CATHOLIC HEALTH
Australia

Catholic Health Australia

Initial Submission to the Productivity Commission Inquiry *Caring for Older Australians*

April 2010

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About Catholic Health Australia

21 public hospitals, 54 private hospitals, and 550 aged care services are operated by different bodies of the Catholic Church within Australia. These health and aged care services are operated in fulfilment of the mission of the Church to provide care and healing to all those who seek it. Catholic Health Australia is the peak member organization of these health and aged care services. Further detail on Catholic Health Australia can be obtained at www.cha.org.au.

Executive summary

Australia faces significant challenges in caring for its current and future generations of older people.

The more significant challenges include the quadrupling in the number of older people; higher consumer expectations concerning choice and responsiveness of services; the expected surge in the proportion of the frailer aged with more complex high care needs due to neurodegenerative and chronic conditions; and the need to attract, train and retain a growing skilled and flexible workforce as the number of older people needing care increases and the availability of informal carers declines.

Faced with these challenges and the current regulatory arrangements for the provision of aged care services, there is a growing concern among Catholic aged care providers about their capacity to continue to fulfil the Catholic Church's mission of care for older people.

This initial submission to the Productivity Commission's public inquiry into aged care draws on these concerns and the analysis of recent reports, and presents for the Commission's consideration a package of reforms to improve the responsiveness and sustainability of aged care services.

The reforms focus on:

- measures to increase consumer choice of aged care services and promote competition, flexibility and innovation in service provision by making aged care an entitlement based on assessed need, including flexibility to exercise the widely held preference of many to continue living in their own homes for as long as possible with the support of community services;

- securing the sustainability of aged care services by setting subsidies and prices based on the provision of flexible services in an open market and requiring those who can to contribute to the cost of their care and accommodation;

- ensuring access for **all** in need of care regardless of their ability to contribute to their cost of care, where they live or their special needs;

- more widespread use of independence and wellness models of care; and

- an expansion of related health services, such as sub acute and restorative services, respite services, community-based palliative care and primary care services, to support aged care and to take the pressure off inappropriate and costly hospital and emergency department services.

In summary, the reform measures proposed include:

- Funding individuals eligible for assistance under the *Aged Care Act 1997* as an entitlement based on assessed needs and allow people the option to choose what mix of services they receive, which accredited provider delivers the services and where they are received.

- Aligning care fees and subsidies for people receiving care in their own home with those applying in residential care for people with similar care needs in order to allow fair and equitable choice.

- Basing care subsidies and fees on independent periodic reviews of the cost of care and support provided in a less controlled supply environment against benchmarks of care.

- Funding accredited providers of home and community care services for the less frail aged on a per capita basis based upon the number of people assessed as eligible for these services who choose each provider for their services; adjusting accountability arrangements to promote and support the adoption of an independence model of care designed to achieve early intervention and prevention and thereby reduce the need for ongoing support.

- Implementation of the National Health and Hospitals Reform Commission's recommendations to increase the provision of inpatient and community-based sub acute and restorative services and to improve community-based palliative care services.

- Replace the current Aged Care Assessment Team structures and information services such as Commonwealth Carelink and Access Points Demonstration Pilots with a Commonwealth funded and administered national network of access and information centres (or 'one stop shops') to provide a fair, consistent and timely assessment and information service and common entry point for all aged care services.

These reforms entail a very significant change to current aged care arrangements and need to be carefully implemented. A precipitous move to increase consumer choice in how older people use aged care services would pose a risk to the continuity of existing services as there is a high probability that the current regulated balance of care ratios which determine the proportions of residential low and high care places and community care places provided by the sector will not align with consumer preferences.

In order to manage these risks to continuity of service for vulnerable people, it is essential that the implementation of the reforms be accompanied by transition arrangements for the phased introduction of greater choice which would allow a reasonable period for adjustment and clear timelines and milestones. These arrangements should be developed in consultation with consumers and providers.

Given the inherent vulnerability of many people in older age, it is also essential that during the reform process careful attention is paid to maintaining cost-effective consumer protection arrangements.

Timely and coordinated implementation of these reforms would also be helped if they were managed by one level of government. This would allow policy integration around consumer choice, assessment and eligibility, subsidy and fee policies, and accountability, reporting and quality assurance arrangements across the full spectrum of aged care services.

A number of the above reform measures are proposed in *More Support for Older Australians*, a component of the Commonwealth's National Health and Hospitals Network reforms. These include assumption by the Commonwealth of full policy and funding responsibility for all aged care (including Home and Community Care); the establishment of 'one stop shops' to enable easier access to information and assessment for aged care services; and the introduction of Consumer Directed Care packages. It is essential that the Commonwealth is supported in moving quickly to implement these changes.

