ANGLICARE
THE CARE THAT CHANGES LIVES

ANGLICARE Sydney Submission – Caring for Older Australians

Prepared for:
The Productivity Commission

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PREFACE

ANGLICARE Sydney is one of the largest Christian community organisations in Australia; it embodies the Christian commitment to care for all people in need, as Jesus commanded - to love your neighbour as yourself.[1] ANGLICARE Sydney has been providing a wide range of professional services to the community since 1856 and serves many thousands of people every year. These services are broad based across two streams:

- **Chesalon,** the seniors living stream, which incorporates:
  - Chesalon Care – providing residential aged care to 440 permanent residents with both low and high care needs including the specific requirements of people with dementia as well as residential respite support for carers. These facilities are located throughout the Sydney Diocese at Richmond, Jannali, Woonona, Nowra, Beecroft and Philip Bay (soon to be returned to Malabar on completion of the rebuild of this facility) with plans for future facilities at Oran Park and Ingleburn.
  - Chesalon Services – provides a diverse range of Home-Base and Centre-Base support services to frail aged people and people with dementia and their carers. Community programs include: 15 day centres, therapy centre (podiatry, physiotherapy, aromatherapy, music/art & recreational activities), overnight respite cottage, domestic assistance, personal care, respite, social support & dementia monitoring, dementia advisory service (information and advocacy), dementia café in local restaurants, packages (CACP, EACH & EACHD, community visitors scheme in residential setting and monthly social evening events held at the day centre.
  - Chesalon Living – which will complete our continuum of care model by providing both independent living as well as supported accommodation for seniors.
- **Community Care:** which includes: counselling; community education for families; family support services; youth services**;** emergency relief for people in crisis; foster care and adoption for children including those with special needs; migrant services including humanitarian entrants and newly emerging communities; English as a second language classes; aged care both through nursing homes and community services; opportunity shops providing low-cost clothing; emergency management services in times of disaster; disability case management and respite and chaplains in hospitals, prisons, mental health facilities and juvenile justice institutions.

INTRODUCTION

ANGLICARE has a 150 year history of working in the field of aged care and this was, in fact, the work on which this agency was founded. We are rapidly growing the aged care arm of our service delivery with major refurbishments of residential aged care facilities at Malabar, rebuilding at Jannali, rebuild of a new regional community centre at Mt Ousley, purchase of a new regional community centre at Frenchs Forest and a

[1] The Gospel of Matthew, chapter 22 verse 39

new Retirement Living and aged care complex scheduled for Oran Park Town. The Oran Park development will consist of independent living (96 villas, 144 apartments and 17 serviced apartments) together with a 102-bed aged care facility supported by 27 assisted living units and a Day Centre. This expansion has become imperative given that our previous model of service delivery was predicated on stand alone high care, not financially viable under existing funding arrangements.

Our strategic plan is based on a continuum of care model – a planned strategy to assist people as their care needs develop and change over time, supporting them throughout this process with 'aged friendly' accommodation to maximise the duration of independence, and with in home support as needed and a supported transition into residential aged care should the need arise.

It is important for the Commission to understand the context in which we make this submission. There are three important goals for which we strive and which guide our planning:

1. **Holistic care**: We are a not for profit agency focused on the delivery of holistic care across the age continuum recognising that needs are diverse and also change over time. Services therefore need to be flexible and responsive to these needs in order to optimise client and resident outcomes.

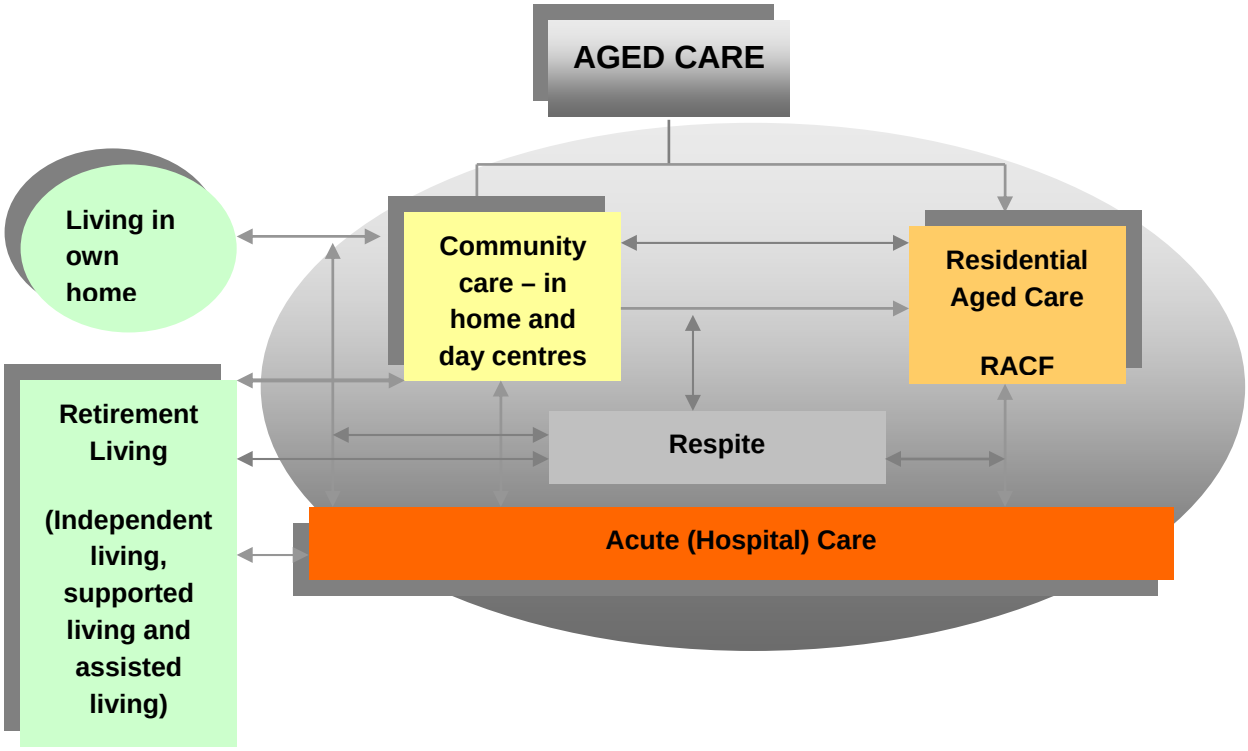
2. **Quality of care**: At the same, time quality of care is regularly monitored and reported to our governing body through resident & client surveys. This evaluation indicates outcomes of a very high standard of care and very high levels of satisfaction with both the residential aged care facilities as well as the community aged care programs.

