ACSA Submission

RESIDENTIAL AND COMMUNITY AGED CARE IN AUSTRALIA

Submisssion to the Senate Finance and Public Administration Committee

DECEMBER 2008

Aged and Community Services Australia (ACSA) is pleased to make this submission to the Inquiry into the funding, planning, allocation, capital and equity of residential and community aged care in Australia. ACSA represents the majority of the aged and community care sector and counts among its members over 1,100 church, charitable and community-based organisations providing housing, supported accommodation and community care services to around 700,000 older Australians, people with a disability and their carers.

ACSA believes that the financial pressures on aged care are reaching a critical point and that, unless action is taken, service failures are likely to result and our system will not be ready for the increased numbers of older people requiring care. This would be a false economy for government as it would result in older people using higher cost care options such as hospitals. More importantly it would represent an abrogation of our responsibility as a nation to the generations who have built it to this point.

Our submission is structured around the Terms of Reference for the Inquiry numbered a) to f) and we would welcome the opportunity to discuss our submission with the Committee.

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

Current funding levels are insufficient to meet expected quality service provision outcomes in a number of important respects:

Hours of service per client have declined in both residential and community care, reducing their quality of life and increasing the risk of more intensive and expensive interventions being required[1]. In residential care the effect has been most marked in high care as ageing in place tends to mask this phenomenon in low care.

The service purchasing capacity of a CACP has diminished considerably since 1995 with funding for packages less able to meet assessed need. The Australian Institute of Health and Welfare's report on the 2002 census of community aged care packages (AIHW 2004) indicated that, on average, clients were receiving 6.1 hours of care per week or 52 minutes per day. A lack of historical data on the amount or type of assistance received by clients means that direct measurements of care provided through CACPs are not yet able to be made over time. Nonetheless, it is possible to use other evidence to act as a proxy. Such data suggests that number of care hours per week has decreased markedly[2].

Wage levels for aged care staff continue to lag behind those paid by other employers in the same labour market, further exacerbating the difficulties experienced in recruiting and retaining skilled staff. Aged care staff are paid less than their counterparts in other parts of the health system, most notably hospitals. Our members around Australia report differentials of around 20% and the Productivity Commission has estimated the cost of closing the wages 'gap' at $450 million, to achieve comparability, and $100 million per annum to maintain a competitive position.[3]

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[1] For example see Bentleys and Underwood's National Residential Aged Care Surveys (2002-2008)

[2] In 1995/96 Community Aged Care Packages were allocated $9,366 per annum to purchase services on behalf of clients. By 2005/06 the value of the package had increased to $11,884. This amounts to an overall increase of 27.24% similar to the cumulative CPI increase over this period. However, the largest component of cost in aged care delivery is wages. Over the same eleven successive years, there has been an overall increase of 64.3% in the ordinary time earnings of full time working adults (64.7% for women). The increase in wages measured through this national data has been more than double the increase in CACP subsidy.

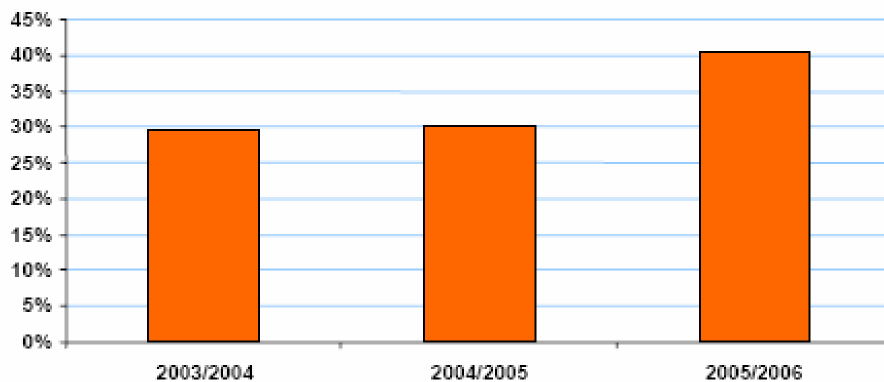
[3] Productivity Commission 2008

The third consequence of inadequate funding levels[4] is the non-viability of constructing new high care facilities. Current payments for capital purposes do not cover the cost of the new buildings required to expand residential care, especially high care, and to meet contemporary standards. This has resulted in many residential care providers putting building plans on hold. Some have announced this publicly, many more have reached this resolution privately. An independent analysis in 2007[5] concluded that, on conservative assumptions about capital costs, on current policy settings there would be a shortfall of $5.7 billion in capital over the following twelve years.