Introduction

This document presents Catholic Health Australia's initial submission on the reforms needed to secure affordable and sustainable high quality aged care services for ***all*** older Australians which are more responsive to each older person's care and support needs.

Catholic Health Australia (CHA) members are major not-for-profit providers of aged care services in Australia. These services are provided in fulfilment of the Catholic Church's mission to provide care and healing for those who seek it.

Catholic aged care services care for up to 19,000 older people in aged care homes across Australia each night, and help up to 14,000 older people continue living at home with care and support services provided through community care packages and the Home and Community Care program.

There is growing concern amongst Catholic Health Australia members, however, about their capacity to continue fulfilling their mission of care for older people in the community in the years ahead.

2. Background

Reform of aged care cannot be considered in isolation of the wider health and hospital system in Australia. This was clearly recognized by the Commonwealth in *A National Health and Hospitals Network: Further Investments in Australia's Health*. The challenges faced by Australia in caring for its older people are also equally relevant to residential and community aged care services, and their interaction will have implications for how well the needs of older people are served.

2.1 The reform debate to date

The challenges faced with the provision of aged care have been well documented in recent Reports. [1] The most significant challenges include:

[1] Report of the Review of Pricing Arrangements in Residential Aged Care (W P Hogan, April 2004)

The Future of Community Care (The Allen consulting Group, March 2007)

Trends in Aged Care Services: Some Implications (Productivity Commission Research Paper, September 2008)

Residential and Community Aged Care in Australia (Report of the Senate Standing Committee of Finance and Administration, April 2009)

A Healthier Future for All Australians (National Health and Hospitals Reform Commission, June 2009)

Review of Regulatory Burdens: Social and Economic Infrastructure Services (Productivity Commission, September 2009)

Leading the Way: Our Vision for Support and Care of Older Australians (National Aged Care Alliance, September 2009)

- a huge increase in demand for aged care services, with the number of people aged 85 and over projected to quadruple over the next 40 years to 1.4million, and the number of people over 65 projected to increase by 4.4million over the same period to 7.1million;

- the higher expectations of the current and future generations for choice, responsiveness, and flexibility in how they access and use aged care services, including a preference for independent living arrangements supported by community care;

- a surge in the number of people living with dementia and other neurodegenerative conditions, and the increasing prevalence of chronic disease among the aged, which are expected to increase the proportion of frail aged with more complex high care needs and the proportion of older people living with co-morbidities;

- the need to attract, train and retain a growing number of skilled carers as the number of older people needing care increases and the availability of informal carers declines;

- continued dependence of the overwhelming majority of older Australians on the age pension to support basic living standards and Government funding for their care needs, with life time savings for the majority being in the form of home ownership; and

- an ongoing need for services for groups with special needs, including older homeless people and older people with psycho-geriatric conditions.

The Reports also canvass a range of reforms to address these challenges. The reforms include specific recommendations for change by the National Health and Hospitals Reform Commission as well as calls for consideration, with varying degrees of emphasis, of a range of reforms proposed by the Productivity Commission, the Senate Standing Committee on Finance and Public Administration (Senate Committee), The Allen Consulting Group and the Review of Pricing Arrangements in Residential Aged Care (Hogan Review).

The major reform directions include:

- Ensuring greater choice and responsiveness in how people use aged care services by:

    - directly funding frail aged people according to assessed needs rather than aged care places (NHHRC);

    - developing a more flexible range of care subsidies for people receiving community care packages determined in a way which is compatible with subsidies for care provided in residential facilities (NHHRC);

    - funding services for the less frail aged on a per capita basis (The Allen Consulting Group); and

    - allowing service providers greater flexibility by lifting the current restrictions on the services they may offer (NHHRC, Productivity Commission and Allen Consulting Group).

- Achieving the most effective use of public monies through more choice and competition while protecting those older people who are most in need, including older people with fewer means (NHHRC, Productivity Commission and Hogan Review).

- Reducing the regulatory burden on the aged care sector by tackling the underlying policy framework that stifles competition (Productivity Commission).

- Securing the viability of aged care services by:

    - allowing more flexible payment arrangements in high care as a source of capital funding (NHHRC and Productivity Commission);

    - periodic review of care subsidies to ensure that they are adequate to meet the care needs of the very frail aged in residential care (NHHRC) and establishing a benchmark of care (Productivity Commission and Senate Committee); and

    - establishing a nationally consistent methodological approach to gathering data for researching the financial status of the residential and community aged care sectors (Senate Committee).

- Expanding community aged care funding and services to meet growing demand and expected quality service provision outcomes (Senate Committee).

- Consider dispensing with the planning and allocation system for frail aged care and rely on an entitlement for aged care services established by ACATs, and free up supply constraints in the provision of aged care services (Productivity Commission, Hogan Review).

- Taking a client-centred approach to community (and residential) aged care to ensure that the system is client-focused, and consider options to enable greater flexibility in relation to payments and services directed at providing a client-centred aged care system (Senate Committee).

