Baptist Community Services

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The Secretary
Senate Finance and Public Administration Committee
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Parliament House
Canberra ACT 2600

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Inquiry into residential and community aged care in Australia

Submission from 'Baptist Community Services of NSW and ACT'

The funding, planning, allocation, capital and equity of residential and community aged care in Australia, with particular reference to:

a. whether current funding levels are sufficient to meet the expected quality service provision outcomes;

There is currently not enough funding to provide the overall amount of service required to meet the existing demand for community and residential care at a high level of quality. In residential aged care the focus is on maintaining adequate nursing services in keeping with industry benchmarks. Important areas such as diversional therapy and administration can not be stretched to a 7 day a week service thereby reducing quality of life for residents. Through rationing services to promote equity and access for as many as possible, service quality is compromised. Strategies have been proposed by other organisations in previous submissions to the Government to reign in the year-on-year expansion of places through the Aged Care Approvals Round and use the freed up funds to build the capacity of the existing places to deliver higher quality service. However, the likely result of such a move would be to deny people access to services they may need in an existing environment of unmet need.

The BCS experience of the implementation of Aged Care Funding Instrument (ACFI) has borne out the predictions made by Aged Care Services Association and others in various submissions to the Government that the funding levels are not sufficient in low care. This is particularly the case where organisations are supporting 'ageing in place', an important government policy initiative to support older people's care need transitions. Where a client has entered a low-care facility and aged in place and exits with a high ACFI score, they can only be replaced by a low care client who will have a low ACFI. Newer services that can facilitate ageing in place for longer are better placed as they are able to care for residents in the palliative stage of their life. Older facilities that cannot cater for this level of care are negatively impacted from a funding perspective when out of

necessity these residents are transferred into a high care facility. This represents a significant decrease in the daily income the facility receives.

The Grant Thornton *Aged Care Survey 2008* estimated an average return on investment of approximately 1.1% for modern single bedroom facilities – the type that predominates in new high care facilities as providers have responded to market demand for this accommodation type and Government building certification requirements which limit the number of residents per room. Due to the increased floor plan of these types of services and the ability to care for people longer this has forced up the staffing requirements and cost base of operating accommodation settings with this structure in place. Notably the *Aged Care Survey 2008* highlights a declining EBITDA per bed for the sector over the past 5 years.

BCS finds that there are many people interested in entering low level care for the security and socialisation and for minor assistance with activities of daily living, but the current funding models do not make this type of care readily achievable – let alone sustainable for the providers. For the demographic of those aged population who do not have family support or where housing is inappropriate, this can have a significant impact on their capacity to remain supported in the community with a community care package.

The industry is experiencing increasing difficulties in attracting, training and retaining all levels of staff required to deliver its critical services. This is due in part to a tightened labour market but also to the pay and conditions available. The aged care industry is not competitive with other industries who can offer higher pay for similar qualifications (eg. Nurses and allied health in the health care system) or equivalent pay with less qualifications and responsibility (eg. Retail services such as supermarkets). Current income streams make it impossible to compete with external industries and attraction and retention of staff is a significant issue. This not only compromises the care delivery and continuity but often results in increasing agency usage which has negative impacts on quality care outcomes and drives up staffing costs further.

Personal care workers make up the majority of the community and residential workforces. They are relatively lowly paid and work on a part-time or casual basis. This flexibility is often seen as a positive for the industry in its ability to attract staff. However, the peak periods of mornings and evenings when people most need support are often the times when part-time/casual staff are least able to or want to work. Workers with school age children prefer to work during school hours and the prohibitive costs and availability of care outside of these hours creates restrictions and also can have a significant negative impact on staffing availability. With government policy directives advancing the worthy principle of consumer directed care, providers will find it increasingly challenging to meet consumers' perception of a 'high quality' service with support provided in these peak periods.

The aged care industry is a highly regulated industry with not only accreditation and certification requirements but workcover/OHS audits, food audits, quality reporting, integrated monitoring to name a few. This highly regulated environment has a significant impact on staff and diverts them away from the core business of care. This regulation conflicts with the reason many of them entered the workforce in the first place and subsequently drives staff out of the industry. The increased turnover in high care facilities is also creating additional administration demands on staff which again impacts on the quality of care they are able to provide to the residents. The administrative load of staff is estimated to have increased by 50% over the past three years. Data from the Stewart Brown Aged Care Survey 2008 indicates that administration costs in residential aged care are now only just below the costs of feeding residents.

b. 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;

Community and residential care recurrent funding formulae do not reflect the real costs nor bear any direct relationship to the costs of providing care. Since 1997, the indexation formula (COPO) used to adjust Government subsidies has not reflected the actual costs of service delivery as it fails to take proper account of cost increases faced by the industry. For BCS, increases in staffing costs are tracking at between 3-4% per annum, construction costs are estimated at between 8-9% per annum, utilities around 10% and groceries 5%. In other industries, such as private health insurance it is Government policy to ensure income matches costs (i.e. if they can demonstrate a 7% increase in costs, they get a 7% increase in premiums).

