



**Submission to the Review of the
Aged Care Funding Instrument**

**Prepared by
National Policy Office**

March 2010

COTA National
(COTA Over 50s Ltd)

GPO Box 1583
Adelaide SA 5001
08 8232 0422

www.cotanational.org.au

Authorised by;

Ian Yates AM
Chief Executive
iyates@seniorsvoice.org.au

08 8232 0422

Prepared by;

Jo Root
National Policy Manager
COTA National
jroot@cotanational.org.au

02 62823436

Introduction

COTA National - Council on the Ageing - is the national policy arm of the eight State and Territory Councils on the Ageing in NSW, Queensland, Tasmania, South Australia, Victoria, Western Australia, ACT and the Northern Territory. COTA National has a focus on national policy issues from the perspective of older people as citizens and consumers and seeks to promote, improve and protect the circumstances and wellbeing of older people in Australia.

Consumers' main concern with any funding instrument is that it be linked to the needs of residents in a way that makes it possible for all older people, regardless of the complexity of their needs, to access quality residential aged care. One of the criticisms of the previous funding instrument, the Resident Classification Scale, was that it did not place sufficient weight on some needs and led to aged care providers being unwilling to take certain groups of client with complex needs. This meant that some older people did not have access to the support and care they needed.

COTA National welcomed the introduction of the ACFI as it is seen as a significant move towards using residents' needs as the basis for funding for residential aged care so in part meeting the concerns raised above.

COTA welcomes this review of ACFI as it is important that we evaluate the impact of the ACFI and take action to remedy any problems the review identifies. Our Submission uses a combination of information that aged care providers have shared with us and views from our members collected through our various consultation mechanisms.

Terms of Reference

1. Better matching funding to the complex care needs of residents

COTA National acknowledges that one of the key design criteria for the ACFI was that it was a needs assessment instrument with the actual level of payments set to ensure total funding was within the existing funding envelope. (Acknowledging that additional funds were then committed to cover the supplements). This made it a redistribution tool and it is generally acknowledged that it has been effective in most cases in allocating the available funding according to a hierarchy of need. There are some needs which it has not been effective in addressing and these are discussed in our comments on terms of reference 5 and 6.

The current rates of subsidy for care and support are historically based and have not been properly adjusted to adequately reflect changes in cost structures, resident profiles or community expectations on what constitutes good care. The current levels of subsidy do not provide sufficient funding to meet all the needs of all the clients. This is making it harder for people with higher and more complex needs to access residential care as providers simply cannot afford to meet their needs.

It is now time for the total level of funding to be increased to take account of the real cost of providing care, including meeting the competitive wages needed to attract and retain skilled staff that are crucial if people's care needs are to be met. The report of the Review of the

Conditional Adjustment Payment should throw some light on the required levels of funding and COTA, like others in the sector believes it should have been released prior to the commencement of this review.

Recommendation 1

- a) A benchmark of care be developed to inform determination of subsidy levels
- b) A staged approach to increasing subsidies above the current indexation levels to reflect the real cost of providing care be implemented.

2. Reducing the documentation created by aged care providers to justify funding

COTA National has no independent evidence on this but there appears to be widespread agreement amongst aged care providers that the ACFI has reduced the amount of documentation required to justify funding. This was not the case initially with some service providers, particularly smaller providers, requiring considerably more training and support than was initially provided before they were able to reduce the amount of time for assessments and the error rates.

However, assessment of need must be translated into care provided. What is not so clear is if that reduced documentation has translated to more hours of care for residents, which is what consumers had hoped would happen, rather than those savings being wholly or substantially directed to reducing the administrative overheads of providers.

3. Reducing the level of disagreement between providers' appraisals of the care needs of their residents and the findings of Departmental validators.

Evidence suggests that there has been a decrease in the disagreements between providers and validators. From a consumer perspective this is a good outcome as it increases the likelihood of providers continuing to take on residents with complex needs, because they feel more confident that their funding will be sustained.

Some aged care providers are suggesting that some of the Departmental validators are seeking more information than is required to claim the funding. This is unfortunate as it has the potential to undo the gains made in reducing the documentation requirements discussed above. There is obviously a need for ongoing professional training and support for validators to ensure they are aware of and behaving consistently with the validation guidelines and procedures.

