Municipal Association of Victoria

SUBMISSION TO SENATE STANDING COMMITTEE
ON FINANCE AND PUBLIC ADMINISTRATION

Inquiry into residential and community aged care
In Australia

Date: November 17th, 2008.

MUNICIPAL ASSOCIATION OF VICTORIA

Table of Contents

1. The Municipal Association of Victoria

The Municipal Association of Victoria (MAV) is the peak body for local government representing 79 Victorian councils. The purpose of the Association is to promote and support the interests of local government throughout Victoria, as defined in the *Municipal Association of Victoria Act 1907*.

1.1 Local Government in Victoria

Councils in Victoria have historically played a major role in the planning, funding and provision of a range of human services, including community and home based care services for older people and people with disabilities. In Victoria, local government is the largest public sector provider in both planning and delivery of Home and Community Care (HACC) services, and the major provider of home care, personal care, respite care, property maintenance, delivered meals, assessment and care management and service system resourcing. It thus operates a locally accessible and integrated HACC service model. Thirty – seven percent (37%) of the annual recurrent HACC Program grants in Victoria for 2008/9 are paid to local government to provide these core services, however councils contribute additionally from their own resources to supplement and expand the available community care services.

Local government in Victoria funds a third of the costs of all the local community care services it provides for aged and disabled people. (Victorian Grants Commission data 2006/7).

- Commonwealth and State grants $168 m
- Local government contribution $110 m
- Fees and other contributions $63 m

Although the major commitment has been in HACC services, councils are also providers of other Commonwealth funded aged and community care programs, and also provide significant levels of infrastructure from their own revenue sources e.g.; community transport and local meeting facilities for seniors' social and recreational groups and programs.

- 76 of the 79 councils (96%) provide / fund a range of core HACC services
- 43 councils (54.4%) are providing Veterans' Home Care from 2007 (previously 63 councils – commitment lost through tendering process)
- 23 councils provide Community Aged Care Packages (29%) - although several of these are the lead agencies for regional consortia of councils, so the total number of councils participating is higher.
- 2 provide EACH packages (high level community care)
- 18 councils provide residential aged care (22.78%) (data from 2007 AIHW Reports)

2. The MAV and the Aged and Community Care Context

The MAV appreciates the opportunity to respond to the Senate's current **Inquiry into residential and community aged care in Australia** and will focus remarks mainly on the Terms of Reference on planning and funding. The MAV has previously made

a range of submissions to the Australian Government on models and directions of community aged care, most recently to the **Review of Subsidies and Services in Australian Government Funded Community Aged Care Programs in 2007.**

The MAV has been involved in research undertaken by the Victorian Community Care Coalition on "community care for the aged over the next 10 years", and research undertaken on behalf of the Myer Foundation into the targeting of Home and Community Care (HACC) Services and future models of care for high needs clients and ongoing representation and contribution to the range of HACC and community care research and planning undertaken by the State government.

2.1 Key principles underpinning the MAV and Victorian Local Government's perspective on community care:

- Assist people to maintain independence in their homes as they age.
- Provide care that is client centred.
- Maximise client independence by supporting 'Active Ageing' approaches.
- Provide equitable access to services based on need.
- Provide ease of consumer entry into the care system by offering streamlined community care access points with existing key service providers.
- Deliver community care consistently across all programs.
- Streamline administrative requirements so that more resources can be redirected into service provision.
- Support older people as their needs change by maximising continuity of care and integrated service responses to aged care.
- Analyse and allocate aged care expenditure to the acute, residential and community care sectors as a total package, and that the allocation of community care budget is progressively increased.
- Preserve capacity for early intervention and preventative services, by quarantining basic support services from the pressures of high needs clients.
- For services to be sustainable, and reflect trust in partnerships between government and providers, real wages growth in the sector must be reflected in the method of calculating the annual cost escalator used for grants.

3. MAV Response to Terms of Reference

The Terms of Reference for the Senate Enquiry relate specifically to the adequacy of the planning and funding of aged care services provided through the Commonwealth Aged Care Act 1997. From a local government perspective in Victoria, it is the different histories, focus, planning, funding and administrative arrangements that occur between the Aged Care Act and the Home and Community Care Act 1985 that create an impediment to having a well planned and managed, easy to access and traverse, aged care system of services that can adequately meet the service range, service levels, standards and expectations of an ageing Australia. It is the way the Commonwealth created and funded community care as a substitute to and out of its experience of residential aged care, rather than knowledge of the existing community care services, that has created rigidity and fragmentation between the two systems. Some of the constraints could be addressed by developing a national aged care planning framework, encompassing all of community care as well as residential aged

care. Currently the planning for HACC and Aged Care services is done quite separately, without adequate data and processes for knowledge sharing.
Local government would like to see a national system build on local planning and knowledge, with well co-coordinated supply, demand and utilisation data shared and compared at the local, regional, state and national levels.

