AUSTRALIAN NURSING HOMES
AND EXTENDED CARE ASSOCIATION LIMITED
ACN 053 998 860 **ABN 81 053 998 860**

Representing private enterprise, church, charity and community operators of quality residential care facilities

Mr Adam Cunningham
Inquiry Secretary
Standing Committee on Ageing
Parliament House
Canberra ACT 2600

Re: Joint Parliamentary Committee Into Ageing

The Australian Nursing Homes and Extended Care Association (ANHECA) is an industry association representing aged care providers across Australia. We would like to thank you for the opportunity of making a submission to the enquiry and look forward to viewing the results of the enquiries deliberations.

ANHECA would be prepared to provide any additional evidence the committee may require or appear to give oral evidence in answer to questions the committee may have about the submission.

Thank you for your attention to this matter.

Yours faithfully

Rod Young
Chief Executive Officer

20th December 2002

AUSTRALIAN NURSING HOMES AND EXTENDED CARE ASSOCIATION

SUBMISSION

TO

HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON AGEING

INQUIRY INTO LONG-TERM STRATEGIES TO ADDRESS THE AGEING OF THE AUSTRALIAN POPULATION OVER THE NEXT 40 YEARS

DECEMBER 2002

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INTRODUCTION

The Australian Nursing Homes and Extended Care Association (ANHECA) is a peak employer industry representative body with aged care provider members from across Australia. ANHECA represents providers from retirement villages, community service providers and residential care service providers.

ANHECA has as its mission:

The provision of a sustainable and quality aged care service system within a commercially viable framework.

ANHECA also has a primary objective the provision of advice to government regarding the long-term sustainability of care services for the elderly within the Australian economy.

AGED CARE DEFINED

1. There is need for a paradigm shift in relation to residential aged care

Old age in terms of age care needs, ought not to be negatively viewed from the 'illness' model or 'continuum of decline', but rather on the paradigm of **ageing as a positive life stage where various holistic interventions may be required, and where return to a better state of being is an achievable outcome as much as progressive decline is an acceptable course of events.**

Aged care is now accepted as a highly specialised and holistic area of care, and not the custodial end-of-life environment in the past.

2. A Continuum of Care indicates the need for Flexible Care Options

The existence of and degree of complexity of care needs increase significantly for an aged population. The types of care needs are variable and include not only management of the various acuity levels of the frail aged, but also variable health needs which may be of a short or medium term duration.

Current systems provide artificial divide between frail aged care (long-term care for chronic conditions) from sub-acute/post-acute care for the aged (short-term care for acute episodes). Agency interface problems arise.

A resourceful approach would be to integrate Health and Aged Care services for the aged population, as a Continuum of Care within a Flexible suite of care options.

THE CURRENT AGED CARE SYSTEM

System Access

Within the Australian social welfare setting there are currently approximately 24 programs providing care and services to the elderly within the Australian health and health related system. This proliferation of programs though laudable in their objective does create considerable confusion and difficulty of access for persons, particularly the elderly, endeavouring to find their way around a rather complicated system of Government and service programs.

There is a need therefore for the three levels of government charged with providing the various aged care services to cooperate in at least simplifying the entry arrangements for person looking for services. One solution to this entry point difficulty would be to have a coordinated advise service which would be able to advise prospective users of care or those requiring additional services of what is available, the current providers of those services and the appropriate method of accessing those services. An enhanced service for entry of this nature would be seen as an amalgam of client advocate as well as information service provider.

Currently access to age care service s is controlled by the Aged Care Assessment Teams (ACATs) with ACATs acting as gate keepers to the residential care system, and community age care packages. The Commonwealth funds ACATs to the extent of sixty per cent with States providing the balance of forty per cent. All of the ACATs programs are administered by State or State instrumentalities. Consequently the variability and consistency of decision making between and among ACAT teams is considerable. In addition there is considerable variability in time to respond for assessment as well as the primary decision making process.

There is an urgent need for the ACAT process to be reformed and made more relevant and more time responsive to both the clients looking for entry into age care service programs and the recipients of the decision making by the ACATs such as residential care service providers.