Recommendation 2

The Department put in place more rigorous measures to ensure Departmental validators' practice is consistent with the policy and the intent to reduce documentation requirements.

4. The Impact of the ACFI on the funding levels of Approved Providers, and in particular of low care providers and providers in rural and remote areas

The ACFI places a much higher emphasis on the needs of people who are ill or have a disability. This has led to a significant group of clients in low care who would have received RCS 7 funding no longer attracting any funding at all, although they still receive the resident contributions. This

often leaves people in that category, who were in residential care to have their social and accommodation needs met, with no access to any services and nowhere to go. This appears to particularly apply in regional areas and lower socio-economic areas of the urban fringes. It increases the likelihood of people being socially isolated with all the attendant problems of depression, loneliness etc and creates problems down the track for this group of people.

This move has also had a disproportionate impact on low care providers in rural and remote areas, who were previously able to get some funding for the partners of people with higher needs as they could claim RCS 7 and get the resident contribution.

Recommendation 3

The Australian Government needs to work with the States and Territories to ensure there is alternative accommodation and services for older people who have housing and support needs outside of the aged care system.

5. The impact of ACFI on access to appropriate care, especially for residents with special needs, including whether the design of the ACFI fails to appropriately recognise the relative costs of meeting the care needs of certain classes of residents.

There are two groups of clients whose needs are not adequately met by the ACFI; these clients either struggle to gain access to residential aged care, or when they are admitted the facility struggles to provide the care they need within the available funding.

The first group is people with mental health problems. Under the ACFI there was a trade off between Activities of Daily Living (ADLs) and mental health which resulted in people with mental health problems who can undertake most of the ADLs with only limited supervision attracting very low funding which simply does not meet the cost of the supervision they need. As part of the systemic deinstitutionalisation of mental health services there has been a steady transfer of older people with psychiatric problems from mental health services to aged care services, sometimes when they have very acute mental health problems but often with no transfer of funding and little ongoing support from the mental health services. If residential aged care facilities are to continue to accept these clients then they need to be funded to have the increased staffing that these clients need. Otherwise there are significant risks to the individual, other residents and staff at the facility.

The most efficient way to deal with this, in ACFI terms, would be to have a mental health supplement as any other approach would require a significant change to the ACFI which would have flow on effects on funding for other groups. In addition to increased funding there needs to be some commitment from mental health services to continue to provide professional support and services to mental health clients in the same way as they would to people living in the community.

Recommendation 4

A mental health care supplement be introduced and the Australian Government negotiate with the States and Territories to ensure there is adequate in-reach of their mental health services into residential care facilities to assist with the management of mental health conditions.

The second set of needs not currently being met is for palliative care. For most people residential care is their last place of residence and they either die in the facility or after being transferred to an acute hospital. Not everybody who dies needs specialist palliative care or additional support. However everybody in residential aged care when they reach the end of their life should be treated with a palliative approach and be able to die with dignity and this should be supported within the normal care parameters in the service.

There are a group who do need extra support and more specialised palliative care. These may be people who have lived in the facility for some time and have a condition which deteriorates and they need more care as their life ends. This includes people with dementia, so often ignored in discussions around palliative care; people with cancer; and people with other progressive diseases. Their continuing to stay in residential aged care is entirely appropriate as it is their home and palliative care should be available there as well as in the community.

Sometimes people are admitted to residential care already needing palliative care, often because there is no alternative in the area. They often also have problems with ADLs, sometimes related to their condition and sometimes not and so may score well on the ACFI but even with the highest ACFI rating the funding is still not sufficient to meet their needs. The ACFI simply does not provide sufficient funding for either the intensity or frequency of care required by some palliative care residents. It is very difficult to substantiate claims for palliative care under the current definition which is very restrictive in terms of diagnosis and has a very strong focus on pain management. This definition needs to be broadened and not be prescriptive in terms of what care is provided.

Palliative care also includes providing support for the family of the resident and the ACFI does not take this into account in any meaningful way. Carers often say that what they want is for somebody to spend some time with them, to explain what is happening and to help with their grief. This is often the most time consuming part of good palliative care and there needs to be funding available to allow staff to do this.

If residential aged care facilities are to continue to fill the gap for providing palliative care they need to be funded appropriately. A palliative care bed in a hospital or hospice/palliative care unit can cost anywhere between \$600 and \$1600 and a palliative care supplement needs to be substantial to make up some of the difference between that and the ACFI subsidy.