3. **Equity of access to care**: While providing care without discrimination to all in need, we are especially concerned for the marginalised and socially excluded older Australians who are vulnerable and at risk of homelessness and whose well being and quality of care is further compromised as they age. This is particularly true for indigenous and culturally and linguistically diverse (CALD) people. Equity also includes affordability and we consider that all older people are entitled to high quality aged care, health and support programs, regardless of their income and capacity to pay.

1. CONTINUUM OF CARE

As the baby boomer generation moves into retirement there will be an increasing need for diversity of aged care options reflecting the expectations of this generation, the inappropriateness of current aged care models to meet need and the capacity of the system to deal with the sheer magnitude of this need over the next two decades. Currently the aged care system centres on three options – in-home care, acute care or residential aged care, with not a great deal of integration between them (see Figure 1 below).

Figure 1: Current System



Seniors living has been seen as a paid for, lifestyle choice and is therefore not considered an integral component of the aged care system. Subsequently it is treated under different funding, legislative and regulatory arrangements. However, service providers are increasingly faced with the need for supported and assisted living components to support this lifestyle choice and therefore have to compete for the limited HACC and NRCP funding and EACH/D and CACP packages. Supported living provides hotel type services such as laundry, meals and cleaning to residents in the village. Assisted living extends these services to include personal care. There are significant advantages to the whole aged care system in this expansion of care model under the retirement living banner since it enhances overall capacity of the system and reduces the pressure on RACFs, thus improving both the demand and supply issues within the sector.

ANGLICARE Sydney argues that there is a need to recognise the importance of seniors living – not only as a lifestyle choice, which therefore does not come under the aged care umbrella, but as a model of care which is part of the broader continuum of aged care and, if properly funded and appropriately regulated, could increase the capacity of the aged care system.

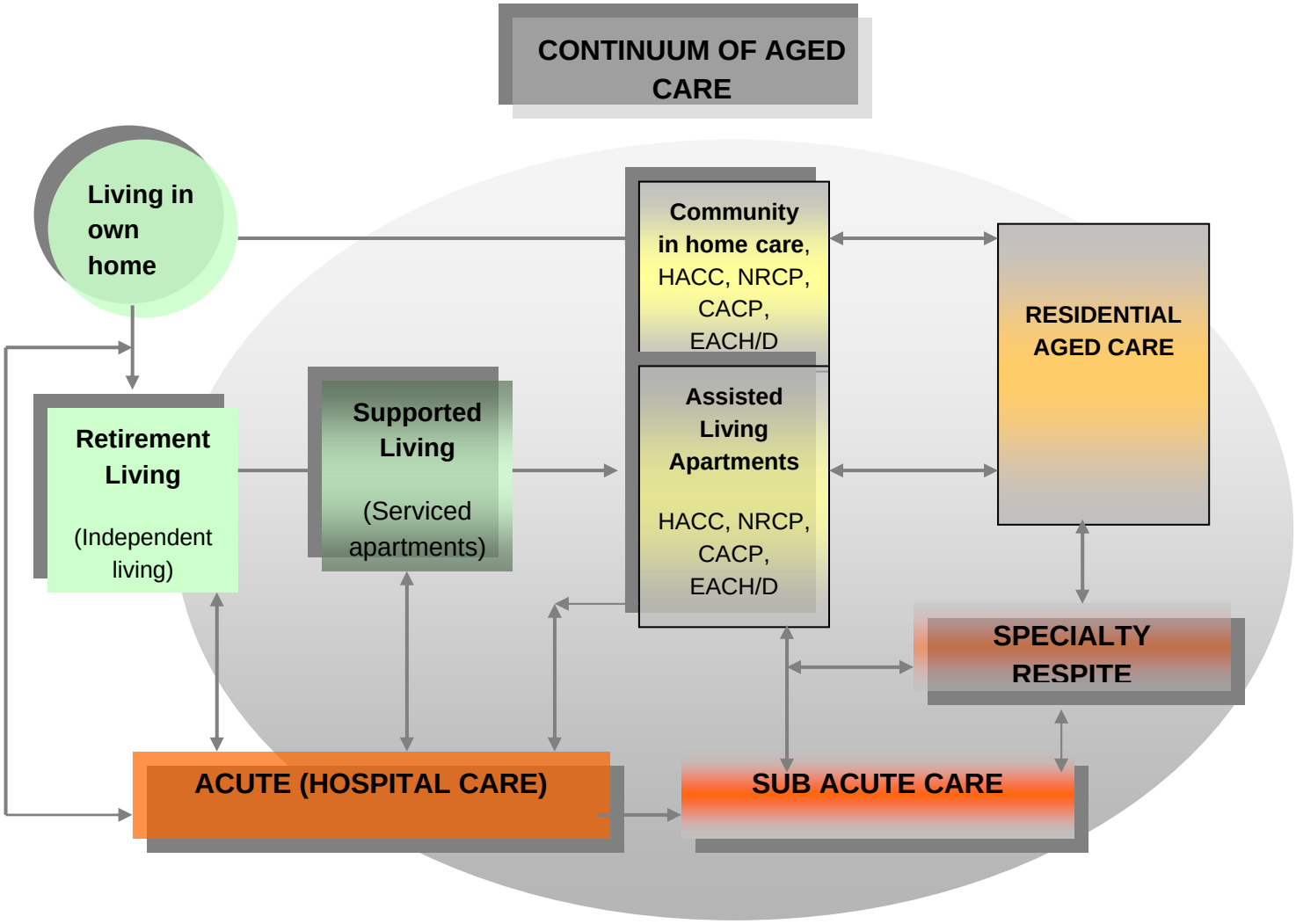
There are two additional proposed streams of service that could be effectively incorporated into the aged care system:

- Establishment of specialist residential respite centres and facilities, appropriately funded, to assist in the transition between acute hospital care and RACF. This would reduce the need for complex care in RACFs and could be achieved by the use of existing small RACFs or quarantining beds in larger RACFs for this express purpose.

- Creation of sub acute facilities especially for aged care which would provide intensive medical care for a period of 6-8 weeks thus reducing the pressure on the acute hospital system as well as the need for complex interventions in RACFs.

Diagram 2 illustrates this model.

Figure 2: Continuum of Care



Recommendations:

1.1 Government consider Supported Living and Assisted Living as part of an integrated aged care system and incorporate them into policy and funding considerations.

1.2 Establishment of specialist respite facilities to assist in the transition between the acute hospital system and RACF

1.3 Establishment of new sub acute facilities to provide intensive medical care for a period of 6-8 weeks.

2. FUNDING

2.1 Capital

Accommodation charges as they currently apply are not sufficient for current and future capital development. They are also being used for current operational expenditure to offset operating losses. Most not for profit aged care providers have a dwindling capital base as a result of the 2008 building certification requirements and instability in the capital markets. Yet with the ageing of the Australian population, high care is set to increase in proportion to low care leaving an issue with funding the development of new high care facilities. This lack of capital to generate new facilities will in turn put greater pressure on people to be cared for in their own home thus increasing the pressure on community care and the acute hospital system.

It could be argued that capital funding should be absolutely quarantined from operational expenditure. This quarantined capital should be attached to the bed licenses and not the provider. This would mean that sale of the facility would inhibit 'profit gouging' for those who are interested in short term profits and not long term investment and returns.

For providers involved in mixed service delivery there has been some cross subsidisation between low and high care facilities but, for stand alone high care providers, future development is not viable or sustainable under current funding arrangements.

Residents, who may be admitted to residential aged care with a low care assessment, can very soon become high care. The number of assessed low care residents is decreasing as a result of the increasing support to these potential residents in their private homes through HACC and CACP programs. This is having a significant impact on the development of new facilities by providers who rely upon the accommodation bonds as a source of capital.

2.2 Accommodation Charges

Access Economics research indicates that if accommodation charges were raised from $26.88 per bed per day to $40.32 per bed per day it would be possible for the aged care provider to carry debt to develop new facilities.

In 2002 the Allen Consulting group calculated that the average income from accommodation bonds per low care resident was almost three and half times the average per high care resident.[2] Again in 2002 the Fitzgerald report claimed:

> *There is widespread recognition that the current arrangements for capital contributions to high care residential places are not sustainable.*[3]

This is thus a long standing matter of contention and one with which the Productivity Commission has previously engaged.

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[2] McCallum John and Greg Mundy (2002), *Australia's Aged Care Service System: The Need for an Industry Strategy*, The Myer Foundation.
[3] Fitzgerald Vincent, (2002) *Financial Implications of Caring for the Aged*, The Myer Foundation.

By making residents pay the same accommodation charge, irrespective of the type of accommodation, choice is reduced and may lead to unfair outcomes for residents. Currently, the accommodation charge is set by the Government for every aged care facility regardless of location and standard of accommodation. This extends to whether the accommodation is a single room or shared room.

In addition there is no flexibility in relation to payment options. Some residents may prefer a weekly charge, others to pay a lump sum on entry and still others to have the amount deducted from their estate on death. It is a standard capital subsidy that does not recognise variations in capital cost related to location. For example, acquisition and development of aged care facilities on property in inner Sydney for the homeless or people with long term psycho social and psychiatric problems etc, is not tenable.

Currently mandatory concessional minimum ratios vary according to socio economic advantage. An apparently unintended consequence of setting concessional / supported resident ratios is that those regions with higher ratios, that is, lower levels of income / assets, have a higher number of places for which a capital amount cannot be sought. This creates a disincentive for providers to build facilities in those regions of high ratios because of the increased difficulty in raising the necessary capital to cover construction costs.

The supported resident supplement has a minimum rate for up to 40% occupancy with supported residents and a higher rate once the 40% target is achieved. The current system of stepping concessional supplements acts as a disincentive; there needs to be a sliding scale increasing the supplement in smaller steps – eg every 5% - and continuing above 40% to between 60% and 80%. This would act as an incentive for those of us not for profit providers, who work with socio economically disadvantage groups, to widen the aged care support for these groups and still be able to maintain financial viability.

Recommendations:

2.1 Remove the distinction between high care and low care with regard to accommodation costs. All residents should be required to pay for accommodation separately from their care needs.

