1 December 2008

The Secretary
Senate Finance and Public Administration Committee
PO Box 6100
Parliament House
Canberra ACT 2600

Dear Secretary,

RE: INQUIRY INTO RESIDENTIAL AND COMMUNITY CARE IN AUSTRALIA

We the undersigned represent three of South Australia's largest not-for-profit providers of residential and community aged care and we welcome the opportunity to respond to the Committee's invitation to provide a written submission to this Senate inquiry.

The matters covered by the Inquiry's Terms of Reference are all of great importance to aged care providers and the older Australians they serve. Decisions made now in relation to planning and funding Australia's system of aged care have the potential to not only shape the scope and nature of services available to older Australians in the future but, importantly, could affect the aged care sector's capacity to grow and adapt to changing community needs.

This submission addresses each of the Terms of Reference as follows:

(a) Current funding levels

The critical state of the sector's financial position has been well documented in a detailed submission from the Aged Care Industry Council (ACIC) to the Department of Health and Ageing's current Review of the Conditional Adjustment Payment (CAP), as well as in the many submissions from individual providers. Links to each are as follows:

http://www.health.gov.au/internet/main/publishing.nsf/Content/72F6764DCAD97E9FCA2574E100077804/$File/Submission64.pdf

http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-cap-submissions-received-2008.htm

Significantly, the Productivity Commission's research paper, *Trends in Aged Care Services: some implications* (September 2008) and the *Aged Care Survey 2008* by Grant Thornton Australia Ltd. both support arguments that have been put to government for some time now that the aged care system is in need of a major overhaul. The links to these two reports are:

http://www.pc.gov.au/research/commissionresearch/aged-care-trends

http://www.grantthornton.com.au/files/aged_care_survey_2008-final.pdf

It is not our intention therefore to repeat the contents of those submissions and reports. Suffice it to say that the current constraints on pricing; the lack of access to a capital funding stream for residential high care; the lack of adequate indexation arrangements; the structure of community aged care funding; and the level of regulation of aged care services and increasing cost of regulatory compliance combine to threaten the capacity of the sector to mount the necessary response to the challenges described by the Productivity Commission and Grant Thornton. Failure in the sector's ability to rise to the challenges will threaten the quality and quantity of care that aged care providers are able to deliver to Australia's frail older people.

We are not arguing for deregulation of the aged care system. Rather, we are putting the case for smarter regulation in terms of providing the necessary level of provider accountability but without stifling the sector's capacity for growth and service innovation.

An inseparable consideration in the prevailing financial circumstances is the effect on the sector's ability to offer market competitive rates of pay to all categories of care staff, be they nurses, care workers or allied health professionals. In this context it is worth noting that 70% or more of costs relate to labour. Without a comprehensive response by government to the overwhelming evidence of the deteriorating state of the aged care sector's financial position, the workforce issues will only grow in significance.

One specific suggestion for a change in the subsidy arrangements concerns the Concessional/Supported Resident Supplement. The Committee may wish to consider a change that would tie the amount of subsidy payable to providers for meeting the applicable regional ratios, to the bond retention rate and average bond earnings. As an offset, the subsidy could then taper away in relation to the number of concessional residents above the regional ratio.

The rates of subsidy could be structured so that the current higher rate of subsidy for reaching the 40% threshold could be dispensed with, while retaining incentives for providers to admit financially disadvantaged residents.

RECOMMENDATION

1. The Australian Government should, as a matter of urgency, examine and respond to the findings and observations of the Productivity Commission

report, the Grant Thornton survey and previous reports with a view to placing the aged care sector on a sustainable financial footing.

2. **Revise the existing value of the Concessional/Supported Resident Supplement to equal the bond retention amount plus average interest earnings on bonds held, coupled with a tapered subsidy for concessional resident ratios above the regional ratio.**

Already, many major aged care providers like the three we represent have decided or are considering whether to consolidate their residential care operations and either severely curtail growth or simply call a halt to any future expansion. Community aged care also faces serious difficulties due to rising costs, inadequate indexation arrangements and flawed allocation policies. Of equal significance are the existing funding structures and administrative arrangements governing the cost-shared Home and Community Care (HACC) Program and the three levels of community care packages.

HACC is a cost-shared grants program with individual clients attracting anything between a few thousand dollars a year in services and as much as $100,000 in the case of people with disabilities. On the other hand, direct Commonwealth-funded community aged care services are paid a fixed subsidy per client, ranging from approximately $12,000 a place for a Community Aged Care Package (CACP) to $42,000 for an Extended Aged Care at Home (EACH) package and $46,760 for an EACH dementia package[1]. These marked differentials result in significant difficulties for providers trying to care for clients' changing needs, e.g. a CACP client whose needs have increased to high care but for whom EACH funding is not available and no intermediary level of funding exists. Many CACP clients are forced to seek care from another provider in situations where, for example, their current provider does not have an allocation of EACH places.

