

# Aged Care Alliance Response to Two-Year Review of Aged Care Reforms

## Issue one - ACCESS

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### Effect on difficulty for particular groups of residents to obtain care

- Residential facilities show a general trend towards caring for people with higher dependency levels and an accompanying decrease in emphasis on those less dependent. Although it is critical to include those less dependent people in the provision of aged care, the amended eligibility criteria for Community Aged Care Packages (CACPs) represent a barrier to such provision.
- Proprietors of facilities previously known as hostels (categories 5-8) can target the level of profit in a year and make acceptance decisions accordingly. High-level care resources are therefore not available to support ageing in place in hostels.
- Facilities previously known as hostels are continuing to operate as hostels accepting people in the lower RCS categories. This means that those places are virtually guaranteed as places in those categories. These facilities find, as peoples' needs increase; it is not financially viable to support a small number of high-need residents to age in place. The defining element in this decision is sometimes building design.
- Based on financial incentive, a general preference to accept people in higher Resident Classification Scale (RCS) categories and conversely, a financial disincentive not to accept people who fall in certain categories has been noted. Some facilities have been instructed by their operators to make a point of accepting RCS categories that attract the higher dollar figures, or to prefer full bond payers. Specifically affected are:
  - Category 4 residents in nursing homes who are frail and who need mobility assistance or assistance with toileting but who are not cognitively impaired or incontinent.
  - Categories 5-8 people who have an illness which is likely to deteriorate rapidly, and who need palliative care. Prior to these reforms, this group would have been admitted to nursing homes immediately in order to avoid their having to move again within a short time. The common assessment tool discourages this arrangement.
  - Category 8 (and some 7) residents in hostels who need residential care due to social isolation or depression. Community Aged Care Packages and other community-based services do not always meet the needs of this group and there is a resulting devaluation of social needs. Level 8 people needing new entry for social reasons are disadvantaged due to lack of subsidy.
- The weighting of points in reforms under RCS has shifted from intensive levels of care towards those with dementia and other behavioural problems, creating competing client bases with the result that dementia specific facilities are favoured at the expense of high care need (i.e. frail older) people. Another issue that this raises is the lack of secure psychiatric aged care facilities.

While the additional funding to people with dementia is welcomed, this should not occur with the result of less available funding for high care need people. Since the overall total funding has not significantly increased, it is only the internal distribution across the categories that have changed. Instead of the people with dementia having the major disadvantage, it is now people with high care needs (other than dementia) who experience the disadvantage.

- People of Non English Speaking Background are less desirable for providers, due to the requirement to ensure that their special needs are met, specifically the need to translate contracts or agreements, employ bi-lingual staff or use interpreter staff. The reforms and the removal of capital funding have closed prospects for the establishment of ethno-specific aged care facilities or services.

### **Effect of reforms on ability of people to receive care in their own community**

- Increased selectivity due to RCS category or financial status has compounded the difficulty of accessing residential care within one's own community. There is no obligation to accept residents – the nursing home can select whom they wish. This change highlights the problem posed by closing state-run nursing homes, which had an obligation to accept residents. Proprietors can be more selective for financial reasons.
- Specifically, for those living alone or Non English Speaking Background people, the hostel provides a sense of home; the opportunity to be with those from the same background and therefore maintain physical and emotional health; and the forum through which to voice problems with or need for services or providers. In addition, selectivity due to RCS also impacts on ability to cluster those of similar backgrounds.

Please refer also to comments on ageing in place.

### **Effect on waiting times for care**

- People who fall into categories 5-8 are less likely to get to a nursing home if there are not enough hostel spaces than are those at the low end of the high and low categories (i.e. category 8 in low category and category 4 in the high category). It is more desirable for operators to admit people who are the low end of each category. They receive the same subsidy even when less care is required, with the net result of decreased costs and increased profits.
- When people in facilities formerly known as hostels are reclassified into a higher category and the hostel indicates that they will no longer provide care, these people appear to be waiting an extended length of time in an inappropriate setting before transfer to more appropriate care.
- Waiting times have increased for those who can pay only partial bond as opposed to full bond payers, due to RCS category or financial status.
- A Quality Assurance project by North Shore social workers showed no change in waiting times, and the initial problems related to the pre-signing of agreements are now beginning to resolve.