Costs have been rising in all areas including: wages (which represent approximately 75% of BCS's expenditure); insurance premiums; compliance costs with workers' compensation regulations and Government administrative requirements; costs of refurbishing or replacing older buildings and/or constructing new ones; fees and other costs associated with accreditation for residential care; and accountability costs for community care.

It is clear that either the COPO indexation method must be changed and that the Conditional Adjustment Payment (CAP), currently provided for residential care, must be extended to cover community care services. If this does not occur service providers will inevitably become unviable. A proposed strategy is that the 8.75% over the past five years be added to the base recurrent funding level and then an appropriate level of indexation be developed and applied which results in no less an increase than 1.75%.

This is evident in recent media articles (*Australian Financial Review*, 30 October 2008, *Herald Sun*, 29 October 2008) with some providers from Queensland and Western Australia announcing that they will cease provision of certain types of aged care due to inadequate funding levels and certainty about future operating costs. If the 'no bonds in high care' stance of various Australian Governments over the years is maintained, it is critical that the current accommodation charge for high care be reviewed. Data from the Stewart Brown Aged Care Report 2008 shows that providers are supplementing the day-to-day operational costs with income from capital. The result of this is high care facilities operating at a net trading loss per day of $7 and low care also showing a net trading loss per day of $4.

Government expectations of an efficiency dividend need to be accompanied by major investments in productivity improvement strategies otherwise the result is more commonly linked to declining quality of service. Currently the level of information and communications technology (ICT) take up across the sector is an area that could yield productivity gains and build capacity within the industry to support more people with a workforce that is projected to decline in number over the coming years. Unless the industry is supported to achieve productivity gains through such measures as ICT, staff training and development, the current funding arrangements will continue to not keep pace with the real operational costs.

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

Other agencies are in a better position than BCS to comment on this aspect.

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 currently inequity in the treatment of asset and pension assessment by Centrelink and the Department of Health and Ageing for the purposes of admission to residential aged care. This has resulted in there being no penalty for consumers (and this is a positive) as the Government

needs to continue to provide appropriate financial incentives for people to stay living at home. At the same time, providers need to have the confidence that they can predict cashflow from potential residents of their age care facilities. Currently this is not the case with differential treatment between the two agencies which impacts on the capacity to charge and settle on bond payments and the ongoing daily accommodation charge.

The experience of BCS in recent years in building high care is that it has had to provide a component of extra service to be able to financially afford the costs of construction and subsequent operation. The initial investment required for an extra service facility is significantly greater than that for a standard high care facility. This initial outlay is significant and requires a more protracted period to recoup. As there are clear market signals in some areas that extra service places will not be taken up by the population, for high care to be a viable service type of the future, the accommodation charge will need to increase from the current level of $28 per day. A proposed strategy is that this amount be doubled or even tripled to entice providers to construct high care beds in the future.

Greater flexibility needs to be afforded to providers in terms of accommodation payments as a means to reflect the different quality of premises (eg. High care facilities with single bed rooms with ensuites compared to 4 bed rooms with communal bathroom). Greater flexibility would also empower consumer choice to make decisions based on individual and family requirements. BCS will always have a high proportion of 'supported' or financially disadvantaged residents, over and above the minimum government requirements, met at our cost, in line with our Mission Statement.

International evidence indicates that Australia has a relatively low level of user contribution to the cost of their care in a residential setting. Canada and New Zealand both have monthly contributions roughly double that of Australia at AUD $7,000. The user pays component for community care is also quite low and whilst this is topped up with government subsidy it can be an issue in some areas with ongoing viability of operation.

e. whether the current planning ratio between community, high- and low-care places is appropriate; and

Current levels of community care have seen rapid expansion in recent years and could still be higher. Recent years have also seen an expansion in the number and type of community based services with the introduction of EACH, EACH dementia, Transitional Care, NRCP and HACC. There has also been a greater emphasis within the primary and acute health care sectors on supporting people in home-like environments with discharge planners focused on returning people from hospital stays to their home with support from allied health services such as Occupational Therapists, physiotherapists, podiatrists and dietitians. Again this has had an impact on residential care as clients are being supported for longer in the community delaying entry and at higher levels of care needs. Increasing acuity of clients on admission translates into increased care staff requirements within the existing funding parameters.

