CATHOLIC HEALTH
Australia

Catholic Health Australia

Supplementary Submission to Productivity Commission Inquiry: Caring for Older Australians

July 2010

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About Catholic Health Australia

21 public hospitals, 54 private hospitals, and 550 aged care facilities 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 organisation of these health and aged care services. Further detail on Catholic Health Australia can be obtained at www.cha.org.au.

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Introduction

Catholic Health Australia's initial submission to the Productivity Commission's inquiry into aged care (April 2010) proposed a package of reforms and transition arrangements designed to ensure that:

- all older Australians assessed as in need of aged care would receive quality aged care and support services of their choice irrespective of their personal and socio-economic circumstances; and
- the provision of, and investment in, aged care services is sustainable for the community and the aged care sector.

The purpose of this supplementary submission is to address a number of matters raised in the Productivity Commission Issues Paper *Caring for Older Australians* which have implications for the package of reforms proposed in the initial submission. A number of 'case studies' provided by CHA members are also presented to illustrate the implications of the current arrangements for consumer access to, and experience of, aged care.

2. Catholic Health Australia's Initial Submission

The key elements of the reform package put forward in CHA's initial submission include the following:

- Funding individuals eligible for assistance under the *Aged Care Act 1997* on an entitlement basis according to assessed needs.
- Allowing eligible people (and their families and informal carers, as appropriate) the option to choose which accredited provider delivers their aged care services and where they are received, and the option of greater control over the mix of services they receive.
- Aligning care subsidies and fees under the *Aged Care Act 1997* for people receiving care and support 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 by the proposed Independent Hospital Pricing Authority of the cost of care and support provided in a less controlled supply environment against benchmarks of care.
- Funding accommodation costs in residential care on a flexible user pays basis for those who can afford to contribute to their accommodation costs, with prices determined in a less controlled supply environment.
- Setting Government accommodation subsidies for those unable to contribute to their accommodation costs at a high percentage of the level required to ensure an internal rate of return greater than the weighted cost of capital for accommodation which is compliant with Building Code of Australia standards, in order to ensure access to quality accommodation for all.

- Funding accredited providers of home and community care services for the less frail aged on a per capita basis linked to the number of people assessed as eligible for these services who choose each provider for their services; reframing accountability arrangements to promote a more client focused approach by allowing services to be tailored to the needs of each individual, including greater use of an early intervention and restorative approach where appropriate to reduce or delay 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.

- Replacing 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 to provide a fair, consistent and timely eligibility assessment and information service, and common entry point for all aged care services.

- Implementation of the reforms to be accompanied by transition arrangements for the phased introduction of greater choice which would allow a reasonable period for adjustment for service providers. Transition arrangements are necessary because the reforms would entail a very significant change to current aged care arrangements which could pose a risk to the continuity of services for vulnerable people if implemented quickly.

- Maintaining cost-effective consumer protection and quality assurance arrangements both during the reform process and thereafter in recognition of the inherent vulnerability of many people in later life.

- Timely and coordinated implementation of the reform package to be managed by the Commonwealth Government. This would simplify the process for achieving greater 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. It would also allow better integration with the Commonwealth's wider primary care responsibilities.

CHA's initial submission expands on the main elements of the package outlined above, and may be viewed at http://www.cha.org.au/site.php?id=18.

3. National Health and Hospitals Network

Since CHA's initial submission, the Commonwealth has announced a number of measures as part of its commitment to create a National Health and Hospitals Network. These reform measures align with the reform directions in CHA's initial submission, and help prepare the way for further reform. The measures include:

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

- the establishment of 'one stop shop' information and assessment services for aged care to simplify access and ensure fair and consistent eligibility assessment;
- the introduction for the first time of Consumer Directed Care packages;
- enhanced prudential requirements to protect resident accommodation bonds;
- the provision of Commonwealth capital for the expansion of multi-purpose services in smaller rural and remote communities;
- significant expansion of sub acute care, including rehabilitation, palliative care and geriatric services; and
- the creation of Medicare Locals and Local Hospital Networks as a mechanism for improving the coordination of primary care, aged care and hospital services at the local and regional level.

CHA supports these measures and considers that they should be included in the reform options developed by the Productivity Commission for consideration by the Commonwealth Government.

4. Access by special needs groups

CHA considers that a key measure of our civil society is that all Australians, irrespective of socio- economic status, personal circumstances and location who are in need of aged care and support, have access to quality aged care services.

CHA notes that the overwhelming majority of older Australians will continue to be dependent, at least in part, on the age pension to support basic living standards[1] and on Government subsidies for their aged care services, notwithstanding the Superannuation Guarantee Scheme arrangements.

In addition, there are special needs groups who, without special measures, would have difficulty accessing quality aged care services. These groups include the homeless aged, older people with psycho-geriatric conditions and other challenging behaviours, Aboriginal and Torres Strait Islander communities and other minority culturally and linguistically diverse groups, and older people living in smaller rural and remote communities.

