NATIONAL EX-SERVICE ROUND TABLE ON AGED CARE

17 November 2008

The Secretary
Senate Finance and Public Administration Committee
P O Box 6100
Parliament House
CANBERRA ACT 2600

Dear Sir/Madam,

Re: **Submission to Senate Inquiry into Residential and Community Care**

The National Ex-Service Round Table on Aged Care (NERTAC) wishes to make a submission to the Senate Inquiry into Residential and Community Care.

NERTAC was inaugurated with a grant from the Minister for Veterans' Affairs approximately ten years ago and comprises representatives of the major ex-services organisations together with state representatives some of whom are aged care providers. After much lobbying, the *Aged Care Act* 1997 was changed in 2001 to include veterans as a "Special Needs Group". The definition of "special needs" was deliberately designed to embrace the whole ex-service community, not just veterans and war widows.

The whole ex-service community has wide characteristics. Whilst some have graduated entitlements to benefits under the Department of Veterans' Affairs (DVA) gold, white and orange cards, many do not. The interface of community care services funded by DVA with other agencies of the Australian Government and State and Territory Governments can be disjointed, thereby adding complexity for consumers. A more "seamless" service is highly desirable.

Numerically, the ex-services community stood for many years at 25% or more of the population of older Australians but this figure is declining with the demise of World War II veterans. Vietnam War veterans, as the largest single group of post WWII veterans, are now predominantly aged over 60 years of age. Smaller numbers are being added as a result of past and current peacekeeping activities and some of these will require whole of life care predominantly within the community care environment. Females, including war widows, now form the majority of the community.

I turn now to the six particulars listed in your Committee's terms of reference:

(a) QUALITY SERVICE PROVISION OUTCOMES

Whilst the quality of care provided in residential care facilities has not been a major issue for NERTAC, there are some aspects which will improve care outcomes:

- Greater focus on the Special Needs of veterans
- Better linkage of military service and clinical conditions
- Demonstration Projects
- Improved funding to enhance lifestyle outcomes

Greater focus on Special Needs of veterans

The *Aged Care Act* 1997 currently defines five "special needs groups". Throughout the aged care environment, there are attempts to address the needs of each of these groups. However, the focus on veterans as the fifth group is not as well defined. In the ACAR process, there have been a few places allocated as veteran specific places. Our estimate is that some 80% of the veterans who are in residential care are in mainstream facilities that are not owned by the ex-service community, and who are in undesignated places.

In the accreditation process, aged care providers are required to provide information about how the facility addresses the special needs of Aboriginal and Torres Strait Islanders and CALD groups, etc, but this is not the case with veterans. Feedback from our visiting welfare officer system is that many facilities do not identify veterans and war widows or the wider ex-services community. People in the first two groups are issued with DVA cards and, therefore, have an obvious inclusion in "special needs".

If the aged care provider does not identify veterans then how can they respond to these needs? A suggestion has been that the accreditation process could be enhanced to require providers to detail the focus which they put on services for veterans special needs group.

Better linkage of military service and clinical conditions

It is acknowledged that the 44 Outcome Standards are written at the highest level.

There is a very large and growing body of academically referenced studies showing the connections between military service and health, particularly ill health. Some of the effects are latent and sometimes do not come out until later stages of life. For example, some veterans find a need to express thoughts and feelings in end of life process in palliative care stages.

Alcohol and substance abuse is common as is the use of legally prescribed drugs and these factors are directly linked to the physical and mental health of veterans.

The families of veterans may be affected as individuals and in the carer role. The effect on wives has been long recognised with more recent studies showing effects on children.

A study on the children of Vietnam Veterans shows a direct connection between their mental and physical health and the service of their parent (usually the father) in Vietnam. As far as we know there are no children (who are typically around 30 years of age) in residential aged care but there could be some who will require community care.

Better knowledge of the military connection by aged care providers will provide better signposts to physical and mental conditions leading to improved quality of care.

Demonstration Projects
A recent study by Professor Tracey McDonald RSL LifeCare Chair of Ageing at Australian Catholic University, North Sydney, shows that whilst aged care delivers dementia care generally well, it does not deliver psycho-geriatric care very well at all. The study was based at the very large War Veterans Home at Narrabeen in northern Sydney where there is a very high percentage of veterans.

Further research is also emerging through RSL (Qld) War Veterans Homes (RSL Care) in Queensland in conjunction with various University research units.

A means of demonstrating better practice veteran care is through demonstration projects and there is some research emerging but more is needed.

Improved funding to enhance lifestyle outcomes
Feedback from the visiting welfare officers engaged with ex-service organisations such as RSL, War Widows Guild, Legacy and others is that aged care staff are extremely busy with significant pressured in meeting quality outcomes. Funding now provided by the Aged Care Funding Instrument (ACFI) places certain values on domains.

Residents report that staff has little time to respond to their physical needs let alone listen and talk to them. The clinical focus prevails often at the expense of lifestyle outcomes. There should be no doubt that clinical care is important but residents highly value lifestyle interactions equally.