Therefore the low care ratio for residential could be lowered further, particularly given the rapid growth in alternate accommodation settings such as independent living units, self care accommodation and retirement villages. These settings have created another component of the aged care service continuum and have been targeted for community packages to enhance the range of services the residents receive within the villages.

The current situation with the international financial markets presents a question over the ongoing sustainability of the rapid growth that has been witnessed in this area of retirement accommodation for people over 65. Future developments may be put on hold as finance is not as readily available and people's capacity to pay for the units may diminish as their own

personal wealth has declined at the same time. This 'economic crisis' as it is being tagged may lead to people prolonging their time in the family home which may not be physically suitable to support ageing in place. This will lead to a greater reliance on community care programs to maintain people in potentially inappropriate arrangements. Early indicators are that prospective clients are very reluctant to cash in stocks or sell their house due to the current uncertainty in the market. This will place a number of people who do require residential care at risk.

The AIHW data for residential aged care in 2006-07 reported that the length of stay for residents has increased by over 14 weeks since the 1998-99 report. This most likely reflects the success of ageing in place in low care facilities and the ability of providers to care for their residents. However, it is felt that this pattern may start turning around soon based on a predicted move to residential care becoming a hospice-like environment.

Another indicator of the changing ratio within residential aged care is the relatively consistent statistic for the proportion of high and low care admissions (62/38) over ten years of reporting by the AIHW, whilst the proportion of all permanent residents with high care needs has risen from 58% in 1998 to 70% as at 30 June 2007 (Grant Thornton *Aged Care Survey 2008*).

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

It is more likely that the current and future residential places allocation and subsequent funding will not impact on community places. Rather the relationship is likely to be the opposite due to some of the factors outlined above. Government policy directions and societal forces are driving providers to have a greater emphasis on community based care and expanding options for clients in this area. This is a positive initiative where the Government and service providers are in synch with the broader community they serve. It would be worth considering whether the ratio of CACP's and EACH packages accurately reflects the needs of the community.

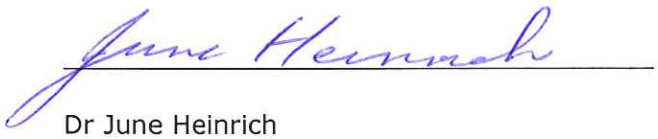
With the evident pattern of delayed entry of people into residential care and with higher levels of need, the funding of residential age care will need to more accurately reflect a changed casemix of residents. That is those who have higher levels of care needs, increased levels of dementia with accompanying challenging behaviours, and a greater need for palliation. It is also evident that residents will remain in high care settings for shorter periods of time with these more complex needs. In order to appropriately care for these residents complex health needs the types of services offered in RAC may need to expand. Whilst this has potential to take some of the pressure of the hospital system further training, equipment and increased funding would be required to support these clients in the future. Thus providers will be faced with higher levels of resident care, increased turnover but decreased access to bonds, due to a reduction in low care residents, which are needed to support the construction costs of new facilities.

The ACFI funding formula is also forcing an operational redistribution of places without being linked to the current 44/44/25 places per 1,000 of the population over 70 years of age ratios.

The service mix in community care in the future needs to be able to easily support the full spectrum of a person's needs from basic to high levels of care. It also needs to be able to support people's transition into residential care settings where their complex clinical needs can be met. In theory the current system does this with basic service provision through HACC and higher needs being met through packaged care. In reality HACC often provides higher levels of support than packaged care or combinations of both are required if an adequate level of care is to be available. People are unable to easily move between CACPs and EACH (or EACH

Dementia) because of availability issues. These arrangements need to be streamlined if the system is to be able to support people efficiently and effectively.

The release of future funding for community care places should be targeted to existing providers who are seeking to develop a continuum of service from low level HACC service types right through to CACPs, EACH and EACH dementia packages. Having providers with the capacity to effectively meet the needs of clients as their needs change will provide a more seamless model of care. The existing fragmentation in the system means that clients often get moved around different providers to have their needs met. Providers with a full suite of community care services would overcome this issue and provide greater continuity of support and care.



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