# SENATE INQUIRY INTO RESIDENTIAL AND COMMUNITY AGED CARE IN AUSTRALIA

## Submission by: Hellenic Community Aged Care

**Background on Hellenic Community Aged Care:**
Hellenic Community Aged Care is a 96 ageing in place residential aged care facility including16 recently completed, as yet unoccupied, dementia specific places.

Hellenic Community Aged Care is stand alone, located in the 'metropolitan north' region 10 km north of Perth central business district.

Hellenic Community Aged Care employs around 80 staff. The original 40 place low care facility was completed in 1992; all single room with ensuite. In 2004-05, 40 high care (single room with ensuite) places were constructed to integrate with the original 40 low care places and 20 of the low care places were upgraded to accommodate high care residents. Construction of 16 dementia specific places is complete and, subject to Bank finance, the upgrade of the remaining 20 (original 1992) low care places is planned to commence in December 2008.

The upgrade is a strategic decision:

- The new Commonwealth funding instrument for residential aged care shifts funding towards high care residents and away from low care.
- It is conceivable the Commonwealth will cease to fund low care at some time in the medium term.
- Commonwealth guidelines permit low care residents to be admitted to high care (class 9c) rooms, but not high care residents to be admitted to low (ie Class3) rooms. If funding of low care residents is phased out, part of the Hellenic Community Aged Care building stock could become non-productive.
- The completed 16 dementia rooms provide an opportunity for residents to be temporarily relocated while renovations are underway.
- Further expansion of Hellenic Community Aged Care on its current site is problematic for reasons of space and of cost-benefit. Residential aged care is not a high return business.

This remainder of this submission addresses each of the key issues of the inquiry:

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

- There is no published basis of commonwealth funding for residential aged care comparing funding levels to expected quality of services outcomes. There is no congruence between drivers of income and drivers of costs.
  - Residential aged care facility income is predominantly Commonwealth subsidy driven: recurrent subsidies (65 per cent), capital subsidies (13 per cent), and resident fees (22 per cent).

        - Commonwealth recurrent subsidies are based on resident diagnoses (via the aged care funding instrument) now displacing care needs funding (via the resident classification scale).
    - Residential aged care facility costs are driven by accreditation standards where personal care and hotel services to residents must meet 44 quality of care outcomes specified in the Aged Care Act 1997 supervised by the Aged Care Standards and Accreditation Agency.
- There is some methodology within the residential aged care funding model if it is assumed:
    - Commonwealth recurrent subsidies point in the direction of costs in providing personal care services to residents.
    - Residents' fees point in the direction of costs in providing non-care or hotel services to residents.
    - Capital subsidies point in the direction of depreciation expenses for the capital costs of providing services t o residents.
- Hellenic Community Aged Care wages and on-costs accounted for $87.30 of the average recurrent subsidy of $97.00 per resident per day in 2007-08. The average hourly wage rate plus on-costs across all staff is about $26.50
- Resident fees average $34.00 per resident per day of which $26.36 is accounted for by: food, interest, insurance, cleaning, medical and continence supplies, laundry, and utilities.

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

Review of Pricing Arrangements in Residential Aged Care - Full Report at 7.3.3 - Industry capacity to pay states:

> Given this evidence there are no grounds for thinking any conventional indexation procedure, whatever the precise measure used, would satisfy the perceived needs of many providers. Half or more might judge their position not to have been met. Changed indexation arrangements would merely form the basis for yet another round of complaints and claims for more funding…….. The strategy developed for the Review is to foster efficiency and productivity in order to secure reductions in the real costs of aged care, especially in the residential sphere but not exclusively so…….. The concepts of productivity and efficiency should be understood as embracing commitment to workforce training and enterprise bargaining.

The Aged Care Industry Council October 2008 submission to the Department of Health and Ageing on the review of the Conditional Adjustment Payment deals with the shortfall between funding indexation and sector costs.

