PARLIAMENT OF AUSTRALIA

THE SENATE STANDING COMMITTEE ON FINANCIAL AND PUBLIC ADMINISTRATION

INQUIRY INTO RESIDENTIAL AND COMMUNITY AGED CARE IN AUSTRALIA

2008

SOUTH AUSTRALIAN GOVERNMENT SUBMISSION

The following is the South Australian Government's response to the Senate Standing Committee on Financial and Public Administration Inquiry into Residential and Community Aged Care in Australia.

Responses to the Terms of Reference highlighting Key Points are included on pages 16-20 of this submission.

Older people are generally higher users of health care services and delays in the aged care system could result in older people inappropriately residing in public hospitals for extended periods of time.

This situation is particularly exacerbated in country areas where there are less non government or private aged care providers. As a consequence, there are considerable numbers of Nursing Home Type Patients (NHTP) residing in South Australia's country public hospitals.

These hospitals are usually located in small and isolated townships where there are no or few alternative residential aged care facilities or aged care packages to support them in the community. Residing in a country hospital as a NHTP is often the only option unless the older person and their family are prepared to receive support in another locality.

Under the Council of Australian Government (COAG) Long Stay Older Patients initiative, South Australia is utilising Australian Government funding to undertake capital works in country areas to upgrade and develop facilities to meet the 2008 Aged Care Standards. This is enabling South Australia to establish Australian Government funded Multipurpose Service (MPS) sites across a range of less-populated country areas, which means that older people are able to access appropriate aged care services and accommodation in their local area.

Service models for aged care are increasingly focussing on community-based care which enables older people to stay in their own homes in the community rather than entering residential aged care. There is an increasing demand for these community

services. South Australia has experienced steadily growing waiting lists for its community based Transition Care and Metro Home Link programs[1].

The shift from residential care to more community-based provision is supported by the SA Government. It is noted, however, that this shift means a generally higher level of dependency in people who require residential aged care, resulting in more residents in high-care places.

Like residential aged care, there is clear evidence that the client profile across community aged care programs is changing. For example, South Australia is experiencing increasing numbers of older people with complex needs being referred to Transition Care and Metro Home Link programs.

As older people increasingly receive care in the community, the level of service and the expertise of care-givers has not necessarily increased; nor has the community care sector's ability to deal with short term crises. If the shift towards community care is not met with an associated increase in service providers' ability to manage complex clients and once-off challenging events then it can be expected that hospitals will bear the brunt of increased demand. This is likely to then flow on to other health care services such as the Transition Care or Metro Home Link programs.

Once assessed as eligible for services, usually followed by a period on a waiting list, the client, their family and the service provider believe that the client will have life-long and increasing care needs. Workers in Transition Care and other community programs identify significant benefits in episodic or short-term higher intensity service provision for some clients leading to lower ongoing support needs. This approach has the potential to provide significant benefits for clients and savings to Governments, but for this approach to be effective a major re-focus of the system needs to occur. Clients and their families will need to have confidence that, should circumstances for the client deteriorate, they will not have to return to the waiting list should higher levels of service be required.

[1] Metro Home Link is a South Australian Government funded service that is available to provide short term support and assistance for people in their own home or residential aged care facility, with an aim

TERMS OF REFERENCE

Service Viability and Quality

The Grant Thornton Aged Care Survey 2008 noted that high construction costs, particularly higher costs in rural and remote areas, and lack of corresponding financial returns for providers are barriers to the redevelopment of age care facilities.

South Australia currently provides 1423 beds for older people who require nursing home accommodation and care in country hospitals. 1174 are funded by the Commonwealth Government and 249 are funded through the South Australian public hospital system.

Responsibilities of the Commonwealth Government under the *Aged Care Act 1997* need to be met so that all Nursing Home Type Patients (NHTP) in SA country hospitals are fully-funded by the Commonwealth Government.

Insufficient funding has placed significant pressure on care workers to complete personal care tasks for a large number of individuals in unrealistic time frames, affecting the quality of care.

Inadequate pay and work conditions of care workers impacts on the attraction and retention of quality staff.

Mental Health

Access of older people requiring mental health assistance to residential aged care and community care is difficult, creating issues of equity for this group.