It is therefore essential that any changes to the current aged care arrangements not only do not reduce current access to aged care services for special needs groups, but actually secure improved and sustainable access. This will be a key measure of the merits and success of any reform measures.

Measures to ensure access for all

CHA considers that the following need to feature in Australia's future aged care recurrent and capital funding arrangements to address areas of market failure and ensure access to quality services by all irrespective of socio-economic and personal circumstances:

- Consistent with the universality principles underlying Medicare, frailer older people assessed with similar care needs should attract the same level of recurrent funding for care to support a

[1] Intergenerational Report 2007 (Commonwealth Treasury)

consistent high standard of care for all. Those who can afford to should continue to contribute towards the cost of their care.

- The level of care funding must have regard to the actual cost of care delivery against benchmarks of care, as periodically determined by independent analysis of financial performance of the aged care sector operating in a more open market.

- Viability supplements for rural and remote services which incur higher operating costs because of scale and/or remoteness should be continued and periodically reviewed.

- The additional costs of caring for older people with challenging care requirements such as those arising from psychiatric conditions, alcohol and drug related brain impairment or intellectual disabilities should be recognized in funding arrangements to ensure appropriate care is provided.

  In recognition of the additional cost of effectively caring for these groups, a number of services in New South Wales receive recurrent funding from both the Commonwealth and New South Wales Governments. With the Commonwealth assuming full responsibility for aged care, Commonwealth recurrent funding under ACFI for all homes catering for these groups of residents should reflect the higher funding levels applying in New South Wales.

- Multi Purpose Services should be expanded with the support of Commonwealth capital contributions to provide aged care, primary care and sub acute services in smaller rural and remote communities, with service delivery managed by Local Hospital Networks.

- In order to avoid systemic and pronounced disparities in building standards (that is, even more pronounced than currently), it is important that the new arrangements feature the following:

  - minimum building standards for aged care homes which are incorporated into the Building Code of Australia;

  - setting the accommodation payment made by the Commonwealth on behalf of residents who do not have the financial capacity to contribute the full cost of their accommodation at a high percentage of the accommodation payment required to allow a reasonable rate of return on the capital cost of aged care; and

  - continuation of a capital grants program to support the development of services targeting financially disadvantaged groups, such as the homeless, Aboriginal and Torres Strait communities, people with psychiatric, drug and alcohol and other mental health issues, and certain rural, remote and regional services where it can be demonstrated that the services would have reduced access to private accommodation contributions.

5. Discriminatory aspects of the current aged care arrangements

Successive Ministers for Ageing have acknowledged people's preference for receiving care in their own homes for as long as possible, and the importance of building community care services to allow more opportunity to exercise this preference.

This preference was acknowledged by the Minister for Ageing in the foreword of the most recent *Report on the Operations of the Aged Care Act 1997* [2] where the following observation was made:

> 'I have had the opportunity to speak with older Australians on a regular basis and their resounding message is that they want to live with maximum independence and dignity. They want to remain active in their communities and close to their families, friends and neighbours. Community care services help many people achieve this.'

Exercise of choice compromised

Aspects of the operation of the *Aged Care Act 1997*, however, are inherently discriminatory with regard to the exercise of preferences. The rationing of overall places means that not all older people assessed as being in need of aged care have an equal opportunity for timely access to services. Also, the current regulations which limit the choice of community aged care to 22 per cent of the aged care places provided under the planning ratios means that older people are effectively being denied equal opportunity to choose whether they receive care in their own home or in an aged care home, or the security of knowing that as their care needs change, they will have the option of continuing to receive care in their own home.

> "By not having the flexibility to offer 'ageing in place' in the community, clients often have to switch providers when their care needs shift from low to high care if the provider does not have EACH. We have had clients with us for several years who requested not to change providers. To support their wishes we cobble together where we can "pseudo" EACH by topping the CACP up with NRCP and private services (in fact we developed our Fee for Service program in response to this increasing need.) This makes it very expensive for the client. It is often the case that despite our best efforts, our clients have had to change providers or move to residential care.
>
> There are also some clients who 'refuse' higher levels of care as they are unwilling to change providers. The system effectively denies service."
>
> Provider

> "ACATS refer clients to those services where they know there are vacancies. For example, we have numerous cases where clients are referred for a CACP, yet on assessment it is revealed that they are actually high care and require EACH. We can sometimes go above our benchmarked hours/week, and top them up with NRCP to keep them going until an EACH becomes available, but tight budgets and accountability requirements often do not allow this. Invariably some people are forced to move to residential care."
>
> Provider

Current regulatory time limits for residential respite also constrain individuals' options for shared care arrangements involving a flexible mix of residential care and 'in home' care with the support of community care, including at times of transition.

