LUCAN CARE

THE AGED CARE ACT

August 1998

Dear Reader,

This paper does not set out to highlight the many detailed matters that are still a problem to us regarding the New Aged Care Act. In fact the paper deliberately seeks to avoid the detail, so has to more clearly set out the "Big Ticket" items that need attention before the detail is addressed.

It would seem to me that a wonderful concept of dramatically improving the overall quality of care for our aged community has gone badly astray in the structure and detail.

The reason why this has failed I suspect, is because of the way that issues were addressed. The setting up of all those wonderful sub committees of "experts" to cover specific aspects of the Bill , without understanding the interaction of the various components and addressing the "Big Picture" has undoubtedly been the main cause.

Seeing every tree but nair the forest; although I would also suggest that they didn't see all the trees either!!

The Act as it currently stands is not the sort of document that is going to lead to improved quality of Aged Care. I would submit that it is more likely, without change, to reduce Care Quality.

Stan R. Beevor
(Chief Executive)

Central Administration: 1 Wetherill Street Leichhardt Phone: (02) 9560 2211 Fax: (02) 9560 0173
PO Box 89 Leichhardt NSW 2040 Email: lucan@one.net.au

A Service Division of Leichhardt-Stanmore Uniting Church Parish Mission

THE AGED CARE ACT

(1) THE INSTRUMENT:
(The Battleground for Recurrent funding)

The Quality of care that is provided to the Aged Community living in residential care is essentially geared to the dollars that are allocated by Government, at least that is so for the “Not for Profit” sector of the Industry. Reduce the recurrent funding dollars and one will see the Quality of Care reduce in our facilities.

It would be unwise of Government to listen and heed those who might be thinking that one can both improve the quality of personal care and the environment in which the care is provided, whilst reducing funding of both or either capital or recurrent funding.

If we have to reduce the Quality of Care that we can provide to our residents as a result of the lack of Government funding, I'm certain that the community at large will react as strongly as they did over the accommodation bond.

The concept of Ageing in place seems to be creaking at the seams as the Government continues to break apart its own concept as they now talk more and more in the old terminology, of Nursing Homes and Hostels. Certainly no one appears to be addressing the Industrial issues relating to the Ageing in place concept.

A couple of Macro Issues that need to be addressed:

1 must start by stating the obvious, which so often gets overlooked:

To produce Quality Residential Care for the Aged community and to sustain a program of continual improvements in Care which is what the Politicians, Bureaucrats and others expouse, requires 2 streams of financial support.

Stream A.
Capital funding to provide the right environment in which to offer the Care.
(The bricks and mortar plus fixtures and fittings)
AND

Stream B:
Recurrent funding to provide the appropriate quality of daily personal care for each resident.
(The well trained, up to date, experienced workforce, dedicated to providing quality care)

Whilst the two financial streams are reasonably easy to identify and understand, what is not so easy to understand , is the impact that the two streams have on each other.

We might just look at another two streams of thought, key objectives, both sound in there own right, but dangerous if considered in isolation.

The New Aged Care Act was and is undoubtedly “financially driven” by the Federal Government's Treasury Department to reduce costs of Aged Care, both in terms of per resident cost and in terms of costs to the community via "User Pay"

The Health Department through the new Aged Care Act is strongly pushing the concept of continual improvements to the Quality Care of the Aged
Most people would fully support the two objectives mentioned, however it must be recognised that the 2 objectives are basically at "odds" with each other.

We can save lots of money in Aged Care, by simply not providing ANY care!!!!!
We can dramatically improve the Quality of Aged Care but this would mean massive injections of dollars.

The real key to success lies in balancing the various issues so as to OPTIMISE the TOTAL system rather than maximising any one segment of the system to the detriment of the total.

Business normally invests capital to REDUCE operating costs. In the Care Industry one invests capital to improve the environment in which one provides care. this means moving residents further apart and hence INCREASING operating costs!!!
As new Ageing in place facilities are built, operating costs per resident increase.
New facilities take us from the 4 to 10 bed wards which are operationally cost efficient; to the 1 to 2 bed wards which certainly provide a much improved environment for care but are more expensive to run.
Utility costs per resident, together with cleaning and maintenance costs, increase by approx. 30% in single bed wards, with the cost of personal care also increasing by approx, 15%.
Why would a provider invest capital in a High Care single/double ward facility which will cost more to run, yet receive the same accommodation charge fee and recurrent funding as for the 10 bed ward?? It simply does not make sense!!! There is a need to rethink the funding arrangements in order to provide real incentives to improve the environment in which we provide care for our elderly.

