executive unit

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Baptist Community Services
NSW & ACT
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5 September 2003

Standing Committee on Ageing
R1-121
House of Representatives
Parliament House
CANBERRA ACT 2600

Dear Honorable Committee Members

About Baptist Community Services NSW and ACT

Baptist Community Services is a large not-for-profit organisation which operates 10 nursing homes providing care to 670 residents, 15 hostels providing care to 987 residents, 2 transition care centres providing care to 58 residents, and 10 retirement villages accommodating 522 residents. BCS also provides care to a large number of clients in the community including approx 700 on community aged care packages, 45 on EACH packages, approx 2,000 Dept of Veteran Affairs clients and provides over 20,000 service hours through home and community service programs.

This year, BCS celebrated 50 years since the opening of its first nursing home in Carlingford, and will also celebrate 60 years since inception next year. It currently has a 7 year vision statement in place and plans to be around for another 50 years and beyond. It continues to grow and expand.

THE ISSUES

Maintaining and attracting nurses to aged care

Costs, especially wages and workers' compensation premiums are rising at a faster rate than increases to subsidies and residents fees. The average increase in funding for the 2003/2004 financial year will not sustain the costs of the aged care industry.

The Commonwealth Own Purpose Outlays (COPO) indexation formula, which is used by Government to determine increases in subsidies, does not adequately recognize increases in wages, representing 70-80% of costs in the aged care sector. This view is supported by the report prepared by Australasian Institute for Primary Care La Trobe University (February 2003) for the

National Aged Care Alliance. In addition the COPO is based on the costs of the previous year and is not adjusted for costs as they occur. Aged care nursing wages are currently 15% under the acute care sector and there is lobbying to have their wages raised by 27%. The rising Worker's Compensation Premiums in NSW resulting from changes in how premiums are calculated will add a further pressure in 2003/04, which will not be reflected in the COPO indexation rate for 2003/04.

Recommendations

Replace the COPO indexation method.

Within the education sector, the Commonwealth has been able to establish the Average Government School Recurrent Costs index ("AGSRC") as the base level subsidy for the providers of private education. The AGSRC tracks the increases in the costs of core components in providing the services and subsidies are adjusted accordingly in a fair and transparent manner. We recommend that a fair index be established for the aged care sector that will enable the level of subsidy to accurately reflect price increases.

The sustainable long term care of older Australians

The Federal Government has imposed a standard resulting in additional building costs for providers but preventing them from charging residents for this higher standard of accommodation.

The inflexibility of the income base for high care facilities results in aged care providers unable to make business decisions to ensure their ongoing viability.
Example:

Estimated cost to construct a 90 bed high care facility:	$11,250,000 ($125K per bed)
Accommodation charge applicable:	$441,000 ($13.45 per resident per day)
5% interest on $11.25 million	$562,500
Loss per annum just on interest	$247K
Other costs:	$$$

	Workers compensation Wages and agency staff Maintenance Depreciation Regulatory costs	

The situation deteriorates over the years, even after 35 years (the economic life of the building) the building never pays for itself. Recouping the cost of the construction of a high care facility cannot be achieved from the present accommodation charges.

Because the Government sets the maximum accommodation charge and the fees which residents can be charged (unless the facility is an extra service one) a provider cannot justify building a new high care facility or operating it on business grounds.

In addition NSW aged care providers are required to gain the NSW Dept of Health approval for new nursing homes, gain local council approval and comply with the 2008 certification standards. It is understandable that the Federal Government would want all residential aged care buildings to be safe and meet fire safety standards and to have a resident/room ratio of 1.5 to create an even better living standard for residents. However, these regulations have imposed significant financial pressure on nursing home providers without any possibility of recouping those expenses.

Recommendations

Allow providers to charge for accommodation reflecting the outlay in providing accommodation to the standard set by the government, or,
De-regulate to the extent that aged care providers can set appropriate fees in a more market place environment.
Provide better levels of government support for concessional and assisted residents.

Review system of resident classification

The present level of paperwork in supporting the Residential Classification Scheme is over complex and for a number of reasons works against resident care.

The present Resident Classification Scale places residents in a level from 1 to 8 based on care needs. Attached to each care level is a subsidy amount. Since the introduction of the RCS in 1997 there have been numerous "refinements" to the interpretation of the questions. Periodically facilities are visited by Validators who, on the basis of the paper work held by the facility, determine whether the resident has been correctly classified. If the Validators believe there has been an error in classification the adjustment is backdated six months. The result of this system is:

A focus on getting the paper work correct
No incentive to improve the health of the resident - the more dependent the higher the subsidy
A need for a highly fluid staffing profile to ensure income and staffing costs are kept synchronised. This results in a highly casualised workforce which does not assist in the provision of quality care.

Recommendation

BCS proposes a simpler system of classification of

Low Care
High Care
Dementia Specific Care

Residents would be classified by the Aged Care Assessment Team into one of these three classifications and would require another ACAT assessment to move from low to high. We believe there would be considerable administrative savings from this system, which could be used to increase funding without additional costs to either residents or the Government.

This is a win win for all parties as it:

Places the focus on increasing client independence.
Allows for considerable administrative savings by not having to use Validators to check patient classifications.
Still allows for appropriate regulation via the Aged Care Assessment Team and Accreditation process.

Discontinue coalescence

In 1997 the concept of coalescence was introduced for the aged care sector. The goal of coalescence was to ensure that all states would receive the same level of care subsidy when the transition was completed. In order for this to be achieved the subsidy indexation has been reduced for NSW by a coalescence factor to

move towards a "National" subsidy level. In the capital cities such as Sydney the cost of land is dramatically higher than land in rural Australia and providers are forced to pay above award wages to attract certain categories of staff because of staff shortages, or use expensive agency staff.

The Productivity Commission in its report into Nursing Home Subsidies (January 1999) wrote:
"However the Commission does not endorse the current coalescence proposal. The national subsidy rates that would emerge from the proposal are the average of the current state based subsidies."

Recommendation

Implement the Commission recommendation to introduce a subsidy regime to provide a clear link to the standard of care which the Commonwealth is seeking.

Relate indexing arrangements to movements in the industry's underlying costs.

Introduce Nurse Practitioners

Consideration needs to be given to the level of funding which will ensure residents in nursing homes do not enter hospitals unnecessarily and that residents discharged to nursing homes whilst still requiring extensive nursing care can receive it. To ensure appropriate medical care in residential aged care settings the concept of each resident being able to have their own GP will need to be revisited. In facilities operated by this organization we have up to 30 GPs visiting each facility. As a result of the increasingly complex care needs of residents in high care facilities there is a need to examine the provision of GP care. The appointment of nurse practitioners who would liaise with the GPs is perhaps one option which needs exploration.

Thank you for considering this submission.

Yours sincerely

June Heinrich

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