## Impact on various groups

- **Financially disadvantaged**  
Concessional people generally have good access and may be more attractive to nursing homes due to reduced administrative costs - in fact, facilities frequently need to refuse a resident who is not financially disadvantaged. This group is not as attractive to hostels, however, due to the absence of cash in-flow and there have been reports of people being refused admission due to inability to pay full bond.
- **Financially advantaged**  
Those who pay a part-bond are financially less attractive than full bond payers or people who are fully subsidised. The financially advantaged can access a better standard of service through extra service places, which creates a 2-tiered system, potentially within the same facility.
- **Residents with dementia**  
RCS weightings are skewed towards residents with dementia. Although this is a welcome change, it may generate some over-compensation. People with the need for secure, specialised dementia care, but at a low level, are still being inappropriately placed in nursing homes.
- **Residents from particular cultural or linguistic background**  
The legislation has not addressed the needs of these groups in any significant way. These residents remain scattered, often distant from their families. They suffer from a lack of specific ethno-cultural facilities, inability to communicate with caregivers or fellow residents, and lack of access to special foods. This results in a dismal quality of life.

There has been a shift from ethno-specific to mainstream provision. Mainstream providers often face great difficulties in contacting ethnic community organisations which can provide culturally appropriate services. Concessional residents from Non English Speaking Backgrounds are particularly affected.

- A number of ethnic organisations who had previously provided hostel care will no longer be able to do so and they may not be able to convert to providing a continuum of care, resulting in less ethno-specific providers. There are no additional resources or strategies to facilitate the provision of care to the culturally diverse aged.
- Quality of care (and accreditation based on quality) for those in a facility where their language is not understood is an issue including: contractual agreements in an understood language; participation in relevant activities; and the understanding of procedures and required tasks. Additionally, accreditation now encourages staff with good English language skills, perhaps resulting in the loss of skilled but non-English speaking staff. The high educational component in the accreditation standards makes the employment of non-English speaking staff less and less attractive, which can disadvantage residents of non-English speaking backgrounds. Access to and payment for translation service is crucial to ensure and monitor quality care delivery to those of all languages and ethnicities.
- **Low care residents**  
Some residents of hostels have always received higher levels of care. The Ageing in Place aspects of these reforms should have supported this; however, the opposite is often true.

For example, some residents of a hostel were referred to the Aged Care Assessment Team (ACAT) for reassessment to high level care, as they were Category 4. The result was premature transfer to a nursing home – a result detrimental to their overall well being.

- **Residents in rural and remote communities**

There continue to be long waiting lists for care. We pose the question of whether Heath House, which was used heavily by people in the Southwest for respite has closed as a result of the reforms.

**Additional comments on access:**

- There are unmet needs for: older people who are users of alcohol and other drugs; those needing psychiatric care and support; and those with severe behavioural problems. Mainstream aged care facilities may not be the most appropriate form of care and accommodation for this group and furthermore they are not attractive to aged care providers. These people are often grossly neglected and may live in boarding houses or be homeless. Additional funding and trained staff are needed to care for this group.

- Younger people with disabilities continue to be admitted inappropriately to aged care facilities due to lack of appropriate alternatives. They are not considered in the planning, thus impacting on places available to older people needing residential care.

- The chronic need for short-term, bookable respite care remains as great as ever. It is adversely affected by the risk of cancellations and the potential losses caused by empty bed days.

*Other issues of access are addressed in the section on ageing in place.*

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## **Issue two - AFFORDABILITY**

### **Effect of accommodation payments on demand and fees and charges**

- Demand dropped initially and then recovered after bonds for nursing homes were rescinded. As aged care is a captive market, demand now remains unchanged, reflecting the fact that residential care is not a lifestyle choice but a forced decision.
- Fear and widespread confusion and misinformation remain and these act as a disincentive to accept or seek residential care.
- The increased administrative work is slowing the entry process.

### **Effect on particular types of residents**

- The bonds were initially a drawback and the fate of asset rich and cash poor elderly remain a problem due to lack of ability to pay fees. This group (a fair proportion of who are in the W.W.II generation) is in need of financial advice.

