HammondCare
An independent Christian charity

Submission to the Productivity Commission

Introduction

HammondCare is an independent Christian charity specialising in dementia care and sub-acute services including palliative care and rehabilitation. Currently, the organisation provides community and residential care for more than 2000 older people, through 14 community care locations and five residential campuses, as well as providing palliative care, rehabilitation and psychogeriatric care to 600 people through three sub-acute hospitals and their community outreach teams. HammondCare is acknowledged as the leading provider of dementia care in Australia. More information can be found at www.hammond.com.au. This submission covers four areas as listed below.

Summary

1. Convergence between Aged Care and Sub Acute

The provision of sub-acute services such as palliative care and rehabilitation outside the hospital environment will allow people to receive services where they are located – in their own home or a residential aged care facility, improve medical care and professionalism, and will lessen the burden on acute care. It will also decrease costs to government.

2. Regulation

Poorly administered regulations diminish the experience of aged care for many older Australian citizens. Reducing the choice of foods older Australian citizens can eat is an example of a 'protective disciplinary culture' which is unacceptable and attacks the dignity of our ageing population. Regulations – and their administration – need to be focussed on a quality of life outcome so that older Australians in aged care have lives worth living.

3. Assessment of Funding for Dementia Care

The current method of funding for residents with dementia places significant strain on the economic security of aged care. This is an unintended consequence of the Aged Care Funding Instrument that can be readily rectified without budgetary strain.

4. Supply and Price of Residential Aged Care

There are already enough financial resources for an excellent aged care system in Australia. It is simply that those resources are not only in the public purse but in the pockets of many Australians. Residential aged care is currently funded as a universal welfare system. This is an unnecessary and unsustainable approach to funding the needs of our ageing population over the next 40 years. Provided that residential aged care providers have a nominated minimum number of concessional residents, are accredited and have fully certified accommodation, then the charges to those residents who are not financially disadvantaged should be de-regulated.

1. Convergence between Aged Care and Sub Acute

1.1 Current patterns of use

Presently, there is limited integration and interfacing between the aged care and sub acute health system. This is both inefficient and costly and there are many advantages in integrating sub-acute and community and aged care services.

1.1.1 Use of sub acute services in hospitals

Currently sub acute services represent a significant proportion of Australia's hospital services. Rehabilitation, palliative care and geriatric care are the third, fourth and fifth most common types of care in public hospitals throughout Australia. These services cared for 75 446, 21 598 and 19 307 patients respectively, in 2007-2008.[1]

1.1.2 Increasing use of the hospital system

Persons over the age of 65 are the most significant users of the public hospital system in Australia.[2] The extent to which this group is using the hospital system is increasing rapidly. From 2003-04 to 2007-08, there has been a 21% increase in separations by patients aged 75-84 and 28.8% for those aged 85 and over.[3]

1.1.3 Use of sub acute services by residential aged care

In 2008, the Department of Health and Ageing noted that 'for people who reach age 65, a third of all men and half of all women will go into permanent residential care…'[4] These residents are significant users of sub acute services. The inefficiency and cost of moving residents between residential aged care and the providers of sub-acute services is significant.

David's Case: David has spent the last decade in and out of acute, sub acute and residential care facilities. Despite a history of sub clinical psychiatric disorders, alcohol abuse, and an estranged family, David is fit, strong and mobile. Over the last few years he has developed a pronounced dementia. He has had protracted stays in sub-acute psychogeriatric units, while medication trials are conducted and behavioural strategies developed to minimise the effects of his harmful and impulsive behaviour. With each admission, the search for a residential facility willing to take him becomes more difficult. Even when a place is found, David's tenure has been short: each incident has resulted in an ambulance or police trip to emergency and eventual transfer back to a sub-acute psychogeriatric unit to begin the cycle again.

[1] Productivity Commission *Public and Private Hospitals*, 2009, p31

[2] Tracking in 10 year increments, the age group 65-74 had the highest number of public hospital visits, 737,577 separations, FY2007-08. The age group 75-84 was the second most significant; 711,267 in the same period. Australian Institute of Health and Welfare, *Australian Hospital Statistics 2007-08, Health Services Series no. 33*, 2009, p166.