[2] Report on the Operation of the Aged Care Act 1997 for 2008-09 (Australian Government Department of Health and Ageing)

Discriminatory accommodation payment arrangements

The operation of the *Act* is also discriminatory in relation to the contributions older people make towards their accommodation costs in residential care. Bond paying low care residents (including those who 'age in place') and bond paying high care residents (Extra Service) are paying more for their accommodation costs and are subsidizing the overall cost of aged care accommodation. [3]

Data in the *Report on the Operation of the Aged Care Act 1997* suggests that the cross subsidy is deepening. The steep increase in recent years in the median bond amount held by providers continued in 2008-09 (by 29 per cent from $155,000 to $200,000), and the average new bond increased by 13 per cent to $213,000. There was also a sharp rise (36 per cent) in the number of places approved for Extra Service in 2008-09.

These statistics suggest that more and more residential aged care providers have to turn to Extra Service and higher bonds as a source of capital for the renewal and expansion of residential services. They also illustrate that the burden placed on bond payers to provide the capital for renewal and expansion of services increased during 2008-09, thereby increasing the inequity of the current arrangements.

One consequence of these dynamics is that priority access to residential high care for those paying bonds will become more common, with providers limiting admissions of ACAT assessed (non Extra Service) high care residents or favouring low care residents who are at the cusp of needing high care.

> "In order to meet our capital needs for new and rebuilt services, we have developed a model of care based on 'ageing in place'. This model provides the resident and the family with the security of continuity of care while allowing the rollover of bonds to support capital funding. Direct admission of non Extra Service high care residents is avoided."
>
> Provider

Because the Government sets the maximum price for high care accommodation regardless of amenity, high care residents (of equal means) pay the same for accommodation regardless of room configuration, aspect, location within the home and quality of appointments.

> "I was assessed as needing to go into high care and the need was urgent. Despite the fact that I was used to living alone and wanted to have my own room and bathroom, I was told I had to go into a four bed room. I subsequently found out that I had to pay the same for my bed with shared bathroom as my friend in a single room with an ensuite.
>
> The DON explained that the government sets the maximum price and it's the same for all residents regardless of room configuration."
>
> Care recipient

[3] The Henry Tax Review (Australia's Future Tax System) estimates that when the accommodation bond exceeds $90,000, it results in residents paying more for their accommodation than those paying an accommodation charge.

Another discriminatory aspect of the current arrangements arises from the perverse consequences of regulations intended to 'encourage' service providers to take in residents of fewer means (supported residents). Encouragement is considered necessary because the rationing of services means that service providers have the option of 'cherry picking' residents.

To deal with this situation, rather than setting a price for care with reflects the real cost of care, the current regulations instead seek to penalize providers by discounting the accommodation supplement for all eligible residents in a home by 25% if the ratio of eligible care days used by supported residents in the home falls below 40%. In some regions, however, service providers are having difficulties maintaining the 40% threshold. In such cases, the incentive for providers is to maximise the proportion of non supported residents at the expense of supported residents. As a consequence, and contrary to the objectives of the regulations, supported residents in some regions are being denied care.

6. Sustainability of the current capital funding arrangements

CHA draws the Commission's attention to the financial analysis by Access Economics [4] which demonstrates that, with revenue streams based on current accommodation payments for residential high care ($26.88 per bed day), construction of a new residential high care home would not proceed even with a construction cost per bed as low as $138,000 as the present value of revenues is less than the estimates of all the costs, making the internal rate of return (IRR) less than the weighted cost of capital (WACC).

Based on an average construction cost of $187,000 per unit to build an aged care home to contemporary standards, the required accommodation payment per day was estimated by Access Economics at $40.32 per bed day (excluding the cost of land).[5]

The short term fix

A consequence of this situation has been under allocation of residential high care places in recent Aged Care Approval Rounds (ACAR), and the handing back of allocated places (bed licenses).

The under allocation of residential places in the 2009 ACAR was 1,915 places or 25% of residential places advertised (5,748 allocated compared with 7,663 places advertised). To compensate, the allocation of community care places was 69% higher than advertised (4,699 allocated compared with 2,784 advertised).

Seemingly in anticipation of another under allocation of residential high care places in the 2010 ACAR, the Commonwealth has temporarily increased the high level community care ratio from 4 to 5 per 1,000 people aged 70 and over in order to make up the shortfall.[6]

Cross subsidies from bonds and the provision of basic care and living services

Those residential developments that have proceeded have relied on the cross subsidy of low care and Extra Service bonds, and in some cases entry contributions from retirement village units. These developments either incorporate Extra Service and/or low care places in the design or are extensions to homes which already have beds for which current regulations allow bonds.

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[4] Economic Evaluation of Capital Financing of High Care (Access Economics, March 2009)

[5] Under current Government policy, the accommodation payment is scheduled to increase to $32.38 per bed day by September 2011, and thereafter be indexed to CPI. This is still short of the $40.32 per bed day (March 2009 prices) estimated by Access Economics as needed to justify investment in a new or rebuilt high care home.

[6] 2008-09 Annual Report (Department of Health and Ageing)

An indication of the dependency on bonds, and as noted already, the median bond held increased by 29% in 2008-09 to $200,000, and Extra Service places grew by 36% in 2008-09. [7] Taking a longer term perspective, the average new bond has increased from $58, 400 in 1997-98.

