OPENING STATEMENT

AGED CARE QUEENSLAND
SENATE INQUIRY INTO AGED CARE

Tuesday 7 April 2009

Thank you for receiving us. Aged Care Queensland welcomes the opportunity to summarise our position on matters covered in our submission and answer any related questions from the Committee.

Anton Kardash our CEO is recovering from surgery and I am appearing on his behalf, supported by Pam Bridges and Michael Isaac.

While not the author of the ACQI submission – I am familiar with its content and will do my best to represent the collective views of our members.

The analogy used to describe the Aged Care sector in Australia in the opening statement of our submission is apt (the taut elastic band stretched beyond its limits) – other witnesses have varied in their views on whether there is a crisis or whether there is a crisis coming, but all agree that the industry in its current form and under the current funding regime is not sustainable.

Our position is that the industry operates at marginal levels. Government department and consumer expectations of providers are increasing exponentially yet there is no commitment to increase capital or recurrent funding to meet increased costs. In most service or accommodation businesses services or standards of accommodation are established and defined. Consumers then generally get what they pay for. In aged care if the standard or requirements are increased the provider is expected to absorb those costs with no recourse back to the consumer (or funder) to increase charges to accurately reflect costs and thereby create profits and thus sustainability.

We are advocating freeing up the environment to provide choice to consumers within a safety net of support for the vulnerable aged in our society.

Specific remedies noted in our submission include:

- Uncapping daily accommodation charges for high-income older people and increasing the charge for medium income people.
- Approving refundable deposits for high care accommodation.
- Linking concessional payments to the real cost of providing care
- Ensuring ACAT assessments relate to entry into aged care and not the level of care required.
- Ensuring national consistency of fees across all programs

- Applying appropriate indexation of payments to keep pace with the increasing cost of care and service delivery.
- Reviewing planning ratios based on evidence of need not outmoded statistics.

Dealing specifically with the terms of reference:

(a) Current funding levels and mechanisms are not sufficient to meet the expected quality service provisions.

The funding model is unresponsive to changes in the cost structure of care delivery.

- The industry has sustained wage increases across all positions and there is further pressure to gain parity with staff in the acute sector.
- The full ACFI subsidy should be paid for high care recipients in recognition of the care they receive not be artificially capped as is currently the case.
- Increased demands for staff training and skill development occur largely as a result of the complexity and burden of compliance not care delivery.
- The cost of compliance increases year upon year yet other industries are having some success in cutting Government red tape...
- There are additional costs associated with workforce attraction and retention in an environment of significant skills shortages and competition for qualified labour.
- The cost of innovation including new information and assistive technologies is rapidly increasing in line with consumer expectations, Government initiatives and compliance action.

(b) The current indexation formula does not recognize the increasing cost of aged care services:

The Conditional Adjusted Payment (CAP) supplement was introduced as an interim measure on the basis of 3 conditions:

- Audited financial reports.
- Encouragement of workforce training.
- Survey and census participation.

CAP supplements range from $3 to $12 daily. Taking a hypothetical average of $7.50 per day the annual CAP income would be $2738 per person per year for a 100 place facility. By removing the CAP supplement an EBITDA of say $4750 will reduce to $2012. This is a reduction in return on capital employed from 2.4% to 1.0%. A return that never was and will never be sustainable.

The industry has overwhelmingly adopted a significant number of costly initiatives over the past 10 years including:

- The new ACFI model
- Certification and the attendant cost of capital upgrades
- Accreditation
- Technology upgrades in keeping with the complexity of the regulatory framework
- Police checks
- Compulsory reporting and complaints investigation processes
- Claims validation
- Surveys (often involving duplication of information)
- Unannounced visits
- Food safety standards
- Bond protection and prudential processes
- Electronic ACFI submissions

And the list goes on

Also COPO as applied to community care has not kept pace with increased costs of service delivery. The common issues faced by residential care providers are compounded for community care operators.

(c) Regional variations in the cost of service delivery and construction of facilities are a reality in Queensland.

The initiatives absorbed by providers located in regional and rural centres carry an additional impost due to location. In particular the attraction and retention of qualified staff carries an additional cost burden if the service is in a remote location.

It is clear that the mainstream issues mentioned just before are magnified for rural and remote services in Queensland. The viability supplement is insufficient to meet the true cost of service delivered by those providers.

The cost of construction in rural and remote areas can increase by as much as 50% due to increased consultant fees, transport of materials and the importation and accommodation of skilled construction labour.

(d) There is structural inequity in user payments between different consumer groups:

ACFI targets people with higher care needs. Low care places with bonds have for some time subsidized high care places paying an accommodation charge. Concessional residents are paid for by Government subsidy.

Individuals with the ability to pay a bond in high care are unable to do so yet are often incapable of paying the applicable accommodation charge. There is evidence to suggest that these people would rather pay a refundable deposit and be relieved of daily fees.

A minimum ACFI payment for anyone admitted into aged care with high care needs more appropriately being addressed at time of entry would resolve a multitude of issues. An ACFI payment following from ACAT assessment and the increased care needs of a person entering care some time after assessment, often means the care recipient is consuming greater resources than the funding allows and in many instances for an extended period of time.

Different fee structures across programs have also resulted in consumers not progressing through the different levels of care because of inbuilt financial disincentives.

(e)The planning ratios are built on work undertaken in the mid 70's and do not reflect contemporary knowledge of today's aged care environment.

Changes in life expectancy and health status data as well as rates of access to different service types are not reflected in the current ratios.

People are not entering retirement living estates until their mid-eighties yet aged care planning ratios are based on a formula including 70 as an entry age.

In the last 10 years high dependency demand has increased by 4.1% and low dependency demand has dropped by 2% (now further exacerbated by the ACFI funding arrangements).

Age structures vary considerably by region and as a result the current planning ratios and subsequent allocations cause over and under supply in some areas.

The data formerly made available to support detailed planning down to local government areas has not been available from Government since 2001 which seriously inhibits industry research capability and reduces the effectiveness of responses to Aged Care Approvals Rounds.

(f) Residential place allocation and funding will impact on the provision of community care places.

Recent research indicates that the high care client proportion in aged care is reaching close to 70% and this growth will continue as a result of ACFI.

The introduction of high care community packages has also had a significant impact on movements to residential care.

Future planning ratios should reflect these trends and changing patterns of service to appropriately facilitate ageing in place so that the transition from community care to residential aged care is seamless and not brought about by crisis.