13 November 2008

The Secretary
Senate Finance and Public Administration Committee
Department of the Senate
PO Box 6100
Parliament House
CANBERRA ACT 2600

Dear Secretary

Senate Inquiry into Residential and Community Aged Care in Australia

Thank you for the opportunity to make comment in relation to the Senate Inquiry into Residential and Community Care in Australia. I make these comments

- following personal experiences with my parents and various relatives and their use of the health and aged care system
- having worked for the Commonwealth Department of Health and Aged Care in Aged Care for 15 years and the Office for the Ageing in State Government for 7 years
- while currently working for a large NGO aged care provider and a NGO aged care provider for people of Italian background
- as a board member of an ATSI residential and community aged care provider

While the current system of aged care in Australia has working reasonably well for people I believe that it has been added to incrementally over time and that the existing programs are in need of fundamental generational change and re-alignment. I believe that there are developments in Europe and North America such as Consumer Directed Care that Australia can look to in order to further develop its current system. Those developments are clearly aimed at **giving the consumer the best possible choice and control** over getting health and aged care services and supports (e.g. the "Cash and Carry" schemes in the USA and the "Direct Payment" and "Individualised Package" initiatives in the UK.

From my working and personal experience I believe that existing programs

- Could better assist people to stay in their own homes and communities which is by far the preferred choice of people
- Are not resourced to meet the level of care and support expected by people
- Could have a much greater preventative approach to people needing care and then preventing movement to higher levels of care

- Overlap in their targeting of need
- Are complex to consumers and providers in terms of their eligibility, administrative and accountability requirements – there is far too much regulation by the Commonwealth government where consumer choice and flexibility are lost in the pursuit of uniformity and accountability. Contracts in particular are overwhelming to consumers
- Could be better constructed to enable consumers to exercise maximum choice and control
- Ought to move from the current rationed system of care to one of universal eligibility subject to eligibility criteria and means testing
- Ought to be more seamless across the aged care and health care systems. The acute care system and its requirements for vacant acute beds and speed for decision making plays far too great a role in the "streaming" of people to often premature and inappropriate placements that limit the future of people

In relation to the specific questions in the Inquiry I would make the following brief comments in order to assist the Inquiry in its deliberations.

a) Whether current funding levels are sufficient to meet the expected quality service provision outcomes;

The expected quality of care meets minimal compliance levels – outcomes are not directed at peoples' expectations for care, lifestyle and amenity. I believe that the current levels of funding from Government and personal contributions are insufficient to meet each of

- The quality of care requirements of government and the care and support expectations of consumers and their families and
- The capacity to invest in the future funding of aged care services at the levels predicted by the demographics over the next 5, 10, 20 years and
- The operating costs of aged care providers
- The costs of competing for nursing, allied health and care staff against the public health system

There would appear to be a number of options that ought to be investigated to resolve these issues and in the main they have been well canvassed in the Hogan Report, the recent Productivity Commission Report and from various aged care industry spokespeople. I believe that consideration needs to be given to

- allowing for the market place to have a much greater influence in aged care through greater levels of de-regulation around the allocation of places, bonds, fees and other charges
- setting up a system of universal eligibility based on need rather than the current system of rationing eligibility. However
  - if the current system is retained establishing a system of allocation that could bear stronger resemblance to demand. My observations in relation to demand are that there is clearly not enough availability of community care (particularly higher levels of care) under the current system.

- The current system is still weighed too heavily to Residential Care.

    - funding the consumer directly in order that they make their own decisions about the form and nature of the services they want – this system is already operational in Australia for the Carers Benefit. It is a growing movement in Austria, Germany, France, The Netherlands, many of the States of North America and elsewhere

- separating out "housing services" from "care and support services"
- establishing a tiered level of care subsidies under the Consumer Directed Care system similar to that which occurs now(e.g. high, medium, low) that predicates the level of subsidy/consumer directed care to be paid to an eligible person. This would require a change in the role of the Aged Care Assessment Teams.
- increasing the levels of funding, capacity to raise capital and/or increasing the level of consumer contribution but in return for greater choice and control
- setting up a universal insurance scheme for aged care as occurs in many Western European countries
- establishing a range of consumer protections (as compared to specific aged care protections) within the context of "Consumer Affairs" legislation recognising the vulnerabilities of many older people. In particular re-invigorating services concerned with
  - access to information and advice
  - access to advocacy, complaints and dispute resolution bodies/mechanisms
  - web based contracts, information, consumer forums etc

  and making as many of these services as independent as possible of government.

The current levels of funding in the main only provide sufficient resources for the maintenance of people in their homes and residential aged care. Programs such as the Transition Care Program which encourages a restorative approach to care ought to be applied across the mainstream of Residential and Community Care programs – Transition Care has already demonstrated its capacity to get people to and maintain them at lower levels of care for longer periods.

