Senate Finance & Public Administration Committee

Answers to Written Questions on Notice

Presbyterian Care Tasmania

Questions:

1. In your submission you state that almost 95% of aged care provided in Tasmania is provided by the non-for-profit sector. Further that surveys by Stewart Brown clearly demonstrate that almost half of NFP aged care facilities in Tasmania are operating in deficit and face potential closure. Would you like to detail your experiences to the committee? What would the closure of your centre mean in terms of the provision of care within the surrounding communities and the potential loss of jobs?

Tasmania is unique in that there are only three for profit providers in the State namely Vaucluse Gardens , Japara Group and Cordorna House. All other services are provided by not-for-profit organisations and the State operating small rural services, MPS and MPC models. The two big providers are OneCare, Southern Cross and Uniting Care, with the medium size providers of service being Queen Victoria Homes, Masonic Homes, Presbyterian Care Tasmania, St Anne's and a large number of small providers such as Grenoch, Medea Park, May Shaw, Huon Eldercare etc. As previous Vice President ACST I served on the Board at a time when several Homes sought support of the ACST Board in conjunction with DoHA to case manage or assist them review services to improve financial performance and sustainability services such as Umina Park, Pleasant Banks, Maranartha, Windermere all which have either closed or been acquired by other larger organisations as each has endeavoured to grow in the belief that the critical mass in size was between 80 – 120 beds per site.

Our sites are 79, 80 and 37 beds in size with each currently running at a loss. From the outside we observe that for-profits up to recently have been building 120 bed homes but this has stalled as most proviers now realise that the return on investment to build high care beds needs to be in the vicinity of 8.85%. Currently I would welcome anything above 0%!!

We have recently worked closely with Deloitte and tabled their validation report on several models that we developed for our Southern (37 bed) home and the construction of a further 48 beds (85 bed facility). In all cases we operate from a loss with the loss escalating over

time based on COPO + CAP funding. Our cash reserves will allow us to continue to operate for a further two years and then we will close the business. This will mean that there will be 244 older people of which 72 have severe dementia that will need to be placed in other homes as it is unlikely that the business will be able to be sold. In addition unless we receive Capital Grants from the Commonwealth in the ACAR round to be announced in June 2009, we will be forced to hand back to Government a further 44 Northern Region bed approvals. The deadline for hand back is January 2010.

The impact on our staff is horrendous – over 450 people will be unemployed. The registered and enrolled nurses will probably be able to gain re-employment but most will require re-training to work back in the acute sector. This is a small group of the 450 staff.

It is not believed that other providers will be able to absorb the residents or our staff should we be forced to close our doors.

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2. ACST raise in their submission a number of particular points of difference when it comes to the provision of aged care in small largely rural state like Tasmania. Specifically the sector in Tasmania is dominated by smaller non for profit providers, who:
   - largely rely on commonwealth funding to stay afloat;
   - face significant location based costs;
   - have trouble attracting and retaining trained staff; and
   - have trouble attracting bonds.

   Would you care to comment on this from personal experience? What do you think is needed to help smaller remote providers such as yourself in Tasmania?

   We rely on Commonwealth funding completely. The societal scale for the Northern region is the lowest in the state and the value of housing low compared to interstate markets. The recession has further damaged the value of the housing market and also has seen a fall off in the numbers of low care waiting list clients – in 2001 we had a huge waiting list of low care clients some waiting in excess of a year for a bed, now we have less than five low care clients on our waiting list all of whom are concessional (supported) clients. We also have a high number of concessional clients in care with our ratios always in excess of the 40% mark and recently as high as 50% in our Norwood home.

   The location costs we face as Tasmanians are influenced with the need 'across the

water' key medical supplies and unique changes such as a 15% increase in our energy costs with the likelihood that this will have increased by 30% by June 2009 due to energy becoming contestable within this state. As an employer of choice we have an excellent staff safety record given that we operate four secure and specialised dementia units where aggressive behaviours are common. Our insurance claims history has resulted in a very low (1.8%) workers compensation rate but our broker has advised that when we re-insure in July 2009 expect our overall insurance charges to increase by 10% – 15%.

AS an employer of choice we have not until recently experienced a labour market shortage. In our 2001 Strategic Plan we identified that a major risk and vulnerability point for our organisation was the potential inability to recruit Registered (RN) and Enrolled Nurses(EN). We have been up-skilling our own staff and supporting those with potential to career advance. This has held well until the takeover of the Southern Home where we have had moderate success in attracting RN staff. The end result is that our site managers – senior nurses have had to do double shifts or roster other carers on duty at night to enable them to sleep over to provide RN coverage. We have developed Critical Care Pathways for our EN's and where we can, we roster them onto night duty with a RN on remote call. Double shifts, sleep overs and being on call are the dis-satisfiers that soon wear or burn out staff who find it easier to either find a Monday to Friday job in a Drs surgery of leave the work force.