Recent advice from CHA members suggests that the capital funding issue is impacting particularly in those regions where the Commonwealth Government considers that the Extra Service high care provision ratio has been reached, and is not allowing new Extra Service places. CHA is aware that, as a result, a number of applications for high care places in those regions have not proceeded in the 2010 ACAR.

In the absence of adequate capital funding or the cross subsidy, the shortfall has to made up by surpluses generated from the provision of nursing and personal care services (reduced hours of care or labour substitution) and/or from the provision of basic services such as meals, cleaning and utilities. The potential of these areas to contribute surpluses to offset the cost of capital is limited.

The fee for basic services such as meals, cleaning and utilities, the *basic daily fee*, is equivalent to 84% of the single basic pension, a level designed to support only a basic standard of living for a person living at home independently and catering for themselves. The cost pressures facing nursing and personal care as a result of the COPO indexation of the *basic care subsidy* and care-related supplements are reflected in financial performance surveys which show that margins are declining and a large proportion of providers are operating at a loss.[8 9]

> "In 2007 we restructured our care staffing to enable registered nurses to take on greater responsibility for care management and oversight. Team leaders (certificate III and IV staff) under the supervision of a registered nurse became responsible for medication rounds. There was no reduction in registered nurse hours and the registered nurse classification was increased to Level II in recognition of the responsibilities of the role. We believed that in the face of increasing acuity and complexity of clinical and palliative care we needed to retain existing registered nurse hours and develop RN skills to ensure the quality of clinical care. Our nursing wages have also been indexed to retain a degree of competitiveness with wages in the acute sector. In recent years, increases in the cost of providing care, including nursing wages, have been well above the rate of indexation of care subsidies. Our current substantial annual operating losses are funded through an erosion of our capital and future sustainability."
>
> Provider

[7] Report on the Operations of the Aged Care Act 1997 2008-09 (Department of Health and Ageing)

[8] For example, financial performance surveying by Bentleys (Bentleys National Aged Care Financial Survey 2009) shows that 40% of providers are currently operating at a loss, with average profits having halved in the past three years to less than 5%. A similar trend was identified by Grant Thornton's Aged Care Survey 2008. Stewart Brown's survey (Aged Care Financial Performance Survey 2009) shows that only 34% of facilities made an operating profit in 2008-09.

[9] CHA notes that in the Report of the Operations of the Aged Care Act 1997 2008-09, the Commonwealth indicates that residential aged care funding can be grouped into two main categories: *care payments* to fund care and related services (the basic care subsidy, income tested fees and supplements) and *payments for accommodation and hotel type services* to cover the cost of food, utilities and accommodation (the basic daily fee, accommodation charges and bonds).

The current situation is not sustainable

The diversion in the recent ACAR of advertised residential places to community care is presented as a response to older people's preference for community-based aged care. However this is an ad hoc response and is not sustainable.

First, the current policy (balance of care ratios) which restricts consumer choice to age at home with the support of community care remains in place, contrary to consumer expectations.

Second, the pressure on the availability of informal carers, combined with the ageing of the population and the rising incidence of dementia and chronic and complex health conditions amongst the 'older' aged group with high dependency needs, will require a significant expansion of residential high care. Notwithstanding that more would choose to age at home for as long as possible if they were given the opportunity, there will be limits to the capacity of community care to cater effectively for these groups throughout later life.

Third, because of the long lead times involved with new service development and renewal, a slowdown in building activity will inevitably result in a shortage of supply of suitable residential services in the medium term which will be difficult to reverse quickly.

The recent temporary extension of the Zero Real Interest Loans Scheme (albeit on more favourable terms) is targeted at selected regions. As a result, it is only a partial response to the inadequacy of the current capital funding arrangements to sustain the expansion and renewal of residential high care services. [10]

Importantly, the current balance of care ratios and accommodation bond policy together raise a more substantive issue, and that is the extent to which they pose a structural barrier to giving care recipients and their families greater choice to elect to receive care and support services in their own homes.

If care recipients were to be given greater choice, it is likely that a significant number, especially at the low care level, would opt to have their care needs met in their own home for as long as possible, thereby threatening the current supply of low care bonds and the viability of future high care developments. Under the current balance of care ratios, this choice is restricted as only 22% of aged care places are available for community care, (and there is no certainty that a person can continue to receive care in their own home as their care needs change).

Hence the current partial application of bonds in residential aged care also presents a structural impediment to reform designed to respond to the well documented and widely acknowledged preference for care recipients to have greater choice to receive their care in their own homes.

Basing long term capital funding arrangements for aged care on the approach outlined in CHA's initial submission would go a long way to addressing the inadequacies of the current arrangements.