Take for example Electricity costs in new and older type facilities:
LUCAN CARE -- Electricity costs 1996/T

Aldersgate House (100)bed	= $444 per resident per annum.*
Audrey Hawkins (56)bed	= $261 “ “ “ “
Thomas Roseby (40)bed	= $610 “ “ “ “
Harold Hawkins (72)bed	= $312 “ “ “ “

The facilities with the * are less than 5 years old. It can be seen from the above that power costs increase considerably as we improve privacy and dignity for our residents.

New facilities provide an enriched quality of environment care but are more costly to operate. Walking for example is a significant cost factor and as we increase the living distance between residents we increase the cost of providing personal day to day care.

The older style Multi ward facilities can be said to be operationally efficient when compared with newer single or double ward facilities, but do not provide the privacy or the appropriate environment for the aged.

If we are to pursue excellence in Aged Care in real terms, rather than simply talk about it, we have to look at the 2 streams of financial support together.

Recurrent funding is the Gateway to the provision of personal care. We need to recognise that the basic structure of a new instrument must be set against a particular environment and incentives provided to improve the environment. (We therefore will need more than one recurrent fee structure to be successful)

STICKY COSTS:
Care costs like most other costs in service type industries are "sticky" in the short term. An organisation cannot reduce labour costs quickly if it suddenly loses a number of category 1 residents and receives as replacements category 4 residents. Many of the costs are indeed fixed costs.
We need to operate with a system that recognises the employment market that we work in and the award systems that we have to work under. The alternative is that we will be forced to discriminate/be selective on the basis of financial need to survive when choosing our residents, rather than be Care Need driven.

Cost Increases: The instrument must be geared to labour award increases. Quality of Care will suffer if long delays occur between award increases being brought down and the instrument scales being adjusted . The instrument must therefore be subject to regular review based to actual cost increases, whether these be award variations or costs that are Quality improvement issues that Governments have Legislated to occur. The Health and other Government Departments must be made accountable for costs that they impose on the Industry.

The Instrument:
As clearly shown thus far in this paper, the Instrument is flawed, in that it does not take into consideration the environment in which the care is provided.

It is further submitted that the Instrument is flawed in its variation of funding per classification when one converts the dollars to real time hours of care. Also there are a number of inconsistencies within the framework of the instrument. Clearly it does not encourage us to improve/reduce the classification of residents and clearly it does not recognise the importance of pastoral and chit/chat care!!!!!!???? Concessional residents are generally not only financially disadvantaged but are also socially disadvantaged, having few if any relatives or friends that visit. Someone has to make up for this loss if quality of care is to mean anything!!!

The Instrument is the means through which one validates the care level required by each resident and is also the tool which enables the care provider to obtain recurrent funding. It is essentially the "BATTLEGROUND" whereby the provider and the Department each with allegedly the same "care motives" and concerns for "Mary JanJ the resident; often have very different views over care needs. One of the real problems is the interpretation of the various words contained in the instrument and the inconsistency between those who undertake the checks. 1 would ask the question as to why it is necessary to establish a set of documents covering the assessment of each resident for recurrent funding purposes?? particularly when such documents are so wide open to interpretation and simply become the "Battle Ground". The cost of setting up and maintaining the system for both parties is high and whilst the documents purport to be all about the Care of the resident they often bear no real relationship to the actual Care provided.

WHY BUILD INTO A CARE PROCEDURE A SYSTEM OF REGULAR CONFLICT BETWEEN PROVIDERS OF CARE AND THE DEPARTMENT!??

WE SHOULD BE ESTABLISHING PROGRAMS OF COOPERATION BEWEEN PROVIDERS AND THE DEPARTMENT THAT FOCUS ON CARE QUALITY IMPROVEMENTS NOT CONFRONTATION!!!!!

Whilst perhaps there is not a way of totally avoiding conflict it would be dramatically reduced if the funding system was based on Averages and where a facility considers itself to be well above the average in terms of care levels, it could appeal through a review process for additional funding. Aged care providers could then focus their linkages with the Health Department on CARE rather than financial issues.!!!