There are clear advantages to all concerned in having a single, comprehensive system of aged care that is fully funded and administered by the Australian Government (refer to comments under (f)).

The Minister for Ageing, the Hon Justine Elliot MP, has indicated an interest in the concept of Consumer-Directed Care (CDC) and we would encourage the government to consider the concept in the context of the broader reforms referred to in this submission. CDC has many forms and any version considered in Australia needs to have an Australian context. However, the central feature of CDC, which is providing consumers with greater choice in how services are delivered to them, can be introduced into the Australian aged care system. At the heart of choice in the Australian context is the over-regulation of pricing strategy. A more challenging issue for Government is access based on entitlement as opposed to access limited by a defined ratio of places. When an older person is assessed as being entitled to receive aged care services they should be able to access such services immediately if they wish to.

The degree of choice that some forms of CDC can make available will not suit every community care client or all service providers, but it does offer potential benefits for many clients, for many providers and for government. However, to offer maximum

flexibility and choice, CDC needs to be developed along with re-structured and simplified funding arrangements that allow a single provider to continue to support their clients with staff who are familiar with the client's needs and preferences, as their care needs increase.

Comments on the allocation of places appear below in section (f).

RECOMMENDATION

3. **Transfer the aged care share of HACC to direct-funded Commonwealth control, thereby delivering an end-to-end community aged care program administered by the Australian Government;**
4. **Transfer the Aged Care Assessment Program to direct-funded Commonwealth control;**
5. **Reform the funding structures and administrative arrangements (including fees) to establish a single, seamless system of home and community aged care in Australia by combining HACC and the community care packages programs(namely, Community Aged Care Packages and the two types of Extended Aged Care at Home packages);**
6. **Remove the barriers and inequities inherent in the present HACC and three-tiered system of funding community care packages that militate against ageing-in-place in the community.**

(b) Indexation

The aged care sector has long argued for an indexation formula that reflects the real costs of providing services. Once again, the issues are detailed in submissions to the CAP Review but notably, the ANZ Bank's Chief Economist, Saul Eslake, commented at the recent Aged and Community Services Australia national conference that the historic aged care indexation formula (based on the Commonwealth Own Purpose Outlays (COPO) index), even in combination with the CAP, does not reflect the reality of rising costs.

We note the lack of focus on aged care at the Council of Australian Governments (COAG) meeting held on 29 November 2008. The COAG communiqué highlights an increase in the indexation level to be applied to the health sector to 7.3% pa, and to 6% for the disability sector. Such outcomes, clearly needed, will cause a significant mismatch in outcomes achieved in aged care relative to the acute care sector (acute care, or State Government Health departments, being the price leaders in increasing wage pressures between the aged care and health sectors). Older Australians should not be discriminated against by the application of a lower indexation rate and we submit that the indexation factor for aged care should be tied to that applying to the health sector.

RECOMMENDATION

7. **7.1 With effect from 1 July 2009, introduce a new aged care indexation formula for both residential and community aged care that reflects the real and rising costs of service provision.**

7.2 As a minimum, tie the indexation rate for aged care to that applying to the health sector.

(c) Regional variations in costs

The higher costs of delivering services in rural and remote communities have been recognised in part through government initiatives such as the Viability Supplement. However, it is becoming increasingly evident that the central funding models and regulatory framework applying to both residential and community care do not take into account the stark cost differences evident across a metropolitan area or a State. Issues such as construction costs, service quality, economies of scale, business and service diversity, resident mix/profile, the capacity for cross-subsidisation, organisational maturity and sophistication, and community capacity, all play a part in determining a service's viability and quality.

The ACFI could have an impact on the many small to medium-sized, stand-alone facilities in regional areas and indeed, in different parts of the larger cities. Measures such as remoteness alone may therefore not adequately reflect the actual costs of delivering such service.

(d) User payments

As others have noted, the costs of delivering aged care services are driven by market forces while revenue is capped through government regulation. Accommodation bonds are not able to be charged for high care unless the service has Extra Service Status (there are only 10 such services in South Australia, accounting for just 4% of all operational residential places). However, Extra Service Status only applies to the so-called hotel services available to residents, not to care or other services.

We would argue for the abolition of the current Extra Service arrangements and, subject to certain quality and financial safeguards, simply allow the 'market' to determine the value and cost of services. Under such a scheme, any resident could choose to pay higher fees for a higher level of service, irrespective of which aged care service they chose to enter. Freeing up the market in this way would increase competition and lead to greater choice for residents. Similar principles could be applied to community care in terms of clients being able to pay higher fees for additional services.

