prpa for non-rural and remote services.

As acknowledged in the Report, the capital grants program allocation in 2014-15 was double the normal size ($103m compared with a normal annual allocation of approximately $50m). This one-off event may overstate the result compared with other years, noting that in 2014-15 capital income on average accounted for about 60% of non-operating income. [5] The 311 in-scope facilities received $33m of the total capital grants allocated in 2014-15.

Home care

Compared with residential care, the average EBITDA result for rural and remote home care services in 2014-15 ($1,712 per package per annum) is not that much different than for non-rural and remote services ($1,885 per package per annum). This is despite evidence that home care services incur higher direct labour costs and administration costs and receive lower basic care fees.

To help compensate for these higher costs, home care providers in rural and remote locations receive a Viability Supplement, amounting in 2014-15 to $1,997 per package per annum (pppa) on average. Without the Viability Supplement, average EBITDA for home care services in the study group would have been slightly negative.

The fact that average EBITDA and care-related expenses pppa are not too dissimilar may well reflect that, unlike residential services, home care services do not incur the higher fixed costs required to deliver legislated specified care and services 24/7 for residents when needed. Instead, home care providers have greater flexibility to deliver the volume of services that their budget and local costs allow.

A more relevant comparison to examine, therefore, would be the number of hours of service provided by metropolitan and rural and remote services from within the funding received. Aside from the Viability Supplement, this funding is the same for all eligible consumers with the same assessed care needs. Adequate data on home care service hours was not available.

Factors affecting financial performance of residential aged care providers

ACFA's examination of 2014-15 data identified the following locational factors influencing the financial operations of rural and remote residential aged care providers.

ACFI

Rural and remote providers on average received $6,650 prpa less ACFI funding in 2014-15 ($48,348 prpa compared with $55,005 prpa). The lower funding reflects a higher proportion of low care residents (26% compared with the sector average of 11%), but also less experienced ACFI assessors and the difficulty accessing ACFI 'consultants' and allied health staff. [6] This highlights one of the inherent shortcomings of the ACFI, ie. each facility's revenue is significantly influenced by its capacity to administer the ACFI.

ACFA's sector-wide analysis also demonstrated that high care facilities achieved better financial performance than low care facilities.

The higher proportion of low care residents in rural and remote locations may reflect that these services exist just as much to offer a housing solution for older people in rural communities as a care service. While the ACFI subsidy is low, these facilities are eligible to receive capital grants and their low means residents attract the accommodation supplement.

Higher staff costs

Higher staff costs are incurred in all categories, amounting to $16,360 prpa more than for non-rural and remote services. Registered Nurses and Enrolled Nurses account for a large proportion of this difference (about 60%), noting that they also work more hours than their non-rural and remote counterparts, even though overall rural and remote facilities provide fewer hours of care prpa. The higher labour costs reflect higher pay and the cost of other supports such as assistance with accommodation, relocation costs and travel expenses.

Other areas where higher labour costs are incurred include catering, cleaning, laundry and repairs and maintenance.

Rural and remote facilities also incur higher staffing costs due to the fixed nature of labour costs, especially care costs, being shared over a small number of residents due to facility scale (average

39 beds for the facilities in the study group compared with 81 beds for the Stewart Brown non-rural and remote benchmark group). As a result, rural and remote services direct a higher proportion of facility income to wage costs (80% compared with 68% for the Stewart Brown non-rural and remote group).

The higher staffing costs are only partly offset by rural and remote services receiving a higher Viability Supplement, an average of $2,774 prpa compared with $60 prpa for non-rural and remote facilities. [7]

However, the higher average staffing costs need to be interpreted with care because state and local government services (of which there are 101 amongst the in-scope services) incur significantly higher wage costs than the non-government services ($209.39 per resident per day compared with $123.63 per resident per day).

Scale of facility

ACFA's sector-wide report on the Factors Influencing the Performance of Residential Aged Care Providers noted the correlation between scale of facility and financial performance, with larger facilities generally, but not always, out-performing smaller facilities. This correlation was also borne out in this study.

In residential care, the average scale of the in-scope rural and remote facilities is 33 compared with 76 in the non-rural and remote group. However, unlike metropolitan facilities, scale of facility reflects the smaller population catchment rather than a business decision, ie. location dictates facility size in relation to rural and remote facilities.

Occupancy rates are also an important part of the equation. The high fixed costs incurred in operating a small aged care home means that even small fluctuations in occupancy will have a higher relative impact on their small revenue base.