Residential Care

The residential care system is totally funded by the Commonwealth Government with a subsidy scheme, which lays down a highly regulated formula as to what residential care services can charge. There are approximately 146,000 approved places that are currently operational within the residential sector.

For nearly twenty years the Commonwealth has operated on a planning ratio of 100 aged care places per 1000 persons aged seventy years and older. During this period the acuity profile of residential care service users, the demographic profile and the usage of community care service has changed considerably. Currently, 63.8 per cent (AIHW2002) of all residents within residential care are classified in the high care category. Twenty-five per cent

of all residents in low care services are now classified as high care recipients. The Commonwealth planning ratio of 100 places per 1000 over seventy is split into 50 low care places, 40 high care places and 10 community care places. It is obvious that with 63.8 per cent of all recipients of residential care being classified as high care that the existing planning ratios of 50 low and 40 high care places no longer have any particular relevance.

There is an acute need for the current planning ratios to be reviewed and to particularly be put into the context of anticipated future needs in the first two decades of the 21st century.

The 1997 aged care reforms were meant to create a single residential care system. The previous difference between nursing homes and hostels were supposed to disappear. With nearly 25 per cent of all low care residents being classified as high care due to the policy of 'aging in place' this original intention of the 1997 reforms is partly being achieved though in a much less transparent and open fashion. There is a need for this reality to now be dealt with in an open and transparent fashion.

Another issue of major concern to residential services is the method in which cost escalation is recognised within the current COPO Indexation system. The Commonwealth totally funds and controls the income stream to residential care services by the imposition of the subsidy framework that all age care providers must apply. At the same time age care services live and operate within State based economic jurisdictions. One example is the variegated costs of workers compensation within the 8 State and Territory jurisdictions in Australia. The Commonwealth applies a single subsidy rate to all age care providers no matter that one state workers compensation tariff rate can be 7.6 per cent and another 3.6 per cent. At the same time there is no ability for the State with a higher cost to charge its residents more to defray the addition expense. Similarly, a State with a much higher pay structure simply has to live within the single subsidy rate no matter its capability or viability to sustain itself without an income stream that truly reflects the cost base.

COPO Indexation has, until quite recently, relied for the salary and wages component of its adjustment on the safety net adjustment. As 70 per cent, on average, of residential aged care costs is associated with the employment of labour the ability of residential age care providers to adjust their cost structure is restricted. If COPO Indexation only adjusts for the safety net which has been for historical situation until recently then residential services have been considerably disadvantaged as the safety net adjustment is considerably less then the true cost of salary and wage increases.

There is a strong case for residential age care services to be removed from the COPO indexation program all together. The Commonwealth must recognise that a combination of restricted income alternatives and an indexation formula which is considerably below the real costs escalation within the sector is rapidly leading to a viability crunch.

SUB-ACUTE AND POST-ACUTE CARE

Sub-acute care and post-acute care are those services outside the immediate/acute care needs of the aged person, usually supplied in the acute care environment in medical and post-surgical beds, and appropriately met community needs in the past.

Changed demographics in relation to aged care have over-burdened the system (demand and cost) to the detriment of the whole population.

Management of the sub-acute and post-acute care needs of the aged person within the acute care environment suffers a number of disadvantages:

- There is evidence that when the aged person requires medical intervention within the acute care environment, their health and well being decline significantly.
  - Many in-patients admitted for short-term acute care decline physically and emotionally to the degree that they are assessed as no longer capable of returning to their home environment.
  - Those who had come from a residential care environment are frequently returned to their aged care facility with a raft of physical and emotional problems arising from the neglect/oversight of their specialised aged care needs.
  - The acute sector paradigm and expertise is to focus upon the acute care treatment need in relative isolation to the active and specialised attention required to appropriately manage (chronic) age-related care needs.
- The cost of acute sector bed is higher than the aged care sector bed.
- Demand outstrips supply in the acute care environment, with problems of overcrowding, ‘bed blockage’ by aged persons awaiting placement, and increased stress to hospital personnel.

