March 2011

BANKSIA VILLAGES

Response to the Productivity Commission's Draft Report: 'Caring for Older Australians'

Contents

1. Introduction

Banksia Villages Ltd welcomes the Productivity Commission's draft report '*Caring for Older Australians*'. The issues addressed in the report are complex and diverse, reflecting the ageing process itself. The comments provided in this document have been confined to areas where our organisation has concerns. They have been listed in the order of the draft recommendations to which they apply. Wherever possible, we have given examples and provided suggestions.

All other draft recommendations are viewed by our organisation as being either essential, reasonable or matters to which the aged care community can adapt.

2. Periodic Payments and Accommodation Bond Equivalents – *Recommendations 1.4, 1.11, 1.6, (1.7)*

2.1 Costs of Accommodation Supply Versus Construction Costs – *Recommendations 1.4, 1.11*

The sources of funds have to fully provide for the cost of accommodation supply. The cost of accommodation supply includes all costs associated with:

- land acquisition,
- design fees,
- statutory fees (headworks charges, development approvals, etc),
- site infrastructure costs,
- construction cost,
- fit out,
- furnishing,
- initial equipping,
- refurbishment during the life of the building,
- finance costs, including those associated with the reality that new facilities do not achieve full occupancy on day one of operation (for quality of care and other reasons) and can easily take up to a year to fill despite the fact that, for a range of reasons, the building needs to be complete in its entirety (other than some furnishings) from the first day.

2.2 Retentions, Building Life and Repayment of the Last Accommodation Bond – *Recommendations 1.4, 1.11*

Initial bonds recoup accommodation supply expenses (often they repay a development loan). Subsequent bonds replace the refunds to outgoing residents. At the end of the life of the building, there are no subsequent bonds. During the life of the building, sufficient funds have to be generated from each occupant such that when they are combined with the residual value of the asset at the end of the building's life, there are sufficient funds available to refund the last resident's bond.

If the income required to ensure sufficient funds are available is not to be generated through retentions, then it will need to come from elsewhere. In particular, accommodation bonds (or period

payment equivalents) will need to be of a size that is in excess of the initial cost of accommodation supply.

2.3 What is a Sensible Cap For Accommodation Bonds (Including For Use in the Australian Pensioner Bond Scheme)? – *Recommendation 1.6*

Any attempt to place a ceiling on accommodation bonds and their periodic payment equivalents has to address:

- all the costs of supply (criteria 1),
- the high level of unavoidable variability in costs of supply (criteria 2),
- the low level bond amounts that are received from those who do not qualify for government supplement but also do not have the assets to pay a bond or periodic payment equivalent that meet the cost of supply, as well as the difference between the government supplement and the cost of supply (criteria 3),
- generation of sufficient funds from each occupant, which, when combined with the residual value of the land and building at the end of the building's life, ensure that there are sufficient funds available to refund the last resident's bond (criteria 4), and
- resident choice (criteria 5).

2.4 Two Reasons for Having a Cap = Two Caps - *Recommendation 1.6*

In general discussion, and in places in the draft report (eg page xxxv), there are two 'cap' concepts:

- The first cap concept amount is that which addresses the cost of accommodation supply, and should be the point at which pension and co-contribution calculations are impacted.
- The second ceiling is an absolute ceiling that gets tied to discussions about older people not being asked to pay large amounts of money, even if they are able to do so.

2.5 The First Cap: A Cap That Addresses the Cost of Accommodation Supply, and Above Which There is an Impact on Pension and Co-Contribution Calculations – *Recommendations 1.6, 1.11 (1.7)*

It is our contention that the first cap (ie after which there is an impact on pension and co-contribution calculations) has to address the first four criteria for a sensible ceiling – ie

- Cover all costs of supply (criteria 1),
- Allow for unavoidable variability in costs of supply (criteria 2),
- Allow for the cross subsidisation of bond amounts that are less than the cost of supply and government supplements that are less that the cost of supply by bonds that are in excess of the cost of supply (criteria 3), and
- Allow for the generation of sufficient funds from each occupant (via retentions or interest earnings), which, when combined with the residential value of the asset at the end of its useful life, to ensure that there are sufficient funds available to refund the last resident's bond (criteria 4).

This contention reflects the notion **that the bond cap should be a maximum at the top of a cohort, not an average of the cohort. That is, whilst there is an average per place cost of supply, not all residents are able to pay a bond that meets that average and so the ceiling on the bonds needs to be above a point that counter-balances those lower bonds**.

