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Moreland City Council

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Submission to: Parliament of Australia
House of Representatives
Standing Committee on Ageing

From: Moreland City Council
90 Bell Street,
Coburg, VIC. 3058

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

Moreland Council welcomes the opportunity to comment on the impact of current Commonwealth aged care policies on its aged community, given that the elderly already represent a higher proportion of the Moreland population than the national average.

Moreland Council welcomes the Commonwealth's initiative in recognising the importance of the demographic changes, and the need for community debate on the inter- related planning issues and policy choices.

Based on the local experience of current unmet need, Moreland Council would favour a reform of the current policies to achieve adequacy and administrative efficiencies and strategies which address cost benefits to create a stronger foundation for a robust aged care system capable of catering for increasing numbers.

1. Aged Population Growth

Moreland is located 8.5 km north west of the Melbourne Central Business District. It covers 50.9 square kilometers and is one of Melbourne's most populous and culturally diverse municipalities. It has a population of 136,894 (ABS 2001), with

35,475 (25.8%) in the baby boomer's age range of 35 – 55 years, and 22,636 (16.5%) over 65 years of age. There are 2,155 persons over the age of 85 years.

Only 36.5% of Moreland's older population (55 years +) were born in Australia. 25% were born in Italy, 16% in Lebanon and 9% in Greece. Under half of the population over 55 years speak English at home. 22% of residents over 55 years live alone, and just under 22,000 receive the age pension, 1,600 with rent assistance and 1,400 receive a Disability Support Pension. (Centrelink Knowledge Desk Data, Qrt 1, 2002). There are nearly 1500 veterans receiving service and other pensions.

Some of the key characteristics of the current Moreland "baby boomer" population from the 2001 ABS Census include:

- 58% are married, notably lower that the Melbourne averages of 69% and the 62% of current 55 + year olds
- almost 13% aged 35 – 54 years are living alone, higher than for metropolitan Melbourne as a whole (9%)
- 7% of 35 – 54 years olds are living as non-dependent children with parents, compared to a Melbourne average of 3%.
- 54% of persons aged 35 – 54 years were born in Australia with a decrease in numbers born in Italy, Greece, Lebanon and Malta, compared with those currently over 55 years, and an increase in the percentages from the UK and New Zealand, Turkey, China, Vietnam, Philippines and Iraq.

The baby boomers in Moreland are likely to enter old age with a much higher rate of single living than the current generation, and with a greater proportion born in Australia and English speaking countries. There will be further differences in education levels, employment histories, home and car ownership.

Policy needs to acknowledge locality variations to the national norms, the capacity of individuals and communities to pay for needed services, and the additional costs associated with servicing CALD communities.

2. Current Service Provision Gaps

Moreland has already experienced significant growth in its older population. Those over 85 years increased by 79% over the past 5 years. Over the past few years in particular, Moreland has experienced a real gap between service need and provision in both residential and community care, with long waiting lists and community concern over this.

2.1 Residential Aged Care

Against the Commonwealth provision norms of 90 beds per 1,000 70 years +, Moreland has been under bedded by around 35% (538 beds short). The demand has been greater for high level care, but as the planning norms indicate a greater gap in the low care beds, most of the Approvals in Principle allocated over the past three years have been for low care. A number of facilities with low care beds are struggling to implement ageing in place and are now seeking to add high care units. Other providers are advising that it just isn't a viable investment to build high care units. As the viability factors force providers to a larger scale, the availability of suitable sized and priced land becomes a greater issue for inner and middle urban municipalities. Council has spent considerable time and effort trying to identify and facilitate the acquisition of sites and partnerships suitable for residential care development. Because the local aged community is essentially one with modest resources, the high land and building costs cannot be recovered through additional service arrangements.

There is also concern over the uncertain future of the small scale local community based not for profit providers who enjoy the support and regard of the local community. There is a potential loss of community connectedness and choice arising from the seemingly inevitable competitive edge of the large scale commercial providers.

Moreland, like the rest of the Northern region, has also had a high, unmet demand for residential respite care, and it would appear that the incentives and funding for providing flexible respite, especially to those with dementia and complex medical and physical care needs just doesn't make it worthwhile for the residential providers to address this need. This puts a lot of pressure on families and community care and leads to earlier residential care placement.