There is significant potential benefit for aged persons to receive sub-acute and post-acute care within the residential care environment.

Advantages are that:

- Residential aged care possesses resources in terms of specialised and qualified/professional nursing and allied health care for aged persons (eg Registered Nurses, physiotherapists, occupational therapists).
- The resource base of skills and knowledge facilitates appropriate and relevant holistic assessment, care planning and intervention for the active and ongoing management of chronic and/or complex care needs, whilst at the same time managing the presenting short-term care need.
- Aged care possesses established service by pharmaceutical suppliers.

- The residential aged care environment is inherently physically structured and more attuned to the emotional needs of the aged person – ie the home-like environment of the ACF is less threatening and quieter than the acute care environment.
- Technology and communications development permit the relay of clinical data to the acute care professional (eg ECG reading) from the external environment, thus allowing 'at length' control and case management by those professionals for as long as the episode dictates.
- Pathology collection is not dependent upon the setting.
- There is benefit to the aged person with potential for:
  - Faster and more effective rehabilitation
  - Greater likelihood of return to the home environment (due to the specialised assessment, care planning and interventions to address underlying chronic age-related needs).
  - Less emotional trauma (eg distress, confusion).
- There is potential for changed community perceptions regarding aged care – a positive perception of residential aged care as a dynamic system where short-term specialised health care is available as much as long-term aged care.

RESOURCE CONSIDERATIONS

Sub-acute/post-acute care provision in the residential aged care setting imply a need for:

- *Appropriate funding*. Given the higher cost of acute care bed, outlays on appropriately equipping and maintaining successful tenders from the residential ACF environment, would likely to be budget neutral at worst, and more likely provide significant surplus once the initial capital costs were expended.
- *Education.* Professional staff (eg RNs, and allied health professionals) may require re-skilling in acute care. By definition an RN is considered qualified and capable of providing nursing services in any general-acute environment or aged care environment, but may require re-skilling in acute care technologies and practices.
- *Development of Electronic and other Communication Networks and devices between the ACF and cute care hospital* **–** eg. Data transmission; reporting and care planning with the medical services of the acute sector; advisory services/hot line; assistance services (eg flying squads).
- *GP involvement*. Issue of availability of GP services and appropriate recompense a separate strategic issue.
- Nurse Practitioners. Underway in WA and development in other States, NPs can manage a percentage of tasks and responsibilities currently managed by GP services.

CAPITAL CREATION

The 1997 aged care reforms intended to introduce an innovative new way of creating sufficient capital to ensure a substantial rebuild and upgrade of the existing residential care building stock. The intention was that residents entering the system would pay an accommodation bond which would be means tested and based upon the capital capacity of each resident to pay.

Unfortunately, due to a number of factors the bond scheme was only ever introduced into low care or hostel type facilities. High care or nursing home type facilities had to implement a scheme, which involved a daily fee or accommodation charge. The accommodation charge is a set amount based upon the capital capacity of the resident and is currently capped at $13.45 per day.

The annual report on the Age Care Act 2001/2 as prepared by the Department of Health and Ageing clearly indicates that the capacity of the high care residential sector as opposed to the low care residential sector to create sufficient capital for the future is approximately half.

The residential age care sector has been estimated to have a capital value of approximately $17 billion. Whilst the capital upgrade and new building work of the current ten-year cycle will involve a capital outlay of approximately $8.5 billion. The low care sector will during this period directly raise from bond income approximately $3.5 billion whilst the high care sector will raise from accommodation charges approximately $1.8 billion (The Two Year Review, Len Gray, 2001) as the high care sector is the large of the two sectors within the residential age care industry the capacity of the larger sector to raise only half the capital as compared to low care sector raises a major issue as to the ability of the high care sector to continue to develop and expand at the level desired by Government to meet the future demographic requirements of an ageing Australian population.

