Victorian Healthcare Association

18 November 2008

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

The Victorian Healthcare Association Submission on:
Senate Inquiry into residential and community aged care in Australia

The Victorian Healthcare Association welcomes the opportunity to submit on the Senate Inquiry into residential and community aged care in Australia.

The Victorian Healthcare Association

The Victorian Healthcare Association (VHA) is the major peak body representing the interests of the public healthcare sector in Victoria. Our members are public hospitals, rural and regional health services, community health services and aged care facilities. Established since 1938, the VHA promotes improvement of health outcomes for all Victorians from the perspective of its members.

The Victorian Context

Victoria has the highest proportion of Public Sector Residential Aged Care Services(PSRACS) of any Australian jurisdiction. Further, Victoria has strong community involvement and opportunity for innovative programmes through its decentralised community governance structures. The VHA strongly supports the State Government's commitment to PSRAC.

Victorians and their health workforce are ageing rapidly like all other states. The VHA values the interest that the senate committee has shown in residential and community aged care.

The VHA's Response

The sufficiency of current funding is being eroded by increases in staffing and capital costs which are not matched by funding increases from government. The inability for Victorian PSRACS to staff their facilities with Health Care Assistants, due to the Nurses' Enterprise Bargaining Agreement; places significant costs on PSRACS, not borne by private providers. A freeing-up of the health workforce – not just nursing – is required to address this issue.

The attachment of bed licences to a facility rather than a service provider reduces the flexibility for agencies with a number of sites and obstructs ageing in place. Services cannot transfer bed licences from one facility to another to meet demand. This can force elderly and frail residents to move to facilities in neighbouring towns, away from friends and family. This dislocates them from social networks and prevents ageing in place. When a place becomes available at the original facility, the resident may then be unwilling to move.

To remain financially viable, services are pressured to ensure that their occupancy remain as close to 100% as possible. This fact inherently prevents health services from effectively managing requirements for respite services due to the long term planning required. Ideally, services should have available 5% of beds devoted to respite care allowing for management of the most urgent respite workload – taking the load off carers and allowing people to stay out of the hospital system for longer.

Access to respite care is affected by funding decisions also. Currently, individuals are entitled to 63 days of respite care annually. The VHA has anecdotal evidence to show that if this entitlement was increased to 90 or 120 days annually families and carers would have

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much greater capacity to care for loved ones without resorting to permanent residential care; thereby, keeping people at home and out of residential care for longer.

Delivering aged and community care across rural and regional Australia is hampered by distance. The ability for assessment, nursing, allied health or home care staff to reach disparately located clients is not accounted for by current funding structures. Further, in the current workforce crisis, rural services contracting the provision of health professionals from larger regional centres are forced to bear the cost of their travel time. This may mean that while paying for 8 hours, only 4.5 hours of service delivery occurs.

Government must account for the variable of rurality and appropriately fund services to clients who are already suffering inequality due to where they choose to reside.

Many areas of Victoria have serious shortfalls in their numbers of aged care and community places; while others have an over-supply. Local needs are best addressed by local decisions that lead to local solutions. To achieve this, data must be available at the local-level to demonstrate need and structure of service provision rather than the current regional approach.

This data must be available to services so they can plan for correct placement of services and aged care places. The same data must be available to decision makers to educate their policy and funding decisions.

In releasing its recent position statement on data applicability, the VHA noted that data must be readily available, presented from a wide variety of sources and collected using a systemic methodology. Australia delivers some of the best health and community services in the world; yet it remains data poor when demonstrating their need, success or financial viability.

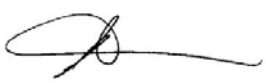
In relocating existing or allocating new bed licences and aged care packages, careful consideration needs to be given to areas of population growth. The Federal and State Government have shown awareness for future aged care provision in Victoria's high-growth areas. The VHA notes that when allocating beds or community places; government must also have regard for the services that will be needed to support these places for example the availability of nursing, medical, pharmacy and allied health services.

Conclusion

The VHA welcomes the interest shown by the Finance and Public Administration Committee into aged care funding. The VHA strongly believes that local needs are best met by local solutions. As our communities and health workforce continue to age, government must work to remove the service inefficiencies that hinder high quality, cost-effective patient care.

Please contact the VHA for any more information regarding this response. We welcome the opportunity to represent the Victorian public healthcare sector throughout this or future inquiries.

Yours faithfully



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