Manningham Centre is operated by a not-for-profit, community-based incorporated Association (Manningham Centre Association – MCA) governed by a Board of volunteers drawn from the community of the City of Manningham in Melbourne's eastern suburbs. Half the Board is appointed by Manningham City Council from the community and the other half is elected from the community by the community. The mission of MCA is "to assist older people in the Manningham community to sustain and reinforce their independence, social relationships, personal wellbeing and community interaction".

MCA commenced operating in 1985 in response to a growing need for aged care services in the City of Manningham. Services now comprise two residential aged care facilities (150 low and high care places), a rehabilitation service (day therapy centre), aged care packages (low and high care), Planned Activity Group, National Respite for Carers Programs (overnight cottage respite, employed carers respite, day respite demonstration project), and a HACC-funded Home Maintenance Service. The mixture of residential and community aged care, the integration of these services and the primary focus on a relatively limited geographic area (the City of Manningham) is a model that works very well for clients and gives MCA an advantage compared to aged care providers offering only one type of service.

The majority of the services provided are managed on behalf of Manningham City Council under long-term Management Agreements.

This brief submission by MCA will concentrate on residential care because this is the area that is of most concern to us from an ongoing operations perspective. In doing so we don't discount the importance of wider issues within the aged care sector. The observations below come from our direct experience.

WORKFORCE ISSUES

- We are constantly battling to attract and retain good care staff. There is a broader workforce shortage in all three care roles (Personal Care Attendant, Registered Division One and Two Nurses) exacerbated by the nature of the sector. The work in direct care is physically hard, confronting to the senses, not well remunerated (particularly for non-nurses), emotionally testing in having to deal with the inevitable death of those being caring for, and is not held in high regard by our society. In terms of Registered Nurses, we find ourselves competing with other aged care organizations for the relatively few nurses that may be available. Aged care is not seen as an attractive area for many nurses. For others, it is seen as a way to earn some "pocket money" rather than as a full time career choice.
- We are caught in a remuneration spiral for senior nurse managers, paying more and more generous remuneration packages in order to attract those relatively few good people who may be interested. Many of these Division One Nurses are good clinicians but lack the management skills or aptitude required to effectively manage the complexities of an aged care facility. At the same time our funding is not keeping up with the rise in our basic costs. Smaller organizations are at a distinct disadvantage as they cannot offer some of the supports and career prospects available in larger organizations.
- Our workforce is typical of residential aged care consisting of a high number of part time staff the overwhelming majority or who are female. Entry level care positions (Personal Care

Attendants) and Registered Division Two Nurse's tend to be in the age range from 20 to 40. However a high proportion of our Registered Division One Nurse's are in the 50 year plus age group and will retire in the next 10 years. As these are the positions that are expected to be the leaders, supervisors, managers and clinical experts in an aged care facility, and given the chronic workforce shortages in aged care, we are marching towards a management crises in years to come.

- A growing proportion of our staff who are recruited to entry level care positions were born overseas. Often they form the bulk of applications for vacant positions. Many have come to Australia as students and are working within the restrictions of their visa. While having the right personal attributes, we struggle constantly with issues of them having functional competence with written and verbal English necessary to fulfill the exhaustive documentation requirements associated with providing residential aged care.
- A proportion of our staff, particularly those from overseas, work at more than one facility and personally work more than 38 hours in a week. We have experienced examples of staff who work a full shift in one of our facilities and then go straight to another unrelated facility to do a second shift. We do not support this practice but in all probability we are on the receiving end as well. We are concerned about the implications of this sort of practice for the quality of care provided to residents and for staff safety. It says something about the workforce shortages in aged care.
- A long-standing issue in Victoria has been the disparity in wage rates for Registered Nurses between the public and private sector. The Award rate for nurses in aged care is in the order of 10 to 20% less than what is paid for a similar level position in the public sector. This has contributed to difficulties in attracting and retaining nurses in our sector. However, we have observed that because of nursing shortages we end up elevating the nurses we have to more senior positions much more quickly than in the public sector. In many cases their level of experience and competence wouldn't match their equivalents in the public acute sector.

FUNDING

- In our experience, the funding for residential aged care is not adequate to meet the expectations of our community via the government for providing quality care while at the same time meeting the reasonable costs of providing this quality care. The basic increase has been below the Consumer Price Index for years and if it wasn't for Conditional Adjustment Payments over the last few years the residential care sector would now be in serious decline. The latest increase of just 1.7% with no CAP supplement is laughable and not because it is funny! For too long it has been our staff who have borne the brunt of inadequate funding through lower wages, minimal staffing levels and crushing workloads.
- Like many others, MCA is caught on a knife edge of trying to keep costs down while maintaining the quality of care to residents. Too often we get the financial side under control only to find that our staff are stretched beyond the limits causing standards to fall. No self-respecting aged care provider wants to provide a poor quality service.
- In most businesses, if costs rise despite best efforts at control and margins are fairly tight, the rational and normal response is to increase prices. This is not possible in aged care. The ability to do this was taken away from providers in 1997. Now, if a resident is assessed as having the means to pay, the higher fee is offset by a reduction in government funding: the resident gets nothing for the higher fee they pay and neither does the provider. The sole beneficiary is the public purse. The only ways for providers to meet increased costs is to cut harder (be constantly on the look out for better deals, use cheaper sources) and/or increase government funding through even more rigorous ACFI claiming and admissions practices.
- Viability considerations force providers to often make admission decisions based more on how much money the potential resident will bring the facility from a combination of personal finances and government subsidy than on urgent personal needs. This means that there is a group of frail elderly people in the community who are deemed eligible for and in need of care but who will languish in their home until they deteriorate to the point where the assessed level

of government subsidy makes their admission to residential care worthwhile for the provider. This extended delay may be tolerable if the necessary community supports are in place but, in our experience, this is not necessarily the case. All our community services have a waiting list as does the local Council-operated HACC services.

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