Anecdotally it would appear that stand-alone age care facilities in the residential sector are no longer being built. From across the sector providers are saying that it is not a viable decision to build long-term care places unless this issue of capital creation is resolved. In addition, it is the opinion of ANHECA that in the 2002 aged care approvals round which allocates additional care places to match the aging population on an annual basis that the number of high care places being allocated to new operators or stand alone new facilities is almost non existent.

AGED CARE BUILDING STOCK AND DEPRECIATION

Currently all aged care building stock is depreciated over a 40-year cycle or an annual 2.5%. However, government policy ensures that most building stock is renewed or replaced within a 20 year cycle. The current 10 year building program for residential services involves an expenditure of approximately $8.5 billion (The Two Year Review) which represents approximately a 50% rebuild or regeneration of aged care residential building

stock if total capital value of the sector is accurately valued at approximately $17 billion.

Providing a more appropriate depreciation period for residential building stock would have the value of making investment more attractive as well as allowing both private and voluntary sector operators to more accurately reflect the true building life cycle of the asset within their accounting systems.

COMMUNITY AGED CARE PACKAGES

In 1992 there were less than 2,000 community aged care packages in the residential aged care program. Community aged care packages were introduced by the Commonwealth to provide an alternative care stream, which would assist persons requiring support, and care to remain in their own home and not have to seek immediate admission to a residential facility.

On current government projections there will, by 2006, be 40,000 community aged care packages within an overall aged care funding program of 200,000 places nationally. This represents one in five places in the Commonwealth funded aged care program being provided in the community by 2006.

This has been a significant and major policy initiative, which is having a significant impact upon how aged care services are delivered. There seems little doubt that members of the community seeking care would, where possible, prefer to have that care delivered within their own home environment.

However, care must be taken to ensure that this rapid transfer in care delivery modality does not adversely impact upon the capital intensive residential sector to the extent of making the residential sector non-viable or questionably viable.

There has been no study or research into the current government policy and the interrelationship between community aged care packages and residential care. ANHECA believes that is essential that the current policy framework be examined with particular emphasis on the need to consider the number of community aged care packages being made available, the number of residential care places being made available and the interrelationship between the two and likely impact upon the future viability of residential care if community aged care package numbers continue to grow at the current level.

The provision of community aged care packages is a cheaper option for government as virtually no capital is required as the recipients own home is utilized as the place of care delivery. However, there is anecdotal evidence that the quantum of care being provided is often of lesser value to residents and places considerably greater demands on carers and family and that the quality of the care being delivered does not attract the same level of government supervision or standards requirements as is required of the residential sector.

HOME AND COMMUNITY CARE (HACC)

In a similar context to the expansion of Community Aged Care Packages (CACP) the evolution of the Home and Community Care program (HACC) has been a fast and rapidly expanding process.

Again, there is an underlying public policy position that wherever care can be provided in the community utilizing family and carer support networks that this should be supported.

The provision of HACC funds over the last 5 years has expanded considerably. There are those that will argue that the current allocation is insufficient to meet demand. However, for the purposes of this discussion ANHECA believes that there is a requirement that the interrelationship between HACC and residential care needs to be studied and understood.

The combination of HACC and CACP's is, it is contended, having a major impact upon the demand for residential places. This demand is a hidden factor as most recipients of community based care will be recorded in any databases as having their needs met. The delay or ultimate deferment of access to residential care is therefore unidentified and certainly unclear in any known database within the residential care program or HACC programs.

The most obvious and apparent affect upon residential programs of the impact of community based care services is the rapidly escalating age of entry to residential care which has in part been caused by the deferment of admission due to community care program support. The current age of admission to residential care is now slightly over 80 years of age (AIHW 2002). The average age of residents in residential care is now 83.5 years of age (AIHW 2002).

ANHECA is strongly of the belief that there is an urgent need to undertake a major review of the relationship between community based care programs for the aged and the current and projected future impact of such programs on the requirements for residential care. ANHECA believes that with the substantial capital investment in residential aged care infrastructure and the projected future investment requirements for the sector it is essential that the industry and government clearly understand those issues that are likely to impact upon the demand for residential care particularly where that demand is being influenced by other government policy settings such as CACP's and HACC.