- Entry to a nursing home is often precipitated by a crisis. Those who are asset rich or on a part pension come to a nursing home and can pay an additional \$12 or more per day. These people may be faced with the need to either sell their homes and live off the interest or rent their homes out in order to afford this \$12/day. (Specific statistics on this issue can be obtained from Centrelink.) The interim period before sale is extremely difficult and those who sell their homes and then rent them out may be subject to asset or income tests that impact on their pension.
- Self-providing residents in retirement villages who entered as “self care” with available support services may now not have access to the higher level of care facilities which represent a strong incentive to buy into the villages. One type of resident in retirement villages has been especially affected by the reforms – specifically, those who entered as self care who provided their own accommodation by selling their homes and investing the remaining funds to generate income in order to support themselves. If these residents are in a village which is an incorporated facility funded for higher levels of care, it is unclear whether they have lost priority access to the funded places for which their entry contribution provided. It is also unclear how any further entry bonds will be assessed, including:
  - price at which the self-care unit is sold
  - configuration of assessed sum
  - assessment of payment of ongoing fees
  - assessment of entry bond
  - treatment of provider retained money when it is used as capital for provision of aged care facilities within the same village

### **Fees and charges as cause of unreasonable hardship**

- The high proportion of income required for payment of ongoing fees and charges means that the majority of residents face forced poverty. They are financially marginalized through lack of means to access or participate in community life; purchase presents for grandchildren; burden of legal costs and access to appropriate transport. Their dependence and vulnerability are therefore compounded.
- The cost of residential care is falling more heavily on the frail aged through the user pay system. This group is therefore disadvantaged in comparison to the rest of the community without the same needs.
- Homes are not merely an asset but represent social meaning and independence, particularly among older Australians and migrant groups. In some cases, families are reluctant to facilitate entry to residential care due to their fears of the impact on the family home. In particular, those being discharged from the hospital to the nursing home are being forced to make huge financial decisions. The fees, charges and bonds are hard to understand especially when one is in crisis and unwell. People in this situation often want to keep options open to return to their own homes. One way to achieve this end would be to increase respite time, allowing a period of time to adjust, explore options and make studied decisions while still receiving needed care in a non-hospital environment.

## Issue three - QUALITY

### Building Standards

- A general improvement in the quality of building stock due to the need to comply with Certification and Accreditation requirements has occurred. It is noted that old facilities are closing and new ones are being built. However, operators are using the certification instrument as a goal or standard instead of its intended use as a minimum standard with the goal of continuous quality improvement.
- There is a need to monitor the effect of single rooms with ensuite instead of 2-bedded rooms.

### Provider investment in quality of buildings

- It has been noted that in order to comply with the ongoing certification standards there is investment in buildings, especially in the for profit sector.

### Effect on standards

- Care hours are being decreased with the elimination of CAM/SAM, as funds are not quarantined for staffing or care. As standard rosters have been replaced with flexible rostering related to resident care needs, there is a lack of response to care needed in rostered hours. It is possible that the surplus is going to capital works. Please refer to the attached NSW Nurses' Association Survey.
- It is felt that standards are driven by accreditation and there is some industry perception that the organisations may not be failed in the first round of accreditation. Standards should be care-driven, not dollar driven, as was the case when accommodation bonds drove compliance and relatives were the forces behind improving standards.
- Additionally, it is unclear what the final standards will be especially for capital works (e.g. toilet/resident ratio).

### Adequacy of staffing levels

- Facilities' capacity to change staff mix to meet the needs of the fluctuating levels of resident care is no longer possible under the new system. This is because there is no longer an isolated funding component for staff which makes it possible to adjust client/staff ratios and levels of care. Consequently, the Directors of Nursing are now more likely to accept a person according to the existing level of staffing rather than the needs of the person.
- Reduced care hours do not result in less work being done, but it does impact on the way the care is delivered. Care that is rushed decreases the residents' sense of well being, staff satisfaction and morale and results in increased rate of injury and morbidity for residents. Dedicated staff may well be underreporting longer working hours, while staff suffering

from burnout due to high work demands and inability to meet resident needs may be delivering poor care.

