18 November 2008

Submission to the Inquiry into Residential and Community Aged Care in Australia

1. Introduction

The Brotherhood of St Laurence (BSL) operates 3 residential aged care facilities with a total of 133 beds, and provides a large number of Community Aged Care Packages, including EACH and EACH- Dementia. In addition the BSL provides a wide range of community aged care services including respite, day care, community care options and flexible service response.

The BSL has been providing services to older people for over 60 years and has an excellent reputation for high quality care. This is demonstrated in all our facilities achieving the maximum 3 years accreditation at each round since the commencement of this accreditation system, and our community care services meeting all required quality standards at each audit, including being fully accredited with ISO.

The BSL, in following its vision and mission, targets older people who often find it hard to access aged services. This includes people on low incomes with few assets, people with various forms of disabilities and people with behavioural problems. In other words, the BSL provides services to people who are often socially excluded from our mainstream society.

2. Terms of Reference (a) and (b): Current Funding Levels and Indexation Formula

2.1 Residential Aged Care

The BSL operates in an extremely efficient way and has introduced a number of productivity savings. In particular the BSL is involved in regular benchmarking exercises covering financial measures, clinical care and workplace practices. As a result of these benchmarking exercises, the BSL has implemented changes in staffing structures and rostering as well as efficiencies in purchasing of supplies and new maintenance contracts.

In addition the BSL has a comprehensive staff training plan involving on-line, internal and external training sessions. The BSL is also covering all costs for 6 staff to upgrade their qualifications to a RN Division 2 level. Further, the BSL is just introducing a new IT program for all its facilities which will streamline documentation, and allow staff to spend more time with residents.

However despite these efficiencies we are continually struggling to remain sustainable. The BSL currently incurs a large deficit of over $500,000 per annum in operating its facilities and it is only through the generosity of our donors that we can continue to provide our residential aged care services. It is important to note that this operating deficit is in line with the results of the recent Grant Thornton survey which found that around 40% of providers nationally operate in deficit.

As shown above it is clear that the current funding levels are completely inadequate to meet expected quality service provision outcomes. Another example is that in order to provide quality services aged care facilities need to recruit and employ suitably qualified staff. However pay rates for nurses for the aged care sector are up to 20% lower than the acute care sector and as aged care facilities are unable to pay this additional amount it is extremely difficult to recruit and retain nursing staff. An example of this is that one of our facilities has been trying, without success, for over 3 months to fill a vacancy for a Registered Nurse Divison 2.

Also, consistent with its mission to provide services to the most disadvantaged older people in our community, the BSL has consistently accommodated a high level of concessional residents across its residential care facilities (80–90%). It is acknowledged that there are differing opinions about the ability of the concessional resident payment to fully compensate in lieu of accommodation bonds, however, the BSL's experience is that the concessional payments did not fully compensate for the non receipt of bonds. This "opportunity lost" has had a significant impact on both our operating result and the capacity to fund any redevelopments and / or upgrades. This situation is further exacerbated by the cessation of concessional rates under the new funding arrangements.

The inadequacy of the current indexation formula is demonstrated in that the BSL's current Enterprise Bargaining Agreement allows for an annual salary increase of 4% for staff, which is around the industry average, and the current annual increases for most supplies is in excess of 4%, with the CPI for the year to September quarter 2008 being 5%. However, the annual COPO increase is around 2.3%, which leaves a gap of a minimum of around 1.7%, which for the BSL, on its current expenditure, means a funding shortfall, in terms of indexation only, of nearly $98,500 for the current financial year. These figures take into account the Conditional Adjustment Payment (CAP) which at present is frozen at 8.75% and without the annual increase to CAP of 1.75%, which has been occurring over recent years, the BSL facilities will suffer an additional loss of nearly $100,000 per annum.

The BSL has been using the CAP funding to assist in meeting the costs of new initiatives, as mentioned above, and including new programs for residents, such as our spiritual care program

It is clear that the current COPO indexation is inappropriate for the Aged Care industry. The Veterans' Home Care program does not use the COPO index and private health insurance premiums have had much higher increases authorized by successive Ministers for Health, which have actually fuelled wages growth. Also the CAP needs to continue to increase by at least 1.75% per year as while the CAP has been seen as adding value to service provision it now needs to address other costs such as arising from climate change and the Carbon Emissions Trading Scheme.

A new long term indexation formula needs to be introduced which accurately captures all the cost drivers such as wage increases, consumer items, building costs and energy and water prices.