We need a simple recurrent instrument that sets out High Care rates based to the environment in which the Care is to be provided e.g. maybe : 1bed, then 2 up to 4bed and then 5 up to 10bed wards for High Care.(The assumption being that all Low Care facilities are single room).

Other Issues re the Instrument:

Lucan Care as an organisation, seeks to obtain the appropriate funding for the Care that we provide. We do not seek to obtain funding that we are not entitled to.

(1) If the new Instrument is to be retained in its present conflict and cumbersome form, we need to have the thought processes of the validators geared to care needs and not focused on an Audit/police type role.

(2) We have concerns that Providers of Aged Care are becoming De Facto Tax Collectors for the Government. Whilst a variable fee for accommodation is reasonably easy to explain to residents because of the variable nature of accommodation

provided, variable fees being paid for the same level of Care is causing problems between residents and between residents and staff. Those who are paying more, believe that they are entitled to more care than others, this situation again impacts adversely on Care Quality.

(3) ln circumstances where the Department lowers the care status of a Resident it must accept the responsibility for that resident should a matter of care, or lack of it, be disputed by the resident or others on behalf of the resident.

CONCLUSIONS Re: the Care Instrument. (note attachment "a")

IT:

(a) Is not NECESSARY in its present form.
(b) Will result in the Quality of Care being REDUCED
(c) Will result in ongoing CONFLICT between Providers and the Health Department.
(d) Will RETARD the development of New High Care Facilities.
(e) Penalises those who innovate and improve efficiency e.g Webster packs is a classic example of this.
(f) Simply does not do the job that it is designed to do.

SOLUTIONS:

(i) Create an Instrument that is based on the average mix of residents in a facility, accepting that High care facilities will need a structure, based on the number of beds per Ward.(review the mix on say a 12 monthly basis)

(ii) Provide an appeals mechanism for those facilities who consider that they are well above the average set.
(iii) Provide a structure of recurrent funding based to average costs in various areas of Australia. The cost structure to embrace the environment in which the care is being provided as well as the real time costs of the care.
(iv) Re act quickly and positively to changes in Providers cost increases that are imposed either through Awards or Government Departments.

(v) Use the newly created Link Department to undertake all residents financial assessments necessary and collect fees through the Tax Department.

The above solutions would enable the skills of all parties to be more effectively used .In particular we would minimise the conflict situations that the act introduces both between the Department and Providers but also between Residents. Most importantly the solutions would enable all parties to better focus on

"The Care of the Elderly"

CERTIFICATION/ACCREDITATION PROGRAM

Whilst no one doubts the good intents of the Accreditation program, for Lucan Care to achieve certification for all of its facilities in the next round is going to be a real problem - We provide excellent quality personal Care for some 500 residents in 7 locations in a mixture of very good, reasonable and poor buildings.

We have achieved certification for all of our facilities but know from a detailed analysis of the results that we have at least 56 of our High Care residents and 146 of our Low Care residents in facilities that require replacing; a total of 202 residents. The buildings in question are designed in a manner, which indicates that upgrading is not an option.

The buildings have to be either gutted and rebuilt or we must build elsewhere.

The capital cost of building Ageing in place facilities which are of reasonable standard in or around the City of Sydney lies somewhere between $80,000 and $140,000 per resident(let us use $100,000 as the most likely figure) plus the cost of land which is approx $50,000 per resident in the inner west of Sydney.

LUCAN CARE will require therefore around $30 million dollars to meet the standards required under the new Act within a relatively short period of time .

Now it is not being said that the intent of the Act is wrong, but what is being said is that the time dimension set to address the problems of several decades, is simply not achievable. It is submitted that it is not possible in the physical or financial sense to undertake and complete the work on the scale that LUCAN CARE needs in the 3 to 5 year period set.

Furthermore it must be recognised that organisations like LUCAN CARE do not have access to the sort of capital that is needed. We have a concessional resident level of approx 80% and would certainly have problems borrowing capital with the current Government funding levels.

On the basis of receiving the maximum government Capital funding of $4380 per annum for each of the 202 residents requiring new facilities, this would only provide us with $884,760 per annum!!!
So it can be seen that a real problem exists!!!

The issue of Capital funding must be urgently revisited, together with the linkages between capital investment in a new facility, the recurrent funding and the time dimension for accreditation.