This problem is exacerbated by the changing patterns of demand for residential care and may be further heightened by the incentive structure built into the new Aged Care Funding Instrument (ACFI). These factors are discussed further below.

While people may argue about exactly when the tipping point will be generally reached, there can be no doubt about the direction of the financial trend in aged care which is consistently downwards.

% of providers with RAC segment loss



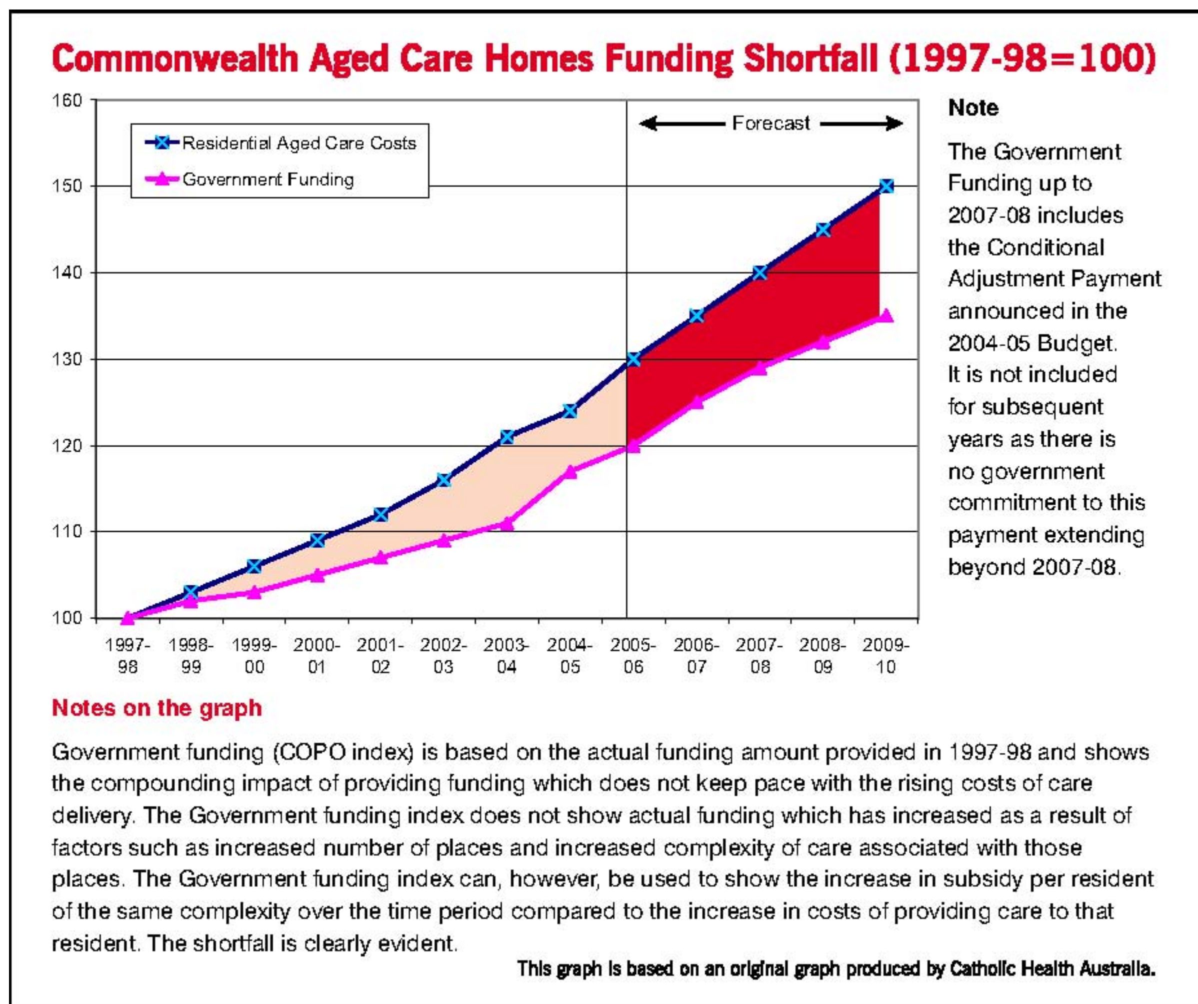
As the chart above shows, increasing numbers of residential aged care services are operating at a loss and all are suffering declining returns. Clearly this cannot continue indefinitely and equally this state of affairs cannot be good for service quality.