Residential aged care more so than most face-to-face service sectors by its very nature has limited maneuverability to achieve increased productivity and efficiency through more capital intensive operations. Capital investment to improve occupational safety and

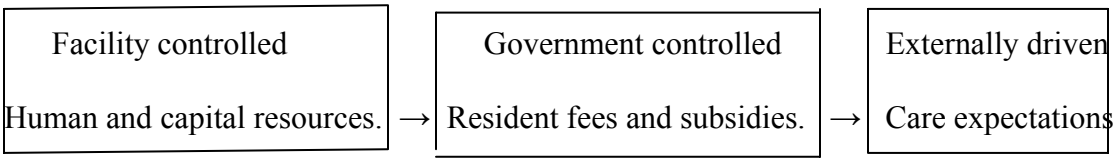
health is important and some processes can be improved with better communications and electronic means. Productivity gains in the face-to-face care function rely on improved labour performance.

Training, education, work skills, will accrue to performance if employees can found, inducted, trained, and retained within the sector. Increasingly the sector is seen as an 'employer of last resort' where there are jobs for those prepared to accept the 'pay' just to have work. Staff arrive and depart for 'better opportunities', or 'they never knew aged care would be like this' or 'another facility is paying more' or for some other reason. The churning of 'arriving and departing' staff forestalls any hope of gains through labour performance. Productivity declines through ongoing rounds of recruiting, inducting, training, with existing staff taking on the burden to buddy and mentor new arrivals. The sector is facing a declining pool of experienced qualified registered and enrolled nurses, a declining pool of experienced non-registered personal care staff, and limited pool of inexperienced, non-registered, potential personal care staff.

Inexperienced and non-qualified staff are fast growing and becoming the largest proportion of the aged care workforce in metropolitan facilities in Perth.

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

Residential aged care suffers from a 'lopsided' model:




Facilities use their human and capital resources (the only items facilities control) and from government controlled fees and subsidies try to satisfy care expectations driven by residents, families, politicians, the Minister, the media, the Department, Aged Care Act, and the Aged Care Standards Agency.

In the lopsided model, care expectations can only be met if fees and subsidies will fund commensurate human and capital resources.

If there is reluctance in government to match fees and subsidies with care service expectations, then expectations of deliverable care services must adjust to the reality of human and capital resources available to the aged care sector.

If the government is not prepared to fund at a level to meet the externally driven expectation of aged care services, then consumers must bear the cost or modify expectations.

This means price signals to consumers of aged care must reflect service delivery costs.

In the terms of the above quoted Review of pricing arrangements in residential aged care - full report, 'productivity and efficiency' in the aged care sector cannot be left to carry the burden for governments not prepared to meet care service expectations with realistic subsidies.

**D. Whether there is an inequity in user payments between different groups of aged care consumers and, if so, how the inequity can be addressed.**

The capital funding model for aged care is flawed:

- The capital cost of building and refurbishing aged care facilities is increasing, particularly in Western Australia.
- Recurrent and capital subsidies are insufficient to meet debt servicing on bank finance for building and upgrades.
- Bonds have been the prime source of debt reduction so capital subsidies can cover reduced debt servicing.
    - Only low care residents with assets (or high care residents in extra service facilities) are eligible to pay bonds.
    - Government policy is encouraging low care residents to stay in their own homes. More high care residents, ineligible to pay bonds, are presenting for aged care.
- The aged care sector confronted the erosion of accommodation bond finance by building and selling independent living units to fund nursing home construction. This model has limitations, it is land intensive because it needs space to accommodate independent living units alongside aged care places. Land on this scale near to potential work forces, services, and Doctors is scarce and expensive.

Accommodation bonds are the most effective means of funding capital expenditure in aged care. Accommodation bonds must be extended to high care residents (without the need for extra services) if capital investment in high care facilities is to resume.

**E. Whether the current planning ratio between community, high- and low-care places is appropriate.**

See 'D' above.

**F. The impact of current and future residential places allocation and funding on the number and provision of community care places.**

See 'D' above.

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