SUBMISSION TO THE PRODUCTIVITY COMMISSION ON AGED CARE

"GETTING THE RIGHT CARE FROM OUR SYSTEM WHEN AND WHERE IT IS NEEDED"

BACKGROUND TO KELLOCK LODGE

Kellock Lodge is a Not-for-Profit organisation, built on land donated to the Anglican Church - Diocese of Wangaratta, but built with funds raised from the community and Shire of Alexandra, supported by Commonwealth Government Grants in 1983, 1990, 1995 and 2008. The PROVIDER is the "Trustees of the Anglican Diocese of Wangaratta".

Kellock Lodge commenced with 29 beds in 1984 and now has 39 Beds, 2 of which are Respite Beds and 17 are "Ageing in Place" – Classification 9c under the Building Code of Australia. The remaining 22 Beds are from 15 to 25 years old, of which 12 beds are in need of urgent refurbishment. We have also built 7 Independent Living Units (self-funded) in 2008/2009, all of which are occupied. We have a waiting list of approximately 14 and an occupancy rate of 97.5 %. Kellock Lodge has spent over $1 million on self funded improvements (Fire Sprinklers, a new kitchen, new laundry, air-conditioning for residents rooms, storage space) over the past 7 years, in addition to the $2.4 Million contribution to the 2008 Class 9c extension and conversion (partly raised from the community and philanthropic Trusts).

AGED CARE IN THE DISTRICT

The Murrindindi Shire has three Aged Care facilities in Alexandra & Yea (which are 20 Minutes apart):

- Kellock Lodge in Alexandra - Commonwealth Licensed and Funded 39 Beds
- Darlingford and Upper Goulburn Nursing Home in Eildon 51 Beds
  (former Hospital - affiliated with DHS - Victoria, but receiving Commonwealth Funding) - All High Care Beds.
- Yea Hospital (annexed) 11 Beds
- Kinglake – Part of Murrindindi Shire which is serviced by Whittlesea within another Shire.

The Population of the area served by the two Alexandra & Eildon facilities is about 11,000 people in the Eastern section of Murrindindi Shire comprising Alexandra, Eildon, Thornton, Yarck, Taggerty, Buxton, Marysville and Narbethong.

FACTORS AFFECTING THE AREA

This entire region has been drastically affected by the Black Saturday Bushfires of 2009. An important component of the area was the 2500 Hospitality beds in Marysville, which have effectively disappeared. Marysville/Narbethong/Buxton has been most impacted by the loss of jobs and services, but Alexandra businesses (particularly food suppliers) have been hit hard by the loss of business. Until one or more large Conference Centre/Guesthouses are commenced, this area will remain seriously depressed.

RETIREES FROM MELBOURNE & THEIR IMPACT ON HEALTH SERVICES & AGED CARE

Marysville was a centre for retirees or weekenders from Melbourne, but the whole area has such a focus. Alexandra is only just over an hour, by car, from Lilydale in Melbourne`s eastern

suburbs. For some years, but at an accelerating pace, retired people in Melbourne have recognized that they can sell their Melbourne home and buy a "Life Style" property near Alexandra, Taggerty or Buxton or a comfortable home in Alexandra at half the price they received in Melbourne. A look at the Golf Club, the Bowling Club, and the Rotary Club memberships clearly shows this trend.

The area has always been an ageing one, because the lack of Tertiary education and employment opportunities sends the young people, emerging from Secondary College, off to Melbourne for those opportunities.

Alexandra has a new Acute Hospital being built and the existing Hospital is already attracting a good range of Medical Specialists and has a good Operating Theatre.

The Aged Care Facilities therefore must plan for an increasing demand for Aged Care Residents.

THE FUTURE OF KELLOCK LODGE

The Lodge Master Plan recognises the problem of distance to be traveled for residents, nurses & Staff on a single level site. The difficulties and costs involved in an additional storey have been examined and excluded. Therefore, Kellock Lodge is seen as growing to a maximum of around 52 in the Residential Aged Care block and perhaps 15 Independent Living Units. To cope with the ageing of the population in the District a satellite site may be necessary in time.

A very successful "Caring for the Future" Appeal to the Community and Philanthropic Trusts in 2008 raised $750,000 and with existing Reserves gives the immediate funding for the next stage of our expansion and upgrade of out-dated facilities.