This situation has arisen because of the indexation system used across the aged care program and the system of user charging for the costs of accommodation particularly in high care.

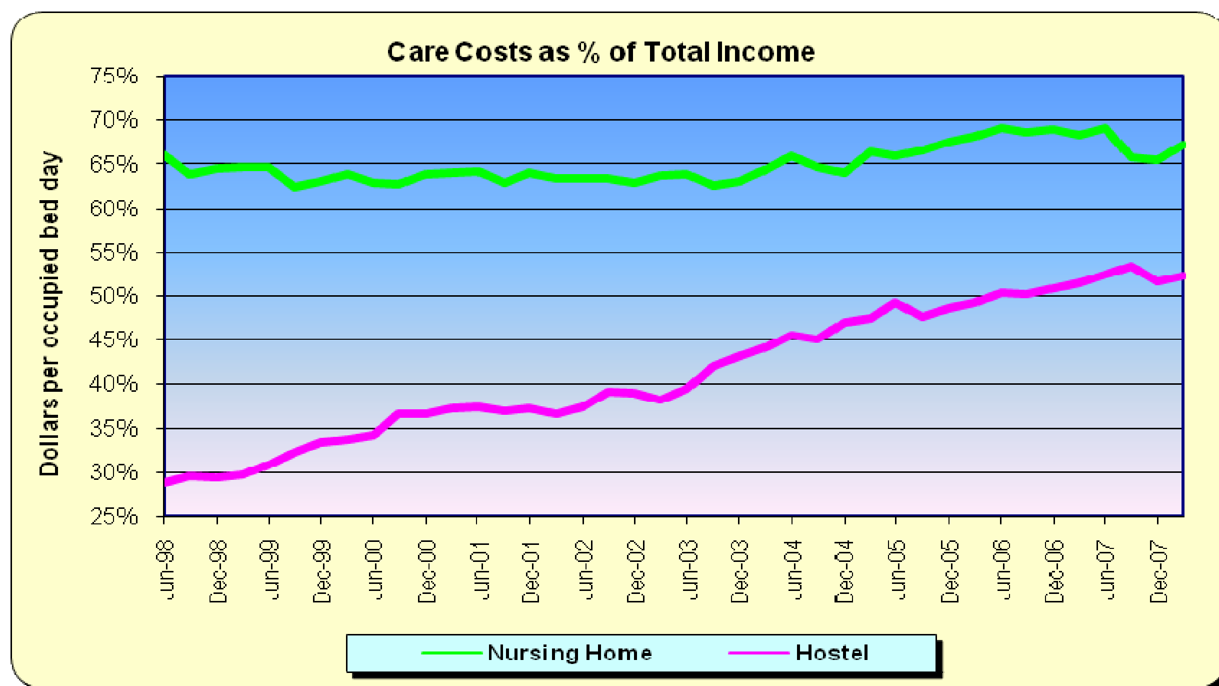
b. how appropriate the current indexation formula is in recognising the actual cost of pricing aged care services to meet the expected level and quality of such services;