- The chronic industry problem of inability to attract and retain staff due to heavy workload is worsened. There is also a decrease in use of ancillary services (including diversional therapists) that improve quality of life, as these services are not classified as core activities and are therefore not regulated.
- As a result of global budgeting and standard rosters, proprietors are now in the position to decide how much of their budget to use on staffing, whereas with prior funding mechanisms they were obligated to spend the money on staff or risk losing the money. The lack of prescriptive levels of trained RNs as a ratio of overall staffing remains unaddressed. The Act has not addressed issues of increasing client acuity and the need for increased paramedical and trained nursing staff in specialised areas such as polypharmacy, post-CVA and amputee care. There must be a mechanism by which standards that ensure that adequate money is spent on staffing can be enforced.
- The reliance on nursing agencies due to insufficient staffing gives rise to multiple problems, among them staff who are inexperienced in aged care, unfamiliar with residents, may be non-English speakers or do not have adequate time to review notes and familiarise themselves with residents. The effect of workers not working to standard is worse than prior to reforms, as each worker is more and more critical now.
- With the increased emphasis on dementia care for financial viability, frail residents with high care needs may be receiving less care. Residents of Non English Speaking Background in mainstream facilities, who require additional care hours, are not provided for. Additionally, it is unclear how care plans and service satisfaction are assessed for this group.

### **New complaint mechanisms effectiveness in protecting user rights**

- The current Commonwealth complaints mechanism does not cover the Standards Accreditation Agency activities and the roles of NSW Health Department and the Commonwealth are unclear. It remains to be seen whether or not the Agency is empowered to effect compliance or closure of unsatisfactory facilities.
- Complaint mechanisms are not well utilised, due to the poor cognitive levels and vulnerability of clients, leaving both clients and families very reluctant to raise issues and particularly to lodge a formal complaint.
- The groups of residents without families and of Non English Speaking Background do not have clear mechanisms by which to lodge complaints or advocates to work on their behalf.

## Issue four – EFFICIENCY

### Impact on administrative costs and documentation requirements for aged care providers

- **Certification and accreditation requirements**

Administrative costs and documentation requirements are high. The certification and accreditation process have increased capital outlay and documentation without increasing funding to support these activities. Therefore, administrative costs are being recovered from care services. There is a huge amount of unpaid overtime required to support the system, resulting in potential employee exploitation. There are large costs associated with program development to meet accreditation requirements.

Larger providers may benefit from economy of scale and more easily absorb accreditation costs while the reverse is true for smaller providers. A one-off structural reform package to set up accreditation certification needed to supplement the \$12/day paid by the user and deal with the non-receivable costs to prepare for accreditation, upgrading and compliance on a needs basis is initially needed to get all agencies up to accreditation standards. There are several industrial issues regarding different awards impacting on the sector such as PCA and AIN.

- **Resident agreements**

It is not mandatory to sign these agreements and therefore issues of advocacy, potential for high legal costs and costs of interpretation need to be raised.

- **Resident Classification Scale (RCS)**

As there is variation in interpretation of RCS by different auditors, there may be inconsistency in assessing quality staff and quality of programs in diversional therapy

- Underlying all these issues is the question of the fate of residents whose nursing homes are closed due to inability or unwillingness to meet accreditation standards.

### Duplication

- It is unclear what has been done at the governmental level to assist in the move to a more integrated structure.

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## Issue five - INDUSTRIAL VIABILITY

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### Viability of individual facilities

- The changes to capital funding are based on the assumption that the aged care industry has the capacity to raise these capital funds as needed in the short term. Based on the daily resource (resident) contribution, the accumulation of capital reserves is a long term strategy for providers who have no capital reserves at the time of the reform, putting these providers into short term crisis while working towards accreditation.
- Capital upgrading presents financial problems for providers, who are not certain of their ability to repay loans at present rates of interest (assuming no significant changes to RCS)

resident mix). There is uncertainty about the continuation of government subsidies at present rates, which are taken into account as the basis for loan guarantees. These sorts of pressures are driving proprietors to pick and choose their residents according to subsidy levels (i.e. preferring clients who fall into the top four categories but who are at the low end of each category).

- **Effect on individual facilities**

Residents with dementia are now more attractive because of the funding they attract. Proprietors are targeting dementia residents despite not modifying facilities to dementia-specific requirements and find that their accompanying higher resident subsidies enhance their viability prospects. Before the reforms, facilities which had no dementia residents could remain financially viable because there was appropriate funding for their frail aged residents. Since the reforms, proprietors are finding it necessary to maintain their financial viability. This has two negative consequences:

- decreased access to residential care for needy non-demented elderly
- decreased quality of care for dementia residents admitted to facilities without dementia specific buildings and programs

This situation gives rise to the concern that the legitimate needs of demented residents are now in competition with the legitimate needs of frail elderly. Both dementia specific facilities and facilities providing care to frail elderly should be provided with adequate funding levels to remain viable. Those facilities who provide care to both demented and frail residents should have funding adequate to allow them to provide building, staffing and programs adequate to meet the needs of each resident and allow them to remain viable. In practical terms, prior to reforms, dementia-specific providers were struggling to break even, sometimes operating at a loss while facilities providing care to frail aged were operating at break even or better. Since reforms, the financial situation of dementia specific facilities has improved while facilities catering mainly to the frail aged are now struggling to remain financially viable.