The following planning and policy changes are recommended:

- a review of the planning/ provision norms given the greater need and use of residential care from the 80+ population, the projected growth in that population and the 2 – 3 year delay between approvals and building completion
- improved funding incentives for building high care facilities, offering the more difficult respite/ shared care and in areas where land and building costs are high.
- Data collection and reporting on the characteristics of the population choosing residential care, particularly related to choice of location, financial contribution, length of stay, consumer and carer evaluation etc. It is difficult at the local area level to determine who is in local facilities and why, and with the under provision in Moreland , we cannot readily track where local people are ending up instead, and the degree to which that is acceptable to them and their families

2. 2 Community Care

In relation to community care, Moreland Council is the major local provider of home care, home maintenance and delivered meals, as funded by the HACC Program and Department of Veterans Affair's Home Care Program.

Notwithstanding the welcome growth afforded by the new DVA program last year, there was an administrative cost to Council (equivalent to a full time staff member for 6 months) in participating in the transfer of clients to the new program. The implementation was particularly protracted and complicated by the instability of the DVA computer program and the design of the program whereby every veteran has an individual case plan and services have to be invoiced monthly for every individual (a substantial ongoing administrative impost for a service with 250 veterans).

The outcome of the Commonwealth introducing yet another community care program with different funding arrangements has been to increase the costs of administration at the service level and create even more fragmentation requiring inter agency co-ordination time. It has also created further inequity in access – eligible veterans in Moreland get a service within two weeks, regardless of priority of need, whilst the wait for those using HACC funded services can be months.

The DVA Home Care Program does contribute directly to the State HACC program in Victoria, by which the State department re-imburses Council for veterans using additional places in HACC funded day care and meals services. This is administered as part of the monthly HACC grants, with annual reconciliation, thus adding extra services for little extra administration at any level. It would be hard to argue that the administrative costs incurred by DVA in managing the home care program directly is adding extra value to the home care outcomes for veterans.

In relation to HACC funding, the Commonwealth CPI formula used in the annual HACC growth funding has not adequately acknowledged real wages growth. Thus to maintain the base services, Council has had to increase its contribution, and / or decrease the additional hours it had traditionally funded from rates. Moreover, at a time when Moreland had 35% less than the residential care provision required by the norms, there have been no mechanisms for the Victorian shortfall generally, or the Moreland shortfall in particular, to be compensated for by increased community care (HACC) funding.

It is acknowledged that the Commonwealth has tried to improve community care through its aged care funding via the Community Aged Care Packages. However, because the distribution and allocation of these has been done in the context of residential care planning and not the State based community care system, the results have been disappointing in the additional system fragmentation and administration costs that has resulted, at least in Victoria. Moreland Council provides home care

services to at least 9 different CACP providers, often at below full cost recovery, in order to provide continuity of services to citizens who formally received HACC funded services, but needed additional hours and/or case management. Just as the "Ageing in Place" policy supports continuity in residential care service provider as an individual's care needs increase, so the CACP should allow for this in community care. Individuals often don't want to be referred to another organisation to get more of the same services they currently receive, with different rules re fees etc.

Because the packages often don't meet the full cost of all the services an individual requires, as well as the agency's administrative and case management costs, case managers are often negotiating with Council's home care services for a better (cheaper) deal, particularly for meals, and for a contribution to service hours if there is a family carer. (that is, the carer remains a HACC client in his or her own right). This form of manipulating the system, which puts an eligibility barrier between the Aged Care program and HACC, to get the best possible results for some clients is very time consuming, inequitable and also represents another form of cost shifting on to local government.

Council contributes significantly to community care, (approx $2 million per annum) through the additional costs associated with being involved in the DVA, HACC and CACP programs, through the provision of information, advice and assessment services, additional service hours in home care, and the provision of largely unfunded services such as community transport.

Reform of the design and administration of the aged care and community care program to achieve improved inter – government planning and streamlined administration is an essential stage in achieving an effective long term care system for greater numbers of older people in the future. There needs to be a greater policy commitment to achieving adequacy and certainty in the community care system, so that the community can be clear about what they can expect to be available. A lot of the smaller programs that have been introduced to address particular gaps or aspects of need simply mask that the core services are not adequately funded and provided equitably.

The following policy changes are recommended:

- Structural and administrative reform of the Commonwealth community care programs (such as CACP, EACH, DVA) and merging with the HACC program to become a national community care program, with clearer goals, targeting for both high and lower levels of need and strategic direction to provide an adequate home support program for an ageing Australia. This may involve prioritising core service types, such a care management, home nursing, home care, respite and benchmarking provision levels, or having provision norms as has been used to distribute residential care place equitably.