- Expanding the independence model of care supported by appropriate use of care coordination, and shifting the emphasis of community care funding arrangements from inputs to client outcomes by giving service providers greater flexibility about how they can provide services (The Allen consulting Group).

- Consider options for consumer directed care and expanding the opportunity for people supported in the community to determine how the resources allocated for their care are used (NHHRC, Productivity Commission, The Allen Consulting Group).

- Better information for older people and their families on the availability and quality of aged care services and how to access these services (NHHRC, Productivity Commission, The Allen Consulting Group, Hogan Review).

- Consolidating aged care under the Commonwealth by making aged care under the HACC program a direct Commonwealth program (NHHRC).

- Developing and introducing streamlined and consistent assessment for eligibility across all aged care by transferring ACATs to the Commonwealth, developing new assessment tools and

integrating assessment for HACC with assessment for higher levels of residential and community care (NHHRC), and affirming ACATs as a single nationally consistent program which genuinely serves as a single entry point for aged care services (Senate Committee).

- Setting clear targets to increase the provision of both inpatient and community-based sub acute and restorative services to reduce the number of people accommodated inappropriately in acute hospitals and reducing the need for residential care by maintaining or increasing people's independence (NHHRC).

There is coherence in the reform directions in these Reports which, together, would take the provision of aged care and support to a new level focused on quality, responsive, flexible and client-centred care.

It is widely acknowledged, however, that successful ageing also requires complementary policies at all levels of Government and age-friendly community attitudes. While the above reform directions focus on the delivery of aged care services, successful ageing will also require policy development in areas such as retirement incomes, health, transport, housing provision and design and urban design. All of these factors bear on the welfare of older people, especially those with fewer means.

2.2 The reform experience to date

It would be incorrect to proceed with a mindset that aged care policy development has been standing still in recent decades. Responding to a population which has already aged significantly, and enabled by increasing national and personal wealth, changes have been made to increase the accessibility and quality of aged care services.

These changes include an increase in the availability of aged care places through a gradual increase in the provision ratio; the introduction and expansion of a wider range of services such as community care packages, respite services and dementia-specific services; greater attention to quality through an accreditation system, a national complaints handling mechanism and building standards; and greater integration through mechanisms such as 'ageing in place' and integration of care subsidy arrangements for residential low and high care.

However all of these changes have been made within a regulatory framework largely driven by the Commonwealth's over arching policy objective of managing fiscal risk by rationing the supply of subsidised services.

As a consequence, while the Commonwealth has had budget certainty, it has come at a considerable cost to those Australians needing aged care and their carers, including:

- a lack of individual choice and control over aged care services, where they are received and who delivers them;
- gaps in services and lack of flexibility;
- reduced capacity and incentives for service innovation and responsiveness;
- inefficient and sub optimal service delivery, including an increase in consumer complaints;

- under-investment in aged care with implications for the capacity of service providers to compete for skilled staff and raise capital for service expansion and renewal, especially residential high care;

- high regulatory and administrative costs to protect consumers in an environment of limited competition, the necessity for which is created by the regulated scarcity of services;

- over reliance on compliance and sanction activity to drive minimum standards which in turn feeds negative stereotypes of aged care in the community and the workforce;

- a large bureaucracy to administer a web of regulations for planning and administering the supply and distribution of aged care services (including service types) and the allocation of aged care places to approved providers; and

- older people inappropriately accommodated in costly hospitals and unnecessary presentations to emergency departments.

Nevertheless, many of the policy changes to date have helped pave the way for the next generation of reform in response to the further ageing of the population and increasing demand, rising consumer expectations and changing needs, and increasing national wealth.

In this regard, a number of the aged care measures foreshadowed by the Commonwealth in the context of the National Health and Hospitals Network are further essential steps towards improving aged care service standards. In particular:

- assumption by the Commonwealth of full responsibility for all aged care services;

- the establishment of 'one stop shops' to enable easier access to information and assessment services for aged care and consistent eligibility assessment;

- the provision of Commonwealth capital for the expansion of multi-purpose services in areas of market failure;

- the introduction for the first time of Consumer Directed Care packages; and

- enhanced prudential requirements to protect resident accommodation bonds.

The Productivity Commission inquiry presents the opportunity to build on the reforms to date and take the provision of aged care services in Australia to a new level.

Drawing on the research and analysis available in the above Reports, the views of its membership and the reforms already foreshadowed by the Commonwealth, Catholic Health Australia recommends the following package of reforms for consideration by the Commission to improve the provision of aged care services.

3. Reform directions for aged care

3.1 Increasing consumer choice, flexibility and access

There is a need to change the current highly regulated arrangements for the provision of aged care services in response to the higher expectations of current and future generations for choice, responsiveness and flexibility in the way they use aged care services, including choice over what services they receive, which accredited provider delivers the services and where they are received.

