3 December 2008

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

Dear Secretary

Residential and Community Aged Care in Australia

Aged and Community Services SA&NT, on behalf of its 130 members, is pleased to make this submission to the Inquiry. While we are aware that our national body Aged and Community Services Australia (ACSA) and other state sector associations will also be forwarding submissions, our separate 'participation' recognises the importance of the inquiry in helping create a sustainable aged care system in Australia.

As an association we are keen to be actively involved both through the presentation of the information contained in this submission and also, if deemed appropriate, by giving additional evidence at a future Senate hearing.

Given the time constraints this submission is intended to provide an overview of the issues as well as providing an operational perspective where appropriate. Rather than incorporate residential and community viewpoints into the one document, two separate documents have been produced with a specific residential and community focus. Both documents are structured around the Terms of Reference.

Of crucial importance to the sector is the need for a new national vision for aged care to be developed. The sector has known for sometime that because of the intersection of a number of issues, workforce, capital and operational concerns, that it is at a crossroads. It is imperative that sound policy decisions are made that create a sustainable but equitable system which is able to cater to the needs of our older citizens.

Yours sincerely

Alan Graham
Chief Executive Officer
Aged and Community Services SA&NT

Senate Finance & Public Administration Committee

Submission to the

Inquiry into Residential and Community Aged Care in Australia

Aged and Community Services SA&NT

Community Response

Whether current funding levels are sufficient to meet the expected quality service provision outcomes.

Quality service provision includes both fundamental issues of safety, as well as the protection of the rights of older people, to drive and manage their lives according to their own priorities and preferences. ACS SA&NT support new quality measures including basic safeguards such as Police checks and quality audits, as well as improved levels of training and skills, to underpin public confidence in community aged care. However these quality measures incur costs which impact adversely on service delivery to clients.

There needs to be an increase in funding for recovery and maintenance programs that support and enable older people to remain in the community. In addition, there is a need for higher level packages, beyond the current Extended Aged Care at Home Package/ Extended Aged Care at Home Dementia (EACHP/EACHD).

The 'turn over' for EACHD packages is high creating additional administration costs that are not provided for. Providers need to allow a greater 'lead and development time' for people receiving an EACHD package. Generally funding allocations need to recognise that anyone with dementia takes more time and effort to support at any stage of the continuum of care.

To ensure quality service provision to rural and remote communities and to people with special needs there needs to be recognition, beyond the current rural viability supplement (measured by remoteness), that there are additional costs associated with providing services. The current funding does not cover the cost of components such as culturally appropriate training, interpreter services, recruitment, complex needs and culturally sensitive relationship building. Nor does it acknowledge that there are other issues directly related to the organisation delivering services or the economic capacity of the community in which the organisation is based which will have an impact on the quality of service delivery

The current level of funding is based on an understanding that there is a level of co-payment from the client. This is not occurring consistently enough for a variety of reasons. A person's inability to pay doesn't restrict access to services but does impact on the provider. There needs to be an appropriate system for objectively and consistently determining financial disadvantage and client co-payment levels. This needs to be balanced with the actual cost of collecting fees. The client fees are an integral component of the viability of the program and where there are financially disadvantaged people with limited capacity for co-payment the Government should consider concessional payments to compensate the provider for loss of income.

The existing 'siloed' funding structures and administrative arrangements within the HACC program and the three Commonwealth community care programs are also a significant concern. The allocation differentials between HACC (a few thousand dollars up to $75,000 +) and CACP ($12,000), EACH ($42,000) and Each D ($46,000) result in difficulties for providers trying to care for clients' changing needs. It is not uncommon for a provider who may have a CACP client to not be able to offer an EACH package because they have none available. Individuals have by necessity had to seek another provider.

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

The delivery power of the community care system ~ quality, quantity, innovation ~is at risk when indexation falls behind and there are not enough resources to deliver the services. Viability and indexation issues need to be addressed. Increased costs, particularly related to wages and travel, which are well above the subsidy indexation offered each year, are pushing down the average hours of services directly provided to older people. This affects all aged care programs and service providers delivering aged care who are struggling to deliver viable aged care services in some regions, which ultimately diminishes client choice and limits service flexibility.