- Planning for both residential and community aged care to be better linked at the local, regional and State level, supported by improved and integrated data sets.

- Recognition of the lower payments to States with lower levels of residential care and cost compensation for increased community care.

3. Financing Aged Care and Reducing Costs

Australians in 15 – 40 years time may not see low taxation and balanced budgets as critical policy objectives. Containing costs and maximising cost benefits through promoting and managing technological advances and providing a publicly funded, adequate, accessible and administratively efficient health and aged care system should be the important policy goals. The following examples of local experience raise some of the concerns about focussing on alternate revenue raising.

3.1 Private Insurance

Market approaches to financing long term care through self-insurance don't necessarily deliver the promised benefits. The local experience to date of the efficacy of private health insurance to adequately meet the health and care needs of older people has been poor. Moreland General Practitioners estimate between 40 – 60% of their older patients (predominantly low income pensioners) have invested in private health insurance, and Commonwealth policy has encouraged such action. However the local private hospital closed its emergency department last year with no community consultation (now re-opened). Doctors also reported the difficulty of obtaining admission for elderly patients with particular conditions, as the hospital prioritised its focus, which excluded a number of specialty areas, so admission was only possible in a private hospital outside the area. Elderly people and their families have been distressed to find themselves subject to early discharge, but unable to get the needed home supports quickly from the local over loaded HACC services, not eligible for the State funded Post Acute community care services provided to patients of the public hospitals, and no coverage for such support from their private health insurance. In most of these situations neither the older people nor their families were in a position to pay for private services.

3.2 Use of equity in the family home to finance care

Council has a Residential Aged Care Advisory Committee, which brings together a representative range of local interests in aged care. Over a number of years, the view has been expressed that the demand for low level care in Moreland is lower than the norm because of the high proportion of older people born overseas, and their reluctance to relinquish the asset of the family home to pay for hostel care as an accommodation bond. Cultural norms and the migration and re – settlement

experience creates expectations around inter generational support in families. Given that Moreland also appears to have a higher proportion of non dependent adults living with parents, and higher than average numbers of unemployed adults entering old age, the role of inter generational exchange through housing requires very careful analyses before the sale, or reduced equity in the asset of a home, are proposed as basic ways of paying for care, notwithstanding that this may be a choice some individuals want to make.

3.3 Technology

The Intergenerational Report acknowledges technology in health services as a major cost driver. Further investment in domestic technology could significantly reduce the costs of home care. It doesn't take a lot of disability for older people to need regular assistance with tasks such as vacuuming floors and cleaning baths. With increased longevity and greater numbers of old people, the costs of providing these simple forms of domestic assistance alone will be substantial. It is already, and may become increasingly difficult to have the workforce to do this work and the repetitive manual handling involved creates injury risk and workcover costs. There are currently forms of remote controlled vacuum cleaners, which require little manual handling, but they are very expensive. Government led support for research and development of accessibly priced domestic technology to reduce manual handling could produce significant cost savings.

Similarly, the escalating pharmaceutical costs needs to be selectively evaluated against cost benefits for reductions in other parts of the health and aged care system, as well as strategies to increase doctor and community education to reduce waste.

Recommendations:

- A review of the planning/ provision norms given the greater need and use of residential care from the 80+ population, the projected growth in that population and the 2 – 3 year delay between approvals and building completion.

- Improved funding incentives for building high care facilities, offering the more difficult respite/ shared care and in areas where land and building costs are high.

- Data collection and reporting on the characteristics of the population choosing residential care, particularly related to choice of location, financial contribution, length of stay, consumer and carer evaluation.

- Structural and administrative reform of the Commonwealth community care programs (such as CACP, EACH, DVA) and merging with the HACC program to become a national community care program, with clearer goals, targeting for both high and lower levels of need and strategic direction to provide an adequate home support program for an ageing Australia. This may involve prioritising core service types, such a care management, home nursing, home care, respite and benchmarking provision levels, or having provision norms as has been used to distribute residential care place equitably.

- Planning for both residential and community aged care be better linked at the local, regional and State level, supported by improved and integrated data sets.

- Recognition of the lower payments to States with lower levels of residential care and cost compensation for increased community care.

- Encouragement for domestic and other technologies that have the potential to reduce costs in the health and aged care system

CR. JOE CAPUTO
Mayor