We have outlined below the other changes to the aged care system that would assist Menarock Life to provide higher quality services with would provide greater safety to Australians residing in aged care home. We have broken this up into sections under various key headings.

1. **Funding**
2. **Dementia Supplement**

In August 2013, the Government introduced the Dementia Supplement to aged care providers for the purpose of enabling the aged care provider to dedicate more resources to assisting residents living with dementia with severe behaviours.

With effect from 1 August 2014 (through an announcement made by the Government on 27 June 2014) the Dementia Supplement was removed. This has had a significant impact of aged care providers from a funding perspective and has significantly impacted resources deployed for residents living with dementia. There is growing demand for specific specialised dementia care for care recipients.

***We request that the Commission recommends to the Government that the Dementia Supplement (or an appropriate replacement) be reinstated to enable more resources to be dedicated to residents living with Dementia.***

1. **Payroll Tax Supplement**

The Government previously provided the “for profit” aged care providers a Payroll Tax Supplement (PTS). The basis of this was to even the playing field between “for profit” and “not for profit” operators wherein the “not for profit” providers do not pay payroll tax for the employment of their employees. The existence of the PTS for “for profit” providers enabled an even playing field amongst all providers in the recruitment of appropriately qualified nurses to call for residents in the aged care environment.

However, with effect 1st January 2015, the Government removed the PTS from “for profit” operators thus creating an uneven playing field for the recruitment of appropriately qualified nurses to provide care for the elderly in an aged care home. This has made it challenging for “for profit” providers to recruit appropriate qualified nurses to provide care for residents in aged care facilities.

***We request that the Commission recommends to the Government that the PTS be reinstated to even the playing field between all providers thus enabling more appropriately qualified nurses to be recruited to the “for profit” providers.***

1. **Fringe Benefits Tax (FBT) Concessions**

Similar to the point raised above in relation to the PTS, “not for profit” providers are able to provide attractive fringe benefits to their employees on the basis that they do not pay FBT. Contrasting this to “for profit” providers who must pay FBT on fringe benefits provided to employees, once again this creates an uneven playing field between providers in the aged care environment.

In our experience we have either not been able to recruit the best qualified nurses or been able to retain the best quality nurses as they are drawn to the “not for profit” sector where they are able to be provided with attractive FBT concessions.

If the “for profit” sector was able to provide similar FBT concessions to staff, we would have a greater ability to recruit and retain higher quality care staff to provide care for our residents and provide a safer living environment for them to live.

***We request that the Commission recommends to the Government that the FBT concessions either be extended to “for profit” providers or alternatively, the generous FBT concessions be removed for the “not for profit” sector.***

1. **Freezing Indexation**

The main revenue source for aged care providers is the ACFI funding regime. Under the ACFI funding regime, the level of Government funding available to aged care providers, varies according to the needs of the resident. In broad principles, the higher the resident care needs, the higher level of ACFI funding is available.

To maintain the real value of ACFI funding for aged care providers, ACFI funding was indexed each year. However, for the 2018 financial year, indexation of ACFI was frozen and the 2019 financial year saw increases of only 1.4% across the Activities of Daily Living and Behaviours domains, and a mere 0.7% across the Complex Health Care domain, such that the real value of the ACFI funding to aged care providers is diminishing despite the increased costs of providing aged care.

***We request that the Commission recommends to the Government that the indexation of ACFI funding be reinstated.***

**(2) Quality**

***(a) Quality Audit Regime in place***

Currently each aged care provider needs to satisfy the 44 accreditation standards. In order for us as providers to satisfy these standards, we have implemented a quality audit regime wherein each of our home’s self-assess their performance against a number of the standards each month.

Should any of the audits result in less than 90% satisfaction, the shortcomings from that audit are placed on a Continuous Improvement (CI) form which is then actioned the following month and the audit is retested the following month.

To ensure that the homes provide an honest assessment when completing their quality audits, we have developed a culture of self reflection and honesty and a zero tolerance for falsifying audit results.