[4] Including revenue from both the Australian Government and aged care clients.
[5] Pricewaterhouse Coopers 2007

The current indexation formula has resulted in a steadily widening gap between the costs of providing a service and the subsidies provided by the Australian Government. The graph reproduced below illustrates this. In the case of residential care, this has been ameliorated to a minor extent by the payment of the supplementary Conditional Adjustment Payment which is due to expire in June next year, pending the outcomes of a current review. No such payment was made in respect of Commonwealth-funded community care services despite their being subject to very similar cost pressures – principally on wages. The main problem with the Commonwealth Own Purposes Outlays (COPO) formula is that it drastically underestimates wage movements in the health and aged care fields by using movements in the overall, national minimum wage as the basis for calculation. This does not reflect actual labour market conditions in health and aged care. The Department of Veterans Affairs is understood to have abandoned the COPO index for its Veterans' Home Care program for this reason.



The graph below indicates that such increases as have been made available, including the CAP, have been applied to the wages costs of providing care.



This graph shows the increasing wages cost of low care (hostel), due to these residents 'ageing in place' and a relatively constant proportion of revenue being applied to the care of high care (nursing home) residents. What residential aged care providers receive in the form of subsidies, they spend on the care of residents.

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

Currently supplementary payments are made to both residential, and more recently, community care services in remote locations. This principle is a sound one, there are unavoidable cost penalties involved in ensuring access to aged care services by all Australians. ACSA believes however that the amounts of the supplements for care provision need to be increased to more fully compensate for the circumstances in rural and remote Australia. The current viability supplements measure remoteness to assess eligibility but, like the aged care program as a whole, make no realistic empirical assessment of actual costs.

Findings to date of research currently being conducted by ACSA indicate that the viability supplement for community care has not covered regional margins of up to 50% on food and fuel costs and is falling short of maintaining, let alone improving, access to services in rural and remote areas.[6]

Construction costs and property prices vary widely around Australia in response to local market conditions and yet the user and Government payments for high care facilities are made at a uniform national rate. Greater alignment of these payments with local market conditions would assist in addressing this issue of varying cost structures[7]. ACSA believes that the underlying concept for setting accommodation payments which would be equitable, adequate and responsive to local property markets is that of a *rent* that covers the replacement cost of the accommodation with

[6] ACSA work in progress.
[7] Variations in property prices also mean variations in the assets owned by prospective aged care clients and hence their capacity to contribute to the cost of their accommodation and care.

reference to real costs. The Australian Government would continue to pay for the accommodation of concessional residents and a cap would still apply for those on incomes below an assessed level. A range of payment options should be offered to aged care consumers to fit in with their needs and financial plans.

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;

Increasingly since 1997, low care residents paying an accommodation bond have been cross subsidising high care residents paying an accommodation charge and concessional residents paid for by Government. This is becoming increasingly the case since more new residents are entering as high care and the average value of bonds has increased with the value of residential property in many parts of Australia.

This inequity is compounded by the fact that high care, accommodation charge paying residents are treated differently to bond paying low care residents if they sell their home. For high care entrants any lump sum they hold, and use to pay their accommodation charge, is included for pension assessment purposes whereas the lump sum bond payment made by a low care resident is exempt.

Early indications are confirming the industry's view that the new Aged Care Funding Instrument (ACFI) will result in a re-targeting of residential aged care to people with higher care needs. This will further accentuate the inequities outlined above.

People who until March this year may have been admitted at the lower end of the low care spectrum (as RCS Category 6s or 7s) are unlikely to gain access to residential care under the ACFI because they receive little or no subsidy. This outcome was foreshadowed in passing in the 2004 report of the Hogan review of residential aged care. This issue will also require a rapid and substantial policy response if the care needs of affected people are to continue to be met. One important component of this will be bolstering the community care system including an increase in the price paid by government for services. To a minor degree the effect of reduced subsidies for low care residents may be offset by the fact that they may pay an accommodation bond. This could have very damaging consequences for prospective residents without substantial assets and, without an appropriate policy response, for equity.