2.2 **Community Care**

A similar situation is occurring in community care where current funding levels and the current indexation formula (CPI increases) are completely inadequate in relation to meeting the spiraling costs of providing the required quality of care. In this financial year the CPI increase applied was 2.3%, whereas the costs of services provision have increased within a range of 4%–10%. As in residential care this does not take into account increases in staff salaries, the introduction of innovative programs and rising fuel costs. The following two case studies are real life examples of these inadequate funding levels.

Case Study 1

Mary has been a community care client with the BSL since early 2005 and receives services funded by a CACP package. Her level of services has remained stable throughout this time. She currently receives 3 hours respite plus transport and 3 hours domestic care per week from After Care. The cost of providing these services has increased by $10 per week, or by 6.7% in the 06/07 financial year, costing an additional $520 per annum. In the 07/08 financial year it increased by a further $9.50, or 5.7% costing a additional $494 per annum. This means that over the last 2 years, the annual package costs have increased by over $1000 or 13%.

Mary's services costs funded by her package now exceed the funding provided by her CACP package. She is now in a position where her health has deteriorated and she requires a further increase in services. She is not eligible for an EACH package as she is still low level care. BSL community care has been able to fund the 'gap' between what can be funded from the CACP package and the actual cost of services (appox. $38.50 per week). However the recent increase in service costs means the BSL is unable to fund a further ongoing increase.

Mary’s only source of income is the aged pension and she is now in the desperate position of having some of her services withdrawn unless she can find another source of income such as from relatives. If this occurs there is a real possibility that Mary will be forced to enter residential aged care.

Case Study 2

Fran is a 74 year old woman who lives with her husband, and for both of them their only source of income is the aged pension. Fran has Multiple Sclerosis and continence issues. She has received services funded by an EACH package since 2004.

Her current services include; Personal care 7 hrs per wk, Domestic tasks 2hrs per wk, RDNS 2.25 hours per week, Flexible respite 1.5 hrs per wk, scheduled regular respite 3 hrs every 4 wks. Continence supplies every 6 wks, gardening every 4 wks.

In this calendar year alone, the cost of services has increased by $33.25 per week due to increases in nursing care and personal care costs. This is an increase of 4.75% per annum, increasing costs per annum by a total of $1729.00.

Fran's care costs exceed the funding provided by an EACH package but BSL community care is covering the gap between the cost of services and the EACH funding. However, Fran's services are now at a level where BSL community care has little capacity to respond to any further increase in her support needs. This means that, as with the previous case study, Fran will eventually be forced into residential care.

The eventual movement of these two people into residential care when it is not their choice is an inevitable result of the situation where funding is not meeting the needs in community care.

As with residential aged care the BSL has introduced a number of innovative changes in its community aged care services which have resulted in efficiencies and improved service delivery. One example of this is the new community care model where a "one-stop shop" is being set up for all potential users of the BSL's community care services and independent accommodation services. The centre of this model is the one telephone number for all services. This means any person wishing to use a community care service only has to call one number and will be given all information on the service plus a direct connection for an assessment if required.

Another example of innovation in service delivery in community care is the development of a socialization program where all clients are asked about their personal interests and then connected to a group or activity in the local community. Transport is provided for the client to attend the activity of their choice and support is provided as required. Volunteers are utilized to assist in this program which has shown to play an important part in overcoming the social isolation of the aged participants.

BSL has also invested in the appointment of a Dementia Consultant and the development of a Dementia Model of Care which provides training, tools and a dementia pathway to assist staff to gain a better knowledge and improved processes when assisting clients and carers, and also enhances the outcomes for clients and carers.

However the future of these innovative programs, which are about service quality and continuous improvement, is by no means certain as the current funding levels and the current indexation method do not provide the funding required for their operation.

3. Terms or Reference (d): Inequity in User Payments

3.1 Residential Aged Care

It is our experience that it is becoming more difficult for people on low incomes and with few assets, who are assessed as being low care, to access residential aged care. The new Aged Care Funding Instrument (ACFI) usually gives low scores to people requiring a low

level of care (formerly RCS 6 or 7) and as these people do not attract much, if any, funding many residential aged care facilities are reluctant to accept them. The exception to this is when potential residents, assessed as low care, have a level of income and assets where they can pay a reasonably high accommodation bond, and also a high fee if entering an extra service facility. These findings from our experience are being supported by anecdotal evidence from other service providers, and the BSL intends to undertake further research into this issue.

It is also the experience of the BSL that a number of potential residents, assessed as low care, who are on low incomes and have few assets, often enter residential care for their accommodation needs as much as for the care. The exclusion of these people from residential care because of their inability to meet the user payments required by many facilities is an inequity which must be addressed. The re-introduction of a payment, such as the concessional payment, would make it more attractive for service providers to admit these people.