2.2 That Capital subsidies received from Government and Capital income received from Residents be quarantined from operational expenditure. It should be attached to a funded place and not the provider. If the funded place is sold or transferred then accrued capital income should be transferred. If licenses are surrendered then accrued capital income should be returned to the Commonwealth.

2.3 Accommodation should be paid either in a lump sum (Bond or equivalent refundable capital amount) or a daily charge that is at a level that enables aged care providers to carry the cost of debt needed to fund new developments.

2.4 The federal government should consider providing capital grants to 'not for profit' providers who commit to providing care to higher levels of concessional residents for the development of new aged care facilities. Additionally government loans could be made available interest-free and repaid from accommodation bonds or accommodation charges that were at a level enabling the repayment of these amounts over the lifetime of a facility (typically 30 years).

2.5 An alternative to 2.3 above might be the federal government acting as a Guarantor to the lender of capital to aged care providers to enable the development of aged care facilities.

2.6 The current system of stepping concessional supplements acts as a disincentive – there needs to be a sliding scale increasing the supplement in smaller steps – eg every 5% - and continuing above 40% to between 60% and 80%.

2.7 There should be a regular review of charges to ensure they adequately reflect real costs of capital.

2.8 A consistent platform for means tested fee setting, and for the payment of subsidies, should be set across the system. Those with high levels of wealth should fully meet the costs of their services and care while those with limited or no capacity to pay should have their care costs subsidised at a fair and reasonable level.

2.9 The accommodation charge should not be regulated by Government. It should be set by the market so that people willing and prepared to pay for a higher standard of accommodation may choose to do so, whereas others may be content to pay for more modest accommodation. However, those with limited or no capacity to pay should have their accommodation costs subsidised at a fair and reasonable level.

2.3 Inadequacy of ACFI

While the shift from RCS to ACFI has been positive in reducing some administrative burden it is not funded adequately to meet care needs, particularly for those high dependency interventions which may require IV, tracheotomy, dialysis, ongoing tube feeding etc. The movement from medium to high funding for Complex High Care is less than $20 per day. Such funding is far below the hourly rate of the average RN required for this care. Subsequently facilities are reluctant to accept, or retain, such high care needs residents as they are not adequately supported by funding. These people then take up places in the acute hospital sector.

Nor does ACFI adequately fund people with low care needs. As a result, prospective residents who fell within the RCS categories 8, 7 or 6 cannot easily find places in residential aged care because the funding under ACFI is far below the costs needed to care for these people. Nevertheless, these people still exist. ANGLICARE is addressing this need by planning developments that include assisted living in apartments that provide physical and care support. However, this type of care is not funded under the Aged Care Act and so the individuals have to meet the costs of this level of care and support.

There has been a trend in aged care over the last 2 decades aligned with constraint in places and population growth towards an increasingly medical perspective on aged care and its funding. ACFI is a more medicalised model than the RCS and the RCS was more medicalised than SAM, CAM and OCRE. There is no funding based on social need, or recognising human need for social interaction, in any of our funding models or in any of the reviews of funding that have occurred over the last decade. As a result residents get much less social interaction and much less time with staff. ANGLICARE resident feedback is that one of the things they value most in service delivery is the time taken by staff and staff interaction. However, that is exactly the element of care that is withdrawn as funding gets tighter and tighter and so called ‘efficiencies’ are sought.

Recommendations:

2.10 Increase ACFI funding for complex cases

2.11 Establish sub acute care places with higher levels of funding

2.12 Establish a legislative regime that enables recommendation 1.1

2.4 Indexation

COPO funds staffing and the care side of aged care at below the rate of inflation and has been inadequate over the last decade and is becoming increasingly so. In order to cope, community care programs are reducing their hours of service delivery and the margins for residential care facilities are narrowing so that currently only 50% of aged care homes are financially viable, at least in the short term. The remainder operate by eating into capital reserves which is clearly not sustainable in the long run.

For the last decade funding has been at least 1% pa below real cost increases. Effectively this has led to an, at least, 10% gap between funding and cost ratios. Wages are rising at a faster rate than funding.

Much has been argued about the need for aged care to make significant productivity gains to offset rising wages but the labour intensive nature of the industry and the constraints on income are so significant that it is almost impossible to be innovative and achieve significant increases in productivity. Further, how are such productivity gains to be achieved, in a human service industry? They can only be achieved by doing tasks more quickly, spending less time with each resident and doing fewer things for people or in other words, significantly reducing the quality of care.

Given the issues of wage discrepancies between the aged and health care sector and the need to restore parity to aged care workers in order to attract and retain staff, this issue threatens the survival of current operators.

Although the CAP was introduced as a temporary measure, it restored viability to many in the sector because of the inadequacy of indexation and funding generally. Its withdrawal will adversely impact all providers but in particular those providers who operate close to break even. It may lead to closures in the sector.

The rising cost of utilities, food, transport etc is not covered adequately by the indexation of funding in community care, leading to demands to maintain outputs with real diminishing funding. Efficiencies here are achieved at the cost of reduced time and quality of care.

Recommendations:

2.13 The current COPO model of indexation should be replaced with an indexation method which accurately reflects the productivity constraints which operate in the residential aged care industry and prohibits the erosion of real subsidy values.

2.14 Government funding needs to be indexed to account for the increasing costs associated with the workforce and daily expenses such as food, transport and energy.

2.15 The Government needs to endorse an independent cost of care study to determine pricing and indexation structures that work.

2.16 Funding for both residential and community care should be increased by immediately restoring and extending the CAP (or a similar mechanism) which is indexed until long term reforms are finalised and implemented.