Recommendation 5

A palliative care supplement be introduced that is consistent with other payments for palliation and in addition the definition of palliative care be broadened to include the provision of family support, with the payment covering that as well.

6. Gaps or anomalies in the ACFI in relation to care needs

ACFI does not adequately deal with sub acute needs, particularly one-off or ad hoc needs like wound management or the onset of a temporary illness such as flu which requires short term increases in care. With the increasing trend to keep residents at home in their residential aged care facility and manage such conditions there it is important that there be some way of funding

this activity - otherwise there is an incentive for facilities to have residents admitted to hospital, which is not good for them nor for the health system and budget.

Recommendation 6

The Department of Health and Ageing investigate mechanisms for funding short term increases in care needs.

7. Proper recognition of the roles of care providers in relation to the delivery of care needs, including the role and scope of practice of enrolled nurses and allied health professionals.

The level of and mix of staffing is determined by the level of funding and the needs of the residents. As discussed in 1 above COTA believes that the level of subsidy attached to each ACFI category needs to be increased to maintain the capacity of providers to meet residents' needs. The role and scope of practice of various health professionals should not be determined by the ACFI but an appropriate skill mix would form part of the discussion round a benchmark of care that would in turn determine appropriate levels of subsidy.

8. The appropriateness of Schedule 1 of the *Quality of Care Principles 1997* ('specified care and services') in determining the services to be provided to residents of aged care facilities with differing levels of care needs

From a consumer perspective it is important it is clear as to what services a provider is supposed to give within the standard residential aged care service and price. The Schedule has attempted to do this in the past. It has not been updated since 1997 and its strong demarcation of low and high care is no longer relevant for the majority of services that provide a mixture of both types of care and have residents whose needs change quite markedly over time. Consumers often raise the issue that support outside of the narrow range in the Schedule can be hard to access. There is also a feeling that the current system is quite inequitable as those with different needs do not get "the same value for money" as they have to pay extra for support outside the Schedule and do not use some of the services that are on the Schedule.

Rather than the one size fits all approach of specified care and services of the Schedule there needs to be a mechanism for matching the support and care needs of the resident as identified by the ACFI with what facilities provide. This could be in the form of a negotiated agreement with a broader range of supports and services being in scope for that negotiation and the agreed services could change as an individual's needs change.

Recommendation 7

The current Schedule is reviewed to identify a broader group of support and care services that could be included in any individual resident's agreed package of care.

9. Options to improve agreement between the levels of approval granted to a resident by an Aged Care Assessment Team and the Approved Provider's appraisal of the care needs of the resident.

Consumers and providers both flagged this as a significant issue under the previous RCS and it has not been addressed by the introduction of the ACFI. The problem lies in when there is a difference between the ACAT and providers on whether the person is low or high care as this can impact on entry contributions and being able to access a facility that can meet the persons needs.

The problem stems in part from the fact the ACAT makes an assessment either in hospital in a post-acut context, or in the person's own home where there may not be appropriate support, and based on one or two meetings, whilst the provider uses the ACFI to assess over a period of time and when support is being given. Added to this is the fact that ACATs and providers use different needs assessment tools and the fact that the ACAT's determination is partly dependent on what services they know are available.

The solutions for this go beyond the ACFI and are probably more in scope for the Productivity Commission's Inquiry than this review.

However a useful first step would be for ACATs to use a modified version of the ACFI rather than their current assessment tools. It would also be necessary to change the ACAT approach to be an objective assessment of need rather than taking into account the availability of services

Recommendation 8

A modified version of the ACFI be developed and mandated for ACATs to use.

CONCLUSION

Overall COTA National believes that the ACFI has more closely aligned funding with care needs and so it has been effective in redistributing the funding towards those with higher needs.

What is overwhelmingly clear however is that the total funding available is not adequate to sustain good quality care, particularly given the increasing age, frailty and care needs of people entering residential aged care. COTA is hopeful that the proposed Productivity Commission Inquiry into Aged Care will address the need to increasing the level of subsidy across the board, rather than redistributing the existing pool, so that we can be sure that older people's needs can and will be fully and appropriately met when they move into residential aged care.

11 March 2010