In Multi-Purpose Services, this is dealt with through block funding so that revenue is unaffected by occupancy levels.

Socio-economic status of residents

The average supported resident ratio for the study group was 44.5%, compared with a sector average of 40%.

The higher proportion of supported residents does not affect care revenue. However, it does increase the proportion of residents for whom the provider receives the capped accommodation supplement, compared with the market-based accommodation prices that providers can seek from non-supported residents.

Lower accommodation payments

As well as having a lower proportion of non-supported residents from whom market-based accommodation payments may be sought, lower house values in rural and remote areas mean that, on average, Refundable Accommodation Deposits (or the Daily Accommodation Payment equivalent) paid by non-supported residents are about half the national average, ie. $151,526 compared with the national average in 2014-15 of approximately $350,000, and the average for the Stewart Brown non-rural and remote survey participants of $289,000.

The current system attempts to make up for this locational disadvantage through the capital grants

program which provides grants to refurbish, extend or build new facilities. Receipt of a capital grant does not affect access to the accommodation supplement for supported residents. Capital grants are effectively a substitute for lower Refundable Accommodation Deposits.

ACFA's analysis indicates that in 2014-15 18% of rural and remote facilities were receiving the higher Accommodation Supplement ($240 prpa) compared with 15% for the non-rural and remote facilities ($147 prpa). It seems, therefore, that rural and remote services are accessing capital grants to refurbish their facilities in order to access the higher accommodation supplement.

Non-operating income

Rural and remote services are more dependent on non-operating income.

Rural and remote services in the study group reported on average a non-operating net surplus income of $5,110 prpa in 2014-15, compared with $1,062 prpa for the Stewart Brown non-rural and remote benchmark, including non-operating income of $5,004 prpa derived from capital grants under the Rural, Regional and Other Special Needs Building Fund.

The survey data did not allow a detailed dissection of non-operating income ('Other Income' of $3,960 prpa). However it can be assumed, based on audited General Purpose Financial Reports examined by ACFA for its sector-wide Report, which revealed a much higher level of donations received by rural and remote providers, that this figure includes a high proportion of donations.

Ownership

The overwhelming majority of residential care facilities and home care services in rural and remote locations (excluding Multi-Purpose Services) are operated by state and local governments and not-for-profit providers (96% and 92% respectively).

State and local government providers (again excluding Multi-Purpose Services) had an operating EBITDA in 2014-15 of -$10,870 prpa compared with $843 for not-for-profit providers. This result is largely due to significantly higher labour costs in government facilities. Care-related staff costs in government facilities were $31,317 higher than for not-for-profit facilities ($74,259 prpa compared with $42,942 prpa). At the same time, government facilities received additional funding from state and local government sources (average of $8,625 prpa), but this did not offset the additional staffing costs.

Variations in performance

Consistent with the finding from ACFA's sector-wide analysis of financial performance, the reported data for the study group of rural and remote residential facilities revealed significant variations in financial performance within the group.

The top third reported an average operating EBITDA of $11,487 prpa ($16,065 if non-operating income is included). This compares with an operating EBITDA of -$17,868 for the bottom third (-$13,245 if non-operating income is included). On the other hand, the average operating EBITDA for the top third of rural and remote services is more than the average EBITDA per resident per annum for the sector as a whole ($9,224 in 2013-14).

The ACFA Report concludes that this divergence in financial performance illustrates that locational factors alone do not account for the poorer financial performance of rural and remote services. As is the case for the sector overall, management capacity also affects financial performance.

Multi-Purpose Services

The in-scope services included 165 Multi-Purpose Services (MPSs).

An analysis of the financial performance of MPSs was not possible because of the lack of financial data relating to their aged care services.

In any case, because the funding and operating arrangements that apply to this joint Commonwealth/State funded service model are so different, including the scope of services provided, comparisons with dedicated aged care services would not have been particularly meaningful. Nor was it possible to assess the efficiency and effectiveness of the MPS model for providing services in remote communities, nor whether the model represents 'good value' for either the Commonwealth or the states or both, and for the communities they serve.

However, the MPS model warrants a review. The essential features of the model have not changed since the early 1990s when MPSs were first introduced. Since then there have been significant reforms made to aged care, and more is in prospect as aged care moves closer to being a market-based and consumer-driven system. Issues to be addressed include whether the current contributions to pooled funds are still appropriate, the equity of consumer contributions to care, living expenses and accommodation costs compared with mainstream facilities, and the appropriateness of quality assurance and prudential arrangements. These issues were beyond ACFA's remit for this study.