[3] AIHW, *Australian Hospital Statistics 2007-08, Health Services Series no. 33, 2009*, p185

[4] Department of Health and Ageing, *Ageing and Aged Care in Australia*, July 2008, p.7

1.2 The benefits of convergence

The increasing deployment of sub acute services within the aged care setting will:

1. increase continuity of care;
2. assist with the Federal Government's National Health and Hospitals Reform Commission agenda to deliver integrated care designed around the needs of patients;
3. improve medical care;
4. increase professionalism in non-acute health environments; and
5. lessen the burden on acute care; and
6. significantly reduce overall cost. An acute hospital bed in NSW costs $1,223 per day. One of HammondCare's sub-acute hospital beds in the same State costs between $650-$900 while an aged care bed costs around $160.[5]

1.3 Access and cost

Table 1: Current access and cost

	Hospitals and Primary Care	Aged Care
Access to entry	Relatively easy	Relatively Difficult
Cost to Government	Higher Cost (uncapped)	Lower Cost (capped)
Cost to Private Health Insurers	Private Health Insurance coverage	No PHI
Services offered	■ Accident and Emergency ■ Acute Care ■ Sub Acute Care ■ Other Primary Health Care	■ Residential Care ■ Community Care

Table 1 shows:

- Access to hospitals and primary care is comparatively easy. You present to an acute hospital environment and wait; you present at a GP's surgery. While 'wait times' are often publicly criticised, Australians receive hospital and primary care in a comparatively quick and efficient manner.
- The same cannot be said for aged care. Aged Care Assessment Teams cannot meet demand in a timely fashion. This means that there are delays of weeks and months for an older person to be assessed. Such delays increase the likelihood that a prospective client or resident for an aged care service will be admitted to an acute hospital while waiting for an aged care service. The irony of this dichotomy is that hospital places cost more than aged care places.
- In the same vein, hospitals are a cost to Private Health Insurers while aged care is not. As a practical matter, the lower overheads of aged care campuses will provide the prospect of a reduction in the long-term costs of sub-acute services to both the public sector, and PHI providers. If this is combined with further privatisation of the responsibility for aged care finance, then an associated insurance market should emerge, which will further reduce average cost of sub-acute services.

[5] Professor Merrilyn Walton, Sydney "Can we afford to keep people alive?", in Sydney Morning Herald, 28 July 2010 p. 12. Professor Walton is the Professor of Public Health at The University of Sydney. The cost of a sub-acute rehabilitation bed is around $670 while a palliative care bed is around $870 (2010 figures). The cost of an aged care bed is around $100 average Federal subsidy to which should be added the various resident daily fees.

Table 2: Proposed access and cost

	Hospitals and Primary Care	Aged Care
Access to entry	Relatively easy	**Easier** (discussed below: 'speed of access into aged care')
Cost to Government	Higher Cost (uncapped)	Lower Cost (capped)
Cost to Private Health Insurers	Private Health Insurance coverage	**Sub Acute Services**
Services offered	■ Accident and Emergency ■ Acute Care ■ Other Primary Health Care	■ Residential Care ■ Community Care ■ **Sub Acute Care**

Table 2 shows:

- Sub acute consultant services should be provided within the aged care environment as well as within existing community and hospital settings.
- Private Health Insurers should be encouraged and enabled to fund health services outside of the hospital environment in ways that promote hospital avoidance and substitution. This will include the provision of sub-acute services within the aged care setting.
- This is a more natural distribution than the current allocation outlined in Table 1: the coincidence and co-morbidity among aged Australians of conditions requiring sub-acute services argues that these can be much more efficiently treated within the aged care environment. This will both reduce bed-blocking for patients requiring acute care, and will provide psychological benefits to aged patients who associate hospitals with more acute risks to their health.
- Palliative care patients who cannot be supported in their own home have a financial incentive to remain in a hospital environment. Patients are hesitant to move out of a palliative care bed to residential aged care because of price. This is inefficient when the average cost of an acute hospital bed $1,223 a day; a palliative care bed is $870 a day and a an aged care bed costs around $160 a day.'[6]
- Alongside the financial benefits, the devolution of sub-acute services into the aged care system would provide constructive competition and consumer choice in a critical area of health. There is an unintended consequence of the new health finance model that market power may be further concentrated in traditional State-owned tertiary hospitals. Our proposed changes would substantially lessen that risk.

Under this converged model, David's life could be very different:

David's (possible) Case: David was admitted to a joint aged care-sub acute program that caters for older Australians who have difficulty accessing mainstream aged care services. Essentially, David's condition is unchanged. He is still sometimes violent and will hang onto people with arm-breaking force; he is highly intrusive of other people's personal space and has little impulse control: he will hit out when he feels threatened. The converged aged care-sub acute program that cares for David has, however, changed his life. The ability to provide consistent, visiting consultant psychogeriatric services to the aged care facility has meant that David can be monitored closely and appropriately treated without the need for a psychiatric hospital admission.

