Melaleuca
HOME FOR THE AGED INC.
73 Mary Street, East Devonport, Tasmania, 7310
ABN: 11 358 382 701

SENATE ENQUIRY INTO AGED CARE - Melaleuca Response

Melaleuca is a very small **Not For Profit**, non-sectarian Aged Care Facility consisting of 36 Beds i.e. (1 Respite and 35 High Care). We are a "stand alone" *community based* organisation that has no financial support from the larger church or other such community groups. Additionally we have been servicing the Rural sector of the North West Tasmanian community for the past 26 years.

The following points are *our* thoughts in relation to your "Terms of Reference"

"Are current funding levels sufficient to meet expected quality service provision outcomes?"

FACTS AND DATA

1. Real funding is being eroded, as wages, energy, consumer and building costs outstrip government payments.
2. Implementation of the ACFI and "Grand-parenting" providing a false basis for future income
3. Nurses wages up to 10 per cent higher in public hospital sector.
4. Organisational Wages increasing by 3 to 5 % per annum
5. CPI running at around 3.2% for goods, and 6.2% for services
6. Regional fuel and energy costs skyrocketing by up to 30% (this is before the proposed Emissions Trading Scheme costs).

Some examples of how this affects our service:
Melaleuca has introduced streamlined processes that allows us to operate in an extremely efficient manner without effecting the standard of care. Our staffing levels in administration, support services and clinical care areas have been "trimmed" to the bone, however our staffing structure still allows for efficient work practices. Costs such as training, costs associated with empty bed periods, accreditation, quality assurance, continual improvements, police checks and many other incidental areas are seemingly always on the increase and never supported by additional funding.

We currently provide a high level of quality service to our residents, however there is always room for improvement. Presently approximately 80% of our income is paid out in wages to provide the necessary care. Like many other Aged Care Facilities we believe that the staff are "stretched" to the extreme and often give "voluntary time" to ensure that all that can be done for our residents, *is* done given the limitations of funding. Melaleuca has no alternate income source, we survive from Federal funding and resident contribution alone. It is our opinion that *if* the funding levels *were* sufficient we would not suffer a distinct lack of funds to support more "Care Hours" to provide the highest possible quality of care. Some of our concerns are as follows:

1. Staff are currently so busy they can't spend quality time with residents and families. In three to five years time – what happens if this is not addressed?
2. Staff burn-out, or loss to the acute sector; innovative programs put on hold or run on a "shoe-string" because staff/finances not available.
3. Industry wages – particularly support staff and extended care assistant wages are very low in comparison to other sectors. Due to unsatisfactory funding this will always be the case and we are finding it increasingly difficult to attract good quality staff to these positions.
4. The number of Volunteers may soon disappear as many of the younger generation have alternate values

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"How appropriate is the current indexation formula in recognising the actual cost of providing the expected level and quality of services?"

FACTS AND DATA

1. CAP frozen at 8.75% for next four years – no annual 1.75% increases.
2. In the last financial year 07/08 inflation travelled at 4.3% whilst CAP and Commonwealth Own Purpose Outlays (COPO) together was below this at 4.05%.
3. CAP loss will mean funding drop of $750 per annum, per resident.

Some examples of how this affects our service:

As stated at the previous question, Melaleuca has been well trimmed and has some excellent efficiency in place to manage and maintain our staffing levels and our finances, however we are unable to trim further and we have no control over waiting lists and empty beds. The most recent increases appear to be below the CPI and well below Regional inflationary costs. The costs of having beds empty cannot be carried and we are unable to "reduce" staffing levels at the "drop of a hat" for further fear of loosing further good staff. Beds can be empty for less than a day or up to many weeks depending on the numbers on the waiting list, however there is almost always a "change over" period of at least a few days from one resident to another. This timeframe varies depending on circumstances but the cost is ultimately worn by the provider.

Gas, electricity, fuel, wages, essential service costs, repairs, maintenance etc….have spiraled during the past 2 years in particular. The CAP increases are around 1.75% per annum which is well below CPI and we have absorbed much of the spiraling costs ourselves during the past few years. This has resulted in Melaleuca running a deficit for 7 out of the past 9 years, and if not for our auxiliary and efficiencies we had introduced, we may not have survived to provide the services we do.

We have responded to funding pressures by increasing our efficiency, but there is a definite limit to how much can be squeezed from facilities without compromising care. Our concern (mirroring the Hogan Report) is that unless a realistic costing formula is used to set Commonwealth subsidies, facilities will be increasingly forced to cut costs via unpalatable methods such as replacing registered nurses with less qualified staff; and squeezing costs by skimping on the provision of quality care as well as reductions in the quantity and quality of food, furnishings and general amenity.

1. Industry like a "taut" rubber band, which won't stretch any further.

2. A long term "Aged Care Index", which properly recognises all cost drivers, wages growth, consumer items, building costs and increased energy and water prices, is now required.

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"Measures to be taken to meet variations in service delivery costs and construction"

FACTS AND DATA

1. 60% of residents now have complex and high care needs, upon entering facilities
2. 2008 Grant Thornton Report found 1.1 per cent average return on investment for new, single room facilities.
3. Average cost of building a new room is now somewhere between $160,000 to $200,000.