The changes should encompass the ability for older people to exercise the widely held preference to continue living in their own homes for as long as possible with the support of community care.

Increasing the supply and flexibility of aged care service provision to support consumer choice would also encourage greater innovation and competition in service delivery, including greater innovation in the development of 'age appropriate' housing options for older people so that they are better placed to exercise the choice to remain living in their own home for as long as possible.

Changes to current arrangements along the following lines are recommended in order to make the provision of aged care services for the frailer aged more responsive to community preferences and more accessible.

RECOMMENDATION

For the frailer aged:

a) **Funding be provided to individuals eligible for assistance under the *Aged Care Act 1997* as an entitlement based on assessed needs, rather than funding places according to a quota, and allow care recipients and their families choice over what mix of services they receive, which accredited provider delivers the services and where they are received.**

b) **The current restrictions on the services providers may offer be lifted.**

c) **Clearly separate fees and subsidies for care and accommodation and hotel services in residential care so that choices about each are as far as possible independent of each other, thereby enabling more options and choice over both services and where services are received (as well as providing an incentive for the development of innovative housing options for older people, including community housing options for the large number of pensioner renters).**

d) **Align care fees and subsidies for people receiving care in their own home with those applying in residential care for people with similar care needs in order to help the exercise of equitable and free choice over where care and support is received, including the option to continue to receive care in the community as a person's care needs change.**

e) **People in receipt of community care be allowed the option to determine how the resources allocated for their care and support are used.**

f) **An appropriate suite of quality of care and quality of life indicators be developed to help older people and their carers /families choose services that meet their needs.**

With regard to the less frail aged, allocating funding to each individual as an entitlement based on assessed needs would be complex to administer centrally at this time given the large number of potential clients in this group and the variation in the nature and intensity of services needed.

However, a feature of the current funding arrangements for this group is that providers are limited to providing only those service types for which they have obtained funding by tender, which constrains their flexibility to tailor services to the needs of each care recipient and carer. Understandably, such arrangements tend to encourage a service delivery and reporting mindset focused on inputs rather than client outcomes, and is not conducive to innovation in service delivery and workforce flexibility to optimize client outcomes.[2]

The current arrangements also mean that some care recipients need to access services from a number of providers. The current funding arrangements also support a large and expensive bureaucracy in each State to plan and administer the distribution and allocation of service types amongst some 3,300 agencies across all regions of Australia.

An alternative and potentially more efficient funding arrangement which would be more amenable to a client-centred approach is to shift the emphasis from inputs to client outcomes by giving providers greater flexibility over how they provide services, giving consumers a choice as to which organization provides their care, and making providers more accountable in terms of client outcomes.

Such arrangements could also be seen as a step towards introducing over time individualized entitlement funding for the less frail aged.

RECOMMENDATION

For the less frail aged:

a) **Individuals assessed as in need of community care would become eligible to receive community care and support services and to enrol with an accredited community care provider of their choice to receive their care services.**

b) **Each accredited community care provider would receive funding on a per capita basis for each client who chooses to enrol in their service. The per capita amount could be reviewed to reflect the profile of each provider's client group (including, for example, the degree of rurality and cultural diversity of the client profile and client capacity to contribute towards the cost of their care and support).**

[2] It is noted that under the National Health and Hospitals Network proposals, responsibility for care and support of younger people with long term care needs (i.e. people under 65) would be transferred to the States and administered under the National Disability Agreement.

3.2 Properly funded and sustainable aged care services

There is currently no objective basis for setting prices and subsidy levels for the provision of aged care and accommodation under the *Aged Care Act 1997*, including meeting the competitive remuneration needed to attract and retain the skilled staff that will be required to care for the increasing number of older people with more complex high care needs. Nor are there benchmarks of care to guide the setting of prices.

Revenue to cover the cost of **living expenses** in residential care (the *basic daily fee*) is linked to a percentage of the single basic pension which is designed to support a basic standard of living for older people supporting themselves in their own homes. All residents of aged care homes, pensioners and non pensioners, are required to contribute the same towards their living expenses.

The current prices and subsidies for **care and support** in residential care (the *basic care subsidy*), as embodied in the ACFI scales and income tested fees, are historically based and are subject to minimum wage adjustments under Commonwealth Own Purpose Outlays arrangements (Wage Cost Index 9). The latter assumes that wages in all sectors are offset by productivity gains and uses the flawed assumption that the aged care sector has the same ongoing capacity as all other sectors to achieve productivity gains through labour substitution. [3] The report of the Review of the Conditional Adjustment Payment (2009) which examined productivity trends in the aged care sector has never been released by the Commonwealth.