An example of a more flexible version of extra services (that is not limited to a certain ratio or a specific wing) might be an updated version of the model introduced by the Labor Government in the 1987 reforms in hostel (low care) accommodation. The model involved a variable daily fee together with accommodation bonds that could now be applied to both high and low care.

Unbundling the accommodation component from personal care costs would take the concept one step further. Aged Care Assessment Teams would continue to determine a person's care level (high or low), but the subsidy levels would be the same, irrespective of

whether the person received community care or residential care. The difference would be in the accommodation costs and charges, and in the fees applying to their particular circumstances. This would remove the existing anomalies between the fees and subsidies applying to residential and community aged care.

The current definition of high care could also be changed to coincide with the highest pay-points on the ACFI scale, thereby allowing bonds to be charged to a greater number of residents, but still not to high care. The profile of high care residents has changed enormously over the years and it is time for a new definition that reflects both the current reality and introduces greater equity into the system of bonds and charges.

In the case of community care, there is no national fees policy or framework, which has led to individual providers having to make their own arrangements. There is an urgent need for a consistent, equitable approach across both HACC and the community packages programs. Such an approach also needs to address the issue of the absence of consistent means-testing regimes across residential and community aged care.

RECOMMENDATION

8. **Abolish the current system of conferring Extra Service Status and allow those who can afford to do so to make an accommodation payment in either residential low or high care;**
9. **Redefine 'high care' to coincide with top 12 pay-points of the ACFI scale**
10. **Uncap fees for other than Supported Residents;**
11. **Apply consistent funding and fees principles across residential and community care, based on the person's assessed needs and their capacity to pay, including for additional services.**

(e) Planning ratio

The original supply planning ratio of 100 (residential) places per 1000 persons aged 70 years and over established in response to recommendations of the *Nursing Homes and Hostels Review* 1986, introduced an important policy precept, namely, that of population-based planning. While the ratio has changed over time, we would argue that the use of a population-based ratio should be retained as it connects growth in service provision with growth in the older population.

However, while the ratio is arguably evidence-based, Professor Warren Hogan comments in his *Review of Pricing Arrangements in Residential Care* (2004) that:

'At the time the ratio was introduced, it was acknowledged that there was no generally accepted optimum level of provision of places. However, there were a number of indications that the then current provisions were sufficient for the then and projected needs.' (page 103)

Our position on the overall ratio is that there is still no generally accepted optimum level of the provision of places. There is however, some indication that the 88 residential places per 1,000 aged 70+ is sufficient. In South Australia in particular, where actual supply now

approximates the planning benchmark for residential care, there are signs of real competition to attract new residents, and some providers, even with new facilities, are reporting difficulties in achieving and maintaining viable occupancy levels.

There has been some argument in favour of changing the basis of the planning ratio from a basis of age 70+ to 80+. These views are premised on the higher demand for services among the 'older old' (those aged 85 years and over). However, there is lower demand for residential care services in newer suburbs where the concentration of the ageing population bulge is more in the 70 to 80 age group.

While there is a superficial attraction and logic to the argument for changing the age basis of the planning ratio, there are other factors at play. For example:

- 35% of community care clients are less than 80 years of age (*Aged care packages in the community 2006-07: a statistical overview*, AIHW 14 August 2008);
- 28% of residents are less than 80 years (*Residential aged care in Australia 2006-07: a statistical overview,* AIHW 12 June 2008);
- use of age 70+ is inclusive of the 80+ population and represents the Australian Government's target group;
- use of 80+ could lead to perverse outcomes in that the allocation of aged care places would favour Australia's older, more established, more affluent (healthier) communities at the expense of communities in greater need.

Hence there is an argument to maintain the current overall ratio (113:1000), but to introduce flexibility in its application that reflects the general move towards community care services and the relatively lower demands for residential aged care of an emerging population of the 'younger old'.

RECOMMENDATION

12. 12.1 Retain the current overall planning ratio of 113 places per 1,000 persons aged 70+; but
12.2 Introduce flexibility into Aged Care Approvals Rounds to allow variations in the residential and community care allocation ratio across regions, according to the differing demand needs of the younger and older age cohorts.

It is clear from all the research that the overwhelming preference of older people is to remain living independently in the community and not to enter a residential care facility. Nevertheless, present indications are that some level of growth in the provision of residential care will be needed well into the future, even though the nature of the care could shift even further towards higher, sub-acute levels.