Some examples of how this affects our service:
Zero Interest Loans were never really "Zero", and the timeframe for repayment places them outside most facilities ability to repay the loan. Organisations such as ours sought out these loans as a means to replace existing four (4) to a room shared arrangements with single rooms for those residents that shared. This would result in no further income but would increase our building footprint and add significant servicing issues and additional costs. The Zero interest Loans therefore were not a financially viable option as we would not have the ability to service the Loan.

Shared room arrangement is something we do not want to carry into the future however, the current system does not encourage you to discount them because of the low returns on singles with ensuites. The single rooms have the potential to make your operation unsustainable – however customer demand, quality and accreditation almost demand such moves – a contradiction

The ACAR application process is very competitive and complicated. Because of that, the process has become expensive and rarely successful for smaller providers who are unable to employ the services of a "tender writer". Additionally the timeframes are ridiculously short for providers to correlate important information and the necessary supporting data within the required timeframes. This has probably contributed to smaller organisations such as Melaleuca, not applying through the frustration of "better to submit NOTHING than submit a poor application that will get you nothing anyway!"

The ACAR application timeframes place immense stress on the smaller organisations who have limited time and resources to address the necessary criteria. Additionally as in our case the timeframe fell in the middle of our Accreditation Process and therefore we found it almost impossible to concentrate on both Accreditation and ACAR 2008 let alone the fast closing Festive /Christmas season.

1. "No bonds in high care" is unjust – cross subsidisation is creating two tiers of residents.
2. Pressure on space in older facilities – restricts ageing in place, as lifting equipment is required for higher care residents.
3. Funding Rounds need to be simplified, fair (more weight given to Rural areas where predominately small providers operate in the community) and the timeframes realistic.

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"How can any inequities in user payments between different groups be addressed?"

FACTS AND DATA

1. There *are* currently inequities in user payments.
2. Income tested fees, paid by non-pensioners, are collected by provider and deducted from subsidies by government.
3. Currently ACAT assessed residents on RCS categories 6, 7 and 8 get no subsidies under the ACFI.
4. Regional Areas attract much smaller Bonds than the larger city areas
5. Some residents assessed as High Care are subsequently re-assessed at a lower category after admission into facilities.

Some examples of how this affects our service:
Melaleuca has only High Care Beds and therefore has limited understanding of the inequities between the user payments of Low verses High Care and those with considerable assets verses those without. Because of our "High Care" status Melaleuca lacks access to bonds. Given the challenges of accessing capital (building our wing) there are some obvious inequities here. Even if we were able to access Bonds the lower income levels and greater dependence on pensions that Tasmania has, means that regional area bonds would be lower. The Department should consider the following:

1. Minimum ACFI payment for all to help with bed, board, food, cleaning and laundry – remove gap between funding and costs.
2. Identify gaps between those paying bonds and those who don't.

Is the current planning ratio between high and low care places appropriate?

Melaleuca is unable to address this criteria due to timeframes and the fact that we have never been involved in Low Care.

What is the impact of residential places allocation and provision of community care places?

Melaleuca is unable to address this criteria due to timeframes and we have never been involved in community care places.

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Summary:

Like many stand alone facilities Melaleuca is finding it increasingly difficult to remain viable. If not for efficient economies and the extreme generosity of good staff and many volunteers, Melaleuca would not be able to continue providing the service.

Our region is only small, and community based organisations like ours are connected to our communities via considerable social (volunteers etc) and economic (employment) role in our community thereby our identity is critical to the local population. In Tasmania consolidation is dangerous because it can de-stablise critical social infrastructure (like aged care facilities) and in the north west there is considerable opportunity for networking, cooperation etc and investment by Government in supporting this would result in efficiencies.

We are Community owned and operated and very proud of our heritage. We are fearful that our balloon is about to "pop" as the industry is at the end of the stretched rubber band. We can stretch no further without dour consequences.

We are always trying to improve the service we provide, our facilities, menu choices, activities and many, many more areas, but find it almost impossible to introduce new creative programs and innovations due to the distinct lack of funds to support even the simple changes.

Melaleuca has saved and scrimped monies for over 15 years to try to build a new wing, this year we have given up our hopes on a new wing and commenced a "half project". That project will see some of our "shared rooms" being renovated into single rooms and a new Laundry being constructed to comply with accreditation standards.

Consideration should be given to the following points:

- Regional areas suffer regional issues including additional costs, limited staffing expertise etc
- The funding model needs to reflect the actual costs associated with running the operations
- The CAP funding should align with CPI as a minimum
- Additional requirements should attract additional funding, These requirements include such things as Police Checks, Accreditation and Spot check "down times", training etc.
- A bed subsidy should be considered for the "Empty Bed" Periods
- Providers should receive the pension concessions for electricity, rates, phones etc.
- Introduction of Bonds in High Care
- Keeping residents in the community will create a "bottle neck" in high care into the future
- ACAR should be reviewed in regard to complexity and timeframes

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November 2008

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