The basis for setting **accommodation** subsidies and prices (aside from bonds in low care and Extra Service which are negotiated between the provider and the asset tested resident) is also uncertain. Access Economics has demonstrated, however, that the current prices are inadequate to support new investment in high care residential services built to contemporary standards, putting in jeopardy the sector's capacity to meet the expected significantly expanded need for these services.[4]

The current subsidies for **community care** and support for the frailer aged under the *Aged Care Act 1997* were initially set having regard to mid points in the former Resident Classification Scale for residential care, but have since only had the benefit of minimum wage adjustments (COPO). Residential care, on the other hand, has also received the Conditional Adjustment Payment which has increased care subsidies by 8.75% on top of COPO indexation (1.75% annually over five years). As a consequence of this approach, industry surveys (Stewart Brown) show that average hours of care and support per person in community care have been gradually declining.

As indicated earlier, one approach to setting subsidies for community care for the frailer aged is to link the amount to that applying in residential care for people with similar assessed care needs. This approach is premised on the likely Commonwealth view that it would not wish to pay more for an individual's care in the community than it would cost to care for that person in an aged care home.

Introducing more consumer choice into future arrangements as proposed earlier in this paper would not only improve the flexibility, quality and responsiveness of services, but would also introduce greater competition and provide a more evidence-based and transparent basis for assessing comparative performance and for setting care fees and subsidies in aged care.

As discussed in Section 3.1 above, the separation of aged care costs between care and support, accommodation and living expenses is an important enabler for policies designed to give older people and their carers greater choice as to where they receive their care. Such a categorization of costs is also useful

[3] COPO indexation was supplemented for five years by the Conditional Adjustment Payment (1.75% annual increment), but indexation reverted to COPO after the 2010 Budget.
[4] Economic Evaluation of Capital Financing of High Care (Access Economics, March 2009).

for developing policies on personal contributions towards the costs of aged care. In this regard, a strong case can be advanced that older people who choose to receive their care in an aged care home, and who have the capacity to pay, should continue to meet their accommodation and living expenses (with the latter supported by the pension system for eligible people). However, because the life time savings of many Australians is in the form of home ownership, flexible payment arrangements will be necessary to cater for individual circumstances.

On the other hand, Medicare provides a precedent for the community meeting all or most of care costs, noting that an individual's aged care needs are unpredictable.

The following recommendations are intended to replace the current ad hoc arrangements for setting aged care subsidies and prices by creating a more objective basis for setting subsidies and fees, and providing a sounder public policy basis for personal contributions to aged care costs.

RECOMMENDATION

It is recommended that the following arrangements be implemented to provide a more objective basis for setting care subsidies and fees for the frailer aged and accommodation payments:

a) Special Purpose Financial Reports or equivalent be developed which would allow the collection of comprehensive and audited national comparative financial data and independent analysis of the financial performance of the aged care sector.

b) The Productivity Commission undertake an initial independent review of the cost of aged care and support (including the cost of caring for people with special needs such as people living with dementia, people with psycho geriatric and challenging behaviours and people needing palliative care) to ensure that current care prices are based on contemporary care practices and standards, having regard to benchmarks of care.

c) Independent periodic reviews of the cost of aged care and support be undertaken to inform the periodic rebasing of the basic care subsidy. This role would be analogous to the activity based costing to be undertaken by the proposed Independent Hospital Pricing Authority for the National Health and Hospitals Network.

d) The high care accommodation supplement and accommodation charge be increased to a level which would allow high care service development to generate at least a breakeven net present value (NPV) or an internal rate of return (IRR) greater than the weighted cost of capital (WAAC).

e) Once the removal of controls on what services aged care providers can offer has resulted in sufficient increased competition in supply and price, introduce more flexible high care accommodation payment arrangements, including the choice of an accommodation charge (rent), a refundable lump sum, deferred payments such as a charge against the resident's estate or the purchase of an annuity, or some combination of these, and extend these arrangements to residential low care.

f) In order to facilitate a deferred payment option, introduce a Government sponsored deferred payment scheme.

g) Care subsidies and fees in community care be aligned to those in residential care for those assessed with similar care needs.

The indexation of funding for care and support provided for the less frail aged under HACC has also been based on COPO, but with a 6% additional annual real increase over the last decade to meet unmet need. As HACC is not based on individualized funding, a more practical option may be to develop more appropriate cost indexation arrangements which more closely reflect cost pressures in the sector.

Such an indexation approach could also be used for a per capita funding model for the less frail aged.

RECOMMENDATION

It is recommended that a cost index which more appropriately reflects cost pressures in the delivery of HACC services be identified or developed.

3.3 Independence and wellness

The current focus of community service provision in aged care is to respond to client dependency needs, with the primary objective being to provide basic maintenance and support.

