



Submission to the Productivity Commission Inquiry Caring for Older Australians

July 2010

INTRODUCTION

Baptistcare (WA Baptist Hospitals and Homes Trust Inc) is a community benefit, not-for-profit (NFP) organisation with nearly 40 years experience working in the aged and community care sectors. The organisation was established in 1972 by local Baptist churches who saw a specific need for residential aged care services in the community. From these beginnings has grown a significant organisation, which presently offers the community 267 high care and 612 low care places in 14 facilities located in six metropolitan and eight rural locations within Western Australia.

In addition to its residential services for older people, Baptistcare operates community aged care services through its 203 Community Aged Care Packages (CACPs), 200 Veterans' Homes Care (VHC) packages and a number of private clients. Baptistcare also has a range of independent living apartments in communities in Perth and southwest of the State.

Baptistcare also has a strong profile in the provision of family support services, including residential, home and community based choices for people with mental illness and people living with disabilities.

Thus, Baptistcare is a significant community service provider with extensive experience in a range of services carried out in many communities. Services stretch from Kalbarri in the north to Albany in the State's south. We can speak with solid experience about rural, regional and remote service provision and metro-centricity in service perspectives.

Importantly, Baptistcare's character, service choices and values' base are formed and grounded in its Christian origins, which informs its commitment to its Vision, Mission and Values. These speak clearly on the organisation's motivations and continuing future engagement in the community in a wide range of services.

It is the nature of an inquiry such as this, that submissions will concentrate on 'what is wrong' with the industry and what 'needs to be fixed'. This submission will follow that formula. However, Baptistcare would like to acknowledge that the industry employs a significant number of staff and provides services to a significant number of clients in a professional and caring manner. There is much about the industry that is good and overall it provides an excellent service under quite trying circumstances. The staff who provide these services (which are not adequately funded by government, the purchaser of the services on behalf of the clients) are not adequately remunerated for their

endeavours and often work in stressful situations, but do so with a high degree of pride and commitment.

PROBLEMS WITH THE CURRENT AGED CARE SYSTEM

No other industry in Australia is sourced primarily by government, where government controls the level of income of the industry, controls who can enter the industry as a provider, determines the clientele of the industry and their level of participation and imposes additional costs on the industry by the application of unnecessary bureaucratic processes.

Much has been made of the changes in Australian demographics and the increase in the number of elderly citizens over the next 25 years and the decreasing number of tax-paying Australians to meet the increased costs of providing that care. Much has also been made of the shortage of nurses and action has been taken and continues to be taken, to address that shortage. However, nurses represent a minority of the staff involved in caring for Australia's aged in residential and community aged care. With the changes in demographics, there will not only be fewer tax payers, there will also be fewer semi-skilled staff who contribute a large proportion of the labour in the aged care sector. This means that the new aged care system, in whatever form, has to meet the needs of an increasing aged population at a time of a shrinking workforce. This would suggest that the current Australian aged care sector is not sustainable in the longer term and requires an extensive revision.

The problems with the current aged care system have been looked into, reported on, and generally ignored by government since the introduction of the Aged Care Act 1997. These reports are available to the Productivity Commission and their findings need not be repeated here. Suffice to say, most reports identify an industry that is unnecessarily complex, under resourced, over regulated, and although subject to increasing demand because of the demographic changes faced by Australia over the next forty years, not in a position to face those demands. The structure of the Department of Health and Ageing is itself an inhibitor to innovation.

Complexity

The complexity of the aged care system is compounded by a split of responsibilities between the State and Commonwealth governments and occasionally, local government. This has led to a plethora of programs which overlap with differing eligibility criteria and differing levels of direct cost to the consumer. This results in a number of assessment systems being in place to access programs and this negatively influences client decisions regarding entering programs, based on solely economic considerations (lower fees) rather than need. An example of this was when Veterans Home Care (VHC) was first introduced and eligible clients were moved from Home and Community Care (HACC) to VHC. VHC had a small (\$5) co-contribution, but as HACC had no

direct client cost at the time, this generated significant complaints from the recipients. Similar complaints arise when people move from HACC to Community Aged Care Packages (CACP) and sometimes result in people not accepting a CACP, which includes a 'care' element, in part because of the higher contribution. In maintaining their HACC services which might only provide 'domestic' services, they thereby deny themselves the 'care' that they are assessed as needing.