Transition Care should not just be an early discharge program applied through the State Governments' Acute Hospitals (as it is currently turning into) – it should be taken up as a philosophical approach, an early intervention restorative approach to be applied (and assessed for consistent with our comments elsewhere in our response) across the breadth of aged care. Current administrative practice has the State and Territory Governments "managing" Transition Care.

Transition Care ought to be available as per the system for Consumer Directed Care – i.e. paid to the person and arranged apart from the acute care system. I believe my mother's situation is typical of many that I have seen coming through the acute system – they want to get people out quickly and anywhere as long as they can free up a bed. There is not sufficient time and information for the person and their families to make a choice about what is best for them in the short or the long term.

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;**

See the above comments – I do not believe that the funding/indexation formula is adequate to meet the substantial shortfalls that exist in relation to providing current care to an adequate level and developing the significant levels of capital required to develop new services.

This is particularly so for Ethnic and Aboriginal organisations where there are additional costs associated with obtaining staff who are able to reflect the cultural expectation of services and where the numbers of people in programs are often insufficient to generate the economies of scale of larger/mainstream providers (some have suggested that this is reflective of structural racism).

Similarly country/regional areas are often not able to develop a service with the numbers available to make it viable forcing people to move away from family, friends, neighbours to receive services that "keep them alive while giving up many of the things that they are living for".

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

The costs of service delivery and construction ought to reflect the regional cost of labour, materials and capital. CPI increases ought to reflect regional variations.

Zero/low interest loans (for the full life of the loan/for the period between start up and first bond/some other period) are a useful recent innovation and ought to be considered further.

Moving towards a more market oriented approach will be useful in finding out the true level of demand for services, the overall demand for types of service, the cost of services, the propensity of people to pay for "additional services", the extent to which people are prepared to use their capital to pay for recurrent services and the capacity of people to engage a workforce (family, friends etc) that are currently not being attracted into aged care

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 are inequities brought about by the current "rules" in relation to bonds and the inconsistent application by providers to the level of bonds charged depending on where you live across the country and what service you can get access to etc(e.g. If your only asset is a $350,000 house and you are charged a $300,000 bond as opposed to a $100,000 bond in most other places then you are forgoing interest of around $10,000/year that might be available to someone else purely because of where you live and what aged care service you/they have access to and the applicable bond charging policies).

Additionally many regions are "high cost" regions and so what $100 might be in one region will only by $90 in another region – hence the need for a more sensitive regional application of CPI increases.

There is also the issue of generational inequity – current users of Residential Aged Care Services are paying bonds to meet the forecast doubling of the need for Residential Care in the next decade. They are putting there resources into service for the next generation and based on current estimates the next generation will be doing something similar for the generation after that. As only approximately 7% of people will ever require Residential Care it would seem that this group is being asked to make a much higher contribution than the 93% who do not contribute but who as partners, children, family, friends or as ordinary members of society stand to significantly gain from this group being cared for in Residential Care. The cost of capital development ought to be more evenly shared across our society rather than falling on the few who might have to use it – there are many others who benefit from it

There are State based inequities built on the historical provision of care – some states still have lower levels of care per 1000 aged 70 plus than others.

If the current system were to be retained South Australia is disadvantaged through the allocation of places being based on the current formula of 113 places per 1000 aged 70+. It is not an issue that funding is appropriated using this formula but as the average age of people using services is around about 83 years old the allocation of places ought to based on the number of places required per 1000 aged say 80 places per 1000. On this basis South Australia would be eligible for approx an additional 150 additional places – (preferably as EACHP's as indicated below)

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

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

In answering these two questions together I would say that

- As previously indicated there ought to be a universal approach to eligibility that makes the planning ratios (and therefore the current system of care rationing) obsolete
- There ought to be a universal insurance scheme for aged care
- People ought to be assessed for a level of care and they can then choose the location (at home/in a residential service/elsewhere) where they receive that care. As they can now (but it is rarely done) they can also choose the level of co-payment they might wish/be able to make in order to increase the level of care and support they receive.

If the current system is retained then ACH Group believes that it does not reflect the expressed need of people to ACH Group for more

- Transition Care/Restorative Care
- Community Care (particularly EACH and EACHP's)
- Respite Care (in other than residential settings)

The existing ratios of care (because of their historical bias) are still too oriented towards residential care meaning that too many people go into residential care when programs such as the Transition Care Program are clearly indicating that more people can and should go home with a period of transition/restorative care. In South Australia this is a particularly inequitable issue for people because the existing high levels of service provision (over 113 places per 1000) means that the existing allocative method will take a long time for CACP's, EACH's etc to be distributed in meaningful numbers.

ACH Group looks forward to the opportunity to meet with members of the Inquiry and elaborating on the points we have made.

Yours sincerely