Improved funding to enhance lifestyle outcomes is highly valued by the veterans' special needs group

(b) **INDEXATION FORMULA TO MEET LEVEL AND QUALITY**

NERTAC is not expert on the substance of indexation formulas but it would comment on the effects of the current arrangements on both residential and community care.

Residential aged care
Whilst the Minister for Ageing continues to highlight record spending on aged care, this is hardly surprising since there is record number of funded places and normal inflationary pressures mean that any Minister for Ageing is likely to be able to claim record Government outlays. The claim is quite superfluous but politically appealing.

The benchmarking studies of companies such as Grant Thornton and Stewart Brown continue to highlight the poor financial outcomes of the entire sector. The sector has been encouraged to become more efficient and there is consolidation of facilities and providers which is one indicator of efficiency. However, the poor financial performance of most of the sector and declining profits in the top quartile are indicators that the indexation formulation is failing.

Analysis of the higher performing aged care facilities will show that the higher performers are either offering Extra Services (where the margin is greater) or they are offering multiple bedded older style facilities. However, consumers are demanding single en-suited facilities which cost more to build and more to operate.

In addition, some publicly listed companies are understood to be booking revaluations as profit or artificially charging operational costs to the corporate administration. Both these practices hide the real cost of residential care by artificially escalating claimed facility returns.

The sector is totally controlled in regard to price fixing but subject to enormous cost pressures as State and Territory Governments yield to union pressures to increase nurse wages to the point that there is now considerable difference between the salaries paid to registered nurses in public sector services and that able to be paid by the aged care sector. We understand that an injection of some $400M per annum would be required to correct the parity issue.

The pressure increases as public pressure on fixing the surgical waiting lists mounts and this causes further pressure as more nurses are attracted to public sector from aged care. Workforce competition works against aged care and the public sector is now competing for enrolled nurses who were previously unwanted by the public sector but now realised as a valuable resource.

The residential care indexation system is not working and needs to be revised to encourage providers to increase quality and also to retain them in the sector.

Community Care

NERTAC notes that DVA has an entitlement system that generally does not result in waiting lists for services. After some initial concerns about the cost escalation of DVA's Veterans Home Care scheme, the indexation system appears to be accepted by providers.

The indexation of Department of Health and Ageing packaged care, however, means that value is being lost from packaged care because providers are being forced to reduce the quantity of care provided. They are simply reducing contact hours to fit the budget. On the one hand this is a matter of grave concern especially where non-card holders are concerned. This contrasts with the care of veterans with card entitlements who have much greater access to services at lower cost.

It is a system anomaly that card holding veterans often do not access packaged care because:

- The client can aggregate various DVA services to a greater level than provided under packaged care.
- The client avoids the ACAT assessment which is required under packaged care.
- The client can "age in place" in DVA services whereas a packaged client in CCPs may not be able to access EACH because of waiting lists.
- The client co-contributions required by DVA services (and also HACC) are far less than required under packaged care, eg, $5 per week for Veterans Home Care compared to $46 per week
- This manipulation of the system may suit individual clients but it actually substantially reduces the funding pool available for community care and is a sign of the failure of HACC (and DVA) to agree on a common set of user charges across States and Territories since 1985.

Some progress on Community Care matters was made by the Coalition Government under the *Way Forward* but his has essentially stalled.

The community care strategy needs a comprehensive overhaul to make it more equitable and easily understood by consumers and providers.

(c) REGIONAL VARIATIONS AND CONSTRUCTION COSTS

The regional drift issues combined with high growth of retirement destinations create double jeopardy in the allocation of aged care places. Some provincial centres and country towns will not be able to maintain stand alone aged care facilities because of declining resident numbers and/or the decline of available staff.

People do need to be maintained in their preferred community but the population data analysis must also be taken into account and it may be necessary to restructure or even close some facilities to create sustainability. The use of community care can maintain people for a longer period before it is necessary to make the residential care decision. Greater flexibility on community care will assist as will the availability of "ageing in place" in community packaged care.

"Ageing in Place" in community care is a similar concept to ageing in place in residential care. Providers can be funded to provide the higher level care with associated checks to ensure that quality is maintained.

In 2008, it is an obvious step that community care providers ought to be able to maintain ageing in place in community care within the overall place allocations. The restriction on packaged care is arbitrary especially with the wholesale packaging up of care outside the packaged care program, eg in HACC and DVA services.

Capital Creation environment
Capital creation was examined in the *Hogan Report* with only a partial Government response. Whilst there are some regional differences and some differences between the not for profit and for profit sectors, a crisis in the construction of new and redeveloped places is here already.