Community Care Services, including VHC and HACC provide predominantly domestic and social support services with low levels of care. These are supplemented by CACPs and Extended Aged Care in the Home (EACH) packages which provide progressively higher levels of care. While an assessment is required to access CACPs and EACH, no further assessment is required for increased HACC services and the level of service (hours per week) is determined by the agency providing the service. This has the potential for fewer people receiving additional hours of care at the expense of new participants to the system. It also means that clients can access additional services through HACC that would best be handled by a higher level package such as CACP or EACH. This is to the advantage of the client (more hours, with little contribution) and the provider (more hours to a single client, thereby reducing travel for staff and overhead administrative costs), but at a disadvantage for other potential clients because the total number of hours available is capped.

A truism within aged care, is that 'clients want services to be provided in the home' and the statistical support for such a claim is the increased hours of care being provided in the home. However, this is a self fulfilling prophecy, in that the Commonwealth has, over the past 13 years, changed the planning ratios and increased the number of places it has made available for services in the home and the States have increased funding to HACC which has always been delivered in the home. At the same time, providers of residential aged care have been faced with the capital cost of rebuilding facilities to meet certification and the 2008 privacy standards. During this time, capital costs have increased but have not been offset by increases in funding to service the debt incurred in that capital construction.

While the increase in places in community care is laudable, as 'any service' could be considered to be better than 'no service', community care is the least productive method of service delivery because of the time wasted in travelling between clients. It also has a service delivery model that lacks any sort of supervision of that service delivery and in the longer term, because of projected reductions in numbers of people in the workforce and the level of wages that providers can afford to pay their staff, will have the greatest challenges in attracting appropriately skilled staff. The answer to the 'aged care problem' is therefore not just an increase in community care. If it was that simple, the problem would no longer exist.

Resourcing

The industry suffers because 'government' is the primary source of funds and 'government' is unwilling to invest the recurrent funding necessary to meet current demand, let alone, projected future demand. Similarly, with the exception of small amounts of capital funding, predominantly for rural and remote services, the 'government' is unwilling to invest capital in the industry.

Because of budgetary constraints, the government finds itself both responsible for providing the bulk of the recurrent funds to maintain the system and as gatekeeper for the system, to ensure that the demand for aged care services is constrained to within the funding that is available. The government achieves this by initially, limiting the number of places available within each of the various funding streams, and secondly by determining through its assessment (ACAT) system, the extent of services that will be provided to a new client.

Indexation of recurrent funding occurs through the application of the COPO, which has been, over the past ten years, the subject of innumerable submissions, all of which are available to the Commission. Nothing further needs to be said in this submission.

While the Commonwealth has only a limited input into capital funding, it has over the past twenty years, contributed significantly to increased capital costs over the past 20 years through decisions it has made and standards it has imposed on the industry, with little appreciation of the costs involved. In the 1990s, the Commonwealth encouraged the development of the cluster model for residential care, to provide a more homelike environment, significantly different from the institutional, almost hospital like facilities of the 60s to 80s.

With the cluster model came more sitting areas, more dining areas and single ensuite rooms instead of shared rooms and communal ablutions. The model provided a marked change in standards including improvements in privacy, both laudable outcomes. However, the model initiated significant increase in construction cost due to increased space requirements for additional rooms and living areas. A capital impost, for which there was no funding provided.

Unfortunately, in the long term effect is that the cluster model of care due to the resultant expansion of facilities and specialist staff needing to travel further to conduct their work, thereby reducing their productivity. This model is now one of the most expensive to run because of staffing needs and the commensurate costs of those staff.

The cluster model was quickly followed by the 2008 Privacy Standards which initially included a minimum bedroom size but after reconsideration, the Department merely applied maximum ratios for the number of residents sharing

bedrooms, toilets and showers. Like motherhood, nobody could argue against the new standard, but someone had to pay for it, either the resident or the provider.