Current funding is not meeting real costs and inadequate indexation results in less after hours service provision, loss of real hours of direct care, loss of diversity, loss of matching and 'cherry picking' of waiting lists.

For community packages to be able to maintain a desirable level of quality then it is essential that a sustainable indexation formula be applied. While the recent 6% indexation (up from 1.8%) arrangement that has been given as part of the recent National Disability Agreement is supported in principle it again highlights the disparity between the two sectors. The health sector have also been granted an increase in indexation (7.3%) which further exacerbates the existing disparities between the two areas.

Measures that can be taken to address regional variations in the cost of service delivery and the construction of aged care facilities

Different service models with appropriate funding levels are required for rural and remote areas. Providers cannot deliver the same kind of package when workers have to travel extended distances. This creates inequities for rural and remote communities.

Whether there is an inequity in user payments between different groups of aged care consumers and, if so, how the inequity can be addressed.

The following summarised points, focusing on fees, is presented by ACS SA&NT for consideration:

- There is no consistent approach to fees across the community care system. Although there are some guidelines relating to consumer fees (the HACC program has a draft overall fees policy which is not implemented uniformly throughout states), each agency is responsible for developing their own policy and procedures relating to the application and collection of service delivery fees to which community care clients make a financial contribution.

- The lack of a national or state fees policy has resulted in a myriad of approaches and a range of fees which have given rise to issues for clients moving across programs and/or when receiving services from multiples agencies. Inconsistency also results in inequity and may encourage clients to base their decisions on cost rather then need.

- Realistic fee levels are needed, so that they are not a barrier to access to services.

- All fee structures should be negotiated individually and on the basis of criteria referenced to capacity to pay based on the premise that the client will pay. It is the client's choice to seek a waiver from the provider. Clients with similar income, living expenses and service needs should be charge equivalent fees for equivalent services.

- There should be matching fee levels to the tiered approach to care e.g. HACC service fees increase at higher levels of HACC services to lessen the impact when a client moves to CACP which has generally higher fee levels.

- Members also suggested that an important aspect of a fair and consistent fees policy would be to have a system that was transparent, simple, addressed client specific issues and provided an opportunity for appeal.

- There are a number of service types – such as advocacy, social support, case management and information – where no fee should be charged. The framework

and guidelines should clearly identify which services should attract a fee and which ones should be provided free of charge.

- It needs to be recognised when setting funding agreements and budgets that fee revenue is not guaranteed, and the cost of collection can be a significant proportion of the revenue generated.

- There is significant variation between clients as to what they believe is a fair price to pay - this appears to be "values based" and therefore it is difficult to influence their views on the issue. Some clients refuse to pay for services on principal as they think the "government should pay for it," others are determined to "pay their own way and not rely on the government or others" and want to pay in full for services or "go without" as they may have limited incomes. Others fall between these two extremes.

- Providers in rural areas are unlikely to access fees for many clients, and the rural and remote viability supplement does not take this into consideration. The differences between regional, rural, remote and urban service provision needs to be factored into this process.

- Many indigenous clients do not pay any fees towards their services and any national fees framework would need to take this into account.

A consistent fees policy or framework which also addresses the issue of the absence of a consistent means testing regime needs to be developed. In summary the policy or framework should:

- Appropriate levels of fees and for which services they should be charged;
- Consistency across funding programs;
- Determining ability to pay and waiver of fees;
- Cost efficient administration; and
- Consistent implementation.

It is imperative that fees should not be used as a substitute for inadequate Government funding of community care services.

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

Community services have grown over the years to become a major service system and there are heightened community expectations for older people to remain living in their own homes. This puts pressure on the service providers to meet growing demand, to provide good services and to be accountable and it puts pressure on the system to be adequately resourced and to have streamlined processes so there is not fragmentation and duplication of effort. There needs to be a substantial increase in the number of care packages available in most regions to meet the growing demand and expectations of older people to remain living in the community.

ACS SA&NT encourages the tailoring of resource allocations to local needs to ensure an appropriate mix of services. An overall approach to service provision in local areas should be developed. The Government also needs to evaluate the results of the allocation and the impact of the services and how well they are responding to needs at a planning level. If realignment or enhancements are required it is important that this is done in a way that the sector understands and with a timeframe that supports clients and providers.