[6] *Government working on $158 million transition beds – getting elderly into appropriate aged care* Media Release, Justine Elliot 25 March 2008. The Productivity Commission has previously reported that an aged care bed costs $100 per day but this does not include various resident fees. The Commission has also reported that a hospital bed costs $1,117 per day. We assume this is a national figure.

1.4 Speed of access into aged care

1.4.1 Ease of access

In the hospitals and primary health care system a person can walk into Emergency or a GP's surgery and receive immediate care. In aged care the time it takes for people to receive care is restricted by:

- the speed at which ACAT can conduct assessments; and
- cost structures (which often lead to family discussions and disagreements)

This delay in accessing aged care services increases the burden on the hospital system.

Easy and immediate access needs to be available into the aged care system in the same way it is in acute and primary care.

1.4.2 Aged Care Assessment Teams (ACATs)

ACATs have been the 'gatekeepers' to the aged care system for many years. However, it is increasingly evident that the lack of timely assessment is adding to the burden on the hospital system. There is a case that, with a robust funding instrument (ACFI), together with a thorough validation system, aged care providers should be able to admit older Australians directly into aged care services ***prior*** to an ACAT assessment. This would again have a positive impact on the costs of the acute sector. We would also note that with the Commonwealth's commitment to take responsibility for aged care-associated HACC as well as residential care, the maintenance of ACAT responsibilities within State Governments is anachronistic. This should be a strictly Commonwealth responsibility, and bringing it within a single Federal environment would also provide the capacity for more strategic demand management.

1.5 Language

The current use of the term 'aged care' will not be sufficient to encompass the wider and more holistic approach to caring for older Australians into the future. A new term and framework needs to be found which will include a whole range of health care services, including sub-acute. One such term could be 'Healthy Ageing'.

1.6 Recurrent and capital costs are too complex

The fee structure for both recurrent and capital costs within the residential aged care setting is very inflexible and complex. While you may pay a single daily charge if you go to a private or public hospital, it is far more complex within the residential aged care setting. There are lump sums, Centrelink assessments, statutory declarations, daily income test fees, daily standard fees and so on. This makes the introduction of other health services, such as sub acute care, problematic until this is addressed.

In the same vein, the introduction into the aged care system of health care activities which are concomitant with ageing and disability would substantially change the economics of aged care, by flattening otherwise lumpy cash-flows, and providing a more diversified service model. This is an important prelude to our further recommendations on changes to aged care finance responsibilities. It is beneficial to all reviews of aged care to consider how the risk profile of private investment in the sector can be managed by removing reliance on a single financial instrument: both improved private funding and the introduction of appropriate health services will assist with this.

Recommendations

R1 **Health services - and particularly sub acute services - should be provided within the aged care context.**

R2 **ACAT should be re-positioned to assess residents and clients after they have been admitted to a service.**

R3 **A new term needs to be found to describe the combination of the proposed convergence of the aged care system and sub acute services.**

R4 **A rationalisation of how residents are charged fees for service must occur before other health services can be introduced into residential aged care.**

2. Regulation

The rights of older people are being eroded because of un-necessary and conflicting regulatory regimes in aged care and the officious administration of those regulations. Regulations must be about improving the quality of life of older people so that they enjoy lives that they find worth living. There are many examples of this, including the right to freedom and the right to eat what an older person wants to eat.

Part of the issue is what the regulatory researchers call "the pursuit of precision":

"the pursuit of precision, either by protocols or by the proliferation of ever-narrower rules, causes an unreliability that is a symptom of a deeper and many-sided malaise of regulatory failure. This is especially depressing since the pursuit of precision usually fails in its own terms – it fails to deliver precision" 7

It is striking that, despite the ever-increasing burden of regulations within health and aged care, neither regulators nor service providers appear to engage the regulatory researchers who have studied the area. The regulations that are implemented are rarely evidence-based. John and Valerie Braithwaite, together with Toni Makkai, spent two decades researching regulations in aged care in the US, UK and Australia and produced an excellent book in 2008, Regulating Aged Care. Ritualism and the New Pyramid. The failure to engage the regulatory researchers in what works and what doesn't is all the more curious because these three researchers are based at the Australian National University.