The Commonwealth Government has recently released a draft report on Residential Care and People with Psychogeriatric Disorders. [2] It proposes an optimal service model for people who have moderate to severe behavioural disorders which includes the provision of high dependency units operating as longer-term transition services. These units are proposed to operate within a single 'campus', either virtual or physical, or through a regional network and would provide step-up and step-down care as required for mainly time-limited care.

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to avoid preventable hospital visits/admissions or to assist patients to leave hospital earlier.

[2] Australian Government Department of Health and Ageing Draft Report to the Minister for Ageing on Residential Care and People with Psychogeriatric Disorders 2008.

South Australia supports the service model relating to high dependency units in residential aged care with a transition function as identified in the Commonwealth Government's draft report entitled *Report for the Minister for Ageing in Residential Care and People with Psychogeriatric Disorders*.

Such services will be co-located within large non-government residential aged care facilities and will build capacity and support mainstream aged care services.

Capital assistance from the Commonwealth Government for infrastructure in relation to this high dependency model is needed.

Community Care

Demand for community care will continue to rise as the population ages and people increasingly choose a community care option if possible. Increased Commonwealth Government funding levels will be required within this context.

Services need to be flexible, timely and appropriate to the individual's circumstances to be most effective.

All service types which assist in keeping people in the community need to be available, including good links to services other than community care eg health care, transport.

Research of initiatives adopted overseas which streamline community care services and funding models needs to be undertaken.

Indexation

The cost of providing services is increasing at a rate that is higher than the level of funding from the Commonwealth Government and from resident fees.

The current indexation formula is not appropriate in recognising the actual cost of pricing aged care services to meet the expected level and quality of such services.

For non-government agencies current levels of indexation are not keeping pace with rising operational costs and are being supplemented from capital income sources.

The Grant Thornton Aged Care Survey 2008 noted increasing cost pressures have necessitated more 'commercial' policies in relation to residential aged care admissions, causing further hardship to financially and socially disadvantaged people with little capacity to make a financial contribution.

South Australia cannot operate within these 'commercial' imperatives in rural and remote areas, thereby impacting on levels and quality of services.

The failure by the Commonwealth Government to provide adequate funding results in cost shifting to public hospital systems nationally.

Cost variations between rural and remote and metropolitan areas

Total cost of building in rural and remote areas is significantly higher than in metropolitan areas. Average building cost per new residential aged care place in the metropolitan areas is around $175,000[3] compared to $250,000 to $300,000 in rural and remote areas.

The potential to obtain a component of financing from an interest free loan through the Commonwealth Government's *Zero Real Interest Loans for New Residential Aged Care Beds in Areas of High Need Initiative* is welcomed but the cost of repaying a loan of, for example, $3 million (i.e. 10 places @ $300,000) is still prohibitive.

The rural and remote subsidy is paid to providers based on the number of aged care places and is a component of operational income. Ideally, a similar weighting on the accommodation charge subsidy should be provided by the Commonwealth Government for rural and remote service providers, based on a zone system that reflects the higher cost of construction in rural and remote areas.

Commonwealth Government funding for aged care services needs to recognise the true costs associated with care in rural and remote areas and not simply focus on the number of age care services in a facility.

[3] Ibid, page 7.

Challenges for rural and remote service provision

Placing people in residential aged care facilities close to social networks (ie family/friends) greatly enhances quality of life.[4] Achieving this can be a challenge in rural and remote areas which has resulted in many long stay NHTP's in country hospitals.

Low care facilities in South Australian country hospitals were often built some distance from high care facilities. With an increasing population of older people with high care needs, many of whom are now residing in the facility designed for low care, difficulties exist in providing services across a dispersed site.

Larger, modern facilities generally require higher levels of staff.[5] Statistics indicate the number of registered and enrolled nurses in the aged care sector has declined despite the increase in operational aged care places.[6] This poses particular difficulties in the recruitment and retention of qualified staff in rural and remote areas.

The average level of accommodation bond payments raised in rural and remote areas is significantly less than charged by metropolitan providers. This may be due to lower average value of private residences, lower average earnings, and lower participation rates in superannuation. The current impact of the drought in country South Australia will continue to exacerbate this situation.

In view of the lesser capacity of many rural and remote providers to generate significant capital from bonds, a loading on the accommodation charge paid by the Commonwealth Government needs to be considered.

