CARING FOR OLDER AUSTRALIANS.
PRODUCTIVITY COMMISSION ISSUES PAPER
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Section 2. The current system.

Community Care.

The stated preference by the majority of persons as they age, is invariably that they wish to stay in their own homes and receive the necessary Home and Community Care to enable them to do so.

In real terms, for a person living alone, who is still able to function, although in a restricted manner, in relation to basic showering, toileting, dressing, managing medications, the actual hours of community care, which they are eligible to receive can vary from 4 hours upwards per week. Fewer services are delivered on week-ends.

The services are delivered in daylight hours, not always at times that are suitable for older people, who may stay in bed until later, ie: 10.00 am or so. This is particularly important in winter when heating costs rise. Many people find it is impossible to negotiate appropriate times for these services.

The major gap in Community Care is that they are alone at night, usually for a period of 11/12 hours This is when the majority of falls occur as people get up to go to the toilet and/or access medications.

As the population of older persons increases, the diverging needs and expectations in relation to the provision of aged care will also increase. The population will also be a more widely educated group, who will have had longer participation in the workforce. Therefore the "one size fits all" is not going to be appropriate. There will be a need for more personalised and individual responses to the requirement for care.

This would offer an opportunity for the development of **Consumer Directed Care** when a person could organise support, during periods which are more flexible and would support that person's preferred lifestyle. It would be a more client-oriented manner in which to deliver Community Care.

For family carers **Respite Care** is very difficult to obtain and has to be booked well in advance. This does not take into account emergencies when carers may be ill or injured or have problems with their own immediate families. There is an increasing need for **dedicated respite facilities** to be developed, which are capable of caring for a wider range of older people with a number of differing needs.

If organised in conjunction with **Rehabilitation Units** for older people they could have the added advantage of improving a client's physical and mental capacity for when they return home.

Currently these Rehabilitation Units are included in the Hospital environment, or attached to Residential Aged Care facilities where they are supervised on a needs basis by a variety of medical professionals. This is wasteful in terms of times (for travel), efficiency and expertise.

For community care to be delivered effectively to older persons, **Home Modifications** are usually necessary. The waiting times for, and costs of, these can be prohibitive for some older people. Frequently homes are not suited for modifications, particularly in relation to the size and shape of bathrooms and kitchens. Very few homes allow sufficient space for wheel-chairs and even Zimmer frames require reasonable space for turning.

This underlines the need for **affordable community housing,** which could provide safety with regard to surroundings and could simplify the provision of community care to a number of residents.

Consumer Directed Care could also be a strong component of care in this type of housing and could allow for the provision of various levels or types of care in a more cost effective manner.

Affordable community housing also provides the opportunity for CALD communities and other special needs groups to have housing in communities which are more culturally suited to their needs and supply a far more friendly and supportive environment as they age and/or their health deteriorates.

Residential Care / Retirement Villages.

In the ACT, more recent developments by Service Providers have seen the expansion of complexes which offer Retirement Village living (Independent Living Units and/or Apartments) and Residential Aged Care (Low Level and High Level care) on the one site. These service providers usually also supply HACC and other community care services, both on and off site.

There are 2 differing sets of legislation, (Federal and State/Territory), which apply.

There are various funding models in use in these developments, including up front contributions to Independent Living Units or Apartments, which may be governed by Loan/Licence agreements or the Unit Titles Act. The ACT Office of Regulatory Services currently administers the retirement villages under a Code of Practice. This is not a robust legislative environment for ensuring compliance.

There is a great difference in entry costs, percentages retained by the developer, Capital Gains Distribution, costs and management of Maintenance/Repairs and Capital Replacement. There is also usually no provision of **Annual Prudential Statements** which give residents an explicit accounting of the security or otherwise of their original contribution and the financial security of the service provider/ owner/ operator / management of the village. There is no provision for replacement of contributions in the case of bankruptcy or collapse of the company. As this is, in a large number of cases, the only actual cash amounts belonging to a resident, it will have a disastrous effect on their circumstances iff this occurs and it will have a carry-over effect when they require aged care.

Furthermore, contracts are written in vague and general terms, and many residents are unaware of what expenses may be required to be paid when capital repairs and replacements are needed and, specifically, what contributions can be required to be made by residents. Many residents also do not understand Accrual Accounting Statements and are not provided with clear ex-depreciation statements at Annual Budget meetings.

It is possible that when a resident from the Retirement Village section of a multi-care development goes to the Low Level Care section there appears to be no common arrangement between various providers as to the return of the **Ingoing Contribution**, rather, it can become the **Accommodation Bond** for the entry into the Low Level Care section of the facility. Again it is frequently unclear what occurs financially if a resident goes directly from the Retirement section into the High Level care section. The time frame for the return of Ingoing Contributions also varies substantially between Service Providers.

There is a lack of **Prudential Regulation** and insufficient robust oversighting of financial structures within and between these services. There are many variations in the financial arrangements between complexes, making it difficult for prospective residents, at all levels, to compare services and costs.

Some complexes offer services such as gyms, pools, restaurants and other luxuries which are accessed by the residents on site. Some of these extra services are available only to the retirement section of the complex and are not available for use by Low Level care residents. Many residents are unaware that all the extras will, in the longer term, add considerably to the monthly maintenance fees as the complex ages. Legislation is vague in respect to Capital Replacement and there needs to be clearly defined parameters for this.

The Extra Services Charge in Residential High Care.

The higher standard of accommodation to be supplied is composed of a slightly larger room, an individual bathroom, and a better level of care and food.

As many residents at this level are non-ambulatory it is debateable as to the advantages of what is supplied. There is, in many cases, no obvious difference in care and the standard of food is controlled by the medical and nutritional needs of the resident.

The strengths of the current system:

Community Care allows people to live at home, age in place longer and to be part of the family activities, because they have a variety of support services.

A range of Retirement Living arrangements and Low and High Level care offers a variety of accommodation options.

Weaknesses:

Lack of well-trained staff in sufficient numbers to provide comprehensive care in the residential aged care field.

Better training, better pay and career pathways would improve staffing and would add to the community perceptions of the value of these workers and enhance their work situations.
As the number of people who will require High Level Care increases, the situation will become critical.

Payment by clients (income and asset assessed) for their Community Care services is insufficient and should be increased so as to better indicate the real cost of this care.
This should reflect the fact that they are being supported in their life style choice by this subsidised care, and that this also relieves the pressure on families to take on the role of carers.

High and Low Level care should be regulated under common legislation and Accommodation Bonds (or a similar payment) be income and asset assessed with a regulated retention amount for **both levels of care.**

In High Level care there should be Accommodation Bonds with a cap of 5 years of charges retained from the Bond, as is the current situation in Low Level Care. This should replace the Extra Services Charge.
The advantage of a common up-front charge for both high and low level care would give service providers the certainty of a payment which would allow for further development.

There needs to be a safety net for those people who cannot afford to pay the up-front charges.

There also needs to be recognition by the general community that people should be prepared to pay for aged care, income and asset assessed, in the same way as most made preparations for paying for the earlier part of their lives.

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