3.1 TOR (A) and (B): Adequacy of current funding levels and indexation

Feedback from councils who are CACP providers consistently report on the inadequacy of the current package levels, lack of flexibility for more differentiated levels of care, and the inadequacy of indexation to address real wages growth in the sector. A recent VECCI survey of local government wages in Victoria reported that indexation on wages would average 4.1% in the second half of 2008. Community care service costs are predominantly wages driven, but travel, supervision and training costs also need to be adequately factored in to attract and support a sustainable workforce delivering quality care. There are also additional occupational health and safety risks for community care workers, as they work alone in individual homes, doing manual work, and there are additional costs involved in having to assess and manage risk in every individual home setting. The community care sector has one of the highest work based injury rates.

It is acknowledged that this Inquiry is primarily concerned with the funding adequacy of packaged community care which meet higher needs, however, the current system design of basic community care in HACC and case managed and higher levels of care through CACPs, creates some inflexibility for clients, whose needs can change over time, as well as inefficiencies for providers. Because HACC clients can also move on to needing a community aged care package, complex and inefficient purchasing arrangements are put in place to provide continuity of care from the services and workers they already know, when councils are not also funded to provide CACP. In addition, councils often experience pressure from CACP providers, to continue to provide HACC services so that the value of the aged care package can extend further to address the client needs. This commonly happens with Delivered Meals - and as the HACC contribution now meets less than 13% of the real costs of producing and delivering a meal, it is in reality more a council than a HACC subsidy.

In one metropolitan council example, over ninety CACP clients (formerly HACC clients) continued to have home care and similar services purchased by twenty three different CACP providers, whereas it would have been more efficient for that council to be awarded ninety aged care packages to allow these transitions from HACC to CACP as necessary, rather than have the payment transaction and communication costs with twenty three different organisations. Because of the planning and allocation process used by the Commonwealth government, there has never been a way of negotiating such an outcome, between service providers and government.

Recommendations:

1. That the current Commonwealth subsidy level for the basic CACP is inadequate and needs to be lifted immediately to ensure appropriate care for package recipients, and the annual indexation needs to increase to more accurately reflect real wages growth.

2. That the Commonwealth needs to consider more differentiated levels of package care and associated funding to more closely meet the differing levels of need presented among package recipients.

3. Given their central role in the provision of Home and Community Care Services (HACC) and the HACC population in Victoria, Local Government providers need to be given greater consideration in the allocation of CACPs, for reasons of service continuity, efficiency and knowledge of the consumer base.

3.2 TOR (C): Regional variation in the costs of service delivery and the construction of aged care facilities.

A number of inner urban councils in Melbourne have faced loosing small residential care facilities, but had difficulties in finding land of a suitable scale and cost to facilitate re –location. The Victorian government convened discussion around these issues and came up with the Land Bank project in which several parcels of State government land have been made available to not for profit providers to construct new residential care facilities. Unless there are strategies which address land and construction cost variations, it can be very hard to attract providers in areas of need.

The Australian Institute of Health and Welfare (AIHW) data on residential aged care for 2006/7 shows that community based providers are more prevalent in the remote rural and outer regional locations. When it is not possible to attract the larger not for profit providers, with capital raising capacity, or convert State funded health facilities, in these locations, the task falls to councils and community groups, and thus funding strategies that adequately address access and equity in remote and rural regions need to be furthered.

In relation to community care, the additional cost of travel in rural areas particularly needs consideration, as with petrol price increases, this has become an unacceptable cost burden either directly on to low paid workers, or for rural services.

Recommendation:

4. That regional variations in costs of land, construction, scale and delivery be incorporated into Commonwealth subsidy arrangements.

3.3 TOR (E) and (F): Appropriateness of current planning ratios and impact of current and future residential care places allocation and funding on provision of community care places.