The adoption of this Quality Audit approach has allowed us to ensure the highest level of quality care for our residents. We would recommend that the current 44 accreditation standards be maintained and that the Department develop and issue a Quality Audit regime that can be adopted by aged care providers. This would allow consistency in the measurement of the delivery of quality care and services within residential aged care and ensure a greater level of reassurance for residents within aged care.

***We request that the Commission recommends to the Government that the 44 accreditation standards be retained and that the Government introduce a quality audit regime that can be used by all aged care operators to provide high quality care for the safety and reassurance of all aged care recipients.***

**(3) Bed Allocation Process**

Each year the Government announces the ACAR round which is the allocation of new bed licences to aged care providers which enables the aged care providers to expand existing facilities (brownfield developments) or create new facilities (greenfield developments).

We have applied for bed licences in the past 3 ACAR rounds as shown in the table below. However, we have been relatively unsuccessful in the allocation rounds as evidenced by the table below.

|  |  |  |
| --- | --- | --- |
| Year | Beds Applied For | Beds Allocated |
| 2018-19 | 64 The Gardens 90 Alexandra 30 Sherbrooke 32 Heathmont 40 Shepparton | Results not yet available |
| 2016-17 | 64 The Gardens 90 Pakenham 15 Croydon 90 Alexandra | 0 90 0 0 |
| 2015-16 | Pakenham 90 Alexandra 90 | 0 0 |

However, each year we have seen an increasing number of bed licence allocations being allocated to developers (who are registered aged care operators) who develop the facilities and then sell them for substantial profits. As you will see through the last couple of years of ACAR bed allocations, a number of these successful applicants are developers rather than operators. In our view, it is clearly preferable to allocate bed licences to aged care providers who both operate and run aged care facilities.

***We request that the Commission recommends to the Government that the ACAR bed allocation process required the aged care provider to build and hold the newly constructed facility for a minimum of 2 years post completion.***

**(4) Home Care**

There has been a deliberate policy intent by the Government to allow older Australians the ability to choose to stay in their home or transition to an aged care facility. This shift has resulted in the profile of our residents entering aged care changing over the past 18 months.

What has changed is that the average age of the resident entering an aged care facility has increased, their acuity levels being higher and their length of tenure at the aged care facility getting shorter.

Whilst the shift to remain in the home should be seen as a positive, it is also coming with high risk for the elderly. We are seeing a continuing trend of high care needs residents remain in their home for periods longer than they should and by the time they come into an aged care facility, they are often frailer, underweight and suffering from more complicated co-morbidities and in need of urgent clinical care. All too often the primary carer or family members have not made the decisive action to transition the elderly family member to residential aged care.

We fully support the adoption of Home Care packages for low and medium care residents but have a growing concern for high care residents remaining in their homes for too long a period. This is particularly the case for residents living with dementia who are at potential serious risk by remining at home when they are not under 24/7 care.

With this in mind and to be able to provide a safer environment for the elderly especially those with dementia and those with a disability, we fully support home care packages for low and medium care elderly people, however we need a better system in place to deal with high care residents residing at their home.

1. **Staff / Workforce**

A key component of the provision of aged care in the residential setting is the provision of appropriately qualified staff to look after the care needs of the residents. This has been addressed in part in the above sections.

Wages cost (with on costs) run at approximately 70% of revenue. This is an extraordinarily high wages percentage especially when compared to other service type industries.

Accordingly, aged care providers need to run a roster that balances the care needs of the resident with maintaining a facility that is sustainable. Wages costs plus other on costs are increasing however the rate of increase in Government funding in not keeping pace with the increased wages costs. Margins are being squeezed resulting in some (mostly smaller) operators cutting costs to remain viable.

Based on recent data [Source 2018 Aged Care Financial Performance Survey Sector Report found. (<https://www.australianageingagenda.com.au/2018/10/16/45-per-cent-of-facilities-making-a-loss/> ), approximately 45% of age care facilities are running at a loss. This is clearly not sustainable and puts at risk the safety and wellbeing of the elderly residents. There is no other industry wherein 45% of the industry participants are losing money. This needs to be rectified urgently.

