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Together we Care

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Committee Secretary
Senate Finance and Public Administration Committee
Department of the Senate
PO Box 6100
Parliament House
Canberra ACT 2600

Dear Sir/Madam,

Re Finance and Public Administration Inquiry into Aged and Community Care

On behalf of St Ann's Homes Inc I welcome the opportunity to provide our submission to the above inquiry. St Ann's currently operates two nursing homes in Southern Tasmania, namely St Ann's Davey Street and St Ann's Compton Downs with 110 and 108 beds respectively. In August 2007 we reluctantly closed our St Ann's Windermere Hostel a 30 bed low care facility, due to financial viability factors. We also operate 28 CACP's. In response to the terms of reference to the enquiry:

1. *Are current funding levels sufficient to meet expected quality service provision outcomes?*

It is the experience of St Ann's Homes that current funding levels are manifestly inadequate to meet expected quality service provision outcomes in an organisationally sustainable way. Indeed we have incurred significant losses exceeding three quarters of a million dollars in each of the past two years. Our experience appears to be consistent with many other providers according to the 2008 Grant Thornton Survey and backed up by the most recent Stewart Brown Survey. These indicate that in general aged care providers are experiencing an ongoing trend of gradually diminishing returns and a significant number are incurring unsustainable losses. It is not just the ability of organisations to meet expected quality service provision outcomes that is being called into question under current funding levels but indeed the future financial viability of the entire residential aged care sector.

Organisations are being placed under considerable stress through the dual pressures of financial viability combined with ever increasing regulatory requirements. At St Ann's Homes some seventy five percent of our costs are expended on staffing and our staff resources are continually being stretched to the limit. This is leading to ever increasing incidences of staff burn-out and consequently impacting on our ability to retain staff. We believe our standards in relation to the delivery of care continue to be at the highest level though this is occurring at the expense of the ongoing financial viability of the organisation. We are in no doubt that the pressures being placed on

staff not only impacts on the time being spent with residents but also on the quality of that time.

It is a paradox that the increased lifting of the regulatory bar (accreditation, police checks, compulsory reporting, etc), measures designed to increase quality service provision outcomes, are bringing with them counter and downward pressures on the ability of organisations to meet such expected quality service provision outcomes.

Possible part-solutions to this conundrum, designed to get more funds into the hands of residential aged care providers, might include:

- Introduction of more flexible multi-tiered user-pay pricing models for differing levels of service and accommodation provision as well as on location and geographical considerations, with safeguards and entry mechanisms for the financially disadvantaged;
- Abolition of maximum user-pay fee though user protection would still be maintained through "ability to pay" principles;
- Accommodation Bonds in high care; and,
- Discontinuation of the transitional cap on the maximum ACFI subsidy for high care.

Beyond the ACFI transitional period these measures come at no additional cost to government.

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

The current indexation formula is inadequate with regard to residential aged care. Research commissioned by the aged care industry demonstrates that the differential between increases to costs over increases to income exceeds fifteen percent since 1997, this in spite of the CAP. Income has in the last few years been indexed at around 2% (less in Tasmania for most of these years due to coalescence). The chief cost component in our industry is staffing, as stated in response to item 1 above. In an era of almost full employment nationally and regionally; ageing population; and chronic skills shortage (particularly in nursing), not only has our ability to attract and retain adequate numbers of competent staff in the areas of nursing, personal care and hospitality services been impacted but these have driven this cost component upwards by around 5 to 7% annually. In addition we are currently experiencing upward cost pressures resulting from drought related and global economic factors impacting on the cost of food, transport and energy. The increased regulatory requirements pertaining to the industry, referred to in response to item 1 above, as well as the ramping up of the non-industry based regulation (example Food Safety planning recently introduced in Tasmania, emissions trading on the way) is continually driving up the cost base of an industry unable to price adjust to compensate. From an industry perspective I would suggest that an organisation under financial and operational stress is not best equipped to meet expected levels and quality of services.

The main thrust of any proposed solution can only be an indexation model that factors in the impact of all cost components (in broad categories) in proportionate measures, possibly differentiated on a state by state and/or even a city v regional basis.

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

With regard to the cost of construction of aged care facilities St Ann's considered applying for loan funding under the government's recent "real interest free loan" scheme. Our pre-feasibility study informed us that an application under the scheme could not be justified from a business perspective and consequently we did not submit an application. The main reasons for not proceeding can be categorized as follows:

- Loan funding was being provided at $120,000 per room while our research suggested a "true" cost to exceed $175,000 (and rising). Indeed the research of some providers and industry peaks suggests that the cost of building now exceeds $200,000. We would have had to finance the

balance on commercial financing terms at a time when interest rates were rising and were tipped to rise even further;
- Rates of return in high care (and we are seeing the gradual phase out of low-care in residential aged care) does not in our opinion justify any large scale capital investment in this industry under the "throwing good money after bad" principle;
- Our inability to raise capital through accommodation bonds as most entrants require high care; and,
- Uncertain financial future of both the industry and specifically our organization. Any strategic development initiatives are better targeted at delivering a gradual transition out of the commonwealth funding dependent part of the industry than further investment in an industry with a restrictive and flawed funding model.