At the same time, the government imposed 'certification' on the industry. Once again a laudable concept in that it provided an independent audit of the building fabric and its suitability for purpose. However, certification was based on the Building Code of Australia (BCA) standards for Class 3 (Hostel), Class 9a (Nursing Home) and Class 9c (Residential Aged Care) facilities. BCA standards are enforced and managed for all other buildings in Australia by local government planning authorities, who maintained their responsibility during the construction of new aged care facilities and provided the Certificate of Classification for those facilities. Certification added another layer of responsibility and required an independent auditor to further inspect the building and 'certify' that it met the government's standards. Naturally, certification bears a cost to the owner of the building. The aged care provider must meet that cost. Much of the certification standard can only be assessed, subjectively and as buildings are designed by humans and built by humans, subjective matters easily give rise to disagreement about whether a certain aspect of the standard might be being achieved. Unfortunately, the certification agency had a monopoly across Australia for the audit and although it is possible to appeal an adverse decision of that agency to the Department, the certification agency is a contractor to the Department and advisor on matters 'certification'. Needless to say, providers, their architects, builders and consultants soon learnt that it was easier to accept the outcomes of the audit and pay to rectify the 'fault/deficiency', despite it representing more capital cost.

Regulation

The Department of Health and Ageing is responsible for managing the funding provided by government for the system. It has a responsibility to manage those funds in a prudent manner. It also has responsibility for maintaining and ensuring quality care is provided within the system, a position not necessarily compatible with its funds management role. In addition, it controls entry to the system through its assessment processes and as well as being the regulator of the system, investigates complaints about the system, and penalises providers for infringements of the system. These roles are not all compatible and create conflicts of interest within the department, ignore the principles of natural justice, and fail to adequately serve the interests of any of the stakeholders within the system. While, the Department will point to the existence of the Aged Care Standards Agency and the Complaints Investigation Service as agencies which address some of these conflicting priorities, neither is truly independent, nor operates at a truly arms length fashion.

Aged care is a potentially emotive subject and quickly becomes mired in the political process. Knee jerk reactions to one off incidents can easily lead to

further regulation of an already over regulated system. While not being able to insulate itself against political influence, the creation of adequate independent structures, that can offer alternate perspectives to political issues, could reduce the potential for adverse effects of the wrong decisions.

Aged Care in Australia is subject to additional regulations other than the normal checks and balances afforded to the acute sector. Inter alia, these include:

- Government approval of aged care providers and vetting of all key personnel;
- accreditation of all residential & community care;
- unannounced and scheduled visits by the Accreditation Agency;
- building certification;
- police checks for all staff and volunteers;
- compulsory reporting; and
- an aged care specific complaints investigation scheme;

Workforce

As mentioned earlier, the issue of a shrinking workforce and increasing demand is presenting significant challenges to the provision of aged care services and is well documented.

Particular issues in relation to workforce for Baptistcare are:

- The sector's lack of capacity to pay staff competitive and fair wages is having a severe impact on our ability to attract and retain skilled staff. Benchmark data indicates a significant gap between wages in the aged care sector against comparable positions in the public or other sectors; a direct reflection of funding constraints.
- The average age of staff in this organization, which is not dissimilar to others in the industry is approximately 48 years. The industry's lack of attraction to younger people and males is also problematic. This is also largely attributed to uncompetitive salaries and demanding conditions.
- Our staff turnover is currently running 29% per annum (and on the increase as resource projects in WA come on line). It peaked two years ago with the previous resources boom in WA at almost 38%. This is typical of the industry in WA (based on recent network benchmarking). Such a high turnover has a major impact on operating costs (recruitment and training), operational efficiency and, importantly, has implications for quality of care.
- In residential care, resident care needs are now significantly higher and more complex than in the past. Staff are now managing a range of conditions (co-morbidities) as well as meeting lifestyle and holistic needs of the individual. These challenges are not faced in the acute sector and

places extra demand on staff skills and workforce development/ training, which needs to be recognized in the funding formula.