2.5.1 Example of the Calculation of the First Ceiling

Since the introduction of the Aged Care Act 1997, many organisations have endeavoured to adopt a bonds policy that reflects the criteria for this 'first cap'. An example from one not for profit organisation is:

> *The **average** bond for a facility is to reflect the current average per place development cost of the facility.*

Within that organisation a new facility was provided at the cost of $250 000 per place (all costs included) in 2007. At that time, bonds from zero up to in the order of $60 000 also attracted a supplement from the government. Bonds between $60 000 and $250 000 did not, creating a range of bonds (from $60 000 to $250 000) that was inadequate for funding the cost of supply. The organisation counter-balanced that $190 000 range (from $60 000 to $250 000) by adding that range to the average cost of supply (ie $250 000 + $190 000) to create a maximum bond amount of $440 000. In short:

Average cost of supply (single room and ensuite – homely, practical in terms of technology and work spaces – basic)	$250 000
Lowest possible bond that would not attract additional government supplement	$60 000
Difference (range of bonds that did not reach the average cost of supply and required cross subsidisation)	$190 000
Average cost of supply	$250 000
Ceiling (to allow for cross subsidisation of bonds between $60 000 and $250 000 and cross subsidisation of inadequately supplemented supported and assisted residents)	$440 000

This range of possible bonds was reviewed in light of the real estate values in the area and was found to be realistic. Upon implementation, the funds generated through this approach were also found to be realistic in addressing the first four criteria outlined above.

2.5.2 Impact of Incentives

The reality is that the incentives to pay accommodation bonds and periodic payment equivalents have worked. They should not have limitless application at the expense of the taxpayer (ie in terms of pension entitlement and co-contribution liability). However, the extent of resident funding of vastly improved aged care accommodation (primarily low care) over the last 13 years has been dramatic, and probably previously unhoped for. The improvements to resident dignity have been demonstrable to care recipients and their family members. High care accommodation, on the other hand, has often languished due to the inadequacy of capital funding, and care recipients and their family members

often hold it in contempt – and, particularly with regard to the physical environment, this is often not necessarily without due cause.

The last twenty years has seen the Commonwealth not only complete its exit from the capital funding of retirement villages, but also then exit from much of the capital funding of low residential aged care and then high residential aged care. The users have picked up the difference. This is a remarkable achievement, particularly given the increase in the quality of some of the accommodation (mainly evidenced by low level residential aged care). The trick now is not to take for granted the initiatives that have made this possible.

2.6 The Second Cap: An Ultimate Cap Regardless of Capacity to Pay

It is our contention that the application of a second cap reduces peoples' choice (criteria 5). If an older person has wealth and wants to continue to live in luxury, then why should they not be allowed to do so? There should be an impact (a significant impact) on pension entitlement and liability for co-contributions. The statement on page xxxv of the draft report to the effect that uncapped bonds 'burden' older people contradicts the popularity of higher bond levels amongst residents (also noted on page xxxv).

2.7 Capital Cost and Operational Cost – *Recommendation 1.11 (1.7)*

Our experience is that the process of supply of residential aged care accommodation involves endless decisions in which capital outlay and ongoing operation cost counter balance. Any assessment of the cost of accommodation supply needs to ensure allowance for capital expenditure that diminishes operational cost (of which the taxpayer bears a significant burden). For instance:

- Ceiling hoists reduce the number of staff required to transfer a resident and they reduce the likelihood of an injury to workers. They are difficult (and sometimes impossible) to retrofit. The best option is to ensure that during initial construction of the building the structure is strengthened to accommodate the load on the walls and ceilings and that a power point is included in every room. The cost is in the order of up to $500 per place. The capital cost of provision should also allow for a portion of the rooms to be fully fitted out with the ceiling rails and lifting mechanisms at the time of construction. The additional cost is in the order of $2000 per place. Over a 30 year building life, this equates to $85.00 per year, and we note that one hour of labour costs a minimum of $25.00 on costed.

- Similarly, mechanical slip sheets (used to turn a resident in their bed) have the potential to change a two person task involving manual handling to a single person tasks involving no lifting or bending. These units require a power point (costing in the order or $100 at the time of construction) and the actual unit, costing in the order of $2500. If the unit lasts 15 years, the cost is $175.00 per year, again against a labour cost of $25.00 per hour.

- Concrete that is sealed during construction will not absorb urine that seeps through floor coverings, avoiding the smell becoming permanent in the concrete.

- Inclusion of dementia care technology (eg movement monitors connected to DECT phones carried by staff) not only reduce the need for staff to closely monitor residents, but also

provide better (and less costly) behavioural care to residents by allowing them more freedom of movement within specific areas. The cost is in the order of $2000 to $3000, and over a life of 10 years equates to $300 per year (12 hours of labour). An agitated resident can easily absorb two to three hours of staff time in one night.