ACS SA&NT acknowledges the increase in community care funding. However, there is still a huge demand and most regions in SA have waiting lists for packaged care and in some this is as long as 2 years. This may precipitate people moving to residential care who do not need or want to and HACC providers are faced with duty of care issues where a client requires increasing levels of care and there are no available CACPs or EACHPs. In the Marion/Mitcham area of metropolitan Adelaide there are estimated to be 500 people on the waiting list for CACPs but there were no CACPs places allocated for the metropolitan south 2006-07 or 200-08. The ACAR process could give consideration to being more flexible and allow for the ratio of community care places to residential places to be altered depending on local conditions and unmet demand.

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

In the future aged care, including community aged care, must be more flexible and responsive by enabling older people to move 'in and out' and 'up and down' in terms of their levels of care. An effective service system must provide real choice to enable people to remain living in the community with flexibility to meet individual needs.

Aged and Community Services SA&NT
November 2008

Senate Finance & Public Administration Committee

Submission to the

Inquiry into Residential and Community Aged Care in Australia

Aged and Community Services SA&NT

Residential Response

Whether current funding levels are sufficient to meet the expected quality service provision outcomes.

Current funding levels do not satisfy expected quality service provision outcomes in a number of important areas:

- Service hours made available to clients have declined reducing the quality of care and by implication the quality of life for recipients. Written and anecdotal evidence indicates that as a consequence more intensive and expensive interventions are now taking place adding further burden to the system.

- Wage levels for aged care staff continue to lag behind those paid by other employers in the health and community sector with aged care staff being paid less than their equivalents in the health area, particularly hospitals. By way of example the differential in relation to registered nurses in South Australia is currently about 15% with this increasing in the short term following a recent wage agreement between the government and nurses. The recent Productivity Commission Research paper (*Trends in Aged Services: some implications* September 2008) estimated that closing the wages gap would cost $450m with a further $100m required to maintain the comparative position.

- Current payments for capital purposes do not cover the cost of new construction (estimated in South Australia to be about $180,000 per bed in metropolitan Adelaide without the land but subject to significant regional variation) which is required to expand residential care as well as meet community expectations. The current expectation is for one bedroom and ensuite configuration. The capital situation is further exacerbated by the reluctance to extend refundable deposits (bonds) into high care and by the incentive structure that exists within the new Aged Care Funding Instrument (ACFI). Increasingly clients are moving straight

into high care from the community setting and as a consequence the capacity to raise revenue from bonds in low care is diminishing. This will have a very considerable impact over time.

- Although the same public announcements by providers in Queensland, Western Australia and more recently Victoria, about not making application for the 2008/09 ACAR round have not been forthcoming in South Australia, there is considerable evidence that many have put expansion plans 'on hold' pending some resolution of the current funding problems.

- A number of reports undertaken by independent firms have highlighted the direction of the financial trend in aged care. Recent Grant Thornton aged care surveys (2007 & 2008) have highlighted the worsening situation with over 40% of providers in financial difficulty and average earnings before EBITDA deteriorating significantly between 2007 and 2008.

- Of growing concern to the sector is that the financial 'squeeze' also impacts adversely on the restorative/rehabilitative activities that many within the sector are finding it more difficult, if not impossible, to provide. There is substantive medical evidence which highlights the importance of restorative/rehabilitative programs (arts therapy and anabolic/aerobic exercise) to the well being of older in residential (and community) settings. Typically these are the activities that are cut when funding is tight and yet they are the very initiatives that foster physical, emotional and intellectual health and well-being.

- ACS SA&NT has identified many problems with the new ACFI which impact on quality service provision outcomes. Currently, for example ACFI makes no allowance for all services that are to be delivered. At the moment there is no provision made for cost and time involved in lifestyle activities/diversional therapy, family contact and such like and yet the accreditation standards require it and more importantly the public expects it. One rural service provider has recently advised ACS SA&NT that lifestyle programs are being maintained through fundraising activities being conducted by the organisation.

- Several other problems have been highlighted by this association and others that need to be addressed. It is understood that the Department of Health and Ageing are considering the many problems that have been identified and have recently made positive statements around the management of behavourial problems associated with older people with psycho geriatric conditions.