An emerging trend in community care service delivery is to place more emphasis on promoting and enhancing the independence of clients, often referred to as the 'independence model' of care. This model does not deny the continuing need for services directed at support and maintenance, but in addition includes a commitment to early intervention and prevention for certain assessed clients to promote independence and thereby reduce the need for ongoing support in the future.

More widespread use of the independence model would be helped by the adoption of the per capita funding model for the less frail aged outlined above. Under this model, service providers would have the flexibility to tailor services around the needs of individual care recipients and carers, rather than be restricted to the provision of certain specific service types. This flexibility would extend to making appropriate use of care coordination to support the tailoring of services to the individual.

The increase in flexibility would also provide a better platform for negotiating partnerships and protocols with other health care service providers, such as the proposed Local Hospital Networks and Primary Health Care Organizations, as community care providers would be better placed to respond in a timely and responsive way, and with greater certainty.

As further encouragement of a service model which seeks to reduce dependency, community care providers would be required to report on performance in reducing dependence, rather than only accounting for the outputs of each service type regardless of outcomes for the client.

RECOMMENDATION

It is recommended that the per capita funding model proposed for the less frail aged should incorporate the independence model of care.

3.4 Special needs groups and market failure

There will be a continuing need for Commonwealth Government support to ensure that people with special needs and/or fewer means continue to have access to high quality aged care services and to address areas of market failure.

RECOMMENDATION

It is recommended that:

a) **The accommodation supplement for people with fewer means be set as a percentage of the accommodation charge to ensure access and to avoid systemic and pronounced disparities in building amenity (noting that variations in amenity already exist).**

b) **Measures and incentives to ensure access for concessional residents, including concessional ratios be continued, but with the option for the latter to be applied on either a portfolio or individual service basis.**

c) **Capital grants programs for the development of services for special needs groups with fewer means and viability supplements for small rural services be continued, with an option for contracting out service delivery for services built with Commonwealth capital grants.**

d) **Multi-Purpose Services in small communities be expanded with the assistance of Commonwealth capital grants, with service delivery managed by Local Hospital Networks.**

3.5 Assessment and information

There is a need for a single integrated aged care assessment service regardless of the level of care for which people are assessed which achieves timely, consistent and equitable outcomes, simplifies access to services and ensures that subsidies are directed to those in need.

Accountability for assessments by ACATs for the frailer aged is currently spread across levels of Government, and statutory authorities in some States, which hinders consistency and fairness in eligibility assessments and effective performance management. Assessment processes can also vary across programs and creates confusion and duplicated assessments for care recipients, with assessment for eligibility for services for the less frail aged residing with each service provider.

As noted earlier, there is also the need for easily accessible and understood information and guidance for older people and their carers about how to access services, and about their availability and quality.

The recently announced reforms to create a National Health and Hospitals Network include a proposal to create ‘one stop shops’ which would seem to incorporate many of the above features.

RECOMMENDATION

The following reforms to the current assessment arrangements are recommended:

a) A Commonwealth funded and administered national network of access and information centres (one stop shops) be established to provide an integrated assessment service and common entry point to:

i. ensure that eligibility is determined fairly, consistently and quickly;

ii. simplify access to services for the community;

iii. support consumer choice by providing comprehensive, consistent and accurate information on available services and quality and eligibility; and

iv. manage the Commonwealth's fiscal risk by ensuring consistent and accurate eligibility assessment to ensure that only those in need gain access to subsidised services.

b) The network would incorporate the Commonwealth's delegate with responsibility for determining eligibility, as well as existing information services such as Commonwealth Carelink, the Access Points Demonstration Pilots and the *Agedcare* Australia web based information service. The delegate would have the capacity to contract with third parties for assessment services for the frailer aged whose assessment may require increased clinical input.

3.6 Consumer protections

The reform proposals in this submission represent a significant change to current arrangements. Because of the inherent vulnerability of many people in older age, it will be essential throughout the implementation phase that careful attention is given to maintaining effective consumer protection arrangements.

3.7 Expansion of related services to support aged care

Effective care for older people, including allowing older people and their families greater choice to receive their care in their own homes, needs to be accompanied by increased investment in a range of related services, including sub acute and restorative care, palliative care and respite services.

This investment would reduce the risk of community aged care being used to compensate for a lack of appropriate clinical intervention, or failing as a result of unreasonable expectations being placed on informal carers, or from services not being equipped to manage more complex care needs.

An expansion of these related support services is also necessary to reduce the use of more costly hospital and emergency services. This was recognized in the recent proposals for a National Health and Hospitals

Network which included provision for sub acute care packages, including for rehabilitation, palliative care and mental health.

3.7.1 Sub acute and restorative care

The importance of additional funding to increase sub acute and restorative services was explicitly recognized by the National Health and Hospitals Reform Commission (NHHRC) which recommended clear targets to increase the provision of sub acute services to cover both in patient and community based services.