Hogan comments in the Pricing Review on the mix of residential and community care places. However, while stating that the balance between residential and community care place numbers is problematic, he believes that excess demand for community care places

will increase substantially (p. 105). One of the causes he refers to is the effect of residential care ageing-in-place on the availability of residential low care (as at 30 June 2007, 70% of residents were assessed as high care according to the Australian Institute of Health and Welfare's *Residential aged care in Australia – a statistical overview*, p. 1). We believe this development, coupled with the government's increased general emphasis on high care, supported by the Aged Care Funding Instrument introduced in March 2008, warrants an offsetting increase in the provision ratio for community care places.

One rather crude solution that has been suggested by others would be to adjust the residential care ratios to reflect actual usage. In other words, only 30% of allocated residential places would be for low care. The residential ratios would then become 26 low care and 62 high care places. However, this would have no effect on the availability of older people's strong preference for community care and overlooks other issues such as:

- the potential exacerbation of providers' growing inability to attract accommodation bonds for low care in sufficient number and value (at least in the absence of an offsetting alternative high care capital funding stream);

- despite a continuing increase in the age profile and frailty levels of residents into the future, there is still no agreed optimal level of supply of residential care places, let alone residential high care places;

- the increasingly irrelevant distinction between residential low and high care as more and more residents enter as needing high care; low care residents quickly age-in-place to become high care; and the government's own funding emphasis on high care;

- the prevailing regulatory framework which restricts the ability of providers to determine an optimum resident mix for themselves.

In light of older people's preferences and the predictions about the increase in the age profile and frailty levels of the 70+ population, our recommended alternative is to adjust the ratios to a mid-way point between the current planning ratios and actual usage. The question of the relative ratio of Community Aged Care Packages as to Extended Aged Care at Home packages would be at least partially avoided by the changes to community care administrative and funding arrangements recommended above.

RECOMMENDATION

13. Adjust the future planning ratios to be 78 residential places with no distinction between low and high care, and 35 community care places.

(f) Residential care funding and places vs. Community Care numbers and provision

Present indications in South Australia are that the planning ratio of 88 residential aged care places per 1,000 persons aged 70+ years is at least sufficient. However, to persist with this level of allocation of residential places is likely to be unsustainable both in terms of future government outlays and the aged care sector's capacity to deliver. In any case, older people's preferences and Professor Hogan's predictions of demand are for more community aged care. It therefore seems to be not just unsustainable but undesirable to continue with the current mix of residential and community care.

The current distinction between residential high and low care places is accompanied by a requirement that a resident admitted to a post-1997 approved low care place have a low care assessment (although they can then literally age-in-place). This restriction prevents providers from admitting a person with a high care assessment to that place irrespective of the person's greater care requirements.

A further consideration is the impact of the Aged Care Funding Instrument (ACFI), introduced in March 2008, on the mix of high and low care residents. The ACFI is weighted towards high care residents and the inevitable outcome will be a reduction in admissions of people assessed as requiring low care. Not only will many people requiring low care simply not be accepted into residential care, there will be a concomitant reduction in bond revenue.

There appears to be no community aged care strategy being developed to respond to this phenomenon, which adds further importance to the need for a change in the provision ratio for community care and for a merger of the HACC and other community care programs.

The relationship between residential care and community care funding also bears examination. There is almost no flexibility between the two systems that encourage rehabilitative and restorative approaches and that might facilitate the return of a person to the community from residential care or prevent their admission. The Transition Care Program offers an alternative approach but only to hospital patients. The availability of short term residential care, in conjunction with community care support for other than respite care could offer opportunities for:

- supervised recuperation from illness;
- a temporary alternative to unsuitable housing; and
- rehabilitation and restorative programs.

All of the abovementioned situations can be triggers for older people having to move prematurely or inappropriately into (more costly) permanent residential care.

RECOMMENDATION

14. 14.1 Remove the distinction between residential low care and high care; allocate places simply as residential care places; and allow providers to determine the optimal mix;
14.2 Remove the distinction between pre and post-1997 residential places.

Summary

The aged care sector is at a crossroad and the wrong decisions now could seriously damage its collective capacity to respond to the many challenges facing service providers and government alike. Ultimately, these decisions will have an impact on the availability, choice, quality and cost of services for Australia's frail older people.

Now, perhaps more than ever in their history, aged care providers are struggling with the compounding effects of a number of intersecting issues that warrant an urgent national response. The issues have been elucidated at length in the various analyses and findings of both industry-funded and independent research.

The government's attention now needs to turn to these issues, and not simply be focussed on the failure of a very small number of aged care services to meet their legislative and moral obligations in caring for Australia's frail and vulnerable older people.

Australia needs a national vision for aged care, a strategic future direction that will continue to guide what is unquestionably one of the world's best systems of aged care. That system is currently under threat and we urge the Committee to bring our concerns to the Senate's attention.

Yours faithfully,

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