In respect to attracting bonds we do experience difficulty and a significant shortfall in this year's budget expectation ($1m less than target). Bonds held currently are of limited value due to the falling interest rates with PrescareTas best rates currently on investments being 4%. The people currently paying bonds are also coming into care later in life and in a frailer state with reduced lifespan. The result of this is that to cite one resident we retained a high for us bond of $250k for less than 1 month! The retention for this bond was of no value to the organisation given the administrative costs associated with the admission process, resident's agreement etc.

A new funding model is required to ensure that a fairer user pay system is introduced where those with wealth can pay for services provided and Government can pay for supported clients. The artificial difference between low and high care and funding differences is morally and ethically wrong and prone to abuse by families who are able to manipulate ACAT's to get a high care 'label' to avoid paying a bond. On assessment these type of clients come up as low care and the home receives limited funding.

ACAT's need to use the ACFI tool to assess clients so there is consistency of assessment.

3. Other witnesses have of raised a number of options, which included:

    1)Charging bonds in high care; and
    2) Making more accurate and more flexible funding arrangements for rural, regional and remote facilities - including the viability supplement being extended and/or a supplement being established for facilitates in regional areas.

    What do you think of these suggestions?

    We believe there should be one set of rules for elderly people seeking residential care and if Bonds are to stay for low care residents then yes bonds should be charged for high care residents.

    Alternatively, increases to ACFI with a narrowing of funding bands to four would improve the funding of residential care facilities as cited in my previous paper to the Senate Inquiry namely:

    Cat 1 – Extensive Care
    Cat 2 – High Care
    Cat 3 – Medium Care
    Cat 4 – Low Care

    ACFI has now been in operation for 12 months and is a valid, reliable tool. It's funding allocations are wrong and no additional funding was allocated when the industry was indicating that this was required before ACFI introduction.

    Given that PresCareTas as a medium size provider with Homes of 80(-+) beds is not financially viable a viability supplement may need to be set on Homes with less that 120 beds to ensure profitability. This would require the bar to be lifted significantly for the supplement.

4. A number of Witnesses also outlined the problems associated with changing bonds for high care, particularly in rural and regional areas, including the shorter period of time high care patients spend in facilities and the difficulty residents face in coming up with the finance to pay the bond. Would you care to comment on this?

The change in the aged and fragility profile of high care residents entering homes (average age 85 years) has resulted in a reduced length of stay and higher morbidity rate. This would impact on the time the bond was held and an increase in high care bond turnover. The value would however be that the bonds holdings would be held at a higher constant level thus benefiting the provider with the interests earned when the economic markets recover. The introduction of a standard user pay system for high and low care residents needs to occur and be rebadged as a residential aged care entry fee for those able to pay such a bond – a bond for all by a different name. The rules regarding non payment of bonds or a residential aged care entry fee up front can be overcome through existing provisions; - i.e. deferral of bond payment = payment of the annual admin component to the facility through instalments and interest on the outstanding bond set at the deeming rate plus say 2%.

5. ACST In their submission highlight the fact that providers in Tasmania are integral members of their local communities and in some areas one of the top three employers.
   Can you provide the committee with an insight into the important role those providers in Tasmania play within local, often remote communities?
   What would it would it mean for older residents and the broader community if a facility such as yours where to close?

   Two of our Homes are located outside of the greater municipal area and the impact on the closure of these homes would be significant given that people chose to live at our Legana Home located in the West Tamar Region because family live also in this area. Similarly with the Warrane Home which is located in the Clarence municipality. Both Homes are located in areas of planning interest to DoHA as being areas of additional need for residential care services.

   Our Norwood Home is located in the Launceston municipality and closure of this Home would result in residents needing to be transferred to other Homes in the area if they too have not already closed their doors!.

   Each of our Homes is a major employer in their local community and the impact of staff unemployment in the community would have significant on flowing impact.

   Waiting lists would increase dramatically at a time of increased need for residential facilities.

6. ACST in their submission suggest that the department should play a stronger role in co-ordinating provider networks in an attempt to facilitate better co-ordination of resources between existing providers – would such network assist your organisation? Do you think that such a network would benefit providers in Tasmania?

   There is value in a review of the ACAR process to ensure that there was an initial call for expressions of interest for residential, community places and capital grants and that DoHA was then empowered to have open discussions with providers to determine which provider would be asked to provide a detailed business case for their proposal. This would stop a significant amount of duplication and wasted money in preparing applications for a limited resource – e.g. in the northern region 5 providers each has submitted ACAR 2008 applications for limited growth opportunities and Capital Grants for which based on our size Tasmania can expect to get say $4m of the nation's share. Some providers pay up to $20,000 to have applications written for them – not us but in terms of our labour costs I 'go of line' for 2 weeks to complete applications which involve architect costs and the time of three other members of my Executive team. Lost time costs and opportunities would be in the vicinity of $10,000 to produce a archive size box of applications – can't be emailed to the DoHA has to be hard copied (3 copies) of each application – all different.

   PresCareTas networks closely with other providers and has two meetings with a national network of Presbyterian Care providers. I am not sure what more the DoHA can offer as I have a very effective working relationship with the State office and officers. I believe however decentralisation of ACT power and decision taking to the States needs to be achieved to enable increased local decision taking and flexibility.

Robin Philps
Chief Executive Officer

15 April 2009