- One other significant difficulty worth mentioning concerns the domain known as Activities of Daily Living (ADL's). Currently if a resident is not totally dependent in every aspect of ADL they do not qualify at the highest level which is of course counter productive to what is trying to be achieved - maintaining independence (and a sense of dignity) for as long as possible.

Another immediate financial concern is developing around the ACFI validation process. Evidence available to ACS SA&NT indicates that there are substantial 'mark downs' occurring with some providers indicating the rate of mark downs at 70%. Rather than cast blame at staff who undertook the initial assessments (implying a complete lack of professionalism and attacking their credibility) what this suggests is that there is a systems failure and (within the sector) as nothing more than an income recoup strategy. In the short term there are financial implications for the sector.

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.

The current indexation formula based on the Commonwealth Own Purposes Outlays (COPO) and supplemented in recent years by the Conditional Adjustment Payment (CAP) is inadequate. While the CAP (currently subject to review) has in recent years partly off set the inadequacies of COPO (which drastically underestimates wage movements in the health and aged care areas by using movements in the minimum wage as its basis for calculation), the real issue of concern around indexation is that the current arrangement does not actually reflect the health and aged care labour market conditions. Interestingly, the Department of Veterans' Affairs, which also provides aged care funding, has abandoned COPO for this very reason.

In other areas of responsibility the government has also recognised the concerns expressed around indexation. The recently announced National Disability Agreement increased increasing the amount from 1.8% to 6% for the 5 year period of the agreement.

If the industry is to arrest its declining financial position and, acknowledging the information highlighted from the Productivity Commission's recent research paper, then any indexation system would have to be reflective of existing and future labour market conditions. It is imperative that a new aged care indexation formula be developed.

In assessing an appropriate indexation arrangement what also needs to be borne in mind is that residential aged care providers spend all the subsidies they receive on the care of residents and what ever increases have been made available, through COPO and more recently CAP, have been directed to providing care. It is worth noting that when considering care costs as a percentage of total income on the basis of dollars per occupied bed the percentage has remained constant in high care (between 65% to 70%) over the last decade. However in low care, in the same period, the percentage has increased from under 30% to about 55%. This is reflective of 'ageing in place' in low care facilities and the constant 'spend' in high care.

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

ACS SA&NT is aware that supplementary payments are already made to both residential and community care services in remote locations. ACS SA&NT is very supportive of this arrangement which clearly acknowledges that there are unavoidable costs involved in

ensuring access to aged care services by those living in remote parts of the country. Evidence available to ACS SA&NT strongly points to the need to increase the level of compensation over and above what is currently applied. Current eligibility is measured by remoteness but more appropriately should be tied to actual costs. Recognition also needs to be given to a range of factors that impact on service delivery including: service quality, economies of scale, resident mix and profile, the capacity for cross-subsidisation (retirement units, residential and community packages), organisational stability and also the community's economic capacity to provide support to name a few.

The Department of Health and Ageing is well aware that the ACFI could have a substantial impact on smaller stand alone facilities in regional areas.

Mention has already been made about the variability of construction costs throughout South Australia. To ensure a more equitable arrangement greater attention needs to be given to the local market conditions and aligning payments to the 'on the ground' situation.

Whether there is an inequity in user payments between different groups of aged care consumers and, if so, how the inequity can be addressed.

A very significant issue of concern within the sector is the blatant cross subsidisation that exists between high and low care and the inequities in the current system.

Two specific points for consideration are:

- Low care residents paying an accommodation bond and cross subsidising high care residents paying an accommodation charge or concessional residents covered by the government. As mentioned this is increasingly the case as more people enter at the high care level. The situation has also been exacerbated by the increase in the average value of bonds linked to the increasing residential property market.

- High care residents being are treated differently to low care residents if they sell their home. Any lump sums held by high care entrants which they may use to pay their accommodation charge is included for pension assessment purposes whereas bonds in low care are exempt.