2.5 Acuity

The preference for people to remain in their own homes for longer, combined with the community care programs which enable this, means that when people do enter a RACF they are usually frail with high levels of dependency, which is usually degenerative. New entrants to the nursing home often come straight from the acute hospital system and can require considerable medical intervention and high levels of care. This places considerable strain on nursing and staff resources as the funding is insufficient as per section 2.3. At the same time it should be recognised that the use of RACFs for these purposes greatly reduces pressures and costs in the acute hospital system. Increased acuity and dependency raises issues in relation to costs of care and also the need for new palliative care models and sub acute care.

Recommendation:

2.17 That additional supplementary funding be provided for special medical interventions such as IV Therapy, dialysis, intensive pain management, rehabilitation and tracheotomy management.

2.6 Community Care Access

For most people the preferred option in ageing is to stay in their own home and maintain independence for as long as possible. This is a less costly option for Government as well. However services and support for older people living at home have been reduced: Community Aged Care Package clients, who once received seven hours support a week, now only receive five. There is a stronger focus, because of funding pressures, to meet outputs and get the task done. There is less focus on the individual and their need for social interaction.

A further issue relates to the need to align funding with level of need. For example CACPs which are dementia priority are allocated the same funds as those for standard frail aged people – unlike EACHD which recognises the level of care required and thus offers a greater financial benefit than EACH.

Apart from funding there are also issues of choice. Clients are often fearful of leaving service places behind because there is a risk that they will be put on a waiting list to access different services. This is the incentive for clients to stay with existing services regardless of whether their needs have changed. Clients in receipt of CACPs often have prolonged stays on the package, despite increasing acuity and need, because it is often difficult to access the limited EACH and EACH/D packages. It means, with increasing dependency, the CACP is inadequate but becomes the fall back if no other packages are available. A tiered system of packages is required which reflects differing levels of need and this funding needs to be sufficient, and packages numerous enough, to make this transition accessible and streamlined.

Recommendation:

2.18 There is a need to develop more flexible care subsidies for people in receipt of community care packages. What is needed is a five tier system beginning with CACPs and ending with EACH and EACH/D which are accessible, appropriate and timely.

3. REGULATORY CONSTRAINTS

3.1 Administrative and Compliance Burdens

The governing legislation for aged care regulation in Australia is the *Aged Care Act 1997*. Under this umbrella, funding arrangements, approval and responsibilities of providers, client rights, eligibility, accountability and quality of care are all subject to regulation. These are also supported by certification standards, a Complaints Investigation Scheme and prudential regulation in relation to bonds.

Under the current regulatory framework people are only entitled to care if they have been assessed as suitable by ACATs, they can only receive such care from an approved provider and they are limited to where and how they can receive that care.

Documentation and reporting are required in the areas of financials, resident details, admissions and discharges, registers of injuries and skin integrity, monthly base line observations, incident and hazard reporting, audits, systems analysis, external health registers, resident care needs, medication review audits, accreditation, and resident classifications.

The burden of regulation has increased significantly in the last decade which has:

- Raised compliance costs across the sector
- Impacted on costs of service delivery
- Increased pressure on staff
- Adversely impacted quality of care as care resources are diverted to administrative and bureaucratic functions to ensure standards are met.

Recommendations:

3.1 Funding system does not recognise the increasing costs of regulatory compliance and they should do so or compliance burden should be reduced.

3.2 Facilities that have a proven and consistent track record of compliance should not be required to have additional 'spot' visits on top of scheduled accreditation audits.

3.2 Supply Side Inelasticity

Under the current arrangements the number of subsidised age care places is strictly controlled by the Department. This supply is determined on the basis of forward planning gauging the proportion of people aged over 70 per 1000 of the population. Such a scheme reduces the hazard to government of budget funding arrangements since funding requirements can be clearly determined on an annual basis. Demand is also managed by the needs assessments carried out by the ACATs. In a paper delivered to Catholic Health Care in 2007 Hogan summarised this situation as follows:

> *The existing regime in residential aged care reflects a centrally-planned arrangement without any role for users of services and their families; boards and management of entities offering services are constrained in their investment decisions; and, the policy setting restricts entry to and exit from activities thus curtailing potential competition. Overall the policy is directed to a state of regulated scarcity.*

This rationing system creates a number of market distortions.

- Economies of scale are compromised by the availability of beds in certain localities as providers are limited in expanding their market share [Hogan]
- Innovation is stifled both in terms of design of new systems and service delivery [Hogan]
- Competition in the sector is reduced [Hogan]
- Prices do not reflect the real supply and demand and increasingly these prices are not covering costs [Productivity Commission]
- This in turn has led to aged care providers exiting the sector further impacting sector capacity in what Catholic Health Care calls an 'investment strike'. [Catholic Health Care]
- The distortions compromise the ability to maintain high quality standards of care
- Users have reduced and limited choice – it is very difficult to move from one facility to another in the same area when bed capacity is full.

Recommendations:

3.3 The Government consider the removal on the restrictions of bed licenses so that people will not have to accept the only place they can find, thus freeing up supply. This needs to be a staged implementation.

3.4 The Government needs to streamline the current regulatory framework reducing the costs of compliance while maintaining high quality standards of care with a targeted focus on underperforming facilities. The general principle which should operate is that the statutory body which funds RACFs should also be the one that regulates it.

3.5 The system in which accreditation and compliance operates should be streamlined so that RACFs deal with fewer agencies and fewer sets of requirements.

3.6 The Government needs to ensure appropriate safety nets are in place for groups who currently have difficulty accessing aged care services such as those who are asset and cash poor, Indigenous, CALD or living in rural and remote communities.

