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The Secretary
Senate Finance and Public Administration Committee
PO Box 6100
Parliament House
Canberra ACT 2600

7 November 2008

Dear Committee Members

Re: Inquiry into Residential and Community Aged Care in Australia

As the Board Chairman and Chief Executive Officer of Eliza Purton Ltd an Aged Care Provider offering Residential and Community Services in the North and North West of Tasmania we respectfully offer the comments below for the Committee's consideration during their Inquiry into Residential and Community Aged Care in Tasmania. We would both be happy to address the Committee and further develop our concerns.
Firstly however we believe a fundamental question needs to be considered and resolved, and that is;
'Does the Governments strategic view of aged care provision include the current small regional and remote providers, those generally "not for profit" organisations who have been providing this type of community service for many decades".

This question is premised on the prevailing view that the provision of aged care services is increasingly being viewed as commodity to be provided at the cheapest unit cost irrespective of the locality or other impacting variables. In other words all providers throughout the Australia get paid the same unit cost irrespective of the unique variables/disadvantages associated with their location, size, expenses, bond values etc.

If this is the case **will** those regional and remote providers who because of their inability to operate viably under the unit cost system continue to have a role in future aged care service provision.
If they are not considered to have a sustainable role then would the government assist and support provided to these providers to develop exit plans to leave the industry.

If these small providers are to have a continuing role in the aged care sector what is that role to be, and how will it be funded to ensure these providers continue to remain solvent whilst providing government aged care funded services in their localities.

Current research indicates over 40% of aged care providers are currently operating at a deficit and this is not sustainable, this is particularly the case in regional and remote areas.

Issues for Consideration

Whether current funding levels are sufficient to meet the expected quality service provision outcomes.

To be an efficient and effective in business, which is what "not for profit" aged care providers strive to be, requires operating income to be at least sufficient to meet operating expenditure. Creating a profit would allow the surplus to be used to make small improvements for the benefit of residents and staff alike, as has been the case with small community providers over many decades.
For the increasing numbers of "not for profits," those who to ensure rigor in their management, are moving from Boards of Management to Boards of Governance, and from being incorporated associations into companies limited by guarantee are increasingly being faced with the spectre of insolvency and administration.

Under the current funding model aged care providers carry all the risk associated with the operation of their businesses but have no ability to raise their costs to meet actual expenses, a conundrum indeed.

Cost of Empty Beds

The issue of payment ceasing when a resident leaves the facility, either through passing away or transfer, and not recommencing until a new resident takes up the vacancy, which is five days on average is a significant issue for many smaller providers.
Reasons why the bed remains empty include the family wanting to wait to clear the room of the belongings of their deceased member until after the funeral, and it would be most unsympathetic and insensitive to rush them to do this. The room has then to be cleaned, possibly painted, and made ready and comfortable for the incoming resident.
As well there are no guarantees that there are residents interested /available to take the vacancy, regional and remote areas generally do not have waiting lists. Interestingly if a resident passes away at 11.59pm the provider does not get paid for that day, when indeed this is generally a labour intensive day supporting the dying resident and family.
During this down time when the room is empty it is (given Award conditions and general workload) virtually impossible to reduce overhead costs, the main one being staffing wages, and so the provider carries all the expense of having an empty bed without the ability to maintain revenue.

An option would be the consideration of a daily subsidy for the bed for 365 days per annum that applies for all the days the bed is empty. In some European countries subsidy continues until the day following the funeral, allowing family, staff and friends to farewell their friend with sensitivity.

The same situation applies to respite beds which we see as a vital element of the provision of residential aged care services, however the empty beds days cost the provider dearly, and are generally outside of their control. If there is a late cancellation we should have the ability to require payment for the days we can't fill.
The average loss of funding for an empty bed night would be $80 per empty bed per day or $2400 per month.

When a resident dies they are usually of high care status and their federal funding would reflect this. Depending on potential residents on the wait list (if there is one) it is very, very rare to get like for like, that is replacing a high care resident with a similarly funded level high care resident, so the daily funding of the new resident can be reduced by up to $80 per day less than it was previously was. Whilst the argument is that staff could then be reduced because of the lower care needs of the new resident this is unrealistic and demeans the residents and care providers alike, and so again the provider carries the cost.
In other words the costs of staffing remain constant whilst the level of revenue fluctuates remarkably and generally outside of the control of the aged care provider.

New residents also affect Aged Care Providers cash flows when subsidies are not received for up to two months after admission. Could a standard daily fee be considered on admission and then adjusted when the resident's status is identified.

Cost of Compliance

The government is very clear that it expects quality outcomes for the money it pays, not an unreal expectation however it the provider who is expected to meet the costs of compliance, an example of this would be the requirement for police certificates for all employees, volunteers, auxiliaries and so on. The costs of accreditation, mandatory reporting and complaints management all impact on aged care providers in human and financial terms.
Other costs of compliance are less tangible but include both financial and non financial costs. For example when representatives of DoHA or the Agency come on site all relevant senior staff have to be released to meet their demands. This is expensive in terms or time, money and stress, and again no acknowledgement is given to these elements.