This would ensure that older people receive adequate rehabilitation after an acute episode or restorative care while living in the community to support independent living and avoid unnecessary use of hospital and emergency department services, or premature entry into residential care.

The expansion of rehabilitation services should include an expansion of the community based Day Therapy Centres so that they are easily accessible by older people living in all regions of Australia. The current distribution of Centres is very uneven across Australia, with older people in South Australia having the best access.

RECOMMENDATION

It is recommended that:

a) **The provision of inpatient and community-based sub acute and restorative services be increased and include slow stream rehabilitation.**

b) **The number of Day Therapy Centres be increased to allow access in all regions of Australia.**

3.7.2 Palliative and end of life care

An expansion of aged care services for older people with chronic conditions will need to be complemented by an expansion of the capacity and competence of primary health care services to provide generalist palliative care for people living in the community and in aged care homes, supported by increased collaboration and networking with increased specialist palliative care services.

This need was also recognized by the National Health and Hospitals Reform Commission which recommended the expansion of the capacity of primary care to deliver palliative care services, and additional investment in specialist care services to support people living at home or in residential care.

Approaching the end of life, whether through palliative care or longevity, brings up both existential and spiritual issues for older people and their families. To ensure that these needs are appropriately attended to, there is a case for the provision of such services to be explicitly provided for as a cost component of care subsidies.

RECOMMENDATION

It is recommended that:

a) **The Productivity Commission incorporates in its report the NHHRC's recommendations to improve palliative care services in community settings.**

b) **Pastoral care be recognized as a distinct component in cost of care benchmarks.**

3.7.3 Respite services

At present, a substantial proportion of the care and support for older people living in the community is provided by informal carers, especially women family carers. They perform a demanding and stressful role and are integral to the community care framework by reducing the demands on formal care.

However, it is expected that changes in family structures, participation of women in the workforce, workforce shortages and the ageing of the population will combine to reduce the availability of informal carers to support older people living at home with the assistance of community care.

Because of the dependence of community care on informal carers and the above pressures on informal carers, more effective support to help available carers maintain their caring role will need to be a key element of future aged care arrangements.

To this end, reform of community aged care services needs to be accompanied by a significant expansion of more flexible respite services, both centre-based and emergency respite, which can most effectively support each carer and cater for the needs of each care recipient. There is also the opportunity to make more widespread use of a wellness approach in centre based care designed to improve the capacity of older people to live more independently, with fewer demands on their carers.

RECOMMENDATION

That the Productivity Commission recommends an increase in the availability of more flexible respite services to cater for individual circumstances, including allowing recipients of community care packages to use their care entitlement to purchase respite care.

3.8 Workforce

3.8.1 Workforce attraction

The capacity to offer competitive salaries is crucial to the sector's ability to attract and retain the expanding workforce that will be needed because of the growing number of older people and the expected decline in the availability of informal carers.

The reforms recommended to address the viability of aged care services should improve the capacity of service providers to offer more competitive salaries. The proposals to increase consumer choice,

responsiveness and innovation, and the overall quality of aged care services, should also improve community perceptions of aged care and its attractiveness for prospective employees.

3.8.2 Workforce supply and flexibility

As well as the measures recommended to address the viability and responsiveness of community aged care services, there is a need to ensure that there will be sufficient skilled staff to meet growing demand, including to manage the anticipated increased acuity and diversity of aged care needs. Without close attention to workforce supply issues, the sector and the Commonwealth (as the primary funder of the system) will face significant wage cost pressures.

In this regard, there is an important role to be played by the newly established Health Workforce Australia in gaining a better understanding of the projected demand for aged care staff and skill needs to inform the planning of future training place numbers.

As highlighted in the National Health Workforce Taskforce discussion paper, *Workforce innovation and reform: Caring for older people (2008)*, there is a need for workforce planning in aged care to be consumer focused, closely aligned with service delivery plans, multidisciplinary and holistic in its approach to addressing workforce issues. This will require new approaches such as strategies to overcome barriers to increased collaboration and teamwork across disciplines and extending existing roles and scope of practices to provide greater workforce flexibility.

The greater use of assistant roles such as Allied Health Assistants, working under the direction of an allied health professional, would be a particularly effective way of increasing workforce flexibility. Applied in community care, Allied Health Assistants would be an effective means of providing a wide range of services in the home focused on the restoration of function to improve or maintain a client's capacity to stay independent for as long as possible.

Many aged care providers continue to report difficulties in securing GP services for their residents. As well as increasing the supply of GPs, other options to improve primary care services for aged care residents include making greater use of nurse practitioners and recognizing the cost of GP support services incurred by aged care providers, including dedicated and equipped visiting rooms, IT support, managing appointments and the provision of a nurse to accompany the GP to support continuity of care.

Consideration also needs to be given to augmenting the local workforce by sourcing suitable staff from overseas, including staff who could receive further training in Australia.