RETIREMENT VILLAGE ACCOMMODATION

Retirement villages have expanded rapidly in the Australian aged care accommodation service provision framework in the last 20 years. A considerable range of village type, location and pricing structure has evolved during this time to meet the needs and demands of a variety of requirements and financial capacity to pay.

There is, however, mounting evidence that just as persons are wanting to stay in their home in the community those who have elected to make one lifestyle choice to a retirement village or similar setting are also electing to stay within that setting wherever possible and are looking for additional support mechanisms whether they be CACP's, HACC or programs provided directly by the village for some additional fee.

There is also mounting evidence that retirement villages are having considerable difficulty selling additional places and that the natural growth in entry numbers to retirement villages may have either stabilized or in fact be shrinking. This has lead to village operators particularly in areas of considerable over supply providing a range of additional support mechanisms to residents to maintain the resident within the village rather than see the resident exit the village as would have been the case in previous years to a residential aged care program hostel or nursing home.

This conduct is particularly evident where village operators are unable to attract sufficient incoming residents to buy out the asset of the exiting resident.

In addition, there is a growing trend for village operators to provide self-funded low-care hostel type accommodation on campus thus removing the need for village residents to move from the village to a residential care facility until often very late in the life cycle process. This will usually mean that admission to a residential care hostel is avoided and any admission, if at all, is direct to a high care nursing home facility.

Further, many villages have availed themselves of the opportunity to apply for community aged care packages and to make these available as part of their continuum of care program to the broader community. This tends to create a client stream to the village as an automatic extension of service provision.

The Commonwealth Department of Health and Ageing is also currently exploring how to provide specific community aged care packages to retirement villages in order to assist village operators to retain residents within the village environment rather than the traditional transfer to a residential aged care program hostel or nursing home.

EXTENDED AGED CARE IN THE HOME (EACH)

The Commonwealth Department of Health and Ageing has, over the last 2 years, piloted and has now commenced funding as part of the standard residential places program the Extended Aged Care in the Home (EACH) which endeavours to extend the CACP concept to capture prospective future residents of nursing home high care services so that they receive care within the home environment rather than being admitted to residential care.

The numbers of clients within the EACH program is still relatively small, however, if the numbers of recipients in this category are at all reflected in the number of CACP's made available over the last decade then this would have

a significant impact upon the future demand for particularly nursing home high care places.

RESIDENTIAL CARE PLANNING RATIOS

The Commonwealth Department of Health and Ageing has had in place for approximately 14 years a planning ratio for residential places of 100 places per 1,000 persons over 70 years of age. The planning ratio is then subdivided into 50 low care places, 40 high care places and 10 community aged care places. If, as previously stated, the governments current objective is to reach 40,000 community aged care packages by 2006 which will mean 20% of all places are held in the community, it is obvious that this current planning ratio is not reflective of reality.

In addition, the current number of high care residents in the residential system stands at 63.8% (AIHW 2002) meaning that all residents accommodated within the residential care program are approximately 144,000 as at September 2002 are classified as high care that is classified as 1 – 4 on the resident classification scale. It should also be recognized that nearly 25% of all residents within the low care hostel system are now classified as high care recipients.

It begs the question that if 63.8% of all recipients of residential care are classified as high care why the Commonwealth Department of Health and Ageing continues to apply a planning ratio of 50% to low care and 40% to high care. A further more obvious question is why in the last 4 aged care approvals rounds were additional places met made available to the system to match the changing demographic demand when considerably greater numbers of low care places are continuing to be released than high care places when obviously the demand is for high care and not low care.

HIGH CARE BUILDING DEVELOPMENT

As previously stated the creation of additional high care places in the residential sector is a matter of major concern. In the 2002 Aged Care Approvals Round only 6 approvals took place for stand-alone high care facilities across Australia. For the industry this raises alarm bells as it is confirmation of what ANHECA has been saying for 2 years namely that without the provision of bonds on a similar basis to bonds in low care, high care building work is going to come to a stand-still.