Aged Care Funding Instrument (ACFI)

Since it introduced the ACFI in March this year the Government has indicated funding is better targeted and therefore better outcomes are being achieved. From our perspective funding has been reallocated from low care to high care service provision, making the provision of low care services even more financially unviable. We are certainly losing money on our residential low care services.

Since ACFI's inception we have also noted an increase in the number of residents being admitted with high care ACAT status then reverting to low care status on their first assessment. As indicated in the Accommodation Bond section, once a resident has received a high care ACAT and subsequently revert to low care status the ability of the aged care provider to request a Bond is lost. As is the potential income attached to their previous high care status.

Bonuses being paid directly to residents of aged care facilities

Currently aged care providers charge each resident up to 85% of their pension's, these charges go some way to covering operational costs such as electricity, gas, food and so on. A recent government trend has been to pay Bonuses such as the Utilities Bonus to pensioners rather than increase the actual pension.

However when the Bonuses are being paid to pensioners living in Aged Care Facilities, the aged care provider who is actually carrying the costs of these utilities has no recourse to these increases. Eighty five percent of such bonuses should be paid to the Provider when the pensioner is resident in a facility. This will go some way to meeting the huge increase in costs being met by aged care providers.

How appropriate the current indexation formula is in recognising the actual cost of pricing aged care services to meet the expected level and quality of such services.

Sustainable indexation

The annual increase afforded to providers has historically been approximately 2%, not even matching CPI most years. The CAP payment of 1.75% was provided again this year and is most welcome but does not meet the actual cost increases being experienced by providers. For example wages 5% per annum, electricity increase of up to 15%, gas 10%, food 10%, fuel 50%. An average provider is absorbing expenditure increases of between 7% and 10% per annum, whilst revenue increases at 3% - 4% per annum, this is clearly not sustainable.

These annual increases are not made known to providers until after the budget in May well after the time operating budgets have been prepared, and so the process is not helpful to providers in being efficient and effective in their operations.

Measures that can be taken to address regional variations in the cost of service delivery and the construction of aged care facilities.

Accommodation Bonds

Bank Interest on Accommodation Bonds is an important source of revenue for most aged care providers even though it currently only comes from low care residents. We are witnessing an increasing trend away from low care service provision in aged care facilities to community based services, as a result the ability of providers to access Low Care Bonds is significantly eroded. This results in a considerable loss of income to providers. The ability of providers to access Bond income is essential to their continuing solvency and therefore their ability to continue to provide quality aged care services.

Bonds available to regional and remote providers are considerably lower than those available in capital cities for example the average Bond available from the sale of a house in Sydney is $520K, in Ulverstone Tasmania it is $189K, the difference equates to $23K interest (@7%) per Bond per annum, a significant amount of lost income.

Currently if a resident is admitted with an ACAT High Care status and on subsequent assessment reverts to Low Care status we are unable to request a Low Care Bond, again a significant loss of revenue.

Given this data the introduction of high care bonds must be considered if providers are to remain solvent.

Other Regional Issues

There appears to be no financial recognition of the greater difficulties facing small providers in the regional and remote areas. These difficulties include smaller bonds as indicated above, lack of local qualified staff, training costs, and the lack of the economies of scale available to larger providers. Consideration should be given to a tiered structure of funding (as applies to the Education Sector) that better recognises and supports these regional issues.

Regional aged care facilities were established to meet the specific needs of a local community and are generally smaller than 50 beds, and as such do not have the economies of scale available to them to be viable in today's operating environment.
Staffing recruitment and retention, training and development, aging of the workforce etc are much more difficult to manage in regional areas.
Local Board's of Management and Governance are generally reluctant to consider collective relationships with other local organisations for a number of reasons including loss of control, parochialism, individual agenda's etc.

The process of applying for ACAR Grants is complex, expensive, opaque and rarely successful for smaller providers, leading to them no longer taking part in the process. Are the ACAR funding rounds going to continue or are the zero interest loans going to take their place.

The actual costs of construction clearly vary from state to state and region to region. The DoHA currently consider $120K per bed to be the realistic cost when in Tasmania it is closer to $160K per bed, leaving the aged care provider to find the difference and then provide services in a funding regime that does not met actual operating costs.

Threats to the Aged Care Sector (Particularly Rural and Remote Providers)

Insolvency.
Services ceasing to operate, particularly in regional areas.
Staff leaving the sector.

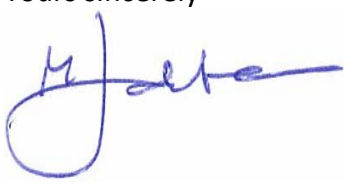
Solutions
Some possible solutions to be considered include;

- The introduction of High Care Bonds needs to be urgently reconsidered.
- Ability to charge the actual costs of residential services.
- A funding model is needed that is at least aligned to actual increases in operating costs.
- A tiered structure of funding that recognises the significant differences between Metropolitan and Regional services.
- A daily subsidy for each day a bed remains empty for reasons outside of the provider's control.
- Support for regional providers to work together on a strategic level whilst maintaining their individual local community identity and culture.
- The ability to charge residents 85% of any bonuses they receive to meet actual costs for which the bonuses are provided to the general pensioner group, e.g. utilities.

Yours sincerely

John Hughes
Board Chairman

Yours sincerely



Malcolm Johnstone
Chief Executive Officer