It really isn't a simple question of comparing, the for profit sector and the not for profit sector results in financial terms. It must be recognised that we are basically operating in two different Aged Care Markets - the "Haves" and the "Have Nots" our primary focus is the "Have Nots"

LUCAN CARE is but one example of the problem that confronts the Aged Care Industry as a whole.

One other matter which is and will continue to cause building delays over the next 2 years or so are the Games in Sydney in the year 2000.Not only is there currently a shortage of tradesmen, but costs are escalating, as market resources become scarcer.

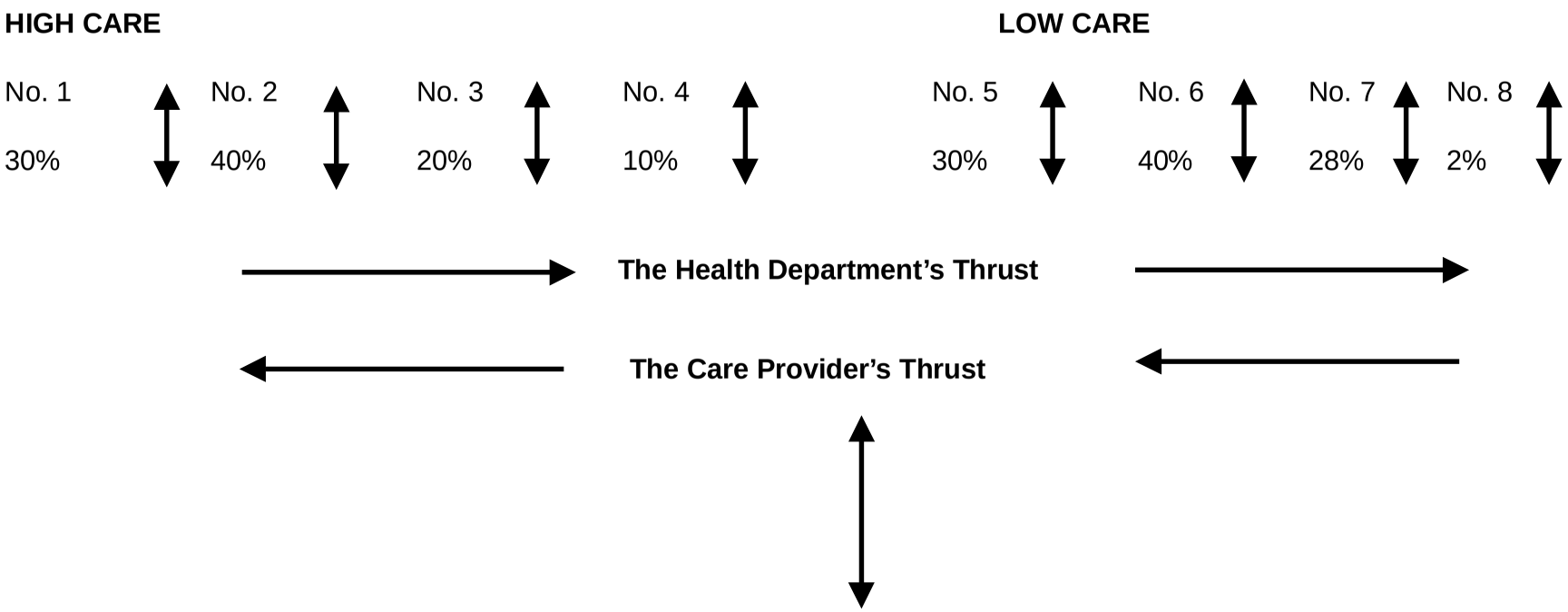
There is an urgent need to review the time dimension currently set for accreditation. It must be based on the "real world" that requires a sensible program of capital injection and the ability of our industry to design, develop and build the desired new Ageing in Place facilities.

Finally it must be recognised that new facilities are going to cost more to run and keep running. recurrent funding must reflect this factor.

Stan R Beevor

Chief Executive
(Lucan Care)

THE INSTRUMENT



Denotes Battle Ground

CurrentIV

- No incentive for Care providers to improve quality of care environment.
- No incentive for Care providers to improve the resident's health.
- Major incentive for Care providers to remove dignity from residents to improve classification.

Conclusion:

1. Do not see why a resident has to be classified in this manner!
2. Why not average - the Act covers who will go into Aged Care facility.
3. Care Plans geared to personal care rather than financial care if an average approach is used.