THE DIFFICULTIES FACING SMALL (STAND ALONE), RURAL AGED CARE FACILITIES

There are often quoted minimum levels of residents (beds) at which a small rural, stand alone, aged care facility can be viable. These range from 80 Beds to 120 Beds.

Not for Profit, stand alone (not associated with a Hospital or other local organization) rural facilities face many difficulties, including:

Transport

- Alexandra is at least 70kms from any larger center of population, in any direction (Melbourne's outskirts 110kms, Healesville 70kms, Seymour 80kms, Benalla 115kms, Shepparton 105kms)
- Transport to any of these is severely limited. There is a Vline Bus daily to Melbourne, via Healesville, but most days this would only give several hours at most in the city.
- There is a daily private bus service to Seymour, linking with the train to Melbourne, but again, limited time in the City.

A Case Study

In Alexandra, transport to Melbourne for medical appointments was available through the Red Cross, with volunteer drivers. Often inconvenient, because the driver might have three or four patients in the car, so multi locations meant a very early start and return well into the evening, with consequent stops for toilets and food.

BUT, even that inconvenient service has been taken away, apparently by Government decree, Aged Care Facilities are deemed to be well enough funded to supply a car and drivers for such

full day trips to Melbourne. Quite ridiculous if the financial situation of most rural facilities is examined.

A Personal Case Study

A resident in her 80's, a diagnosed epileptic all her life, needs to see a Specialist in a Melbourne Hospital several times a year. The Red Cross cannot take her; we do not have a car or a staff member free for a whole day for a trip to Melbourne. There is only one taxi in Alexandra which would be too expensive anyway. She cannot take the bus. Her only option is an equally aged sister, a pensioner living in Melbourne, who has to take three days to drive from Melbourne, take her sister to Melbourne for the appointment (a whole day) and then drive back to Melbourne, involving the commitment of at least two nights accommodation in Alexandra (with food, costing up to $300 + petrol).

Cost of Supplies & Services

- Freight services are private and expensive. Availability of servicing for mechanical, electrical or communication services, except for the most basic services has to come from Melbourne or occasionally from Shepparton. Such services are therefore erratic, unreliable, and often not available when needed as well as very expensive. There are small contractors available in Alexandra, but they know they are in charge, come when it suits them and charge accordingly.
- Processed food services from the only Supermarket in Alexandra are expensive because of the transport costs and most items are around 10% dearer than metropolitan competition. Bulk food suppliers, pharmacy needs (only one in Alexandra) and other needs are equally expensive for Residents and the Aged Care Facility.

Shopping for Clothes etc

We are faced with a similar story in regard to shopping for clothes. Alexandra's clothing shops do not allow for the over large and have a limited range. Residents do need clothes and Melbourne, or Shepparton, in many cases becomes their only resort. How to get there? -see above.

NEED FOR SPECIAL CONSIDERATION FOR SMALL RURAL FACILITIES

As mentioned above, there seems to be a view within Government that Aged Care is adequately funded and should be able to fund transport and other essential services.

The general view, supported by much evidence, within the Aged Care Industry is that funding is inadequate and as also mentioned above, certainly small rural facilities are not seen to be viable (unless supported by a Hospital or another large institution) unless Bed numbers exceed 80 and in some quarters 120 Beds.

While this facility does manage to hover around Operating Cost "Breakeven", through good management and a caring and supportive staff, we strongly urge that the above difficulties are recognised and the existing Viability Allowance be significantly increased for small rural facilities.

EXAMINATION OF THE ADVANTAGES OF HOME CARE PACKAGES COMPARED WITH RESIDENTIAL AGED CARE

The Kellock Lodge Alexandra Inc. Board has on several occasions urged the Government and Department of Health and Ageing to examine the comparative costs of the above.

It is the view of the Board that there is an ideological view that it is both cheaper and more popular to keep people in their own homes, rather than moving into Residential Aged Care. There probably is reluctance for older people to be institutionalised, but this is seen as sometimes a lack of knowledge and fear of the unknown. It is well known to this facility that older people being assessed will often give incorrect answers to questions, because of the instinctive fear of a nursing home. A period in respite will often overcome that fear and we have seen many cases of incredible improvement in people's condition after a period of Care.

We have considered applying for Home Care Packages, but there are not many available in our Region, except Low Care, which from our examination are not an economic proposition in small numbers.

It is our opinion that, ideologically, the Department views Home Care Packages as having an advantage over Residential Aged Care and that Residential Aged Care suffers from that view and is inadequately supported accordingly. We have separately commented on the inadequate level of support for small rural facilities.