- Adequate, safe external areas for residents use are highly effective in reducing distressed behaviour (with a consequence for staffing levels and costs). In terms of cost, the issue mainly relates to cost of the land and is broad in range. Garden and resident circulation areas are also one of the first areas to be cut back when finance is tight and more places need to be fitted into a given area.

It is better that any cap on accommodation bonds, errs on the side that allows these types of operational cost saving tools to be included.

3. Trading Supported Places – *Recommendation 1.5*

We are unsure about this recommendation, and could make better comment when more information is known. Our key concern however, is that there has been an issue with cherry picking of wealthier and/or easier care residents. We acknowledge that providers tend to fall into three broad categories:

- Those who wish to only provide to supported care recipients,
- Those who wish to provide to the full range of care recipients (particularly in terms of wealth), and who utilise some care recipients' higher capacity to pay (particularly with regard to accommodation bonds) to assist in the provision of accommodation and services to supported care recipients and those with more challenging care needs), and
- Those who prefer to supply to wealthier and easier care residents.

We understand the synergy between the first and third categories. It is the impact of the trading on the second category that is the point of concern. We note that the trading is voluntary, but still have concerns about unintended impacts.

Finally, any tendering for accommodation supply to supported care recipients needs to have a minimum 30 year certainty of contract.

4. The Gateway Concept – *Recommendation 8.1*

The gateway concept appears to have much in common with the existing ACAT system, although it is clearly different in specific areas. The gateway concept has our broad support, but there is a one area of concern. Our concern revolves around the fact that any 'gate' of any type impacts on the flow of traffic and, when it is inadequately sized, it generates pressure as a backup accumulates. The consequences in the case of an undersized aged care gateway would be:

- people who require care would not receive it, and/or
- providers who provide care would not be funded for it (eg when an increase in frailty occurs after a service commences).

These consequences do not fall upon those responsible for the administration of the system. They fall upon the end users (the care recipients) and the service providers.

It is also recognised that a gateway needs to serve the purpose of ensuring that taxpayers' funds are not allocated without due cause.

Key features of a gateway therefore are realism with regard to:

- resourcing the assessment personnel,
- the degree of complexity in assessments and its impact on the rest of these key features,
- the timely provision of assessments,
- accessibility to assessments (particularly in regional areas), and
- the need for a fall back process in the event that an assessment cannot be provided through the normal means (ie due to resourcing, accessibility or timeliness failure).

The gateway becomes more at risk of failure in these criteria as the complexity of the assessment system increases (eg as more professionals are involved). Further, history has shown (eg the RCS and the ACFI) that a new system that works well during pilot trials, when it receives high levels of attention and appropriate resourcing, is not guaranteed to work as well once the full roll out across the entire country takes place. In particular, whilst full work ups by a variety of health and allied health professionals may be ideal, a complex process is guaranteed to compromise the timely completion of the assessment process when fully implemented.

Our first suggestion is that there is much to be said for the use of the specifically trained ACAT professional supported by a case worker who co-ordinates the financial assessment with Centrelink, and works with the ACAT professional to provide the initial care co-ordination services identified in recommendation 8.1.

Our second suggestion addresses the issue of a fall back provision in the event that the gateway does not provide a timely service, ie within a given timeframe such as within a month of a request being lodged. In this case, an accredited service provider should be able to undertake an assessment with the assessment capable of subsequent review by the gateway. However, where the subsequent review is no more than a given percentage of funding less than the accredited provider's (eg 20%), the accredited provider's assessment would stand.

This fall back position is designed to ensure that the failure to provide timely assessment that has characterised parts of the existing system, at the expense of care recipients who are in need and service providers who have continued to provide care (partly unfunded), is not exacerbated by the gateway system.

5. Separation of Retirement Village Legislative Responsibilities – *Recommendation 10.4*

The concept that retirement village legislative responsibilities should remain with the states is reasonable. One point we would emphasise is the need for it to be recognised that aged care and any Commonwealth aged care legislation do not operate in isolation of the rest of the ageing phases, processes and legislation that exist in those other jurisdictions.

For instance, currently there is a discussion about prudential arrangements for accommodation bonds. The *Aged Care Act 1997*, currently allows those bonds to be used for capital works for residential care or flexible care in a residential setting. At this point that means that bonds may be used for retirement village development. This reflects practice on which much of the residential aged care and retirement village infrastructure has been developed over the last 40 to 50 years. That is, entry amounts from one area of operation (eg retirement villages) were used as a funding source for commencement or expansion of activity in that area or another area of operation (eg residential aged care), and vice versa. Had that not been possible, infrastructure would not have expanded and would have been at greater cost where it had grown (ie greater borrowing from financial institutions would have been required).

