Senate Finance and Public Administration Committee

Inquiry into Residential and Community Aged Care in Australia

Submission from:
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Background:
Our organisation is funded under the National Aged Care Advocacy Program (NACAP) to provide advocacy for care recipients funded by the Commonwealth in Victoria. In this role we assist approximately 2500 people each year within Victoria with enquiries and concerns regarding their rights when receiving aged care services. Nationally, the NACAP services assist approximately 10,000 people per year across the country.

ERA has been providing advocacy in Victoria for over eighteen (18) years, initially under the Residential Care Rights Inc service name. This remains our incorporated association name, while we trade as Elder Rights Advocacy. We have chosen to comment on only on the terms of reference in which issues arise directly from our work. These comments and views largely come from consumers of services (and their families) as we provide advocacy assistance for them.

In regard to- Terms of Reference:(a) and (b)
Residential care concerns:
Increasingly we are hearing from residents living in aged care homes, and their family members that staff shortages are having an impact on their care and quality of life. They perceive that the shortage of staff to assist them is directly related to the constraints of funding, and this view is reinforced by management of the home when they raise their concerns. Many family members say they feel obliged to come in at mealtimes due to the lack of staff to assist their relative who may require some time and support to eat their meal.

Consumers and their families find this difficult to understand (and accept), when they are paying large bonds and income tested fees for their care. Continence management and time for assistance is another area where we hear complaints, again said to be related to lack of staff to toilet residents at particular times or when they request to be toileted.

We also provide a large amount of staff education and hear from staff members about the lack of time to interact with residents either with assisting with meals, or the time

to chat and provide emotional support. While some of this may be related to workforce issues, it seems from several recent reports that indexation of funding to ensure a high quality of staff training and numbers of staff on the floor, is now identified as being at a critical level. This is at a time when older people and their carers are expecting more in return for the 'user pays' system. The inequity in wages between acute care nurses and aged care nurses is also an issue that many older people and families are aware of and understand this may deter nurses from working in the sector.

Community care concerns:
In relation to community care, we have had numbers of people during the last few years who have been unhappy about the amount of care they could expect to have from their Community Care Package (CACP) or Extended Aged Care at Home (EACH) package. Much of their dissatisfaction relates to the inequity they perceive between the funding provided to the Approved Provider (AP), and the amount they actually receive (or don't receive) in hours of service. Increasingly, family members can find out what the overall funding levels are for CACP and EACH packages, and are angry at how little they may get in hours of service, compared to the administration costs for the AP.

The 'brokerage' model used by many AP's seems to diminish the amount available for direct care, even with the funding levels currently provided. Many providers are taking around 40% of the total package amount for administration and case management, leaving little for care hours. Lack of benchmarking by the Department of Health and Ageing as to what is a reasonable cost for administration and management does not help when we are attempting to challenge the level of service provided, although we would contend that 40% is excessive in most cases.

Recently we have had a number of cases from CACP and EACH clients where their service delivery hours are being cut, often it seems related to higher petrol and travelling costs. It appears that none of this increase in costs is indexed in to the funding for the provider. The consumer is expected to 'pay' through having less care to 'balance' their notional budget allocation.

> In one recent example an AP is charging the care recipient's package of $500 per week, for ten(10) hours of case management at a cost of $400. The AP is now seeking to cut the hours of service due to the cost blow out, even though the care recipient gets (at most), one phone call per week from the case manager. Ordering of continence supplies is also not handled well even with this much case management. The care recipient has had to get a family member to go and buy supplies when they were not ordered despite the supposed 10 hours of 'case management' in place. This case has now been taken to the Complaints Investigation Scheme, and we are awaiting their findings.

Many family members in the situation described above, would prefer to self manage the care for their family member and at least make better use of the current level of funds provided. Many are reluctant to complain however, as they may face either a

reduction in hours, or the only other alternative of moving to residential care, which they do not wish to do. 'Choice' in these situations is therefore a fallacy.

We believe that self managed care (as is offered in much of the disability sector) is one option that should be opened up for consumers as a means to address some of the funding issues for those who are able to take advantage of this option. Whether a voucher system is also introduced for all consumers should also be looked at.

The fees co-payment for community care is also an area that has wide variation. Although the Dept information states that no person will be denied service due to lack of ability to pay, we have had situations where one older person on a pension is struggling to cope with CACP fees, believing they should 'pay their way', while another pensioner client getting the same service is not being charged a co-payment at all. It is not clear how this fee payment is structured when packages are initially provided.

Terms of reference (d)

The negotiation of bonds which are a key component of funding the industry is often a matter of concern to us, with very little advice available for consumers in relation to the fact that the bond may in fact be negotiable. Most people believe they are obliged to pay what is requested, while perhaps understanding they must be left with a base level of assets. This is an area ripe for pressure tactics and misinformation, some of which we have seen in our casework over the years, with families also feeling pressured into providing the level of bond 'required'. Complaints about such tactics are not often successful. With no upper limit on bonds and little independent advice available, consumers can potentially be left with only the minimum level of assets, as raised in a recent Financial Review article.

With the recent change to ownership structures in aged care, consumers are no longer 'negotiating' with a small private provider, or church based service, but with a branch of the large investment banks (Macquarie), international private equity firms, and multinational health service providers (BUPA). As most people are handing over control of their biggest lifetime asset, (the proceeds of the sale of their home), we believe that this is an area where they are entitled to good independent advice. This could potentially be provided through advocacy programs with appropriate resources. In our state people have to pay privately for pre entry advice such as this, with several private agencies and financial planners entering the market.

Overall, the current funding system is largely hidden from consumers, although they are expected to pay income tested fees and provide interest free loans (through bonds), to support the costs of their care. As the level of these bonds (up to $500,000 and more) and fees increase, it will be necessary to provide a more consumer focused system such as vouchers (for community and residential care), and self managed community care to empower consumers, and recognise their real contribution to the costs of their care.