Mention has already been made of the re-positioning of the ACFI towards high care needs which will worsen the situation already mentioned. Of concern to ACS SA&NT is that individuals at the lower end of the aged care needs (old RCS categories 6 or 7) are unlikely to gain access to residential care under ACFI because they receive little or no subsidy. While it is acknowledged that there has been a significant trend from those living in the home setting moving into high care, this should not ignore the needs of those that require lower level care. Many individuals may prefer the collective residential setting because of the social, intellectual and physical dimensions that can be provided.

Typically older people are moving into high care with more complex health problems. As a consequence there are significant staffing implications for residential care providers. Clearly high care facilities will need more skilled nurses which immediately creates problems because of the wages differential mentioned previously. What is also apparent and something that ACS SA&NT raised during the development of the South Australian Health Plan for Older People (currently being finalised for public release) is the potential of high care facilities taking on a sub acute health role. By necessity this would involve closer working relationships between the sector and hospitals and is something that a proposed high level network would explore.

Separating the accommodation component from personal care costs has regularly been mooted within the sector. This unbundling would operate on the premise that Aged Care Assessment Teams would continue to determine a person's level of care with the subsidy levels being the same regardless of whether the individual was in a residential or community arrangement. The point of difference would be around the accommodation costs and charges. This would remove the existing anomalies around fees and subsidies.

Whether the current planning ratio between community, high and low care places is appropriate.

There are key principles that should underpin the planning of aged care services for older people. The most important of which revolve around a recognition that the needs of older people for care extend beyond those things provided under the federal government's programs. It is important to recognise that these needs include issues such as transport, amenity of infrastructure – footpaths, street lighting etc and that the needs must be met at the local (neighbourhood) level rather than a larger geographic setting – regional or statewide. Currently government allocations are made using large planning regions which it is believed 'hides' the needs of specific local areas by dealing with matters in a 'generalised' way.

As acknowledged recently by the Minister for Ageing "older residents prefer to continue living close to their families' friends and within their local community". It is this sense of community identity, rather than conveniently determined lines 'on a map', that should be determining future planning needs. In recent times for example ACS SA&NT have been alerted to the difficulties being experienced in what is known as the Adelaide Eastern Metropolitan region which is considered from the departmental perspective to be 'over bedded'. However all of the indicators for the hills zone suggest the opposite. Providers indicate that they are constantly receiving requests for care and accommodation. Existing respite services are fully booked up to May 2009.

Many interested parties have argued that the allocation of places should be based around Department of Health and Ageing well there could be greater attention given to recognizing the changing aged profile in our communities. Typically people are living longer (and where possible remaining in their homes) and it may be advantageous to reconsider future planning ratios taking into account these changing conditions. For

example it may be beneficial to look at future planning ratios from the perspective of the 'old old' (85+) and consider there geographic distribution along with the 70+ benchmark.

What could be advantageous is if some pilot tests could be run conducted that for example added a weighting for the 'old old' and/or catered for those that argue that demand should be the determinant.

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

Community care, including HACC services, is the centre piece of Australia's aged care system providing about 1.3 million individual services annually nationwide. Clearly it is the preferred option for older people and provides significant cost savings to government because of the lack of requirement for infrastructure. There is a further advantage because of the additional support provided by carers – family and friends.

ACS SA&NT considers that while the interest in community care packages will continue to grow (and hopefully there will be greater flexibility within the system that will enable seamless transfer between existing Commonwealth packages and HACC funding activities), that this will not have an adverse impact on the number of residential places required in the future. All of the future projections indicate that there will be growth in the numbers requiring residential care in line with the ageing population.

There is one significant change that is already evident within the residential setting. The eagerness of individuals to remain as long as possible in the 'community setting' has seen the development of 'collective' residential developments – retirement villages and other innovative housing options. The deliver of community care programs will need to increase to cater to this growing cohort.

From ACS SA&NT's perspective what is important is the relationship between residential and community programs and how they can complement each other rather than whether there will be an impact on one as a consequence of increased activity in the other. Currently there is no flexibility between the two systems that encourage rehabilitative and restorative approaches. The availability of short term residential (respite) care coupled with community care support could provide an important 'connect' between the two systems and alleviate the need for individuals to move prematurely into permanent aged care. It is envisaged that such facilities could provide recuperation from illness, temporary housing (outside the home) in a supervised environment as well as restorative/rehabilitative programs.