Hellenic Community Aged Care: Submission to Productivity Commission

THE PROBLEMS:		
The Problem:	**Impacts on:**	**Outcome for sector:**
1.0. Care subsidies:		
Declining EBITA		
Origins of subsidy formulae unknown. Subsidy indexed by COPO. Health costs increases exceed COPO and CPI. Lack of transparency in subsidy rates.	Income to providers. Rates of pay. Reliance on volunteers. Subsidy vs cost of care	Cannot employ high cost low supply registered nurses. Pool of unregistered experienced staff departing sector. Increasing pool unregistered inexperienced mainly migrant staff entering sector. Labour turnover/churning costs.
Capital subsidies:		
Do not meet debt service costs of new building or up grades. (see Australian Ageing Agenda March/April 2009: *Does EBITA measure up*). Bonds limited by decline in supply of low care residents (see Insite magazine, August/September 2010: *The great demise*).	Providers' abilities to borrow and service debt. Capital expenditure of providers to meet building certification standards. Aged care model now requires independent living unit (ILU) construction and sales to provide capital to fund nursing home construction.	Declining new bed construction and upgrades. Hand-back of licenses. Limited viability of ILU model because scarcity of affordable land near services and workforce.
3.0 Resident fees:		
Do not meet costs of hotel services.	Viability of market driven single room with ensuite facilities compared to lower cost multi-bed facilities.	Declining viability of newer single room with ensuite facilities. Rising costs of meeting building certification standards.
4.0 Expectations driven by:		
Residents/families. Minsiter/politicians. Media. Accreditation agency. Department of Health and Ageing.	Service delivery and costs for facilities. Legislated delivery of services and documentation. Industry image. Increased cost to comply.	Declining investment in sector.

Complaints Investigation. Doctors and allied health professionals.	Increased cost of non-compliance. Demands for in-house facilities.	
Accreditation based on manufacturing TQM model:		
Does not fit sector where workforce non-English speaking backgrounds. Costs driven by 44 accreditation outcomes whereas subsidy income based on diagnosis. Conformity with stated processes used to impute service delivery to residents. Relies on extensive documentation of policies and procedures for 44 outcomes.	Increased cost to comply. Different drivers for income and costs and no point of intersection. Documentation requirements.	Labour turnover/churning costs. Viability of facilities declining. Accreditation documentation driven as proxy for care services to residents.
5.0 In-built cost shifts:		
More care costs to be carried due to increasing proportion high care residents. Increased cost of accommodation services.	Cost to facilities but not to residents.	Viability of facilities declining.
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THE SOLUTIONS:		
Policy required:	**Impacts on:**	**Outcome:**
1.0 Independent cost of care study.		
Origins of current subsidy formulae unknown.	Knowledge of appropriate pricing and indexation structures. Workforce development.	Ongoing investment in sector. Ongoing workforce development.
2.0 Accommodation fees based on amenity.		
Single room with ensuite higher fee than double or shared facilities.	Fees reflecting level of accommodation. Resources to maintain higher standard accommodation.	Improves price signals to consumer. Increases income to providers.
3.0 Accommodation bonds irrespective of high/low care classification.		
Assume 147,000 in residential care of whom 97,000 (66%) are non supported and pay average	Resources to build/upgrade capital assets. Cash deposits to generate income	Improves viability of new construction/upgrades of existing premises.

bond of $100,000 supplying capital of $14.7 billion generating (@ 4.5%pa) $662m income or average $236,000 pa for 2800 aged care providers.		Interest income to employ staff.
4.0 Remove high/low care classification.		
A superfluous dichotomy	Cost allocation between resident and facility for accommodation and care services.	Improves price signals to consumer. Redefine cost responsibilities between resident and facility.
5.0 Increase residential relative to home care subsidy differential.		
Home care subsidies (EACH - $120.50 per day and EACHD - $132.89 per day) for services provided in the care recipients own home equate to residential aged care subsidies where the provider meets accommodation and care expenses 24/7.	Funding to residential care and for home care services.	Redirects funding from lower care home services to higher care residential care services.
6.0 Recognise the aged care sector is a 'step down from hospital care' not a 'step up from home care'.		
Residential aged care is no longer a 'step up from home care'.	Facility perceptions of service requirements. Consumer understanding of provider services. Government understanding of sector services.	Link aged care subsidies to acute sector subsidies.
7.0 Restructure accreditation model.		
Focus on residents by through Accreditation Agency directly surveying residents/families, Doctors, and staff on service delivery. Make documentation and processes a secondary focus.	Relevance of standard setting process. Targets delivery of services to residents. Moves away from: 'If not documented it did not happen'.	Reduces paper and documentation burden to have policies on everything. Reduces resources required to apply for accreditation. Reduces commitment of staff and resources to the accreditation audit and support visits.