RESPONSE TO HUMAN SERVICES INQUIRY ISSUES PAPER

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ATTRIBUTION

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ABOUT ACSA

Aged & Community Services Australia (ACSA) is the leading national peak body for aged and community care providers. It represents church, charitable and community-based organisations providing housing, residential care, community care and home support services to older people, younger people with a disability and their carers.

ACSA members provide care and support in metropolitan, regional, rural and remote regions across Australia.

The ACSA Federation is made up of the following members:

- Aged & Community Services NSW & ACT (ACS NSW&ACT);
- Aged & Community Services SA & NT (ACS SA&NT);
- Aged & Community Services Tasmania (ACS Tas);
- Aged & Community Services Western Australia (ACSWA);
- Aged & Community Services Australia - Victoria (ACSA Vic);
- Aged & Community Services Australia - Queensland (ACSA Qld).

Mission-based and other not-for-profit aged care organisations are responsible for providing services to those older Australians who are most in need. As at 30 June 2015 not-for-profit organisations delivered 57.1 per cent of residential aged care services and 81.6 per cent of home care packages in Australia.[1]

These organisations are visible and highly accessible in the community and as a result, the public relies on them for service, support and care. The broad scope of services provided by ACSA's membership and the leadership they display gives it unique insights into the challenges and opportunities that come with the ageing of the population.

[1] Based on Commonwealth of Australia (Department of Health) material (2015). '2014-15 Report on the Operation of the Aged Care Act 1997', Canberra, 49, 38.

INTRODUCTION

The aged care sector is currently undergoing a significant reform process to increase the role of competitive service provision. As such, the sector provides an interesting light on competition in human services – but is not, ACSA believes, a viable contender for further policy changes while the existing reforms are being worked through.

1. General Comments on the Issues Paper

ACSA believes that the Issues Paper has appropriately identified the key features of quality in human services; however, it is perhaps germane to note that defining or measuring quality involves moving into an inherently subjective area – the Commission may wish to consider how consumers' (subjective) views about service quality can be represented in generalised (objective) standards. While market demand and consumer behaviour can be taken as an indicator of consumers' views about service quality, the Issues Paper recognises that competition cannot always easily be applied to human services.

Implementation of competition reform is an important consideration – while the details of implementation may lie outside of the Commission's responsibility, the progress of implementation can impact on the outcomes of policy recommendations. An example from the aged care sector is the introduction of the MyAgedCare online gateway as the access point for the Australian Government aged care system; difficulties and delays in operationalising the system caused challenges for aged care providers, and raised concerns about difficulties in later stages of the reforms. The challenges of supporting a sector through a large change process should not be underestimated or overlooked – appropriate support and assistance in communicating with both consumers and providers can make a very large difference in acceptance of changes.

2. Competition reform in a context of policy change

Application of market forces is often combined with other policy objectives (such as reducing costs to government) – this can confuse both perceptions of competition and participants' responses. Introduction of activity-based funding (ABF) for public hospitals in Victoria is, perhaps, an example of this: the introduction of ABF was accompanied by an overall reduction in funding; the impact of ABF was often conflated with that of the funding reduction – leading to a negative view of ABF by some in the health system.

Given fiscal pressures on government, it is likely that any reforms to increase competition in human services will occur in an environment of reduced government funding; analysis and policy recommendations will be most effective if this context is borne in mind (including the potential for reform fatigue by service providers and consumers).

3. Limits to competitive service provision

The Issues Paper notes that some services are not suited to competition – in particular, the provision of aged care services in rural and remote areas may not lend itself to competitive provision. Low population density reduces demand, while costs are also higher – in short, it may not be a commercially-attractive undertaking and may not support a sufficient ecology of providers to ensure competition (many regional towns are effectively monopolies, but with limited scope for profit). The Paper refers to GPs as an example of a relatively competitive sector in human services; it is worth noting that rural/remote areas have had a chronic under-supply of GPs, highlighting the challenges of a competitive approach in these regions.

Residential aged care (in its current form of a bundled service) is unlikely to lend itself to competition – residents are mostly of low functional capacity and frequently with a diagnosis of dementia or other mental illness. In addition, their physical impairment often prevents them from accessing alternative options once they have entered a facility. Finally, the average length of stay is shortening – further limiting the opportunity for residents to change providers.

That said, the availability of multiple residential facilities can provide choice prior to entry – any reforms should ensure maintenance of a sufficient number of facilities to achieve competition.

4. Palliative Care Services

Palliative care services are currently provided through a number of avenues that do not, *in toto*, suggest an efficient outcome is being achieved. Palliative care is provided in hospitals, in hospices, and in residential aged care facilities (RACFs). Each of these service types is funded differently and faces different restrictions on its operations; barriers in shifting care recipients between different care types pose challenges in allowing individuals to access care in the most efficient fashion or in the way most closely aligned to their preferences.