To our knowledge, there are no available comparisons or studies of the cost of Home Care Packages and Residential Aged Care, which would support a view that Home Care Packages are more economical than Residential Aged Care. We have obtained some comparisons ourselves which suggest in fact that leaving Capital out of the equation, we can support and care for residents at a cheaper rate than those Packages of which we have become aware. For information, our full Operating Costs are $36,300 per Resident PA.

We contend that, for many aged people, a Residential Aged Care place is much better than the lonely, inadequately fed and cared for existence in their own single home. We would suggest therefore that it is time for a proper examination of this issue.

FUNDING DIFFICULTIES FOR RESIDENTIAL CARE

It is very different from the viewpoints of the grantors and the users of Aged Care Funding. The Departmental Staff who make recommendations to Government about Aged Care Funding may have other priorities and pressures to balance against their recommendations. There is a clear message from Government that Aged Care is adequately funded.

The CEO or Kitchen Supervisor or Care Supervisor or Board Member in an Aged Care facility knows that is not the case. When the Budget of most Aged Care facilities is prepared, the facility staff knows that even with the most stringent economies, extensions of shifts, night duty where only one staff member can be afforded, the best they can hope for is to break-even. This is so for organisations whether they are For-Profit or Not for Profit. We, as a Not for Profit, constantly count our blessings that we do not have to produce a Dividend for Shareholders, but that Capital profits we can achieve can be accumulated for refurbishment, the constant battle to keep up-to-date with changing standards as well as changing views and needs of residents. If we cannot attract residents, we cannot survive.

Does Government and its Departmental staff realise what a strangle hold they have on the finances of Aged Care organizations? Of course they do and work to keep it there.

INCOME

The only sources of income for an Aged Care establishment, particularly in a small rural town, are:

- Daily Care Fees - The fee it can charge its residents. Controlled by Government. Centrelink tells the facility what fee to charge (based of course to a degree on the resident's financial situation) For Pensioners with no, or limited, other assets a maximum proportion of their pension. For others there are established (by Government) room rates. The only flexibility for facilities is the Resident who does not wish to disclose their Assets and accordingly pay the maximum rate. An essential need is to maintain occupancy at maximum, which is not always feasible.
- Care Subsidies - Controlled by Government. The AGED CARE FUNDING INSTRUMENT or for some institutions subject the "GRAND-PARENTING" the earlier RCS. This very recent process (ACFI) is subject to very detailed documentation of each and every approved activity carried out for the resident. If the Facility is not skilled enough or its staff is not sufficiently trained then income is lost. This will be detailed elsewhere.
- Other Subsidies - Concessional Ratio supplement (See separate section)
  -Respite
  -Pension Supplement
  -Transitional Supplement
  -Viability Funding This pitifully small supplement is also referred to under the Section on small rural establishments and does not reflect the problem faced.
- Local Fundraising - An essential need, particularly for small rural facilities, and the only source not controlled by Government. Church Opportunity Shops, Annual Appeals to the local community are sources.

OPERATING EXPENDITURE

The largest component of Expenditure is Wages and Salaries and its associated allowances (Workers Compensation, Superannuation, Long Service Leave etc).
Apart from Staffing Levels, this cost is largely outside the control of small institutions. The recent Enterprise Bargaining Agreement showed this dramatically. The large commercial, Church and Charity organisations capitulated to the Unions, leaving small organizations (like us) with no options, but to agree. Staffing levels are also dictated by Accreditation demands and for organisations such as ourselves, where we are proud of our Care standards, by maintaining those standards. See Separate section on the ANF push for Resident/Staff Ratios, which if achieved would destroy organisations like ourselves.

Other expenditure which represents only 20 % of our Operating expenditure is within our control, except Depreciation. Food, insurance, utilities, medical costs are the largest components and again are largely dictated by our need to maintain standards.

GOVERNMENT CARE SUBSIDIES

Imagine our consternation therefore when we read the Government's announcement of a **1.7 % increase for this financial year.** Compare this with the EBA result of 14% over 3 years and the general inflation level in the economy. **WHY? - A further constriction on Residential Aged Care.**

This seems to confirm that there is a Departmental or Government view that Aged Care is adequately funded, a TOTALLY misguided view to people on the ground.