4. INFORMATION

4.1 For the Consumer

Currently the 'cottage' nature of the industry and the significant fragmentation of the market means that consumers are not well informed as to choice on the number, type, diversity and quality of services operating in the industry. Various websites provide information but none are sufficiently comprehensive to assist consumers in making life choices. ANGLICARE Sydney supports the transparent reporting by Government, or a nominated agency, on the full range of facilities and services

provided, to assist consumers in making informed choices for aged care services. Nor should this be a simple one way flow of information. The care preferences of older Australians have not been adequately investigated or researched in order to inform the design, development and delivery of aged care services.

Recommendation:

4.1 That a nationally benchmarked range of indicators be established that considers a range of factors such as standard of care, staffing ratios, accommodation and lifestyle activities, so that consumers can be better informed when making a choice.

4.2 For the Industry

Currently a significant amount of data is being captured by Government in various databases for various programs across the country. However there appears to be no intention to consolidate and analyse this data for high level reporting back to the sector on performance and outcomes. There is a consistent focus by Government on inputs into the programs but very little reporting of outputs or outcomes back to the sector, Benchmarking and regular reviews of performance in key funding areas would be possible if such global data analysis was carried out.

The Commonwealth is endeavouring to standardize medical records across Australia with unique identifiers to access pharmacies, doctors and aged care facilities. This will require a significant investment in IT within RAC and community care to enable this to happen. Current capital funding does not incorporate the increased costs associated with the development and implementation of these electronic systems.

5. DUPLICATION

5.1 Residential Aged Care

Duplication of regulatory arrangements has the dual impost of additional compliance costs and inconsistent application throughout the industry. This duplication can be reflected in the number of reporting requirements, the protocols between the DoHA and the Accreditation Agency, the overlapping between government departments in relation to compliance, OHS, food safety and accreditation and the duplications which arise between federal and state jurisdictions. There are also duplication issues in relation to building certification standards which would be addressed by including the privacy and space criteria into the Building Code of Australia.

5.2 Community Care

This duplication is also an issue for community care programs since there is no single set of standards to report against but rather a plethora of standards and frameworks that creates significant overlap at a time when community care programs are increasing, in number and service type. Although a common National Quality Reporting Framework is being piloted it is yet to be endorsed or implemented nationally.

There are significant variations in the expectations that various Government Departments place on programs in order to meet accreditation standards. These variations take up considerable resource and staffing time. One agency can have a mix of funded programs where various reporting mechanisms and processes are very different for HACC and Commonwealth funded programs. HACC goes through an integrated monitoring process (IMF) and the Commonwealth goes through a quality reporting process which is dissimilar in that it requires the preparation of the

self assessment desktop audit and continues through to how the workplace assessment is conducted. Some co-ordinators are responsible for more than one program which includes the two types of funding streams; therefore, it would be helpful at the government level to consider changing to a more co-ordinated approach through one monitoring process. Although, there has been preliminary work done in moving to common community care standards as part of merging aged care into one service system, it appears that this arrangement has been put on hold until further notice.

Recommendation:

5.1 It is therefore recommended that government departments at State and Federal levels coordinate their expectations around governance and achieve accreditation for all programs through a one off process.

6. RISK

The current risk approach by the Department and the Agency is predicated on a zero tolerance to risk. While ANGLICARE supports the need to ensure safe practices and reasonable regulatory controls the current risk avoidance being pursued is a significant cost to that majority of providers who, in fact, pose very little risk as they continue to provide high quality care. Accountability is important. A totally risk averse and rigid environment inhibits innovation and initiatives and penalises high quality care providers. For example a complaint to the Complaints Investigation Scheme (CIS) can result in the complaint not being upheld and yet the Agency may still be notified and a 'no notice' visit will still ensue.

The CIS was established as an independent agency to ensure that complaints are adequately investigated and aged care providers are compliant. The 2008/9 results indicate that only 12.5% (1,093) of the reported complaints (7,900) that were in scope were identified as a breach. Of that 1,093 only 181 were found to require further action ie all the other complaints had been addressed adequately by the aged care providers. One could argue that a significant amount of money has been spent on the 181 cases which required further action.

7. BUILDING AND INFRASTRUCTURE

Aged care developers meet the building certification standards but are aware that the higher the certification scores the higher the cost inefficiencies – a reflection of the higher quality of amenity. This means that a balance needs to be achieved between meeting the standard, establishing appropriate amenity and achieving cost efficiency.

There has been a significant slowing down of investment in infrastructure because of lack of appropriate funding for capital investment and the uncertainty around long term viability. Currently many Government funded programs provide funds for service delivery but insufficient funds for infrastructure development – including buildings, office space and IT. Community Care Day Centres, for example, are given limited funding to operate efficiently and effectively where often premises require additional funds to ensure safety and well-being are maintained for both clients and staff. Usually, property and rental expenses are quite high as the rent component is based on usage required for running a day centre, including costs associated with maintenance upkeep.

8. WORKFORCE

Salaries are the predominant cost in the operation of aged care service delivery, being approximately 70% of total operational expenditure. It therefore makes sense to optimise the use of the most expensive resource – the RN – to allow time for assessment, referral, management and advocacy. It also makes sense to maximise the use of the least expensive resource – the less skilled and less paid Certificate III Aged Care worker. However, adjusting this mix can have adverse impacts on the quality of care.

The trend of reducing reliance on RNs is not just a cost saving measure but is also an issue of capacity and the availability of RNs. Thus there are important issues in relation to the disparity in pay rates for RNs between the acute and the aged care sector (on average $300 per week) and the poorer reputation and observed career paths of nursing in aged care. These trends are coupled with a national shortage of professionally trained nursing staff. This shortage also leads to a higher RACF reliance on agency staff which can impact the continuity of care.