There was concern in the sector, during the prudential arrangements review that this capacity would be curtailed in order to allow the provisions of the *Aged Care Act 1997* to be more distinct in coverage and self-contained in its consequences and management. The concern has proven to be unfounded on this occasion. Had it been proven, the ramifications could have been significant.

This is just one of many areas where the operational reality covers a broader area than any one department's, government's or specific piece of legislation's coverage. Recognition of this fact does not appear to have been compromised in the draft recommendations, and **our suggestion** is that the need to always be aware of this issue be reinforced.

6. Carer Support Via Carer Assessment and Entitlement – *Recommendation 11.1 (4.1)*

The provision of support to carers is in everyone's best interests. The care recipient needs a capable carer. Carers need support as their roles can be demanding and gruelling. The more a carer is supported, the more likely it is that they will remain in their caring role – a cost saving to the taxpayer.

Having reflect on the draft recommendation, however, our concern lies with the concept of a carer assessment in order to receive an entitlement or referral. Our concerns are:

- Assessments are inevitably intrusive, often very clinical, and always focussed on identifying where the situation is breaking down. All three of these factors are confronting and degrading to carers.
- The assessments will not have a guarantee of accuracy: Carers will endeavour to portray that they are coping better than they are because they fear being judged, and they fear that they will be letting the care recipient down if there is a sense that they are not coping.
- Assessments require resource allocations which inevitably mean cost and delay.

The end result of these factors can be carers avoiding assessment for themselves and for the care recipient and/or delays in assessments being made. The consequence is that the care will be compromised, and harm may even be caused. Premature admission to acute care and/or residential care could follow, as could elder abuse when the carer does not receive the support they need.

Our suggestion is to attach the carer's entitlement to the care recipient's assessment because:

- If a person is capable of providing care, then they are capable of selecting from a menu of support options that become available due to the care recipient's assessment, even if they need encouragement and guidance to do so.

- If the automatic entitlement for the carer arises from the assessment of the care recipient, there may be a potential for the carer to be able to access more support than they need. However, when we look at the support that can be provided this is not of significant concern. The draft report set outs four key areas of assistance, and we have identified the consequences of 'extra access' by carers as follows –

    - Carer education and training: More education and training than is necessary will enable to the carer to be skilled to continue to care as the care recipient becomes more frail. Further, access to these services usually requires temporary removal from the care situation, which will inevitably have time limitations anyway.

    - Planned and emergency respite: If a carer needs respite, it is better that they get it, than that they do not, as care will otherwise be compromised. Carer burnout and elder abuse can result. It is also possible to control the amount of respite through an allocation to the care recipient (eg the current system of 63 days of residential respite per calendar year already allocated to each ACAT assessed care recipient). In our experience, once respite reaches a particular level, it becomes apparent to the carer and the care recipient that the existing care situation is no longer sustainable.

    - Care counselling and peer group support: The same outcomes apply here as to carer education and training above.

    - Advocacy services: This too can be managed on the supply side if there is a need for limits on access.

In short, whilst attaching an automatic carer support entitlement to the care recipient's assessment may result in a carer 'entitlement' that exceeds that which is immediately required, this would surely be more than offset by:

- the cost of providing the assessment of the carer,
- the pitfalls of inaccurate assessment (and non-existent assessment) caused by carers' perceptions and experiences of the assessment process,
- the carer becoming, in many instances, more skilled and resilient and therefore more able to care for longer as frailty increases, and
- the supply side restrictions that can be applied to the entitlements.

(On 31 December 2011, ABC Radio National transmitted a forum from Melbourne entitled 'The aged care taboo: dementia and sexuality'. In that forum there was some very clear insight into how intrusive and counterproductive the aged care assessment and support processes can be for carers (as well as care recipients), regardless of the frailty or the issues involved.)

7. Staffing - *Recommendation 11.3*

An area of significant concern is the severe restriction placed on flexible care, flexible staffing, and efficient service provision through imposition of mandatory staff requirements. Whilst the draft report addresses this issue, more emphasis is needed on the imperative of addressing the mandatory requirement for high care residential facilities in New South Wales. It's impact on the capacity to allocate resources in accordance with residents' needs and to develop a model of care that provides high quality clinical care in an environment that does not have the operational mechanics of a hospital is profound.

Ageing is highly variable, with a diversity of causes of frailty. A rigorous accreditation system ensures that residents' needs are assessed and met by appropriately skilled staff. This will apply in community care (low and high care) and residential care (low and high care).