The Department

The potential for conflict of interest within the Department was outlined earlier. However, there is a more fundamental conflict in place which contributes to the over regulation of the industry. The Department has responsibility for both a health system, which must meet the needs of the total population, from 'womb to tomb', and an aged care system which relates to a specific segment of the population and by necessity, needs to consider many issues for that segment of the population that are not just health related. The Department's own planning ratios identify that only 130 in 1,000 people over the age of 75, require some form of care. That doesn't mean however, that the remaining 870 people in that cohort don't require wellness or social services which can prevent them from becoming part of the 130. One of the most significant wellness issues for the aged is 'social isolation' which if not addressed, leads to health issues.

A FUTURE AGED CARE SYSTEM

The following outlines a broad picture for consideration in the development of a new aged care system. It is envisaged that arising from the Productivity Commission Inquiry, a team will be established to design and implement the new system.

Entry to the System

To ensure that entry to the aged care system is as simple as possible, the starting point will be a telephone assessment by an approved 'assessment agency' operating at either a state or regional level. Access to the assessment agency will be via a 1800 number that is common throughout the country.

The agency will utilise a standard assessment instrument that determines whether the client requires domestic assistance, support services and/ or personal care. The assessment agency will be independent from the providers of services and based on the client's need, will provide the client with an entitlement (care plan) which allocates a number of hours of service to the client.

The assessment agency will provide the client with the contact details of the providers in their immediate location. The client will then choose the provider whom they wish to deliver their services to them. It will be the prerogative of the client to change service providers if they so choose. (This system is similar to the VHC system currently in place, with the exception that under VHC, the assessment agency chooses the provider).

If a service provider believes that the care plan is incorrect or that a client requires more or different services to those provided, it will be up to the service provider to demonstrate that need to the assessment agency for a change to the care plan.

Care plans will be limited to a maximum number of hours of care and a maximum value. Clients requiring more than the care plan allows, will take their care plan to an ACAT for further assessment, which will then give them access to CACPs, EACH or residential aged care.

In addition to assessing service requirements, an ACAT will assess the home in which services are to be delivered to ensure that it is safe and appropriate, not only for the client, but for the staff of the care provider.

It will be the responsibility of the home owner to carry out whatever works might be necessary to make the home appropriate for the delivery of care services.

Levels of Care

The levels of care will be similar to those currently existing, appropriately valued and allowing for regional variations due to distances to basic services, staff availability and specialist support. From the perspective of equity, a consistent level of 'care' service is the outcome that has to be achieved, rather than a common price.

Residential care will be classified as 'residential care' and will not differentiate between low and high care. The ACFI will determine the funding level for the client and the funding will be purely for the level of care provided.

Accommodation and meals will be provided at the resident's cost, with the ability for those who wish to pay for additional services being available should they wish to purchase those services. The Commonwealth will only provide accommodation / meal funding for those residents who do not have the financial capacity to pay. It is envisaged that this would be equivalent to rental assistance.

Accommodation

While there has been a demonstrable improvement in the quality and standard of accommodation brought about by the Certification process and policies such as the 2008 Privacy standards, there is nothing to suggest that such improvements would not have happened over the same period of time as construction occurred of new facilities to meet increased demand, consumer preference and to replace older stock which had outlived its economic life.

A comparison of the retirement village industries and the residential aged care industries over the same period since 1997 would show a significant

change in accommodation standards, if not greater, in the retirement village sector than has occurred in residential aged care, without the need for legislative and bureaucratic intervention.

In fact, the one major government initiative in determining a standard for accommodation, other than for rooms with ensuites, which would have evolved from consumer preference in any case, was the introduction of the cluster facilities during the 1990s. As outlined earlier, this innovation was short lived, once operators found the staffing costs of providing such types of facility could not be sustained.

While the Certification process may have produced some improvements, the down side of the process was a constraint on innovation in accommodation types because of the need to comply with the BCA and to achieve an arbitrary score in the certification instrument. This led to increased costs of construction which reduced the funds available for other innovations and an accommodation product that once again, has evolved to what can only be described as 'institutional'.