BROADER ISSUES

Concessional Resident Ratios

In rural communities, where Government services are minimal compared with Metropolitan areas, concessional resident ratios are impossible to achieve. In the Murrundindi Shire there is very little public or rental housing. People who move to the area do so for lifestyle reasons and

purchase their own homes. A lot of people receiving the full aged pension have a house as their only asset, and this asset is always valued over $94,000.00. Real Estate values are also low compared with Metropolitan areas, so this has the double impact of lower than average concessional ratios, and lower bonds.
Concessional resident ratios of around 25-30% are more sustainable in rural areas. The other option is to increase the supported resident cut off to $150,000.00. This would make bonds more in line with accommodation charges and change the concessional ratio.

ACFI FUNDING

The weighted average scores for ACFI funding have a negative impact on providing the best possible care for residents. For example:

- In the ADL area, there is no incentive to improve residents mobility and dexterity, and continence when there is such a big jump from low (18 points) to medium classification (62 points). ADL's are the core business of low to medium care facilities, and it is very difficult to receive sufficient funding to meet the care needs of these residents.
- In the behaviours domain, complex behaviours are often not appropriately assessed by staff with minimal training. Difficult, repetitive behaviours are extremely time consuming, but poorly funded. Skilled staff is needed to assess behaviours and provide appropriate interventions.
- The complex health care domain has a number of problems;
  - Some of the objectives do not promote 'best practice' e.g. use of suppositories in bowel management.
  - Complex care must be managed/ordered by an Allied Health professional or Registered Nurse, staff which may be very difficult to access in rural areas.

STAFFING/MEDICAL SERVICES

Medical Services

Medical services are equally limited. The well documented shortage of Doctors and Nurses in Rural areas is known. General Practitioners are overworked, there are only 3 Clinics in the subject area, with a total 5/6 full time Doctors. It is exceedingly difficult to get them to visit their patients in Aged Care facilities, resulting in families (if available) having to take them to Doctors Clinics.

In many cases there are no families available, resulting in an obligation being placed on Aged Care staff, already overworked, to get them to Clinics.
Current funding mechanisms of the Federal Government reward Aged Care facilities only for certain documented activities. Replacing families for shopping or Medical appointments are not included in such activities. The limited staffing thus possible does not permit such activities, so the resident suffers.

Volunteers, where available, do help, but are not often available.

The only good story in Alexandra is a good Acute Hospital, which attracts a small range of Specialists for consultations and with a good Operating Theatre allows a limited range of operations in Alexandra, saving trips to Melbourne.

Allied Health Care - this is another problem. Podiatrists, Ophthalmologists etc. visit semi remote areas like Alexandra and some will come to the Hostel, but not always and not when needed.

Trained Nursing Staff

Finding sufficient trained staff, particularly nursing staff (in our area there are three aged care facilities and an acute 30 bed Hospital, competing for Nurses and Personal Care Workers). The area has a population of some 11,000.

Other issues impact on staffing and include;

- Lack of training institutions i.e. Universities and TAFE Colleges.
- Distances to travel to obtain suitable education.
- Staff staying in the same job for very long periods, with no access to new trends and ideas.
- Long term staff members who do not upgrade their skills as the industry, philosophy of care and regulations change. This blocks access to more appropriately trained staff that may be available.
- Lack of access to appropriate external education opportunities due to cost, back filling and distance to travel. Travel and overnight accommodation significantly increase costs.
- Competition with other institutions for the same skilled staff, but inability to meet remuneration levels paid in other sectors.
- Allied Health staff is also in very high demand in rural areas for all the above reasons.

<u>THE AUSTRALIAN NURSES FEDERATION RESIDENT TO NURSE RATIOS</u>

It is well known that the ANF is conducting a campaign to extend resident/nurse ratios beyond the present Hospital linked facilities. Those facilities are struggling to cope with the enormous financial burden imposed by these ratios. Our staffing costs are already 80% of our operating expenditure. A move to place further burden on organisations like ours would mean financial collapse, removing the only aged care facility in a small country town.

Recommendations

- Review Viability Supplement for small rural towns.
- Urgent review of the 1.7% increase for 2010/11.
- Review Concessional Resident Ratios and the cut off point for supported residents.
- Review the weighted scores for ACFI domains.
- Examine cost benefits of Residential versus Home Care Packages.
- Review remuneration for Doctors and trained Nursing staff.
- Examine the cost/need of resident/staff ratios.

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Susanne Sawyer
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