2.1 Food Safety in Aged Care – poor regulation, poor outcomes

One area where this regulatory confusion has produced poor outcomes for older people is to do with food regulations. In NSW in 2008 the Vulnerable Persons Food Safety Scheme was introduced, reflecting the standards of the Food Standards Authority of Australia and New Zealand. Similar regimes exist in other states. These regulations identify that a 'vulnerable person' is an older person who resides in an aged care facility or in a day centre of more than 6 people. On the basis of this *locational* vulnerability – that is, vulnerability defined by where you live rather than who you are – certain foods are listed as 'high risk'. These foods include cold meats, pate, seafood, soft or semi-soft cheeses, fresh cut fruit and vegetables, soft serve ice cream and soft eggs, such as poached eggs.

While aged care is governed by standards that promote residents' autonomy and control over their own lives, aged care is also subject to legislation that restricts older people from eating

[7] John Braithwaite, Toni Makkai, Valerie Braithwaite, Regulating Aged Care. Ritualism and the New Pyramid. London 2008, p. 230

food that they have been able to eat their whole life.

The regulations do not *prohibit* high-risk foods, but providers serving them have to demonstrate they have "adequate control measures in place to control the pathogens". Fear of not complying often drives service providers to take options that allow for compliance but decrease the quality of life for residents. Examples include serving plastic cheese slices instead of real cheese, taking rockmelon off the menu, and ceasing to serve salads. Moreover, increasingly, food inspectors have moved beyond their regulatory powers by directing service providers not to serve 'high risk' foods or issuing "Improvement Notices" if they do.

This all leads to a manufactured sense of increased liability, which conflicts with the core human right of aged Australians to expect respect for and preservation of their dignity. We believe that there is adequate room for consumer choice here, which should err on the side of quality of life.

The current regulation of food in aged care is inconsistent. While residents may be denied seafood and soft serve ice cream in residential care, they are able to spend their money on prawns and a soft serve ice cream at an outing to the beach.

We believe that there could be successful litigation on the basis that delegated legislation, such as the Food Regulations 2004 (NSW), cannot change or alter existing law, namely the Aged Care Act 1997 (Cth). The Aged Care Act makes clear in its objects[8] and also through clauses 23.12 and 23.25 of the User Rights Principles that elderly people receiving aged care services be given choice with respect to their own care. On that basis, the provisions of the Food Regulations 2004 (NSW) and corresponding legislation in other States are invalid. We conclude with the accurate assessment of Braithwaite et al:

"The impetus to reform subjectivity in standards through objective criteria and protocols is dangerous because quality of life, which is what aged care should be about, is ultimately an irreducibly subjective matter (p.231) [9]

Recommendations

R5 **All regulations governing aged care must be evidence-based, informed by regulatory researchers.**

R6 **Food Safety is one area which is adequately covered by the Accreditation Standards that are administered by the Standards Agency. The Food Authorities of the various states should only become involved with aged care services to support the Standards Agency on a specific issue; in a response to a request for assistance from a provider; or at the direction of the state Public Health Units as a result of an incident.**

R7 **Regulations around diet should have overwhelming regard to the dignity of residents.**

[8] Especially clauses 2-1 (g) and (h), *Chapter 1, Division 2, Aged Care Act 1997*

[9] Braithwaite, Makkai, Braithwaite, op.cit., p.231

3. Assessment of Funding for Dementia Care

The current funding system disadvantages people whose dementia is their primary care condition. It consequently restricts their access to residential aged care

Since January 1, 2010 the Aged Care Funding Instrument has defined a resident as high care if they score 'high' in the behaviour domain together with a score of above nil in at least one of the ADL or CHC domains. Residents with challenging behaviours will often attract a high behavioural score and nearly every patient will have a score above nil in the ADL category.

Therefore, despite having comparatively low clinical needs, these residents will nevertheless be classified as "high care". This will mean that, even though they may have financial resources, they cannot be charged an accommodation bond (except in 'extra service' facilities). Competition for entry to standard high care services is increasingly intense, and the incentives are poor for increased investment in this sector under current funding arrangements.

Thus, while the ACFI has improved in many cases the recurrent funding for people with dementia, it has, perversely, made access to services *more* difficult for people with dementia. This is sadly a simple matter of economics, which is eroding the capacity of the sector to invest for Australians with dementia. The lack of funds for capital development also stifles providers' ability to innovate and create new service delivery methods to support people with dementia

It should also be noted in passing that residents with high behaviour needs and low CHC have a very different set of needs from those with high CHC. It does not make sense to care for both these groups in the same care setting. Often residents with high behavioural needs will be mobile and not have a need for continuous nursing.