However, aged care is delivered in people's private homes (be they single dwellings, villas, apartments, mobile homes, retirement villages) as well as in residential aged care facilities. Not surprisingly, there has been no attempt to dictate standards of accommodation that must be achieved or exist before aged care services are provided in the home. While there are various sources of funding available to people to assist them to modify their homes to improve their mobility and safety, there are no minimum standards applied. The question must therefore be asked about the need for the capital intensive standards applied through the BCA and certification.

As outlined earlier, the cost of accommodation and meals will be the residents responsibility and will not be controlled by the Commonwealth. Residential aged care services will be able to be provided in any location and accommodation type that is safe to do so.

This will ease the demand for capital for new services as it will allow providers to construct the type of accommodation the client wants, in a style that best suits the area and at a cost that both the provider and client can afford. Disbursed care will be possible, within a suburb or throughout an apartment building, rather than a single institution as is currently the case.

To ensure equity is achieved in service delivery, all approved providers who wish to provide residential aged care will be required to meet concessional resident ratios.

Rural and Remote Funding

The costs of providing services in rural and remote areas will be addressed by the application of different funding levels for service delivery in those areas. This will need to be determined by an independent agency whose responsibility it would be to monitor cost changes throughout the industry and recommend funding levels for various areas to government.

The Aged Care Assessment Round (ACAR)

Once an organisation is given the status of 'Approved Provider' in a region, state or nationally, their decision to offer services at whatever level they choose, will be a commercial decision, made by the provider based on their own research into the level of need in the area, competition for service provision and expectations of change over time. That decision will be made without the need of an ACAR round and without the limitations of approved beds or places, as currently exists.

Retirement Villages

Retirement Villages offer the potential for cost effective service delivery at a much higher level of productivity for community care services than is traditionally available. They also offer the potential for the delivery of residential aged care in a home environment, again in a much more cost effective manner than CACPs and EACH packages.

However, retirement villages are first and foremost an accommodation preference for their residents and while some are operated by approved providers within the aged care industry, many are not and many operators have no interest in becoming involved in aged care service delivery. Retirement villages operate under the respective Retirement Village legislation or Residential Tenancies legislation within their state, sometimes because of their structure, both. They do not need to become enmeshed in a further level of regulation.

SHORT TERM ACTION

The proposals outlined above require a rethink of what the industry provides, how it provides it and where it is going. In the short term, there is scope to reduce the level of regulation in the following areas where the current arrangements are either redundant, unnecessarily burdensome and /or duplicate other regulations:

Approved Providers and Key Personnel A one off in depth assessment of the financial and governance structure of an organisation should be sufficient to provide them with Approved provider status for all services. Similarly, once a persons suitability to be a member of Key Personnel has been confirmed, that approval should follow them from provider to provider without the need for further assessment.

Building Certification Having now achieved the upgrading of the building stock across the country, certification should be abolished and the normal planning and inspection processes by the respective authorities be relied upon.

Compulsory Reporting Aged care providers are currently required to report all allegations or suspicions of resident-on-resident physical abuse to the Department and the Police, except where the residents concerned have an assessed cognitive or mental health impairment. While the Department's Guidelines state that investigation of incidents of alleged assault are the responsibility of the police, as is the case for assaults involving residents with assessed cognitive or mental health impairment, it would be more efficient to rely on the Agency audit processes to ensure appropriate systems are in place to ensure appropriate reporting and management of assaults and that the systems are used.

Annual Fire Safety Declaration The annual fire safety declaration was introduced pending the achievement of the fire safety standards under building certification. Over the years it has been expanded to include questions about 2008 standards. Having achieved these standards and as local government has responsibility for fire safety, the annual fire safety declaration has become redundant.

Streamlining Community Aged Care Under current arrangements, care recipients and providers often face disruption and administrative costs in transitioning to higher levels of care because of restrictions placed on the type of care that the provider has been funded to deliver. As outlined above, once assessed as an Approved Provider, there should be no limit on what services a provider delivers.

Police Checks The *Aged Care Act 1997* requires all aged care staff and volunteers to undergo police checks every three years. If staff change employers and become Key Personnel in the new organisation, or new applications are submitted for Approved Provider status, the police certificate must be no more than three months old. Potentially, an employee can be required to produce numerous certificates in a three year period. Certificates should have a life of three years and be transferrable between employers.