Recommendations:

8.1 The paucity of qualified nurses in the industry combined with the wage differential between the aged and acute sectors requires government strategies to encourage more nurses into training, raise the profile of working in the aged care sector and provide sufficient funding to enable adequate remuneration of nursing staff in line with the acute sector.

8.2 Pilot a Teaching Nursing Home model with high level evaluation to determine efficacy of promoting quality leadership and training in the aged care workforce.

8.3 Specific funding is required for the training and recruitment of aged care nurse practitioners and amendment of legislative requirements that would allow nurse practitioners to have an effective role in the care management of facilities.

9. ASSESSMENT

9.1 Time Issues

Approval by an ACAT team is mandatory before admission to a RACF or to receive CACP, EACH and EACH-D packages.

The current waiting time for routine ACAT assessments in the community can be weeks, or even months. This is often exacerbated by the delay between the time of the ACAT assessment and admission to a RACF. Usually assessment occurs because of a sudden and sometimes urgent change in circumstance. Delays can compromise outcomes.

9.2 Consistency of Assessment

There is often a lack of consistency in assessment with considerable variation between the ACAT and service provider understanding of the care needs. There is a need for a more streamlined and consistent assessment tool which adequately reflects levels of need.

9.3 Assessment Options

There is currently a formal assessment process to determine access to funding in residential care – the ACFI. There is therefore little need for another assessment process to identify whether a person needs to go into the various care options. Aged care providers make those decisions when assessing people entering the system. Further, such providers are regularly audited and accredited whereas the ACAT are not.

Community care service providers receive standardised funding per client per day regardless of level of need. ACATs often create the expectation in those clients that they will receive a certain level of support which is not possible under the current funding levels. People who might remain in the community with high levels of need will not be taken on by community care providers because there is not sufficient funding to provide higher levels of service thus these people either go to hospital or to RACFs.

Recommendations

9.1 Eliminate the need for ACAT assessments for people entering residential aged care.

9.2 Community care funding packages need to take into account level of need and accommodate for changing needs over time.

10. TRANSITIONAL CARE

On a day to day basis the routine medical needs of residents in RAC can be met by a General Practitioner although these, along with trained aged care nursing staff, are in relatively short supply. Access to specialist medical services is often problematic because of the difficulty of transporting the resident.

It is often difficult in some locations to get GPs to take on new patients and if people are out of area when they enter a RACF they may not be able to access a GP. The capital funding to set up GP clinics in RACFs and the operational funding to support them would play a significant role in reducing that problem.

There is a need to provide appropriate palliative and sub acute care for residents of aged care facilities as well as those older people in the community who have compromised and serious health issues.

Recommendation:

10.1 Capital funding should be provided to establish GP clinics in RACFs.

11. SOCIAL EXCLUSION

ANGLICARE Sydney's community services deal with the most marginalised and deeply excluded people in the nation. Within the aged care sector we are deeply concerned for the care needs of homeless older Australians, older indigenous people, those who experience ongoing financial hardship and material deprivation, people with complex behavioural, psycho social, psychiatric and psychological problems, and CALD groups which have difficulty accessing appropriate services. More than 15% of the people who access our emergency relief services live in boarding houses, caravans or on the streets. Their future aged care needs are

compromised in some cases by their inability to pay, or the rigidity of our current system, or their anti social and mental health issues, or their lack of a social support network or difficulties in navigating the service network system. This is both an access and an equity issue.

These issues also arise for those with a disability – who do not own their own home and survive on the Disability Support Pension

Recommendations:

11.1 Consideration needs to be given to a special needs category for the elderly and homeless to ensure they can access appropriate aged care services. To meet these needs providers require additional operational and capital funding.

11.2 The issue of elderly homeless should be incorporated into planning and service response of all mainstream health and welfare services.

11.3 There should be specific capital grants provided for the development of residential services for people for lower socio-economic groups.

RECOMMENDATIONS

1. Continuum of Care

1.1 Government consider Supported Living and Assisted Living as part of an integrated aged care system and incorporate them into policy and funding considerations.

1.2 Establishment of specialist respite facilities to assist in the transition between the acute hospital system and RACF

1.3 Establishment of new sub acute facilities to provide intensive medical care for a period of 6-8 weeks.

2. Funding

2.1 Remove the distinction between high care and low care with regard to accommodation costs. All residents should be required to pay for accommodation separately from their care needs.

2.2 That Capital subsidies received from Government and Capital income received from Residents be quarantined from operational expenditure. It should be attached to a funded place and not the provider. If the funded place is sold or transferred then accrued capital income should be transferred. If licenses are surrendered then accrued capital income should be returned to the Commonwealth.

2.3 Accommodation should be paid either in a lump sum (Bond or equivalent refundable capital amount) or a daily charge that is at a level that enables aged care providers to carry the cost of debt needed to fund new developments.

2.4 The federal government should consider providing capital grants to 'not for profit' providers who commit to providing care to higher levels of concessional residents for the development of new aged care facilities. Additionally government loans could be made available interest-free and repaid from accommodation bonds or accommodation charges that were at a level enabling the repayment of these amounts over the lifetime of a facility (typically 30 years).

2.5 An alternative to 2.3 above might be the federal government acting as a Guarantor to the lender of capital to aged care providers to enable the development of aged care facilities.

2.6 The current system of stepping concessional supplements acts as a disincentive; there needs to be a sliding scale increasing the supplement in smaller steps – eg every 5% - and continuing above 40% to between 60% and 80%.

2.7 There should be a regular review of charges to ensure they adequately reflect real costs of capital.

2.8 A consistent platform for means tested fee setting, and for the payment of subsidies, should be set across the system. Those with high levels of wealth should fully meet the costs of their services and care while those with limited

or no capacity to pay should have their care costs subsidised at a fair and reasonable level.

