Thank you for the opportunity for Anglican Aged Care Services Group to provide input into the House of Representatives Committee on Ageing. In line with our organisation's core competence, this submission concentrates only on one of the broad themes identified for the inquiry for investigation – aged care. Our focus is centred on the key issues critical now and over the next 40 years in order to provide a viable, accessible, quality aged care service for older Australians.

1. Introduction

Anglican Aged Care Services Group (AACSG) was established more than 50 years ago with a vision and genuine concern for older people who were poor, widowed and lonely. Pioneered by a few volunteers who heard the appeal of Archbishop Booth back in the post war years, they procured a house in Camberwell called "Tara" (now known as Broughton Hall), raised the funds for furniture, made the curtains and cooked the meals for 27 elderly women.

It is from this foundation that the organisation has grown to become a leading, not-for-profit, specialist aged care services provider. We currently employ 800 staff to care for more than 1200 clients across Melbourne and the Mornington Peninsula and access the resources of several hundred volunteers.

In addition to residential care services, AACSG supports the needs of the elderly and their carers through our community care program, providing Community Aged Care Packages, respite care, day care and extended care services.

Anglican Aged Care Services Group is a company limited by guarantee, guided by a Board of Directors. Operational leadership comes from a team of dynamic people who collectively have the passion, the expertise and the experience to meet the challenges faced by aged care service providers. With an ageing population predicted to reach between 1.1 and 1.2 million people aged 85 years or more by the year 2051, the relevance and need for our organisation to not only survive but to flourish, is more essential than ever. We will continue to seek the support of the wider community and work with government, business, the church and philanthropy, to secure our future for the benefit of all older Australians.

2. Demand and Supply of Aged Care Services

There is at present no correlation between demand and supply of aged care services. The planning ratios used for low care, high care and CACPs are totally inconsistent with client demand and trends. For example, consumers (and indeed all of us) want to stay at home for as long as possible. CACPs (and the interminably long EACH trials) have been increasingly allowing that to happen.

The reality is that more older Australians require CACP's/EACH programs and then nursing home care. However, the government regulated supply mix consists of 50 low care, 40 high care and 10 CACPs for each 1,000 people aged 70 and over. Providers react to government controlled supply by building hostels because they are generally at present the only viable residential aged care service because of accommodation bonds.

The numbers of beds and packages have not kept pace with older population growth and therefore demand. There appears to be no apparent methodology behind the planning formula which has been largely unchanged since 1986. If funded appropriately, community care could be a "product substitute" for residential care which would alter the

formulas to reflect a majority percentage of places as community care (CACP & EACH) and a minority as specialist residential aged care with interim care.

Targeting the over 70 aged group is not reflective of the users of residential care who are mostly over 80 - 85 years of age.

The current method of allocation of beds and packages is also problematic given the short term "lotto" focus. This makes it extremely difficult for quality providers like Anglican Aged Care Services Group to strategically plan and ensure planned service growth to meet aged care demand both in the short and long term.

Flexibility to ensure supply of services to meet client needs is currently not present in the system. For example, if a facility closes, the beds are unutilised for a long period of time, as they are in the allocations process. It generally takes 2 years to build and open a facility. These beds should be allowed to be converted on a temporary basis into CACP/EACH services which are not capital dependent but provide essential services in the are.

3. Recurrent and Capital Funding of Aged Care Services

Both anecdotal and academic research undertaken by the National Aged Care Alliance, consistently shows that the recurrent funding of residential care and CACP's does not reflect or meet the actual costs of care. This mismatch has stripped organisations of reserves or funding that should be used for capital has been used to meet operating costs. The indexation system is fundamentally flawed and needs to be addressed.

The adversarial RCS Validation process is also problematic and demoralising for aged care staff. Again, it is evident that if 40-50% of RCS Validation reviews result in a downgrade, what does this say about the system itself. A hospital's critical care unit would not require the same level of paperwork nor be subject to a funding validation process such as this. Tome taken for complex documentation is obviously time taken away from client care.

The pricing and RCS review outcomes will be required as a matter of urgency for the sector to facilitate much needed change. However, it appears that the pricing review is not determining the “product” to be “priced” which would obviously suggest that funding and pricing issues will continue to be problematic in this industry.

CACP providers in Victoria are being charged full cost recovery rates for basic meals or day care services through the HACC program. As a result, clients are better off not accessing a CACP due to the minimal funding available and the obvious "cost shifting" occurring.

Capital funding for nursing homes, where demand is highest, also needs to be urgently addressed to ensure a viable supply. There are a number of capital raising options which should be evaluated and implemented. To build a (non extra service) nursing home at a cost of approximately $110,000 per bed, based on current funding arrangements, generally means a cash negative position (negative NPV) and therefore an unviable service. Despite the inaccessibility of appropriate capital funding, residential care providers are faced with major building regulatory requirements through certification.

4. Workforce Issues for Quality Aged Care

The provision of quality aged care services is inextricably linked to the quality of aged care staff. However, there are critical issues affecting recruitment and retention of staff in aged care. The National Review of Nursing Education showed that the rate of decline in nurses willing to work in aged care homes is much greater than the overall rate of decline in nursing employment generally.

In Victoria, the wage disparity for nurses, and indeed all staff, and their counterparts in the public sector is 20%. This can equate to approximately $100 per week.

Given the current inadequate funding system, to pay a 20% wage increase would be "financial suicide" for the provider.