7. Extra service – a flawed concept in a system of rationed supply

As has been noted, aged care services for frailer old Australians are rationed according to a population based quota. While the quota means that the volume of services increases as the aged population increases, rationing also generates the need for a raft of regulations to manage the quota. This includes

[10] Extension of the Zero Real Interest Scheme also continues the complex regime for capital funding for aged care by the Commonwealth, including as it does a mix of accommodation supplements, capital grants and zero real interest loans. It is hard to see how fair and equitable treatment of providers is achieved through such complex arrangements.

controlling the type and volume of services that can be offered and their distribution across Australia, and price controls to counter local market power due to limited competition.

Under the price controls, residents of aged care homes, regardless of means, pay the same fee towards their living expenses such as meals, utilities and cleaning, equivalent to 84% of the single basic pension. Similarly, apart from the exception below, care providers receive the same payment to care for and accommodate residents assessed as having similar care needs, but with the balance between the user and Government contribution subject to an assessment of each person's capacity to pay.

The exception to these rules is accommodation bonds in residential low care which, subject to an assets test, are negotiated between the resident and the service provider.

Within this otherwise highly regulated system, Extra Service is a concession to choice by allowing a specified number of high care and low care residents to pay more than 84% of the single pension in return for higher living standards, and to negotiate an accommodation bond in high care in return for superior accommodation. [11] Also, as noted earlier, the renewal and expansion of aged care homes depends significantly on Extra Service as a source of capital.

Nevertheless, in practice, Extra Service has its limitations.

In the first place, by operating within an overall quota of services, Extra Service gives considerable market power to service providers. The average new bond in Extra Service is currently about $250,000 (plus retentions), with many paying bonds in excess of the capital cost of their accommodation.

The upward pressure on bonds in Extra Service is likely to increase further as the development of new and rebuilt non Extra Service high care homes stalls due to viability concerns under the current capital funding arrangements for non Extra Service high care. Further pressure would ensue if the Government were to respond to calls for greater choice for older people to receive their care in their own home. This would see a relative reduction in the availability of low care bonds, the other source of cross subsidy in addition to Extra Service bonds.

A consequence of these dynamics is that priority access to residential high care for those paying larger bonds will become more common.

In addition, because of constrained supply, regulations require providers to demonstrate to the Commonwealth how they intend to meet the higher standards of hotel services and building amenity before their services may be granted Extra Service status. However it is a moot point how well the current consumer protection provisions, including the Aged Care Standards and Accreditation Agency, which tend to focus on minimum standards, can ensure that Extra Service residents receive the higher standards of service on an ongoing basis in an environment of constrained competition.

Moreover, Extra Service status is granted in perpetuity and there is no requirement for providers to lift standards in line with rising community living standards. Hence disparities will, and have, emerged over time in the standards offered by different Extra Service providers. In many not for profit homes with collocated Extra Service and non Extra Service, virtually the same building amenity and standard of hostel services often apply to both groups of residents.

Extra Service as currently conceived also tends to penalize both Extra Service and concessional residents.
Extra service residents not only pay an income tested fee towards their cost of care, but also the care subsidy paid to providers on their behalf is reduced by 25% of the extra service fee. Providers are allowed to recoup this reduction from the resident, which means residents may be paying 25% more for their

[11] Age care regulations allow up to 15% of allocated places in each State or region to be reserved for Extra Service.

extra services than would otherwise be the case. On the other hand, concessional residents cared for in Extra Service by not for profit providers in fulfilment of their Mission have their eligibility for an accommodation subsidy withdrawn.

Overall, Extra Service is a flawed and unsustainable concession towards choice in a system of rationed supply. Choice should not be reserved for a minority; its delivery begets even more regulatory complexity and perverse outcomes. Funding individuals eligible for assistance under the *Aged Care Act 1997* on an entitlement basis, allowing people choice of services and who delivers them and lifting restrictions on what services providers can offer, is a much more effective model for the provision of aged care services.

8. Workforce

The workforce trends and pressures that are currently impacting on aged care, and which are expected to intensify unless effective responses are pursued, have been documented already, including by the Productivity Commission itself.[12] It is also widely acknowledged that the availability of a suitably qualified and motivated formal workforce is central to the quality and sustainability of future aged care services. Just as important is the contribution by informal carers who take on a very large share of the caring role, and who need to be supported in this role.

The responsibility for ensuring the future availability of a skilled workforce and informal carers falls to many, including Governments, training institutions, employers, professional associations and unions. While the issues are well known, remedial action is less well developed.

CHA's initial submission canvassed workforce issues in terms of attraction and retention, workforce supply and flexibility, and informal carers. The following summarizes the key areas that must be addressed to ensure the availability of informal carers and a formal workforce to support quality aged care services.

Comparative wages

The prices paid for the provision of aged care services will need to be sufficient to cover the cost of providing quality care, including the cost of attracting and retaining the skilled staff required to care for the increasing number of older people with complex care needs. The failure of the current funding arrangements to provide comparative remuneration levels between aged care and other sectors (including the health sector)is one of the major impediments for attracting and retaining qualified nursing staff and, to a lesser extent, personal care workers.