User contributions and inequity in user payments

There is agreement that clients who can afford to pay should make a contribution to their care costs. However, there will always need to be safeguards to ensure that a client does not miss out on the support they require due to their inability to pay.

[4] Ibid, page 5.
[5] Ibid.
[6] Ibid, page 9.

National consistency in a fees framework across community care is essential and should take account of all care received. Transparency and equity of like contributions for like needs and services provided is critical. The basis of the framework, whether it be a percentage of cost of service or a percentage of pension or a set/capped fee, requires further investigation.

Inequity in user payments is evident particularly among country/remote residents, Aboriginal people and people with a mental health issue.

One of the Common Arrangements being progressed nationally under *The Way Forward* has been a National Fees Framework. It is suggested this work needs to take into account appropriate levels of care rather than fees charged across programs. This creates incentives and disincentives for people choosing levels of care. For example people who are eligible for Commonwealth Government funded Community Aged Care Package (CACP) may choose Home and Community Care (HACC) because of the lower fee structure. This results in insufficient care for their needs or an inappropriately high level of support through HACC, reducing capacity to accept HACC-eligible clients who have a lower level of need.

Residents in default of fees and payments

Reliable data is not available on the extent of late and default payments of fees and charges. There are indications that a small percentage of residents default on payments. The development of a direct debit system is worthy of consideration.

Impact of new Aged Care Funding Instrument (ACFI) on the demand for hospital services

The Commonwealth Government introduced the ACFI in March 2008. The ACFI is the new Aged Care Funding Instrument to be used for determining the level of payments for residents in aged care facilities. Along with the new instrument, new categories of funding are also being introduced. The new method is simpler, with fewer basic funding categories and two new supplements that will ensure funding is better matched to the needs of people with dementia and those with complex health

care needs. The time spent by aged care homes assessing residents for the purposes of funding will be significantly reduced.[7]

It is expected that the ACFI will result in a further reduction in the number of residents requiring low care. With only 12 of the 64 ACFI funding combinations applying to low care categories, the likely outcome is that only a small proportion of residents will in future enter residential care as a low care category. This in turn will further reduce the capacity of providers to access bonds.

The Grant Thornton Aged Care Survey 2008 expresses concern about the funding of people who have valid residential low care assessments. The Survey notes that under ACFI the level of funding for many potential residents is now so low that it is not feasible to admit them unless they can afford to pay a substantial accommodation bond. As a result many prospective residents without sufficient financial resources may be unable to access residential aged care services.

As there is poorer availability of low care residential services this will have unplanned impacts on the health system such as longer stays than necessary in hospital.

Already the hospital system and services such as Transition Care, are dealing with more complex clients and the lack of available places for long-term care. People approved for long term residential aged care who are unable to find a place result in cost shifting to the public hospital system.

While the Australian Institute of Health and Welfare has researched the movement of clients between hospitals and residential aged care, there has been little work done on the movement of community clients into hospitals and the outcomes. More research on impacts is supported.

[7] Australian Government Department of Health and Ageing Fact Sheet – What is the ACFI? www.health.gov.au.acfi

Current planning ratios

The current Australian planning benchmark is:

- 44 high care places per 1000 people aged 70+
- 44 low care places per 1000 people aged 70+
- 25 CACP and Extended Aged Care Package (EACH) places per 1000 people aged 70+

Current residential and community places allocations are based on the 70+ population. In South Australia there is a significantly higher population of older people. This affects the actual allocation of total residential and community places as well as the number of Transition Care places to support people moving from hospital.

The current "operational" ratio is calculated by dividing the number of operational places by the current 70+ population in thousands (projected from the 2006 Census).

The AIHW (2008:42) Report on Residential Aged care states that:

> *The age profile of the resident population continues to increase. Over half (54 per cent) of the 156,549 residents at 30 June 2007 were aged 85+, and over one-quarter (27 percent) were aged 90+.*

The Commonwealth Government aged care planning benchmark is currently based upon every 1000 people aged 70+, yet over half of all residents are aged 85+. The current benchmark is therefore likely to adversely impact South Australia which has the oldest population in Australia. In the 2006 census 15.1% South Australian population was aged 65 and over as compared to the Australian average of 13.0%.