Organizations such as the BSL, which as part of their mission target people with low incomes and low assets, are incurring financial losses due to the lack of funding the ACFI provides for these people who are on low care. On current estimates two of our facilities will incur a loss of over $50,000 per annum as result of admitting these people with low care assessments. In order to overcome this inequity the ACFI needs to be adjusted so that there is a minimum payment to assist with meeting the costs for essentials such as accommodation, food, cleaning and laundry and the nil payment should be abolished.

Another issue is the high cost of using respite care. Evidence has been gained from our client/carer forums that a number of people are reluctant to use respite care because of its high costs (85% of the aged care pension). As a result these people may have inappropriate use of community care services, and if this is not available may gain premature admission to residential aged care. There is a need to review respite fees for people not receiving assistance from community care packages to pay respite fees.

3.2 Community Care

There is an inequity in user payments for individuals within community aged care. This results from the lack of guidelines regarding the setting of fees for consumers for packaged care and respite care programs. The fee charged by approved providers varies from one of a set fee at the maximum rate that is chargeable (17.5% of pension) to individual fees depending on the person's financial circumstances (this may also include the waiver of all client fees due to a level of financial disadvantage).

Also some consumers who have been provided services through HACC programs often do not wish to change to an Aged Care Package Program if the level of fee is higher than that which they had been paying, even though the package is providing for complex care needs. This can result in consumers remaining on HACC services and then entering the packaged care program at a later date with needs/issues at a higher level and often in crisis.

Approved providers, both in Packaged Care and Respite Care, use the revenue from the collection of fees to support the provision and enhancement of services to consumers. Given the rising costs of service provision, the charging of reduced fees can have a negative effect on the ability of providers to deliver this support.

Another inequity regarding user payments is also the difference in support that individual consumers receive from other sources such as family. Aged Care Packages are currently set at particular funding levels dependent on the type of package (CACP, EACH and EACH Dementia) and allow for the provision of different levels of care/ services. Often families financially supplement the extra care that cannot be provided through a package. Not all consumers are in a position to purchase this care. This is particularly evident in the CACP which is being utilized for more complex needs clients as there are not enough EACH packages available to meet demand. Providers continue to maintain clients if possible. The result may be that those who cannot afford to supplement their package in the long term are prematurely seeking Residential Care.

The inequities described above could be addressed through the setting of a national framework for fees which includes a sliding fees structure that is dependent on the consumer's ability to pay. Brotherhood of St Laurence Packaged Care Programs has a policy and procedure regarding fees (with a sliding scale) and each care recipient's circumstances are assessed and fees agreed between the client and care manager based on income and all outgoing expenditure. To deal with the level of reduced fees and the loss of income to the provider it is suggested that a funding supplement be available to the provider on the production of objective evidence that indicates the reasons for the loss of fee income.

It would also be more effective to have a funding system within packaged care that does not silo the packages, i.e. that packages are seen as part of a continuum of care and that as care recipient needs become more complex and there is a need for higher levels of service that this is supported financially through the packages. This would enable approved providers to maintain the person at home rather than his/her entry into residential care when, as current, a package funding level is exceeded

4. Terms of Reference (e): Current Planning Ratio

The current planning ratio with an equal distribution of 44 places each for high care and low care per population aged over 70 years of age seems unbalanced. The most recent national figures show the proportion of high care residents in residential aged care has now reached 70% (*Residential Aged Care in Australia 2006-2007,* AIHW, July 2008). This growth in the proportion of high care residents is expected to continue for the following reasons:

- People assessed as high care receive high scores under the ACFI and so service providers receive high funding levels for them.

- There is a strong preference for older people to remain at home for as long as possible.
- There has been a rapid increase in community aged care packages (18,309 in 2000 to 42,570 in 2007, *Aged Care Packages in the Community 2006-2007, AIHW 2008).* Clearly this increase enables more older people to stay in their own homes rather than move into residential aged care. As a result the future trend will be for residential care to be sought primarily by those who are too frail and too sick to remain in their own home, in other words, by those who are assessed as high care

Consequently the planning ratio needs to reflect this continuing trend by allocating at least 70% of its residential aged care places to high care, not 50% as currently occurs.