Perhaps the most obvious example of inefficiency in the provision of palliative care services lies in the interaction of hospitals and RACFs. The cost of providing palliative care in hospitals significantly exceeds the cost in RACFs. However, hospitals are often unable to discharge palliative patients to an RACF; similarly, the current provisions of the Aged Care Funding Instrument (ACFI) raise significant financial challenges for an RACF in accepting a palliative patient. Most palliative patients will not reside in the RACF long enough for sufficient care information to be collected to allow an ACFI assessment; consequently, the RACF will receive limited short-term funding. Changes to funding rules, and to hospital discharge rules, to allow more palliative care to be provided in RACFs may increase consumer choice and service efficiency. The Appendix contains some key figures relating to palliative care in RACFs.

It should be noted that very few RACF residents enter hospital for palliative care; RACFs are building up significant expertise in the provision of non-acute palliative care. However, if funding is not adjusted to support this, it is not clear that existing care models will be sustainable. Conversely, with improved funding arrangements, RACFs may be able to offer increased palliative care services in future.

APPENDIX - PALLIATIVE CARE IN RESIDENTIAL AGED CARE FACILITIES – KEY FACTS

In what setting do people in Australia die?

1. 35% of all deaths in Australia occur from residential aged care facilities (RACFs); 50% in hospitals, and 15% in other settings (Swerissen and Duckett, 2011)

What is the cost of providing palliative care in these settings?

1. The average cost of an admission into hospital prior to death for a person aged 50 and over is $19,000. The average length of stay for such an episode is 12.5 days – an average daily cost of $1520 (Swerissen and Duckett, 2011).
2. In 2011, Australia spent approximately $2.6B on palliative care in hospitals (Swerissen and Duckett, 2011).
3. The average cost of a hospital bed in Australia is $1250 per day (AIHW, 2014)
4. The average daily cost of care in a RACF is $164; the maximum basic daily subsidy payable in 2016 is $211.40 (ACFA, 2015; Department of Social Services, 2015)
5. In 2014-15, the Australian Government spent approximately $10.5B on residential care subsidies in aged care facilities (Budget papers, 2015-16).

Where do people come from before a terminal hospital episode?

1. About a third of all deaths in hospital are a person's first admission (Swerissen and Duckett, 2011).
2. Of all residents of a RACF who were assessed as requiring palliative care, 7% had a period of hospital leave – compared with 20% of other RACF residents (AIHW, 2015)
3. 93% of separations from RACFs to hospital come from residents who are not assessed as requiring palliative care (AIHW, 2014). This reflects the provision of palliative care in RACFs – hospitalisation is a response to acute episodes that are not anticipated to be terminal.

Why do people leave RACFs?

1. 81% of all people leaving RACFs are through death, while another 10% are to a different RACF (meaning that 90% of all departures from the RACF system are through death). (AIHW, 2014)
2. This includes 96% of residents assessed as requiring palliative care, and 80% of other residents (AIHW, 2014).
3. Less than 2% of people leaving RACFs leave to be admitted to hospital (AIHW, 2014).

What does this mean?

1. Residential aged care is mostly palliative care – 81% of residents leave RACFs through death.
2. Almost all RACF residents assessed as requiring palliative care receive that care in the RACF – less than 1% of residents assessed as requiring palliative care are discharged into hospital.
3. The cost of providing palliative care in residential aged care is approximately 10% of the cost of providing palliative care in hospital.

What do we need from here?

1. In the short term, ACFI funding should be maintained – while RACFs are providing hospital care, current funding levels do not provide a sustainable basis for this service.
2. Recent cuts to the Complex Health Care domain of the ACFI undermine the ability of providers to deliver palliative care, and should be reversed.
3. The increasing numbers of older Australians mean that the number of people requiring palliative care will continue to increase.
4. In the longer term, there is a need for a strategy to support older people to receive palliative care in RACFs rather than in hospital. This will need to include an appropriate funding model.
5. Investigation of the viability of palliative care in a person's home (and appropriate funding models to support this) should be undertaken.

Sources

Aged Care Financing Authority (2015). 'Third Report on the Funding and Financing of the Aged Care Sector July 2015'

Australian Institute of Health and Welfare (2014), *Palliative Care in Australia 2014*.

Department of Social Services (2015). *Aged Care Subsidies and Supplements – New Rates of Payment from 20 September 2015*.

Swerissen, H. and Duckett, S. (2014). *Dying Well*. Grattan Institute.