A surprising aspect of ACFA's findings is the proportion of Local Government Areas (41) that are served by both an MPS and a residential aged care service. Putting aside those Local Government Areas that are very large, the co-location of MPSs and residential facilities would appear to be contrary to the policy objectives of the MPS model, ie. pooling of funding for health, aged and community care services in small communities under a single entity in order to achieve the economies of scale in service delivery to ensure the continuity of health and aged care services in those communities.

National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP) Services

Reliable financial data for the NATSIFACP services were not available. As a result, ACFA was unable to undertake a meaningful financial analysis of these services.

Summing up - what to make of all this?

The evidence clearly shows that, overall, services in rural and remote locations incur significant additional costs (mainly staffing costs), receive significantly lower Refundable Accommodation Deposits and, to a lesser extent, less ACFI revenue.

To compensate for locational disadvantages, the Australian Government provides a Viability Supplement to help bridge the gap between recurrent costs and income and capital grants to make up for lower Refundable Accommodation Deposits. The question remains, do these adequately compensate for locational disadvantage?

ACFA was not asked to address this question.

In the case of capital, it is a case of individual providers making a case for funding under the Rural, Regional and Other Special Needs Building Fund. It would be useful to know, however, whether the

Fund is adequate to meet demand and whether there is a backlog of unfunded projects with merit. There is a good case for greater transparency in the administration of the Fund that goes beyond announcing successful applicants so that judgements can be made about its adequacy and effectiveness.

In the case of the Viability Supplement, it is clear that the higher staffing costs incurred on average by not-for profit residential care providers are not compensated by the existing Viability Supplement.

But in addressing this question, the Australian Government will no doubt note that the financial performance of the top third of rural and remote residential care providers is reasonable compared with the sector overall. The logic that the Government will be inclined to apply, therefore, is that with good management, many poorer performing services could do better.

What the data does not reveal is the attributes of the better performing rural and remote services that go to better management. Bearing in mind the limited capacity for providers to influence income, other than maximising ACFI, how do the better rural and remote providers manage their main cost centre, staffing? Fewer hours of care? Lower wage rates? Different staffing profiles and rostering arrangements? None of these? Or are there also locality characteristics affecting the top third eg being in a more accessible area near a larger rural centre?

In relation to home care, the Government will note that average EBITAs, with the help of the Viability Supplement, are positive and not much different than for non-rural and remote home care providers.

The Government, as it has done in the past, will also look to leverage the mission and community service objectives that motivate state and local government providers and not-for-profit providers to deliver services in areas that are unattractive for for-profit providers. It will also be mindful of the preferential tax status of not-for-profit providers. As an indicator of the strength of the of the mission and community service obligation, the Government will monitor the level of interest of the not-for-profit sector in accessing the capital Fund, the level of interest of the states and territories in new MPSs, and the number of eligible consumers in rural and remote areas on the myagedcare waiting list for home care packages.

That said, there is a case for better addressing staffing costs in rural and remote areas.

Footnotes

1. *Factors influencing the Financial Performance of Residential Aged Care Providers* Aged Care Financing Authority, June 2015.
2. Home care package consumers may also be liable to pay an income-tested fee, but this fee is revenue-neutral for the provider as it is used to reduce the Government's contribution.
3. ACFA's other reports mostly use financial data from the annual General Prupose Financial Reports which are prepared at the approved provider level, not at the facility/service level.
4. For the purpose of comparison throughout the Report, the study relied on financial data for the non-rural and remote services that participated in the Stewart Brown benchmarking surveys (734 facilities). Participants in the Stewart Brown survey are almost exclusively from the not-for-profit sector which, on average, achieves lower average EBITDA than the for-profit sector. This suggests that a comparison with all non-rural and remote services would show a wider difference in financial performance, on average.
5. For the purposes of this study, the capital grants under the Rural, Regional and Other Special Needs Building Fund were treated an annual income by averaging the amount over all facilities.

6. Of all staff categories, allied health is the only one where rural and remote services spend less prpa than non-rural and remote services ($1,057 prpa compared with $2,054 prpa).
7. As well as remoteness, a criterion for Viability Supplement eligibility is scale of facility (number of beds).

Disclosure Statement: The author of this Update, Nick Mersiades, is a member of the Aged Care Financing Authority. The opinions in this Update should not be read as being an expression of the views of the Aged Care Financing Authority.

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