Entry to residential care is increasingly at the high end of care need (70%) and the utilisation data shows that more residents are also older at admission. In 2006/7, AIHW report that 74% of people admitted for permanent care were aged 80 years and over. Preference for, and greater utilisation of community care packages over residential care for people born in non English speaking countries is a well established trend. All the evidence suggests that the planning ratios based on 70 plus populations should be further refined to more accurately reflect the characteristics of the population using the services.

Councils have expressed concern that the use of 70 plus population data is too crude to reflect demand and can distort priorities. An example is when an inter face council with growing numbers of aged people, and a high proportion with CALD

backgrounds, is identified by the planning ratio as needing beds, but actually have many more people nearer 70 than over 80 in that population, compared to a neighbouring council without much total growth in numbers aged 70 years plus, but rapid increases in the numbers aged 80 and over, who are far more likely to need the beds in the short term.

Councils have also been interested to understand the degree to which local residents are able to, or choose to, enter local residential aged care facilities, or move to other areas, for example to be near families. This data is either not collected, or not made available, at least not at the local area level. Councils are not able to access any supply, demand or utilisation data at the local and regional level from the Commonwealth, because it is not made publicly available, or even to state and local governments who should be planning partners. This seriously reduces the capacity for accountability, transparency, trust and sharing of comparative and qualitative perspectives and hence reduces the effectiveness of the planning process.

There is no connection between the regional and local planning processes and knowledge about the supply, demand and utilisation of HACC and related services and the Commonwealth aged care program. In Victoria, councils have not only the legislative responsibility for Public Health and Wellbeing plans, but also undertake Positive Ageing strategies. They are involved in partnership with the State government and local providers, in local and regional HACC planning and in the sub – regional Primary Care Partnerships, which focus on planning and actions to address health promotion, chronic disease management and service co-ordination. To plan residential aged care and packaged community care in isolation from these other planning processes and local knowledge reduces the potential and impact. The Commonwealth Minister does write to councils for their views as part of the annual planning process, but as no data is shared, this is a one sided process with none of the direct feedback or value that a partnership approach provides, or where comparative, normative, qualitative and quantitative data can be tested against each other and interpreted in light of local knowledge and experience.

There is strong support from councils in Victoria for the need to review and revise the planning ratio methodology and also the process of determining bed levels versus community care packages. However, planning for community care packages can not continue to be done in isolation from the rest of the community care system. Councils have also expressed concern about the allocation process for packaged care as it has resulted in a very fragmented service delivery system with multiple providers for small numbers of clients in some areas. There have been lost opportunities for consolidation for councils who are the major local community care providers and continuity of care for clients. Some CACP providers serve regional areas from one location and thus have no presence in many of the towns and more remote areas. This has resulted in some under servicing in parts of the regions and also reduced professional input and the value of sharing scarce professional resources in rural areas and small towns. Councils believe allocation processes should be based on an understanding of the service delivery systems and be committed to their development and co-operation, not criteria that favour competition over important policy outcomes such as sustainable system capacity and accessible and connected services for clients.

Recommendations:

5. That the planning ratios be reviewed and updated based on utilisation and demand evidence.

6. That a national aged care planning framework be developed, with co-coordinated development and use of supply, demand and utilisation data sets building up from local area data and incorporating a range of related program areas, with agreed processes between the three levels of government.

4. Recommendations:

The MAV welcomes the Senate's Inquiry into residential and community aged care, with its emphasis on the financial adequacy of subsidies to meet access and quality outcomes and the adequacy of the planning and allocation processes, and makes the following recommendations for the Committee's consideration.

1. That the current Commonwealth subsidy level for the basic Community Aged Care Package is inadequate and needs to be lifted immediately to ensure appropriate care for package recipients, and the annual indexation needs to increase to more accurately reflect real wages growth.

2. That the Commonwealth needs to consider more differentiated levels of package care and associated funding to more closely meet the differing levels of need presented among package recipients.

3. Given their central role in the provision of Home and Community Care Services (HACC) and the HACC population in Victoria, Local Government providers need to be given greater consideration in the allocation of packaged community care, for reasons of service continuity, efficiency and knowledge of the consumer base.

4. That regional variations in costs of land, construction, scale and delivery be incorporated in Commonwealth subsidy arrangements.

5. That the planning ratios be reviewed and updated based on utilisation and demand evidence.

6. That a national aged care planning framework be developed, with co-coordinated development and use of supply, demand and utilisation data sets building up from local area data and incorporating a range of related program areas, with agreed processes between the three levels of government.