There have been a lot of articles written about introducing staff ratios to aged care. This introduction of staff / resident ratios will potentially give rise to safety issues for residents as providers will be more focused on the staff ratios rather then ensuring they have the right qualified staff for the identified needs of the resident’s care needs. Fixed staff resident ratios have been introduced into some parts of the hospital system but overall this model is flawed.

Rather then the introduction of staff / resident ratios, the focus should be around ensuring the right qualified staff are appointed to the roster to support the identified needs of the residents. At our aged care facilities, we roster Registered Nurses (RNs) 24/7 in each of our facilities. The purpose of this is to ensure we provide the highest level of clinical governance across our aged care facilities for the safety and security of our residents. This is not common practice amongst all aged care providers.

We also review our roster to identify the key clinical areas for our residents over a 24-hour period, such as increased staffing in the afternoon to support those residents with challenging behaviours associated with Dementia. By dictating ratios, it shall decrease the flexibility of allowing each facility to support identified needs of their residents, decreasing resident satisfaction and increasing clinical risk.

Because of the problems highlighted earlier (such as the removal of the dementia supplement, removal of the PTS, inability to apply FBT concessions and the freezing of indexation to ACFI), we are not always able to attract appropriately qualified nursing staff to residential aged care. Further to this there are insufficient people who want to work in the aged care industry. As such we do rely heavily of 457 visa recipients.

Since commencing in the aged care industry over 10 years ago, we have been in continual dialogue with the ANMF and / or HACSU to negotiate the terms of a new Enterprise Bargaining Agreement (EBA). These negotiations are generally long drawn our processes which adversely impact the operating environment within the aged care facility.

Whilst respecting the Unions Rights to negotiate on behalf of their members, at times some of the requests, if accepted and implemented, significantly add to the cost of providing care to the elderly and can impact the safety of the residents.

1. **Complaints mechanism and Agency role**

Currently there is a Complaints mechanism process in place where, if dissatisfied with the care the resident is receiving, the family member can lodge a complaint with the Aged Care Complaints Commissioner.

We believe this Commission is working effectively and allows all parties to provide their point. We would strongly recommend that the Aged Care Complaints Commission be continued.

In addition, the Aged Care Quality Agency, which has the mandate to undertake announced or unannounced visits on aged care facilities, has over the past few years undertaken numerous audits on our portfolio of facilities. We have found these reviews to be thorough and effective in the role the quality agency plays. We would strongly endorse that the use of the Agency and the process upon which it undertakes announced and unannounced visits continues.

1. **Innovation**

Innovation is central to any organisation to ensure it continues to grow and prosper. Unfortunately given the margin pressure experiences by many aged care providers, there is a lack of innovation within the aged care sector.

Should there be greater innovation within the sector, the lives of the residents residing in an aged care facility will be significantly enhanced thus providing greater quality care in a safe environment. This will also be vitally important to those living with dementia and / or a disability.

We need to see increased Government funding to ensure that aged care providers can undertake an appropriate level of investment into innovation.

1. **Elder Abuse**

Elder abuse (whether by a family member or care provider) is abhorrent and should not be tolerated. Fortunately, the level of elder abuse is limited notwithstanding that the Royal Commission will hear of many stories where (unfortunately) some elderly residents have not been appropriately cared for.

To reduce the risks of elder abuse (within the residential care environment), more cameras can be placed in facilities. At our facilities we have camera in all main corridors and outside the building. For dignity and privacy reasons we cannot have cameras in a resident’s room where unfortunately a lot of the elder abuse could potentially take place.

We have undertaken a lot of training on elder abuse and mandatory reporting with our staff to educate them on how to identify if a resident is at risk or has been exposed to elder abuse, along with the correct procedures in reporting this within the facility and to the Department of Health. It is important that this mandatory annual education of staff in relation to elder abuse (including its reporting) needs to continue.

To protect the rights and dignity of residents from elder abuse, we continue to support a mandatory reporting regime where any staff member who witnesses elder abuse (whether by a carer or family member) continues to report this to an appropriate authority within the facility such as the Director of Nursing or Operations Manager to report to the Department of Health and police. Any staff member who is found guilty of elder abuse, should be subject to penalties which can extend to (but not be limited to) revocation of their nursing registration, reporting to police for possible criminal charges etc.