Nevertheless, as aged care is a relatively small sub set of the wider health and hospital care system, workforce supply policies and dynamics in the overall health and hospitals sector will have a significant bearing on workforce supply and wage cost pressures in aged care.

3.8.3 Informal carers

While it is expected that changes in family structures and participation of women in the workforce will constrain the availability of informal carers to support community aged care, it will nevertheless be necessary to provide support to help available carers, many of whom themselves will be older, to maintain their caring role.

Services to help informal carers will need to include education and information services about effective care techniques and strategies, as well as accessible respite services and income support to offset the cost of caring.

RECOMMENDATION

It is recommended that:

a) Health Workforce Australia be required to undertake, as part of its periodic analysis of projected health workforce needs, an analysis and projection of workforce needs of the aged care sector to inform planning for future training places and strategies to increase workforce flexibility.

b) **Incentives for and barriers to increasing the supply of Allied Health Assistants and Nurse Practitioners be addressed.**

c) **The costs of providing support services for visiting GPs in aged care homes be explicitly recognized in cost of care benchmarking.**

d) **Services to support informal carers be enhanced, including education and information services about effective care strategies, respite services and income support to offset the cost of caring.**

4. Transition arrangements

The proposals in this submission involve a very significant relaxation of the current regulatory arrangements governing the provision of aged care services. As a result, their implementation, if not carefully managed, could pose risks to the continuity of care for aged care recipients.

Most obviously, a major risk would arise because there is a high probability that the current regulated balance of care ratios which stipulate the proportions of residential low and high care places and community care places provided in the sector will not align with community preferences. There is also the need to put in place risk mitigating and reform-enabling changes before any significant relaxation of regulations can occur.

In order to manage the risks to continuity of care for vulnerable people and allow the sector the capacity and time to adjust to the new arrangements, it is essential that the implementation of the reforms be accompanied by well publicized transition arrangements which phase in the reforms.

The phasing of the reforms should:

a) provide an opportunity for a gradual re-alignment of the balance of care types in favour of community care before the overall provision target is removed;

b) maintain controls over accommodation payments until the market has deepened; and

c) allow time for the implementation of other risk mitigating and reform-enabling changes before supply and demand controls are lifted.

4.1 Achieving a gradual re alignment in favour of community care

A gradual adjustment in the balance of care of care types within an overall provision target could be achieved by:

- Extending beyond 2011 the current gradual increase in the supply of community care places (noting that there will still be growth in the number of people for whom residential high care is most appropriate).
- Allowing providers to convert residential low care places to either community care or residential high care to enable restructuring (noting the need to redevelop ageing hostel-type infrastructure so that it can cater flexibly for low or high care).
- Allowing community care recipients to move to higher care subsidy levels as their care needs increase, without having to change provider or move to an aged care home.
- Early introduction and progressive expansion of consumer directed care packages.

4.2 Accommodation payments

In order to guard against the risk of exploitation of the frail aged during the transition period, there is a case for not introducing full flexibility around accommodation payments for those with a capacity to contribute towards their accommodation costs until the market has deepened sufficiently to support competition in supply and price.

In the meantime, there is a need to improve access to capital to allow the development and renewal of aged care homes for high care residents to meet increasing demand. Given the long lead times for planning, design, development approval and construction, the development of new services cannot be allowed to stall. In this regard, the transition period should be used to achieve the following:

- An increase in the accommodation charge (rent) in high care to a level which would allow new high care service development to generate at least a breakeven net present value (NPV) or an internal rate of return (IRR) greater than the weighted cost of capital (WAAC). Going forward, the accommodation supplement should be set at 80% of the accommodation charge.
- Greater flexibility in accommodation payments in high care to include early introduction of deferred payment mechanisms and the option for people to pay a fully refundable deposit if it suits their financial circumstances. A cap on the accommodation charge and the increasing capacity to choose community care should provide a moderating influence on the size of lump sum deposits.
- Once the market has deepened (perhaps this could be a region specific decision), removal of the price caps on accommodation charges and extension of the more flexible arrangements to residential low care.

4.3 Other risk mitigating and reform-enabling changes

There are a number of changes that need to be put in place before supply controls can be lifted completely in order to protect the consumer and manage the Commonwealth's fiscal risk. The major changes include:

- Establishing the national network of 'one stop shops' to support easier access and the exercise of choice, including the development of quality indicators, and to ensure that care subsidies are directed to those in need.

- Aligning care subsidies and fees between community care and residential care to facilitate equitable exercise of choice.

- Completion of a cost of care study to allow a rebasing of the ACFI to reflect contemporary standards and care practices, and the development of Special Purpose Financial Reports or their equivalent to support periodic independent cost of care studies in the future. Pending a rebasing of the ACFI, the Conditional Adjustment Payment should be restored and extended to community care.

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