Submission to Senate Finance and Public Administration Committee — November 2008.

INTRODUCTION:

1. My name is Alan Fowlie. I have been a community representative on Aged Care Boards since 1970 when I joined the Board of Management of the Mt Warrigal Rest Home. The Mt Warrigal Nursing Home is now part of Warrigal Care,
2. I have been a member of the Blue Haven Retirement Village and Aged Care Facility Board from its inception in 1971 as a community committee. The Blue Haven Aged Care Facility is operated by Kiama Municipal Council. I have been Chairman of the Community Committee for the last 12 years.
3. Blue Haven Aged Care Facility caters for 52 high care residents, including 20 high care residents exhibiting dementia specific behaviours, and 30 low care residents. The original 40 H.C. and 28 L.C units were constructed by Kiama Municipal Council and opened in 1979. Over the years the facility has been upgraded and extended to its present condition. The facility has 2008 certification for both the high care and the low care facility and in June 2006 both facilities received 3 year accreditation in all outcomes at an external validation conducted by the Aged Care Standards Agency
4. Kiama Council operates 110 Community Aged Care Packages and a full range of Home and Community Care Packages.

SUBMISSION:

1. From the standpoint of a stand alone aged care facility the current level of recurrent funding is insufficient to maintain the expected quality service outcomes. Kiama Council operates the Aged Care facility without any cross subsidisation. Since the introduction of the Aged Care Act and the conclusion of the equalisation phase (coalescence) the unit has operated in deficit to maintain the service level.
    i. As the facility was constructed in 1979 it has multi–bed wards and is spread across three wings. It requires more staff to maintain the supervision of residents especially in the secure high–care dementia specific wing. Due to the aggression of some residents it is necessary to maintain 2 staff members in the unit at all times. There is no increase in recurrent funding to take account of these facility specific issues.
    ii. As Kiama Council is not a Public Benevolent Institution but operates an Aged Care Facility no differently from all other not–for–profit facilities in the region, its employees cannot package their salaries to the maximum level. This means a difference of $39 per week for nurses working for Blue Haven.

2. The position in New South Wales is exacerbated by the following factors.
    1. The State requirement that there must by a Registered Nurse on duty at all times the facility is open, the dispensing of drugs must be supervised by a registered Nurse and that the Director of Nursing be a registered Nurse with administration experience. (Repeal of the Nursing Homes Act of 1988). No other state has these requirements.
    2. The introduction of the Aged Care Act and the move from an inputs model of funding to an outcomes based funding model removed the necessary link between the cost of service delivery and the Commonwealth Grants. NSW providers had their grants reduced to the national average whilst other States, with lower costs of service delivery, were increased.
    3. The wages of nursing staff varies from state to state. When the Aged Care Act was enacted in 1997 the difference between a R.N. on her maximum in aged care facilities and in acute care hospitals across the nation was $20 a week on average. The last time a comparison was made the difference was $200 per week. Age care wage rates varied from $748.20 for R.N's in Vic to $922.70 in N.S.W. (2005) Now $1,110.

3. The current indexation formula is not adequate to meet the rising cost of the provision of services. As Aged Care Facilities are funded under the Commonwealth Own Purpose Outlays (COPO) rather that a separate funding regime as previously the staffing increases are reduced to only "safety net' increases. This represents 75% on all recurrent grant increases. Four inquires have recommended that increases in Aged Care Funding must reflect the real cost of the service.
    1. The underlying problem facing providers is that the funding formula the RCS was flawed from the start in that it did not link grants to the actual service costs.
    2. The ACFI, whilst recognising the need for greater support for acute care of residents, fails to meet the needs now of those with a lesser level of need (Levels 6 and 7). The grants for low care residents will be now so low that it will be impossible to admit former Level 6 and 7 residents to low care facilities.
    3. Families with loved ones who are suffering from dementia; are wanderers or require a more secure environment are now not admitted to the low care facility because they do not require "complex care".
    4. Under COPO facilities and industries that cannot reach National Productivity Outcomes are constantly under pressure. We hear stories of facilities with one nurse for up to 100 residents on night duty. Productivity increases are very difficult in a "care' industry. See the latest Productivity Commission report of Aged care.