The lack of stand-alone high care facilities in the 2002 approvals round is now substantial confirmation of that position. High care building work has now substantially stopped. Those beds that were made available in the 2002 aged care approvals round related almost entirely to where existing operations are planning to expand existing facilities to make them more sustainable and viable or where a co-location was to occur usually with a hostel where the hostel capital creation capability supported by bonds will in fact cross subsidise the high care beds.

Residential care high care places or nursing homes are still the larger part of the residential care program with approximately 53% of all existing approved beds. Meaning the residential care program covering low care or hostel beds represents approximately 47% of existing approved places.

If based upon the Australian Institute of Health and Welfare figures in 2002 63.8% of all residents in the system are now high care classified it begs the question why focus is not on providing high care residential places to meet the existing demand and recognizing that demand for low care is in fact shrinking with a quarter of all low care places now occupied by high care residents through “Ageing in Place”.

INDUSTRY OCCUPANCY RATES

The viability of residential aged care operations is predicated on the ability of the sector to maintain high levels of occupancy. High occupancy levels at the same time have been dependent upon a supply driven system where demand would always outstrip supply. This has also been a fundamental priority of the Commonwealth in maintaining a controllable cap on residential care outlays.

Residential high care facilities occupancy levels are set at 99.4% or greater with residential low care facilities set at an occupancy level of 93% or greater. In a mathematically relevant model these occupancy levels ensure a high level of effectiveness and efficiency of the subsidy paid by government. If, however, the occupancy level shrank markedly or became highly volatile there would be an urgent need for government to review the adequacy of the existing subsidy and to increase the subsidy to reflect this volatility or reduced level of efficiency caused by high occupancy levels of operational facilities.

Given the considerable evidence now developing from around Australia; ANHECA has been made aware of one relatively small geographic area in Sydney experiencing 32 vacant beds across a number of nursing homes that has lasted for many weeks it is now of a major concern to residential care providers that the occupancy level of many facilities and therefore the capacity of the industry to retain existing viability and operate at the existing income level is now seriously called into question.

CONCLUSION

ANHECA is particularly concerned regarding the medium to long term viability of Residential Aged Care Services and particularly those services that are provided through Commonwealth Government subsidized beds operated under the provisions of the Aged Care Act 1997.

As Residential Aged Care has a particular investment in the built infrastructure of nursing homes and hostels it is essential that the capital currently invested and projected to be required in the future for the provision of residential care is used wisely. The last thing the government is going to want to see is the wholesale closure of nursing homes and hostels across

Australia when the thrust of recent policy has been to match the number of available beds with the changing demographic of Australia's ageing population.

ANHECA, therefore, is concerned that substantial policy change has occurred with the creation of community aged care packages and other programs which impact directly upon the demand for residential care places and that there has been no analysis of the impact of those programs on the existing demand for residential places or the projected future demand for residential care places. ANHECA believes that a substantial study needs to be undertaken as to the impact of the current community base services, their interrelationship with residential care, the impact upon the current demand for residential places and the future impact upon demand for residential places and what allowance the Commonwealth ought to be making for that impact on future planning and planning ratios for residential and community based programs.

ANHECA is concerned that with the capital investment in residential care this is not an industry that can make flexible decisions about alternative uses for the building stock available. Careful planning of current, medium and long-term needs for residential services is therefore essential.

ANHECA would recommend that an in depth review be undertaken into the existing Department of Health and Ageing planning ratios for residential and community aged care places. ANHECA contends that the current planning ratios do not reflect either the department's policy agenda in respect of community places nor the reality of number of residents in the system who are now classified as high care as opposed to low care.
ANHECA believes that the construction of Residential Aged Care high care places, particularly stand alone facilities has almost ceased and that there is an urgent need for high care nursing homes to have access to bonds on the same basis as low care facilities and that the introduction of bonds for high care facilities be contemplated as soon as possible to ensure that aged care beds are built to meet changing demand over the medium term.

ANHECA would be pleased to provide additional information to the committee if sought or to appear before the committee to give evidence and provide additional material if the committee so desires.

Rod Young
ANHECA CEO

20th December 2002