Also, the current ratio between community high and low care places (EACH, EACHD and CACPs) is not meeting the needs of consumers. In 2007 in Victoria, the allocated places were 19.4 CACP per 1000 persons aged 70 years and over to 2.4 EACH and EACH Dementia. (Aged Care Packages in the Community: A Statistical Overview 2006-2007, AIHW 2008). Providers are experiencing great difficulty in attempting to maintain some care recipients who are in need of high levels of service and wish to remain at home, on a CACP package rather than to discharge them to residential care, as there are no vacant EACH packages available in the region. As one provider, BSL in the Southern Region currently has 45 clients being maintained on a CACP while waiting for an EACH package and there are also 177 referrals on the electronic waiting list for EACH across the SMR. In the Northern Region BSL currently has 16 people being maintained on CACPs while waiting to be assessed for a higher package and there are 99 electronically wait-listed people in the region.

The difference in the level of funding provided under each package of care exacerbates the need to transfer clients between packages. A CACP is funded at $12,683.75, EACH at $42,398.40 and EACH Dementia at $46,760.15. There is no possibility of transitioning a client from the lower level of funding of a CACP when need for services increase. This may not necessarily mean to the level of an EACH in the first instance. Another level of funding for a package may indeed be $15,000–$20,000.

The AIHW report 2008 indicates that of those who leave a package of care 47% of those on a CACP enter residential care and 43% of those on an EACH package enter residential care. The difference may well be a consequence of the lower number of EACH packages available. During 2007 when EACH packages increased in numbers 22% of BSL's CACP recipients leaving a CACP package transferred into an EACH package rather than into residential care.

Suggested solutions to the above issues are an increase in the number of community high care places and as stated above, a change to the way packaged care is delivered through a continuum of packages which will allow for the increasing care needs of care recipients.

5. Terms of Reference (f): Impact of Residential Places Allocation and Funding on Community Care Places

As a result of the introduction of the ACFI which discourages residential care providers from offering places to people assessed as low care who cannot pay a reasonable accommodation bond, and the strong preference for older people to remain in their own homes for as long as possible, it is expected that a dramatic growth in demand for community care places will occur. Consequently there is a clear need for a greater allocation of Community Care places, which means the current ratio of 25 places per 1,000 people over 70 years of age needs to be increased.

In addition, the rapidly increasing costs of building construction, the current financial situation with difficulties in obtaining credit and the announcement by some major service providers that they will not be applying for residential care places in the next ACAR (*Australian Ageing Agenda*, October 2008) give some indication that the demand for residential care places may slacken. Another factor is the continuation in the trend for service providers to hand back a number of residential care places as they are unable to make them operational (*Aged Care Industry Council*, October 2008). If these trends continue then these residential care places should be converted to community care where there is a real unmet need.

At present allocation of places are made on a regional basis and this is creating an imbalance in meeting the need for places. Regions are too large a geographical area for equitable allocation as there can be a great deal of variation in needs in such a large area which can distort the picture for the whole region. For example, there can be a high need in one pocket of a region but little demand in other parts of the region. Consequently only a small allocation may be made to this region which may be picked up by service providers in parts of the region where there is not a high demand, and the area where there are real needs can miss out. To overcome this problem it is recommended that all data related to allocations be disclosed on a Local Government Area basis. In this way the areas where there are real needs can be pinpointed and appropriate allocations be made.

6. Recommendations

6.1 That a new long term indexation formula be introduced which accurately captures all the cost drivers such as wage increases, consumer items, building costs and energy and water prices.

6.2 That the concessional payment be re-introduced so service providers will accept people who have low incomes and few assets and who are assessed as low care

6.3 That the the ACFI be re-adjusted so that there is a minimum payment to assist with meeting the costs for essentials such as accommodation, food, cleaning and laundry and that the nil payment under ACFI be abolished.

6.4 That a national framework for fees which includes a sliding fees structure that

is dependent on the consumer's ability to pay be introduced, and that a funding supplement be available to the provider on the production of objective evidence that indicates the reasons for the loss of fee income.

6.5 That the respite fee arrangements be reviewed with a view to allowing a smaller fee for people on low incomes who are not assisted by community care packages to pay fees for respite care.

6.6 That a funding system be introduced that enables packages to be part of a continuum of care so that as care recipient needs become more complex and there is a need for higher levels of service that this is supported financially through the packages.

6.7 That the planning ratio allocation be changed so that at least 70% of residential aged care places are high care, not 50% as currently occurs.

6.8 That the number of community high care places be increased and the way packaged care is currently be delivered is changed so that packaged care is delivered through a continuum of packages which will allow for the increasing care needs of care recipients.

6.9 That the current allocation of Community Care places of 25 places per 1,000 people over 70 years of age be increased, and that residential care places be converted to community care where there is no demand for these residential care places.

6.10 That the Department of Health and Ageing disclose at the Local Government level all data relating to all residential and community care places allocations.

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