Recent publications also support this view. Howe (2008: 18) states:

> *"Age 70 alone is a poor basis for defining the target population for residential aged care and is at odds with the inclusion of dependency criteria in defining the target population for community care. As those in residential care are very highly selected from the total population aged 70+, the great majority of this population are false positives, that is, individuals who are included but who are unlikely to use the service in a given year."*

There are significant demand pressures for community care, in particular Commonwealth Government funded CACPs. 'Waiting times for residential care' (as reported by the Productivity Commission Report on Government Services) is an indicator of the timeliness with which people are able to access residential aged care. In South Australia only 65.1% of Aged Care Assessment Team (ACAT) approved individuals had became CACP recipients within three months of ACAT approval, the lowest rate of any state or territory in Australia.

The current and future allocation of residential places should not occur at the expense of community care provision, particularly given older people's clear preference for independence and support in the community.

Olsberg et al (2004) have stressed the importance of 'ageing in place'. To promote wellbeing and community participation and to reduce costs to the community, mechanisms such as the provision of home and community care can promote ageing in place. It is wise to ensure residential places allocation does not come at the expense of provision of community care places.

ACAT data shows that South Australia has 42.6% of ACAT clients aged 85+ and 69.1% aged 80+.[8] This is compared with New South Wales where 39% of ACAT clients were 85+ and 64.6% were 80+. Data for those aged 70+ shows a much smaller effect. South Australia had 91.6% of clients aged 70+ while New South Wales had 90%.

The current ratios are not considered high enough to meet increasing ageing profiles. Planning ratios for South Australian country areas need review to enable more Multi Purpose Service (MPS) places.

While there is a specific need for high care places, it is important that current allocations across high and low level care are re-considered. The increasing number of clients deemed to be NHTPs in acute facilities indicates the need for increased ratios of residential care places across the population.

[8] National Data Repository Annual Report 2005-2006, September 2007

In remote places where community care services are unavailable, impractical or unsafe, consideration needs to be given to the extent to which the same planning ratios should be applied across all regions.

Affordability will influence planning ratios in the future as the cost of construction of residential facilities may become prohibitive, thereby redirecting the focus to community care.

As part of the Commonwealth Government's review of aged care planning ratios and the regular aged care allocation process, the actual cost of care should also be reviewed to ensure continued industry investment in the expansion and development of aged care services into the future. This should also reflect increased costs for service provision in rural and remote areas.

Increased provision of community aged care would assist a shift to preventative and earlier intervention services, delaying entry to aged care beds.

More regular reviews of planning ratios would assist to meet changing community needs and community expectations in a more timely manner.

Impact on Hospitals

The insufficient number of Commonwealth Government funded aged care beds is a significant issue and is placing significant pressures on the public hospital system.

Access to Transition Care and other community support also impacts on public hospitals. The bottleneck evident across the range of programs has adverse implications for waiting lists and health system efficiency, resulting in a system that is unable to deliver the appropriate care, at the right time and in the right setting.

The Commonwealth Government's increase of transition care services nationally over the next four years, including 176 extra beds for South Australia will provide some assistance in moving patients out of hospital and back into the community. However, transition care places do not address long term residential care requirements.

The Grant Thornton Aged Care Survey 2008 identified that 70% of permanent residents were assessed as requiring high care at 30 June 2007 compared to 58% in 1998. The Survey also notes the ageing of South Australia's population can be expected to greatly accelerate these trends which will require significant investment in modern high care facilities.

Community care in rural and remote areas

Continuity of care is considered an important requirement for those who receive services. This already applies in many rural and remote locations where Domiciliary Care, HACC, Allied Health, CACP, respite, MPS, residential, acute hospital care and related services are all managed by SA Health. In some locations, however, the continuity of care is not feasible when a client moves from Domiciliary Care/HACC to respite, CACP and then to Extended Aged Care at Home (EACH) only to return to the public hospital system when care levels determine residential support is required.

Within the MPS sites in rural and remote South Australia the capacity exists for continuity of care as all services are delivered by a single provider.

The opportunity exists to improve the level of continuity in many other rural locations by reassessing the process of allocating CACP and EACH packages including EACH Dementia, such that a single provider or service site can deliver the required level of care to clients.