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 (COPO) arrangements. The wage index component of COPO assumes that wages in all sectors are offset by productivity gains and uses the unreasonable expectation that the aged care sector has the same ongoing capacity as all other sectors to achieve productivity gains through labour substitution. [13] [14]

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

[13] COPO indexation was supplemented for five years by the Conditional Adjustment Payment (1.75 % annual increment), but indexation reverted to COPO after the 2009-10 Budget.

[14] The report of the Review of the Conditional Adjustment Payment (2009) which examined productivity trends in residential aged care has never been released by the Commonwealth. The public release of this Review would make a valuable contribution to informed community debate on productivity issues in aged care.

The indexation arrangements that have applied to care subsidies and fees and the comparative inability to offer competitive wages (together with an overall shortage of nurses) has contributed to a significant restructuring of the workforce in the residential aged care sector. The most recent data available shows that over the four year period 2003-07, there has been a significant decline in equivalent full time registered nurses, enrolled nurses and allied health staff in residential care (-14%), substituted by a 17.7% increase in personal care workers. There has been some up skilling of the personal carer workforce, with 13% having Certificate 4 in 2007 compared with 8% in 2003. However, the percentage of personal carers with Certificate 3 in Aged Care, viewed as the base qualification for personal carers, remained relatively unchanged at about 65%. [15]

Over the same four year period, the number of licensed residential aged care places increased by 12.5%.

The Department of Health and Ageing's analysis of this data concluded that the labour substitution and the increase in the number of residents together represent a productivity gain of 1.7% per annum over the period, represented by a decline of 2% in the weighted mix of labour inputs and a rise of 5% in the weighted mix of outputs.[16]

CHA has concerns, however, that the decline in nursing and allied health staff may also be a result of, at least in part, funding pressures rather than best practice developments to achieve quality aged care. It should be noted that this restructuring of the workforce is occurring at the same time as the acuity of residents is rising, including increasing numbers of residents living with dementia. CHA notes in this regard that while the percentage of accredited homes remains high (98%), there has been a disturbing increase in the number of reported consumer contacts with the Complaints Investigation Scheme (11% in 2008-09, compared with a 3.2% increase in the number of people receiving aged care), despite a significant increase in the number of visits to homes, both announced and unannounced, by regulatory authorities. [17]

The Department of Health and Ageing in its evidence to the Senate Inquiry acknowledged 'that there must be a limit to the extent of such labour substitution that can occur in the industry so that it is possible that growth in labour productivity will begin to mitigate at some time in the future.' There is no data available to show whether the labour substitution has continued beyond 2007, but this is an area of concern which the Productivity Commission needs to consider further. Consumer perceptions as an indicator of quality cannot be easily passed over.

In summary, because the fees and subsidies reflected in the current ACFI rates are historically based and indexed to minimum wage adjustments, they do not reflect contemporary care practices, standards or labour market conditions. The reforms, therefore, should provide for periodic independent reviews of the cost of care to inform the setting of care subsidies and fees, undertaken by a body such as the proposed Independent Hospital Pricing Authority.

Without a serious effort to address comparative wage disparities, short term incentives to attract qualified staff and to generate career interest in caring for older people, are likely to be of limited value and effectiveness. The shortfall in the take up of Government incentives to encourage nurses back into the aged care workforce is a case in point.

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[15] Who Cares for Older Australians: A Picture of the Residential and Community-Based Aged Care Workforce (National Institute of Labour Studies , Flinders University 2007)

[16] Supplementary Submission to the *Senate Finance and Public Administration Committee Inquiry into Residential and Community Aged Care in Australia* (Department of Health and Ageing April 2009)

[17] Report on the Operation of the Aged Care Act 2007-08 and 2008-09 (Department of Health and Ageing)

Community perceptions

As well as sufficient revenue to sustain competitive remuneration, the attraction of skilled staff to the sector will be influenced by community perceptions of aged care. The reforms will therefore need to foster a more open sector which is driven by greater consumer choice, and which is valued in the community for its responsiveness, innovation and research, and consistently high standards of service.

The current compliance and sanction dominated approach to aged care does not support a positive culture and image, and detracts from the attractiveness of a career in aged care for prospective employees.

Workforce planning

CHA considers that there has been insufficient attention given to the future demand for skilled staff in both the health and aged care sectors relative to the anticipated workforce availability and other competing sectors of the economy.

Close attention should be given to the supply of appropriately trained staff to meet increasing demand for services and to manage wage cost pressures. As well as ensuring that there are a sufficient training places for doctors, nurses, personal carers and allied health, their knowledge and skills base will have to be appropriate to care for more older people living with complex and chronic conditions and dementia, and people needing end of life and palliative care.

The recently created Health Workforce Australia has a key role to play in indentifying the future workforce needs of the aged care sector so that planning for future training places is well informed to anticipate the skills in demand. The planning will need to take into account the overlap with the health and hospital sector labour market.

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.