The upwards targeting of residential care will also have implications for the skills mix of staff required to cater for older people with more complex care needs. We will need more skilled nurses and allied health staff thus heightening the competition for staff with the hospital sector and underscoring the need for aged care to be able to compete more effectively in terms of remuneration.

Under current policy settings this re-targeting of the residential care program is likely to cause liquidity problems as exiting low care residents who paid a bond are replaced by incoming high care ones who are denied the option of paying a bond even if they wanted and are able to.

There are also inequities currently between community care clients receiving services under the Home and Community Care (HACC) program and those on a CACP or EACH package. It is possible, and not uncommon, for a HACC client to be paying substantially less for an equivalent range and amount of services as a packaged care client. This has the effect of clients refusing a CACP because of the lower fees in HACC. A project is in train to address this anomaly.

User charges for aged care should be adequate to cover the cost of what is being provided; equitable between clients in similar financial circumstances; and supplemented by Government for those who lack sufficient means to pay for themselves.

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

The appropriate planning of services for older people should take account of the following points:

- The needs of older people for care and housing extend beyond those provided under the Australian Government's aged care program.
- These needs need to be met in a specific local area rather than 'in general', or 'statewide'[8].
- The use of care services tends to increase markedly with age.

A review of the current planning regime has been foreshadowed by the Australian Government. Any review should certainly address these three factors, among others. Currently little account is taken of services not directly funded by the Australian Government, allocations are made on the basis of quite large planning regions which sometimes mask the needs of specific communities and it would be appropriate to test the effect of introducing a weighting for the number of very old people (85+) in an area.

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

Community care is really the centre of Australia's aged care system in that it cares for well over 500,000 older people, as opposed to approximately 170,000 in residential care. It is the preferred option for older people and has long been seen by governments as a means of controlling the costs of caring for an ageing population[9]. Reference has already been made to the changing targeting of the residential care program and that this requires a parallel strengthening of community care.

The need for residential care will continue to grow in the future but we would anticipate more diverse service delivery models, including the delivery of care services to congregated communities (such as retirement villages), innovative housing options (such as Apartments for Life) and a greater amount of short term usage of residential care for services such as respite and rehabilitation.

We would not anticipate a qualitative change to the current overall situation, in which the vast majority of older people will be living in their own homes, and resource planning and other policy settings should proceed from this fundamental assumption.

ACSA notes a need for more community care services across the board to address currently unmet demand and for adequate pricing of community care services. There is also evidence of the need for an intermediate level of packaged care, between the current CACP and EACH/EACH D and to maintain and enhance the flexible use of packaged care.

[8] With the possible exception of some specialist medical services.
[9] While community care may reduce costs to governments it may reduce total costs by much less given its reliance on unpaid labour from carers.

Action Required

The following issues must be addressed in the short term:

1. The annual increase in the Conditional Adjustment Payment must be continued beyond 2008/09 and a similar payment made in respect of community care services.
2. An aged care index that accurately reflects the cost of providing a quality service must be introduced and used in the annual budget cycle.
3. The accommodation charge for people over the asset threshold must be de-regulated and allowed to follow market forces. Government payment in respect of concessional and other low-income residents must be increased to cover the true costs of their accommodation.
4. An urgent review of the targeting effect of the ACFI must be conducted to ensure that the needs of, now-excluded, prospective low care residents are able to be met by other means.
5. The national community care fees policy must be progressed and current anomalies eliminated.
6. The foreshadowed review of the aged care planning and allocation process needs to address the shortcomings of the current system.
7. An intermediate level community care package is required between the current CACP and EACH/EACH D.

These measures will assist in averting a crisis in the supply of aged care services in the short term and allow consideration of longer term improvements in Australia's system of care for older people that will meet the increasing needs of an increasingly diverse older population.

This consideration should include all the stakeholders, Government, service providers, aged care professionals and the consumers and carers whose needs aged care services must be designed to meet.