THE SENATE STANDING COMMITTEE ON FINANCIAL AND PUBLIC ADMINISTRATION

INQUIRY INTO RESIDENTIAL AND COMMUNITY AGED CARE IN AUSTRALIA 2008

Terms of Reference	Key Points
Whether current funding levels are sufficient to meet the expected service quality outcomes.	Current funding levels do not meet the expected service quality outcomes. Standards of care have increased, placing pressure on providers to deliver services of a high quality within constrained budgets. Australian Government funding frameworks have not been adjusted over time to allow providers to meet consumer expectations, required quality outcomes and increased business costs. All Nursing Home Type Patients in country hospitals should be fully funded by the Australian Government. The cost of providing services is increasing at a rate that is higher than the increase in funding from the Australian Government and from resident fees. Older People Mental Health Services (OPMHS) face particular challenges in meeting the demand of older people with mental illness and with severe behavioural and cognitive symptoms of dementia. High dependency units are needed for people with challenging behaviour, preferably attached to selected residential aged care facilities.

Terms of Reference	Key Points
	Demand for community care will continue to rise as the population ages and the trend for people choosing community, rather than institutional, care continues. Aged care is primarily the responsibility of the Australian Government and failure to provide adequate funding results in cost shifting to States, mainly through pressure on the public hospital system to provide this care. This impacts on the capacity of public hospitals to deliver acute health care. Access to Australian Government funded aged care beds is a significant issue for South Australia.
How appropriate the current indexation formula is in recognising the actual cost of pricing aged care services to meet the expected level and quality of such services.	For non-government providers current levels of indexation are not keeping pace with the rising cost of every day goods and services and the capacity of providers to maintain an acceptable level of continuous improvement is limited due to these increasing cost pressures. SA Health is an aged care service provider across a large range of rural and remote locations. Subsequently, there are a considerable number of Nursing Home Type Patients (NHTP) residing in country public hospitals.
Measures that can be taken to address regional variations in the cost of service delivery and the construction of aged care facilities	Locality is a key factor in operation costs regardless of the number of places. The rural and remote subsidy paid to providers is essentially a component of

Terms of Reference	Key Points
	operational income. A similar weighting on the accommodation charge subsidy should be provided by the Australian Government for rural and remote service providers. This additional subsidy should be based on a zone system that reflects the high cost of construction in rural and remote areas.
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 are equity issues for aged care consumers and there are significant issues of access for country/remote residents, Aboriginal people and people with mental health issues. The Way Forward National Fees Framework is considering differing fee policies and schedules across various funding programs. Decisions to move between programs are being made based on fees charged rather than appropriate care. National consistency in a fees framework across community care is essential and transparency and equity of contributions for like needs and services is critical. There is agreement that clients who can afford to pay should make a contribution to their care costs.
Whether the current planning ratio between community, high and low-care places is appropriate	The South Australian Government welcomes the Australian Government's flexibility and preparedness through its planning review, to consider its rural Multiple Purpose Service (MPS) needs.

Terms of Reference	Key Points
	The current planning ratio for Australian Government funded residential and community care based upon the 70+ population is inappropriate. For South Australia where there is a significantly higher population of older people who are 70+ this affects the actual allocation of total residential and community places. The current and future allocation of residential places should not occur at the expense of community care provision, particularly given older people's clear preference for independence and support in the community. Increased provision for community care would assist a shift to preventative and earlier intervention services delaying entry to residential aged care beds. The Australian Government has announced that it will review aged care planning ratios and the regular aged care allocation process. The actual cost of care should also be reviewed to ensure continued industry investment in the expansion and development of aged care services into the future. Community Care programs have been expanding in recent years and as a consequence this is also reducing the number of residents who are seeking low care residential services.

Terms of Reference	Key Points
The impact of current and future residential places allocation and funding on the number and provision of community care places.	The current and future allocation of residential placed should not occur at the expense of community care provision, particularly given older people's clear preference for independence and support in the community. The insufficient number of Australian Government funded aged care beds is a significant issue and is placing significant pressures on the public hospital system. The ageing of South Australia's population will require significant investment in modern, high care facilities. Regardless of the allocation process for residential places, there are indications that construction, maintenance and replacement costs in rural and remote areas in the future may be prohibitive.