2.9 The accommodation charge should not be regulated by Government. It should be set by the market so that people willing and prepared to pay for a higher standard of accommodation may choose to do so, whereas others may be content to pay for more modest accommodation. However, those with limited or no capacity to pay should have their accommodation costs subsidised at a fair and reasonable level.

2.10 Increase ACFI funding for complex cases

2.11 Establish sub acute care places with higher levels of funding

2.12 Establish a legislative regime that enables recommendation 1.1

2.13 The current COPO model of indexation should be replaced with an indexation method which accurately reflects the productivity constraints which operate in the residential aged care industry and prohibits the erosion of real subsidy values.

2.14 Government funding needs to be indexed to account for the increasing costs associated with the workforce and daily expenses such as food, transport and energy.

2.15 The Government needs to endorse an independent cost of care study to determine pricing and indexation structures that work.

2.16 Funding for both residential and community care should be increased by immediately restoring and extending the CAP (or a similar mechanism) which is indexed until long term reforms are finalised and implemented.

2.17 That additional supplementary funding be provided for special medical interventions such as IV Therapy, dialysis, intensive pain management, rehabilitation and tracheotomy management.

2.18 There is a need to develop more flexible care subsidies for people in receipt of community care packages. What is needed is a five tier system beginning with CACPs and ending with EACH and EACH/D which are accessible, appropriate and timely.

3. Regulatory Constraints

3.1 Funding system does not recognise the increasing costs of regulatory compliance and they should do so or compliance burden should be reduced.

3.2 Facilities that have a proven and consistent track record of compliance should not be required to have additional spot visits other than scheduled accreditation audits.

3.3 The Government consider the removal on the restrictions of bed licenses so that people will not have to accept the only place they can find, thus freeing up supply. This needs to be a staged implementation.

3.4 The Government needs to streamline the current regulatory framework reducing the costs of compliance while maintaining high quality standards of

care with a targeted focus on underperforming facilities. The general principle which should operate is that the statutory body which funds RACF should also be the one that regulates it.

3.5 The system in which accreditation and compliance operates should be streamlined so that RACFs deal with fewer agencies and fewer sets of requirements.

3.6 The Government needs to ensure appropriate safety nets are in place for groups who currently have difficulty accessing aged care services such as those who are asset and cash poor, Indigenous, CALD or living in rural and remote communities.

4. Information

4.1 That a nationally benchmarked range of indicators be established that considers a range of factors such as standard of care, staffing ratios, accommodation and lifestyle activities, so that consumers can be better informed when making a choice

5. Duplication

5.1 Government departments at State and Federal levels coordinate their expectations around governance achieve accreditation for all programs through a one off process.

8. Workforce

8.1 The paucity of qualified nurses in the industry combined with the wage differential between the aged and acute sectors requires government strategies to encourage more nurses into training, raise the profile of working in the aged care sector and provide sufficient funding to enable adequate remuneration of nursing staff in line with the acute sector.

8.2 Pilot a Teaching Nursing Home model with high level evaluation to determine efficacy of promoting quality leadership and training in the aged care workforce.

8.3 Specific funding is required for the training and recruitment of aged care nurse practitioners and amendment of legislative requirements that would allow nurse practitioners to have an effective role in the care management of facilities.

9. Assessment

9.1 Eliminate the need for ACAT assessments for people entering residential aged care.

9.2 Community care funding packages need to take into account level of need and accommodate for changing needs over time.

10 Transitional Care

10.1 Capital funding should be provided to establish GP clinics in RACFs

11. Social Exclusion

11.1 Consideration needs to be given to a special needs category for the elderly and homeless to ensure they can access appropriate aged care services. To meet these needs providers require access additional operational and capital funding.

11.2 The issue of elderly homeless should be incorporated into planning and service response of all mainstream health and welfare services.

11.3 There should be specific capital grants provided for the development of residential services for people for lower socio-economic groups.

APPENDIX A: ANGLICARE CHESALON SERVICES AND PROGRAMS

Chesalon Services (community aged care)

- **Chesalon Northern Sydney**
    - Pittwater Day Centre
    - French's Forest Day Centre
    - Lower North Shore Day Centre
    - Social Support Dementia under 65
    - North Manly Day Therapy Centre
    - North Manly Breakaway
    - Home Respite Support
    - Domestic Assitance
- **Chesalon Western Sydney**
    - Richmond Day Centre
    - Winmalee Day Centre
    - Whalan Day Centre
    - Cumberland Day Centre
    - St Marys Day Centre
    - Blue Mountains Day Centre
    - Nepean Care at Home
    - Nepean EACH & EACHD
    - Home Respite Service
    - Social Support Dementia Monitoring
    - Eleebana Respite Cottage
    - Complex Care Support
    - Personal Care
    - Dementia Advisory Service
    - Dementia Café
- **Chesalon South East Sydney**
    - South East Sydney Care at Home
    - South East Sydney EACH & EACHD
    - Podiatry - In-Home & Clinic
    - Personal Care
    - Jannali Day Centre
    - St George Day Centre
    - Dementia Respite Service
    - Social Support Dementia Monitoring
- **Chesalon Illawarra**
    - Wollongong Day Centre
    - Illawarra Care at Home
    - Community Visitors' Scheme
    - Flexicare
    - Social Evening Events
- **Chesalon South West Sydney**

- Liverpool Day Centre
- Cabramatta Day Centre

Chesalon Care (residential aged care)

- Chesalon Jannali
- Chesalon Beecroft
- Chesalon Malabar
- Chesalon Richmond
- Chesalon Woonona
- Chesalon Nowra
- Chesalon Chaplaincy (includes non-residential)