Workforce flexibility

Also important will be the availability of resources to invest in technology and a capacity for greater flexibility in the use of skilled staff.

Developments in care monitoring and medication management should enable different approaches to scopes of practice to be accommodated. Existing State/Territory regulations that impede changes to scopes of practice for the various qualified skill levels need to be changed so that there are uniform national requirements.

Registered Nurses (Division 1) no longer need to be responsible for conducting medication rounds. Advanced scope of practice for Enrolled Nurses (Division 2) and Assistants In Nursing, together with the adoption of electronic medication management methods, would allow registered nurses, who are in short supply, to focus on clinical management roles where their skills are needed and more appropriately deployed as the acuity of residents continues to rise.

Current scopes of practice for Personal Care Workers, Enrolled Nurses and Registered Nurses need to be reviewed and realigned in accordance with current and future potential models of care. Where these changes require professional development, the qualifications for these workers would be endorsed accordingly. This approach also applies to greater use of, and changes in work practices around Allied

Health Assistants, Nurse Practitioners and Practice Nurses, and strategies supported through Medicare Locals to overcome barriers to increased collaboration and teamwork across disciplines.

Technology

Technology developments have the potential to improve care staff productivity and quality of aged care. The National Broadband Network currently being rolled out by the Commonwealth will provide the medium, and be the catalyst, for technology based innovation to support the delivery of aged care services in both residential and community aged care.

The National Health and Hospitals Reform Commission identified that the safety, efficiency and effectiveness of the care of older Australians in residential and community aged care can be assisted by better and innovative use of technology and communications, including through the introduction of person-controlled electronic health records, improved access to on line and telephonic health advice, increased use of electronic clinical records and e-health enablers in aged care homes, and technology to enable remote monitoring of vital signs.[18]

The development and introduction of the infrastructure and software to support technological innovations that assist the caring role is also relevant, to a large degree, to the wider health sector. In addition, its development and implementation often goes beyond the financial capacity of individual providers and requires collective systems development. The current capital funding arrangements for aged care were not designed to address upfront capital investments of this kind. Accordingly, Governments need to recognise that there is a key policy, standards setting and funding role for them in encouraging the development and take up of technology in aged care settings.

Informal care

There is also the informal 'workforce' - the many thousands, mostly women, who support family members and friends in later life. While it is expected that changes in family structures, increased population mobility and greater participation of women in the workforce will constrain the number of informal carers, it will nevertheless be necessary to help carers, many of whom themselves will be older, to maintain their caring role.

Support for carers should include more flexible respite services, education about effective care techniques and strategies and income support to offset the cost of caring. An innovative respite service conducted by a CHA member has been particularly effective in supporting carers by explicitly focusing on their health and wellbeing as well as the care recipient, noting that many carers are themselves older and frailer.[19]

Access to GP services

Many aged care providers continue to report difficulties in securing GP services for their residents. A recent survey by CHA of its members suggests that the main issues concerning the way GPs interact with their aged care home and their residents revolve to a significant degree around a shortage of GPs and GP unwillingness or inability to engage fully with residential care due to time pressures.[20]

The most common issues raised include home visits being difficult to arrange; timeliness of visits; reluctance to take on new or difficult patients; poor or inadequate documentation; inadequate after hours and emergency access; rushed consultations; and poor communication and information sharing.

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[18] A Healthier Future for All Australians (National Health and Hospitals Reform Commission June 2009)
[19] Carer Respite Wellness Centre Program Study – Our Lady of Consolation Aged Care Services (Elton Consulting November 2009)
[20] Survey of Access to General Practice Services in Residential Aged Care (Catholic Health Australia April 2010)

On the other hand, a characteristic of homes that had no issues with their GP interactions was that they were being serviced by fewer GPs, even though they were more likely to be located in metropolitan areas where the ratio of GPs per head of population is higher. Such homes were also more likely to have visiting GPs who participate in care plan reviews, medication reviews and comprehensive health care assessments, but also more likely to have provided GP support services such as visiting rooms and IT capability.[21]

Feedback from our members also indicates that GPs who care for a significant number of residents are more likely to assist the aged care home with ongoing improvement in clinical systems (including medication management), help out in difficult circumstances when required, and may act as a de-facto Medical Director for the aged care service.

Against this background, CHA suggests that, in addition to increasing GP numbers, an effective way of improving GP access for residents of aged care homes is to provide incentives for those who take on large patient loads in a home. The incentives should also link to special training/competency around the care of frail older people, such as early diagnosis and management of dementia. Similar arrangements could apply for nurse practitioners.

Licensing

A number of parties have advocated the introduction of licensing arrangements for aged care workers in order to support higher aged care standards.

CHA considers that licensing of itself will do little to address the workforce pressures faced by the sector. Closer attention to the matters such as remuneration and workforce supply referred to above, and especially measures to upgrade the skills of the workforce, have the potential to make a far greater positive impact on workforce issues, whereas licensing would add to regulation and administrative costs.