An example: EACH packages are high care. They are most likely to apply when there is a live in carer. The absence of a carer is often the cause of the need for residential care instead. However, there is no mandatory requirement for the presence of a registered nurse, 24 hours per day, where EACH care is being provided. Would it be correct to say that the presence of a live-in (often ageing and untrained) carer obviate the need for the 24 hour per day presence of a registered nurse, but that the presence of certificate skilled staff does not obviate the need for the 24 hour per day presence of a registered nurse? It makes no sense, and, in the case of the residential aged care, it leads to unnecessarily institutional care environments.

The reality is that there does need to be a high level of rigour around ensuring that residents' needs are appropriately resourced, and there will always be those who cut resourcing too fine if that rigour does not apply. However, accreditation is well placed to achieve this.

So through good management and accreditation compliance requirements, facilities with high levels of high care residents, particularly those with residents who have high level clinical needs, will need 24 hour stand up registered nurses. However, there are facilities with blends of residents whose needs are not as extreme, but some of whom are high care (often at the lower end of high level care, or with dementia playing a significant role). These facilities, and their residents, need staffing blends that best meet their needs, not mandatory requirements. These facilities are also only funded to reflect a staffing blend that meets the residents' needs, and are not funded to resource mandatory requirements.

Our first suggestion is a policy that recognises that residential aged care, as a whole, needs buildings and models of care that address aged care's specific needs and issues, and do not draw on the assumption that good hospital buildings and services are the same thing as good aged care buildings and services.

Our second suggestion is the development of training and qualifications that allow a person to pursue a qualification path in aged care all the way from certificate level (personal care worker or assistant in nursing – aged care) to that of registered nurse – aged care. It would be a qualification that can only be used in aged care, but would articulate with the registered nurse qualification and would only require supplementary training and education to be accorded a registered nurse – acute care. This would encourage aged care staff to pursue degree level qualification whilst remaining in

the sector, and would ensure that the education and skills are suited to the specifics of aged care. It would also reinforce the specific needs of aged care provision.

8. Complaints – *Recommendation 12.2*

Our comment regarding the proposed complaints management reforms are twofold.

Firstly, we are concerned that separating the compliance/enforcement and complaint functions at the commissioner level has the potential to result in the same degree of separation of activity, co-ordination and accountability that currently exists between the Department of Health and Ageing's complaint management and the Aged Care Standards and Accreditation Agency's accreditation and compliance functions.

Secondly, in our experience mediation and conciliation are valuable tools that can assist at many points throughout the complaint management process. We are not sure whether Recommendation 12.2 intends this to be the case. We would, however, encourage an approach to the complaints handling process that is not so strictly structured across the three identified areas and lineal in its movement from one area to the next that these types of tools are not available throughout the process.

9. Appeals of The Australian Seniors Gateway Agency Decisions - Role of the Administrative Appeals Tribunal – *Recommendation 12.2*

Given the range of decisions in which the gateway agency will be involved, our concern is that there will be decisions that warrant review, but do not warrant a hearing by the Administrative Appeals Tribunal. Alternatively, smaller organisations may not have the resources to support an application to the Tribunal. Members of our organisation have some experiences involving accountability for incorrect decisions made by ACAT and the Department of Health and Aging, and there is little doubt that the access those entities have to government resources make the holding of those organisations to account extremely difficult, and, at times, impossible.

Our suggestion is that there be a stepped process in which there is a less complex and expensive stage prior to appeal to the Administrative Appeals Tribunal. Such a stage could still be within the Tribunal's jurisdiction and may include options such as the use of registrars who endeavour to see the matter resolved at an earlier stage.

10. Embracing Technological Advances – *Recommendation 12.6*

Recommendation 12.6 includes the provision to require that all providers submit key reports electronically to AACRC. In our experience, the aged care sector has been reasonably adept at picking up on technological advances. Where this pick up has not occurred, it can often (although by no means always) be for valid reasons. Eg, the technological reach into regional and remote areas may not be as strong as that in urban areas, making it more difficult for providers in those areas to

make the transition; or the hardware, software or technical knowledge required may be sufficiently significant or complex to impede smaller organisations with less resources.

Our suggestion is that imposed requirements be avoided where possible, and incentives used instead. Where imposed requirements are unavoidable, resources required by providers need to be minimised and/or supported by eg transition grants. Sometimes a blend of the incentive and the imposed requirement works well.

Closing

In closing, Banksia Villages again emphasises its support for the initiative driving the Productivity Commission's review, and the key elements of the draft report. Our response has drawn heavily on the experience of our key personnel within the sector, going back the best part of twenty years. We would be pleased to clarify any information we have provided, and we look forward to the final report.