Some of the features of the current environment include:

- Land is excluded from the cost on economic grounds but most not for profit aged care providers do not trade in land and find if impossible to purchase land which is excluded from economic modelling on the basis that it might be sold in the future, eg in 50 years time.
- Many quoted costs feature construction costs only when the true cost includes land, local government contributions, consultants' costs, internal and external project management costs, land and holding costs, furniture and fit-out landscaping, finance and marketing costs. True costs exceed $200,000 per place and are higher in initial stages and become even higher with multilevel structures even allowing for less land consumption.
- Banks are declining finance for high care facilities because the provider cannot demonstrate the ability to fund the debt. The places are being handed back to DOHA and recycled.
- Government imposed ceilings on amounts paid by high care residents are far too low to fund the construction of new places or to provide for the redevelopment of existing places.
- The Government accommodation payments on concessional residents in high and low care are too low to fund the construction of new places or to provide for the redevelopment of existing places.
- Providers are imposing all sorts of "work arounds" to remain viable. Some of these include:
    - Limiting admission only to people who can pay accommodation bonds and who age in place to high care with their bond
    - Refusing to admit any concessional residents. This is especially the case with "for profit" providers who flout the allocation provisions and who believe "not for profit" providers will admit concessional residents.
    - Providers who encourage residents to make donations or refundable deposits in order to gain admission especially to high care.
    - Providers who admit all residents via unfunded places with an accommodation bond and the resident being transferred to a funded place later.
    - Competition for available accommodation bonds is robust in some communities with providers holding vacancies whilst waiting for a bond paying resident despite waiting lists. The economic argument supports that it is better to bear the vacancy for a period because the bond will offset the bed cost. This is preferred to subsidising the bed cost for a concessional resident especially as there is little margin to apply to the cross subsidisation.

There are increasing calls for better capital creation models. The answer is not more Government money, although this may be part of the solution. There is ample evidence that a greater user payment, where there is the capacity, is part of the solution.

Consumer groups are supporting these solutions and the Catholic HealthCare and Uniting Churches have also made statements as have the peak aged care associations. All have consistent threads supporting a revision to the existing model.

The Senate Inquiry needs to recommend a revision to the capital creation model. This is not an immediate crisis but a "creeping cancer" as providers innovate for the wrong reasons. However, a solution does require recognition of the problem and a political will to resolve. It will soon be too late and i t would be irresponsible for the current government to pass the consequences onto a future government.

(d) DIFFERENTIAL USER PAYMENTS

The failure of the HACC Program to implement a consistent fees policy has created inequity and introduction of co-payments in other programs has created difficulties for consumers and providers.

The veteran community has an "entitlement culture" which is ingrained in the DVA card system which carries a complex array of benefits related to treatment, rehabilitation and chronic conditions. When DVA introduced Veterans Home Care, there was some trepidation around the introduction of a user co-payment but there has been very little resistance and very few complaints about co-payment for Veterans Home Care.

However, entitled veterans, or their care providers, do "package up" Veterans Home Care and other DVA community care services to a level which can resemble CCPs or EACH and there is then resistance to payment of the packaged care co-payment especially as the services may not be equivalent or better. Similarly, other members of the ex-services community without DVA entitlements may package up HACC services in a similar way.

The ex-service community is a sub-set of the general community and likely to resist additional charges. Some DVA research supports the notion that veterans will be prepared to pay more for additional service but this needs to be tested in the context of the overall model.

(e) and (f) PLANNING RATIO

The Term of Reference to examine the current planning ratio of community, high and low care places is an inadequate and incomplete question.

That there should be sub-targets within the packaged care for CCPs, EACH and EACH-D is further evidence of the inadequate nature of this benchmark. In some communities,

there are vacancies for CCPs whilst waiting lists for EACH and this is a failure to recognise ageing in place. Program funding rules therefore override client considerations and a continuum of care concept.

The *Home and Community Care Act* 1985 was a sensible piece of legislation which subsumed various community care initiatives and created a consistent national environment. Since 1985, the concept of community care has greatly increased and been well accepted by the Australian community, including veterans, war widows and the ex-service community. However, there have been numerous variations and additional programs introduced, all for very good reasons. The current COAG agenda has focussed on redefining responsibility. No system will be perfect but a possible scenario is:

- The Commonwealth to be responsible for care of people over 65
- The States to be responsible for people under 65
- Mental health responsibility to be a State matter
- Disability services to remain a State matter

There will remain some boundary issues such as the ageing of physically and mentally disabled persons and the way in which they might transfer to over 65's responsibility.

Planning ratios for service provision in any particular area need to take into account services provided not only in residential care and packaged care but also the HACC Program, services to veterans and services funded under other programs. The carers will remain an important consideration.

NERTAC strongly takes the view that services to entitled veterans and war widows (regardless of age) MUST remain a responsibility of the Commonwealth and provided with the involvement of the Department of Veterans' Affairs.

On behalf of NERTAC, I am pleased to have the opportunity to make a submission on behalf of the ex-services community. Ageing is a matter of considerable and ongoing interest. NERTAC would be pleased to arrange for representatives to present to the Inquiry either in Canberra or as the Inquiry consults in the States. Contact is best made through Mr Eric McDonald, Secretary NERTAC, at DVA (Tel. 02 6289 6063)

Yours sincerely

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Chairman
National Ex-Service Round Table on Aged Care