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## **Issue six - STATE AND TERRITORY PROGRAMS**

### **Effect on State and Territory Services**

- **Home and Community Care (HACC) Program**

Home and Community Care services are intended for all levels of need but in fact are being directed to higher levels of need at the expense of those at lower levels of need. This situation is being compounded by the reluctance of people with high levels of need to enter residential care.

Anna Howe's research at Monash University demonstrates that low need clients do not automatically progress through to medium and high need categories but hang on until a crisis occurs; thereby entering the system at the highest expense point from personal, social and government financial aspects.

## Issue seven – CHOICE AND APPROPRIATENESS

### Impact on ageing in place

- As more and more facilities previously known as hostels retain their residents who require higher care, they are obliged to provide 24 hour suitably qualified staff (as opposed to low care residents who need only staff to supervise). Two issues involved in providing care to this group are staffing levels and building design for which renovation costs can be prohibitive. Proprietors are not obligated to renovate the facilities thus creating problems of occupational health and safety. The sector has not yet had sufficient time to prepare for ageing in place.
- A number of issues have arisen for existing hostels that have high need residents who choose to age in place:

The increased subsidy to high need hostel residents does not cover the cost of required increases to staffing levels. When a hostel determines that staffing levels can only be increased with a particular number (e.g. four) of high need residents who choose to age in place, there is concern as to what happens when this hostel has one, two or three high need residents who still require high need care. Issues arise when the hostel continues to be staffed at pre high-need levels such as:

- duty of care and quality of care for high need residents
- compromise of Occupational Health and Safety obligations to staff
- expectations on staff become unrealistic and unpaid work becomes unavoidable.
- resource choices are limited
- A number of regions report extreme difficulty in attracting and maintaining staff due to the above effects and the fact that the work is unglamorous, heavy and personally demanding. Some Directors of Nursing have reported that cleaner, less demanding jobs (such as working in supermarkets or department stores) pay comparable wages.

Pre-reform, there were some nursing homes and hostels with a clear delineation between levels of care. Post reform all are now designated as residential aged care facilities. Ageing in place assumes instant capacity to move easily between co-existing levels of care. The Aged Care Alliance applauds the philosophy of ageing in place. However, we recognise the fact that ageing in place is not sustainable without time and resources for providers to make the appropriate adjustments such as building layout and room design; developing staff skills in provision of a range of levels or care; variations in models of care and attitudinal and cultural shift in staff and organisation. There is an accepted community expectation that older people are able to stay at home and receive appropriate support at home. Expectations prior to reform could not be met, let alone expectations arising from new government stay-at-home philosophy since reforms. Additionally, the need for social contact and potential isolation of people in the community who age in place must be addressed along with issues of reasonable support.

- CACP have a 12-month wait list in some areas and HACC meets 50% of need. We are concerned with the strategies that are planned to meet the appropriate mix of residential and community care.

## Other considerations

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- We are concerned with the consultation process undertaken by the Department, which appears to be selective in terms of both organisations and facilities, with limits of attendance placed on each session. In particular, ethno-specific providers were unaware of the review and were therefore unable to provide feedback.
- Potential residents continue to be given poor information by facilities, for example, they may not be given the full range of options for payment of bonds. There is public rejection of user pay and economic rationalist policies as increasingly unacceptable.
- Recently Aged Care Assessment Teams have received instruction to limit respite to “respite for carer” not for “try before you buy” or convalescent post-hospital people. The decision-making process regarding long-term care options needs to occur over time. Instructions that people should not be approved for respite and permanent placement simultaneously do not reflect client needs and client best interests.
- **Advocacy/Guardianship**

Anecdotally, the older person without access to personal advocacy in the form of family member or other has little advocacy in a nursing home. They are at the mercy of the Director of Nursing or other proprietor who may or may not refer their cases to the Guardianship Tribunal for financial management and guardianship.