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

Dear Sir/Madam

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

This is a personal submission to the Inquiry. My views on the funding, planning, allocation, capital and equity of residential and community aged care in Australia are a result of my experiences in a both a governance and an advisory role in a regional public health service, and, as a Legatee and voluntary welfare worker with Far North Coast Legacy.

The terms of reference I wish to address are c, d, e, and f.

(c) *measures that can be taken to address regional variations in the cost of service delivery and the construction of aged care facilities;*

Equity in the provision of aged care services is constrained by variability in workforce availability and, in the case of residential services, by the cost of land and building costs. The allocation of land for public purposes like schools and hospitals and housing has, in the past, provided opportunities for the construction of residential aged care facilities and there are many adjacent to hospitals in rural towns. In small rural communities the Multi-Purpose Service (MPS) model has proved to be very successful where the number of aged care beds required is insufficient to create a viable stand alone facility which could attract investment by an aged care provider.
The MPS model has an added advantage of providing a focus for the delivery of a flexible and integrated health service to a community where general medical practitioners are supported as members of a team by well qualified and multi-skilled nursing, allied health and ambulance staff. Further the residents of the aged care beds have ready access to medical and nursing staff if they are sick or in need of palliative care. Software systems, like Medical Director, further enhance the efficiency of record keeping, creation of prescriptions and ordering of test
Different funding sources for capital and operating costs of MPSs creates extra work, duplication and unnecessary complexity for administrators and a solution to this problem would be welcomed.

Variability in land costs, particularly the high cost of land in coastal fringe areas with greater than average resident populations of older people, in my opinion, can only be overcome by greater flexibility in what can be charged for accommodation. This may involve provision of a government subsidy for accommodation charges for a proportion of concessional residents to ensure equity. Alternatively, residents and their families may be offered an opportunity to either own or invest in the accommodation where they receive services.

(d) *whether there is an inequity in user payments between different groups of aged care consumers and, if so, how the inequity can be addressed;*

There is an inequity between so called 'low care'and 'high care'residential aged care places with respect to the payment of an accommodation bond which is inconsistent with the policy of ageing in place. Further it has the potential to cause distortions and family stress due to 'inheritance impatience' to the point where there is a risk of financial abuse. The difference between high and low care classification is becoming increasingly irrelevant as community care services are being rolled out and the level of acuity of residents admitted to permanent residential aged care increases to the point where they are all classified as requiring high care.
This inequity can only be addresses by a uniform approach to the payment for accommodation with a means tested safety net to ensure poorer people are not disadvantaged and denied care.

The differential rates of charging for publicly funded community aged care services depending on the funding source causes confusion and administrative costs. It is wasteful of resources and needs to be standardized as a matter of urgency. All publicly funded services could use the same fee structure which is realistically priced and indexed appropriately so that all recipients and their families can select what services they are prepared to pay for and what services they are able to provide from their own resources. If this approach were adopted it is capable of being further extended to a consumer directed care model where budget is used to pay family members for certain services such as personal care, cleaning, gardening and meals.
As with accommodation charging for residential care, there would need to be a means tested safety net for poorer families.

(e) *whether the current planning ratio between community, high and low care places is appropriate;*

As the level of acuity increases to the point where all prospective residents are classified as high care, the ratio becomes irrelevant. The total numbers requiring residential high care, that is those older people who are no longer able to care for themselves and whose families are also unwilling or unable to provide care, could possible be estimated using an evidenced base approach and which uses a less crude grouping than 'over 70',

for example using 5 year groupings from age 70. What the 70-75 year group require will be different from the 90 to 95 group. Also there will be differences between special needs groups.

(f) *the impact of current and future residential places allocation and funding on the number and provision of community care places.*

I'm not sure what this question is seeking to answer. What could impact on community care places is whether or not residential beds are built and occupied. If vacancies occur in residential aged care facilities this could lead to pressure from providers to admit residents prematurely. Further, as private homes are built and/or modified for lifelong living, the chances of a particular individual needing a residential aged care placement declines and may only be required at the end of life if there are family members unavailable or unwilling to provide care. However the overall demand is anticipated to increase as the population ages.

The ratio needs flexibility to respond to demand but is 'clunky' because of the lead in time for constructing a new bed which needs to be occupied for a number of years to provide an adequate return on capital. This is why, in my opinion one could argue that it is preferable for the capital to be owned by the recipient of care.

Thank you for the opportunity to make this submission.