Medication administration (for SEN's) is also a key issue given the current situation in Victoria as apposed to other States.

To attract staff to work in aged care there also needs to be an appropriate level of training places, refresher and re-entry programs targeting community based and residential aged care, and the development of a national aged care workforce plan. The overall workforce issue for aged care will not be addressed until older Australians are valued by our society and therefore, the important work of aged care is valuable too - by government, by business and by our community. Attitudinal change has been successful if there is a desire e.g. drink driving. This is without doubt the one over-riding issue affecting our society.

5. Cultural Diversity

According to the Australian Institute of Health and Welfare report, Projections of Older Immigrants (2001), by the year 2011 Victoria will have the most culturally diverse older population. It is expected that immigrants from culturally and linguistically diverse backgrounds will make up about 1 in 3 of the state's older population.

In recognition of our commitment to promote and facilitate culturally appropriate aged care, AACSG was appointed as the auspicing organisation of the Partners In Culturally Appropriate Care Project Victoria (PICCVIC) - a Commonwealth Government funded program. Through its forums targeted at aged care providers, facility managers and ethnic communities, PICCVIC has continually emphasised that cultural diversity needs to be addressed at all levels of service design and delivery.

Based on these key issues in aged care, the following solutions are provided to assist in the inquiry process:

i. Review the planning formula to ensure the appropriate level of service supply to meet client demand. Ensure EACH and CACP's are a majority part of any formula utilised to plan aged care services. Integrate HACC services planning.

ii. Adopt a long term aged care supply planning framework to allow strategic planning and investment certainty for providers.

iii. Build flexibility into the program/service system to allow interim conversions between residential care and community based options.

iv. Lead community care program reform to ensure an integrated client focus, reduce duplication, prevent cost shifting and promote administrative efficiency.

v. Introduce capital funding options for nursing homes to ensure viability and ability to upgrade to meet regulatory requirements and client expectations.

vi. Develop a national aged care workforce plan and implement strategies.

vii. Promote the value of older Australians and the status of aged care.

viii. **Create Centres for Cultural Diversity in Ageing adequately funded to support both ethnic communities (especially small) and aged care providers given the demographics and the subsequent need for all service providers to be providing culturally appropriate aged care.**

ix. **Translate the numerous aged care inquiries and reviews into timely action to positively effect both the services the clients receive and the workforce providing the care.**

Appendix one attached provides a summary analysis of aged care trends and issues. Once again, I thank you for the opportunity of input into the inquiry of the House of Representatives Standing Committee on Ageing. I would be pleased to provide further information and assist in any way as required. Anglican Aged Care Services Group looks forward to your launch of the outcomes of this important inquiry.

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Anglican Aged Care Services Group

APPENDIX ONE: SUMMARY ANALYSIS OF AGED CARE TRENDS AND ISSUES

A. Summary of major environmental trends and issues

Australia is on the threshold of one of the biggest demographic changes in its history. The elderly are, and will continue to be over the next 50+ years, the fastest growing segment of the population. The World Health Organisation (WHO) remarked that its effect will be greater than the industrial revolution. The next five decades will be a period of profound and fascinating demographic, social and political change.

Older people have increasing expectations and increasing personal capacities and resources for achieving them. Baby boomers expect that they will not have to wait, that quality is regulated, and that they will not have to pay for what they do not need. However, there is a general mismatch between expectations and ability to always resource them given the length of the retirement period and longevity.

Societal acceptance of users pays and mutual obligation will see Government funding reduce in real terms shifting focus to specific components of services with minimal accommodation support for the marginalised.

The incidence of complex and chronic illnesses will increase greatly affecting demand for services. Technological and service advances coupled with capacity/expectation to pay, will increase the probability of older Australians realising the desire to remain in their own home longer.

B. Summary of Major Industry Influences

Aged care is approximately a $6 billion industry primarily funded by the Commonwealth Government. The aged care industry is extremely fragmented and is undergoing consolidation. Pressure to meet and fund capital expenditure requirements, particularly for legislative purposes, will mean that many marginal operators will no longer be viable. There has been active rapid growth of the private sector within both the residential (residential aged care and retirement villages/apartment) and community care market (specialist/niche services).

To improve viability through economies of scale, service integration and the size of facilities/programs have increased.

An industry growth forecast is assured due to an ageing population. Occupancy rates are high.

The Government heavily regulates supply of beds and packages, funding and complex accountability, reporting and accreditation requirements. Building nursing homes are not financially viable under the current system despite high client demand.

The Community aged care sector operates within a complex number of different individual programs, funding rules and duplication by Federal and State Governments.

A chronic shortage of appropriately skilled staff, in particular nursing, to meet industry demands has meant a greater reliance on higher paid “agency staff”. Nursing workforce is ageing with nurse registrations/enrolments decreasing in Australia, with Victoria experiencing a 14.4% decrease between 1993 - 1999. Shortages are also likely to occur with skilled direct care and allied health (public) staff.

C. Summary of Major Client Issues

Clients are increasingly older, frailer, culturally diverse, "ageing in place", high care or community care recipients. As Australia's aged population continues to grow there will be a need for a greater number and diversity of services.

Clients will continue to seek care and support to assist them to stay at home for as long as possible. This will see an increase demand in home and community care services.

Residential aged care will need to serve clients with greater levels of frailty, with more complex problems and those with mental and terminal illness.

There is a growing need to coordinate aged care services and allow transition from one service to another made easier. The hospital/acute care system must also be part of this integration.