It is notable that this issue would effectively become moot if our broader recommendations to combine a deregulated financial environment with a minimum commitment to concessional residents were adopted.

Recommendation

R8 The current funding system needs to be modified so that people with dementia, many of whom have challenging behaviours, are not denied access to services. Rather, we need to have a funding regime that actively *encourages* capital creation to support people with dementia.

4. Supply and Price of Residential Aged Care

Residential aged care cost the Australian Government $6 billion in the year ending June 30, 2010.[10] 'Spending on aged care is projected to grow from 0.8 per cent of GDP in 2009–10 to 1.8 per cent of GDP in 2049–50'.[11] There is a great need for alternative models of funding aged care.

4.1 "Everyone on the same bus"

Since 1997, aged care has been provided in two tiers: standard residential care and extra service. The overwhelming number of services are 'standard', with extra service representing only 9% of all residential places[12]. At the moment, we are seeing extra service become the focus of new potential investment. We propose everyone should be "on the same bus", so to speak, and the government should combine these streams of residential aged care.

4.2 Deregulating supply and price

Residential aged care providers should be allowed to set fees in line with market expectations, presuming they comply with three conditions. The provider must:

1. Have a minimum number of concessional residents[13]
2. Be accredited under the Accreditation Standards
3. Have all buildings certified under the Building Code of Australia

This would mean that care recipients can choose the provider that best suits their needs and would have the opportunity to choose the type, location and price of residential care they desire.

4.3 Income tested fees

Providers currently collect income tested fees on behalf of the Australian Government. This is both inefficient and expensive to administer. In FY09 a total of $242.9m of income tested fees were collected by providers. [14] Under our proposed, streamlined approach providers who are accredited, have certified buildings and a minimum number of 'concessional residents' will receive a common subsidy for all residents, with variants only according to ACFI scoring. This is a simple and equitable model, which provides a competitive incentive structure to subsidise concessional residents through access to an open market.

We would anticipate that there would be some caps in this model, to ensure that the middle is not squeezed out in pursuit of higher-wealth residents, and that at a certain level, this latter group would become strictly private residents with no public subsidy, and not counted in the total for calculation of the concessional percentage. However, we also note here the expectation amongst aged care planners that genuinely wealthy persons in need of aged care are more likely to access private nursing than residential care. We presume that for fiscal

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[10] Portfolio Budget Statements 2010-11, Health and Ageing portfolio, p201

[11] Treasury, *The Intergenerational Report*, 2010, p56

[12] Department of Health and Ageing, *Report on the Operation of the Aged Care Act 1997, 1 July 2008-30 June 2009*, p33

[13] The minimum number of concessional residents could be, for example, 25% which is twice the number of older Australians who do not own their home.

[14] Department of Health and Ageing, *Report on the Operation of the Aged Care Act 1997, 1 July 2008-30 June 2009*, p39

reasons, there would still need to be a maximum number of aged care residents under a publicly-subsidised scheme, although anchoring growth to concessional numbers should deliver this organically.

This model would also draw on aspects of the current extra service arrangements, to provide residents with the option to pay either through up-front fees or a greater retention of bond amounts.

All current residential arrangements would of course be grandfathered, though there is the option to include them in the new concessional calculation. Further, we would expect that regional arrangements would be different, although viability within the concessional-target model could be assured by simply increasing the per-resident subsidy to address diseconomies of scale.

We note that the typical objection to this approach is that in reopening the bond market, it conflicts with an accepted principle that the Australian home should be exempt from means-testing for social policy initiatives. We regard this as erroneous, because aged care differs substantially from other welfare activities, due to its substantial cost, large volume of participants and the fact that it is at heart a substitute accommodation arrangement.

We are also of the view that a semi-deregulated model of fees and charges will provide the impetus for genuine innovation in third-party finance, including insurance, pre-payment, health/ageing savings accounts and superannuation-based options to remove the inevitability of house-guaranteed bonds. This will require further consideration of regulatory changes, particularly with respect to superannuation and various tax effects.

Recommendation

R9 Providers should be able to set fees in line with market expectations presuming they have a minimum number of concessional residents, be accredited under the Accreditation Standards and have all buildings certified under the Building Code of Australia.

Summary of Recommendations

R1 **Health services - and particularly sub acute services - should be provided within the aged care context.**

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