St Ann's has been open and receptive towards redeveloping our facilities in the past. Indeed from 2000 - 2004 we financed the redevelopment (and modernization) of our Davey Street campus at a cost of some $12 million. As a non-profit organization our ethos is slanted heavily (even solely) towards the well-being of our residents without an investor stakeholder basis requiring a return on investment. However, we are still unable to justify further investment in the industry under the current financial and operating environment. We believe our situation is not an isolated case but is in fact broadly representative of a large part of our industry.

Partial solutions may include a legislative change allowing the levying of accommodation bonds to incoming residents requiring high-care (as suggested in response to item 1), as well as the introduction of more flexible multi-tiered user-pay pricing models into the industry (also suggested in response to question 1). More scope for providers to secure their financial future would justify further investment in the industry.

4. *How can any inequities in user payments between different groups of aged care consumers be addressed?*

The inability of providers to levy bonds to incoming approved high-care residents is depriving providers not only of a source of capital but also additional income which could potentially relieve some of the financial strain under which they currently operate. Paradoxically this legislation (prohibiting bonds in high care) is also in many instances leading to an unsatisfactory outcome for these residents as they are (unnecessarily in my view) incurring income tested fees and/or reduced pensions as a result. As proposed in response to question 1, the premise of a flexible multi-tiered user-pay pricing system would not only bring more funds into the hands of providers but would also provide greater user-choice and as a result greater competition into the industry with a resultant market-driven upward pressure on the levels of care and quality of services provided. A continuance of the government subsidisation of non-financial residents would ensure continued access for members of all socio-economic groups. A further weakness in the current funding system is the non-segregation of accommodation and care. I think this is where the user-pay proposal comes in whereby (possibly) the user funds accommodation (subsidised by government where necessary) under a multi-tiered system reflecting differentials for accommodation (quality, location, size and ancillary services), meals, activities, local market factors, provider reputation and other variables, and based on "ability to pay", while the government funds care based on contemporary care assessment and co-related funding protocols (currently ACFI). These measures would help eliminate the impact of zero funded residents or ACAT approved high-care residents subsequently attracting minimal low-care levels of funding under ACFI (we have experienced this on more than one occasion).

The part-solutions suggested are:

- Allow for levying of accommodation bonds in high-care;
- Segregation of accommodation from care for funding considerations; and,
- Introduce flexible multi-tiered user-pay pricing model.

5. *Is the current planning ratio between high and low-care places appropriate?*

The planning ratios between high and low care based on our experience are not reflective of the current market whereby the demand for entry into residential aged care (according to our waiting lists which are anecdotally reflective of other providers both locally and nationally) is overwhelmingly from those who are ACAT approved high-care. We would argue that such planning ratios are a hindrance rather than helpful in the development of our industry and would advocate a relaxation of such bureaucratic controls and greater scope for industry development through free market principles. I can point out based on the experience of St Ann's and anecdotally from other providers that the transition of facilities from predominantly low care to predominantly high care is placing a strain on organizations as they attempt to adjust to meet the ever increasing care needs of residents and to appropriately resource wards within their facilities while balancing resources required and funding provided, a scenario exacerbated by the ever increasing phenomenon of residents suffering from advanced stages of dementia.

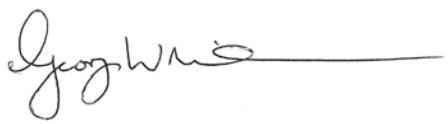
6. *What is the impact of current and future residential places allocation and funding on the number and provision of community care places?*

As a predominantly residential aged care provider I hereby respond to this term of reference from a residential aged care perspective. Government's apparent bias away from residential low-care towards community care in the home aims to satisfy a market driven demand though this market driven demand is partly being fed by government policy. In addition the apparent funding inadequacy of low-care under ACFI (compared to RCS) anecdotally leading to providers not being willing to accept low-care approved entrants will result in a continual stream of prospective clients to community care programs. Apart from market demand I would suggest that cost effectiveness is another motivating factor behind government policy. One wonders whether the greater incidence of referral from the home to hospital compared to residential aged care to hospital, leading to longer hospital stays and the "bed blocking" phenomenon placing greater strain on metropolitan and regional health sectors has adequately been factored in. Given that hospital care exceeds the cost of residential aged care by a multiple of five or six, one wonders whether the supposed financial effectiveness of community care will prove to be a false dawn and is not merely a "shifting of the burden" to an alternative funding bucket rather than a true overall cost saving.

That concludes the response of St Ann's Homes Inc. I am pleased to have been able to contribute to the Finance and Public Administration Inquiry into Aged and Community Care and I thank you for the opportunity. I send you my good wishes for the review and look forward to your conclusions resulting there-from driving forward positive changes to the future financial and operational viability of the sector whilst maintaining and improving on the levels of care currently provided to our elderly Australians in need of such care.

I wish you well but should you have any queries please feel free to contact me.

Yours Sincerely



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