4. The Capital Cost of facilities has far outstripped the capacity of not–for–profit providers to build quality facilities for all Australians. Capital improvements must now depend on Accommodation Bonds to provide the necessary capital for projects.
    1. The cost of high quality facilities with single rooms is now running at $175,000 per bed. This represents an increase approximately $100,000 in 5 years. The expectation of Baby Boomers is having a large impact on the provision of single rooms in place of shared en–suites.
    2. In the current climate of cost of construction and land, returns of 1.1% on investment in single room facilities has become the reality. (Grant Thornton Aged Care Survey 2008)
    3. Recent analysis of the economies of single and shared rooms shows that the returns (EBITDA) from shared rooms is $4233 per bed and for single rooms of $2191.
    4. Facilities are getting larger to benefit from economies of scale. It is recommended that facilities now be no smaller than 210 beds with multi–campus facilities having no fewer than 80 beds on a separate site. The availability of land to build these facilities probably 15,000 to 20,000 sq mtrs is not readily available close to services. This means facilities are being located on cheaper land on the fringes of towns.
5. Hostels were first introduced in 1973 (Aged Person's Hostels Act, 1973) as a strategy to provide a place for residents who customarily entered Rest Homes (Nursing Homes). The early hostel residents were usually mobile and entered the hostel as a lifestyle choice. Many had full lives in their communities, drove cars and enjoyed the companionship of the hostel. Personal Care of hostel residents was not introduced until the early 90's.
    1. Today the situation is very different. low care residents now have complex care needs to enter the low care facility. Almost 40% of low care residents have high care needs.
    2. Residents now enter new low care facilities by paying a bond and with complex care needs. "Ageing in Place" allows them to remain within the low care complex and receive high care. They do not receive the return of their bond until they leave the aged care facility so de–facto they are paying a bond for high care without receiving the "extra services" attached to a high care bond.
    3. The rationale for low care now no longer exists. To place an accommodation bond for entry to high care will compound the problem. Accommodation Bonds should be reserved for those people who make a lifestyle choice not for those receiving medical care. No–one pays a bond to enter a public hospital.
    4. Respite Care is available in blocks of up to two weeks. With carers under stress from constant caring a long break is not always the most beneficial for the carer. Other countries have the possibility of regular respite for a night or two each week. A bus picks up the

resident and takes them to the centre where they remain for the night and return home in the morning. This would be a good use for current hostels.

6. Community Care has increased the number of people living alone. The increase in basic and packaged services has delayed the entry of some of those people to residential accommodation. Now it is customary for persons to enter residential care for the last few weeks of their life – for some it is a matter of days.
    1. This places an enormous burden on staff in assessment and care planning. The whole planning and recording process has placed an enormous strain on resources which are not part of the recurrent grants to facilities.
    2. Due to the cut back in hospital services ACATeams are under pressure from hospitals to transfer patients to residential care.
    3. The Dept of Planning NSW have indicated that the population of aged persons in the Kiama Municipality will increase markedly in the next 30 years.
    4. The projected increase in those over 85 is 325%, in 80–84 is 173% and other groups over 65 show similar increases.
    5. If these projections are correct Kiama could have some 7400 persons over the age of 70 years. This equates to 150 CACP's and 650 residential care places in a town of 26,000.
    6. The increase in persons living alone in self–contained houses (The 2006 census found 987 persons (17%) living in separate houses) has made houses for families in Kiama difficult to find. Greater effort should be made to provide a range of suitable housing options for older Australians. On the Meals on Wheels run we see many single persons living in two storey houses isolated by stairs from their community.

Alan Fowlie.