Given current and foreseeable workforce pressures, the practical implications of licensing arrangements for timely recruitment of staff also need to be recognized. The 2007 survey of the aged care workforce by the National Institute of Labour Studies indicates a high turnover rate for personal care workers, with 25% needing to be replaced each year.

CHA also notes that a regime of police checks to ensure people with inappropriate backgrounds are not attracted to age care already exists, though efficiencies may well be possible through greater integration of the arrangements for child care and age care.

9. Integrated planning and funding framework at a regional level

The Productivity Commission Issues Paper raises for consideration the option of pooling aged care funds (residential and community aged care) at the regional level.

It is unclear whether significant public policy advantages would result from this form of pooled Budget. Allocative efficiency objectives, at least in theory, would be more likely to be achieved if aged care funding were pooled along with primary and hospital funding as it would allow funding at the regional level to be directed in a way that reduces expensive hospital costs through more effective primary care and preventative health strategies.

[21] Catholic Health Australia's *Survey of Access to General Practice Services in Residential Aged Care 2010* identified that in 55% of homes most residents (70 %+) had changed their GP within a few months of entry.

CHA does not support either approach as the inevitable capping of the Budget for the funding pool would run counter to CHA's preference for a national aged care entitlement system based on assessed need where eligible care recipients have a choice of care provider and care setting i.e. a more market based approach.

CHA also notes that the allocative efficiency benefits of funds pooling would be compromised by the unlikelihood that pharmaceutical benefits and Medicare payment for GPs would ever be pooled. Pooling of hospital funds would also involve a major unravelling of the National Health and Hospitals framework recently agreed by COAG. Managers of the capped pool would also need to be able to resist the demands of the acute sector which often results in the urgent and the immediate crowding out strategic realignment of funding priorities.

There is a strong case, however, for better coordination across primary care, hospital services and aged care services at the local level which should be achievable (or at least significantly improved) in the Australian context through mechanisms short of funds pooling. In this regard, CHA welcomes the Commonwealth's National Health and Hospitals Network proposals for Medicare Locals and Local Hospital Networks. If properly implemented, they would provide greater scope for local stakeholders to cooperate to reduce unnecessary and expensive hospital and emergency department episodes and improve patient welfare by, for example, improving access by older people to GP and allied health services and deploying support services such as palliative care and mental health support.

There is scope in particular to support a wellness/independence focus for the less frail aged which coordinates clinical and community care services around the needs of each individual. In CHA's initial submission, it was proposed that funding for aged care and support services for the less frail aged (essentially the current Home and Community Care funding) should transition to per capita funding of approved providers based on the number of eligible care recipients enrolling with their service. The greater funding certainty which this approach would bring, together with flexibility to tailor services to the needs of each client, would enable community care providers to collaborate with other primary and hospital care providers. This approach is discussed further below.

10. Independence and wellness

An increasing focus is being placed by some community aged care providers and by some jurisdictions on promoting and enhancing the independence of people in later life and, subject to individual preferences, maintaining social engagement with the wider community, targeting in particular the less frail aged.

This focus is often referred to as an 'independence', 'restorative' or 'active service' model of care. It does not deny the continuing need for services directed at support and maintenance, but there is an emerging body of research which suggests that an approach to community aged care which focuses on timely intervention, education and assistive technologies can encourage frail older people to resume independence and activity, and can in many cases be effective in reducing demand for ongoing services in a cost effective manner.[22]

The extent of the evidence base for independence models of care is, however, limited, especially as to whether the benefits identified in some of the studies would be realizable if the approach were applied more broadly to the community aged care target group. For instance, an evaluation of the Home Independence Program run by Silver Chain showed improvements on all personal outcome measures for

[22] Enabling Independence : Restorative Approaches to Home Care Provision for Frail Older People (Ryburn B, Wells Y and Forman P Australian Institute for Primary Care 2009)

participants in a trial group compared with a control group, but cautioned against generalizing the evaluation findings because the trial group self selected or were specifically referred.[23]

Nevertheless, it would seem that an independence approach is effective for selected assessed clients at least and its wider application, including the identification of the most effective interventions, warrants further research and support.

Current home and community care services

A question which arises, however, is whether the current program structures for the delivery of home and community aged care services to this target group are helpful to innovation with, and development of, independence models of care for those assessed with the potential to benefit from such an approach. A related question is whether the current arrangements are helpful for tailoring services to the needs of individuals, both currently and as their needs change.

The majority of care and support services for the less frail aged are currently being provided through the Home and Community Care (HACC) program, funding and policy responsibility for which is to pass to the Commonwealth (except in Victoria and Western Australia).

The main focus of current HACC service provision in aged care is to respond to client dependency needs, with the primary objective being to provide basic maintenance and support. These services were provided by 3,300 agencies in 2007-08, assisting some 835,000 people. The average HACC client receives on average four hours of service a month, with domestic assistance being the most common. The most common combination of services is centre-based day care, meals delivery and transport assistance.[24]

Funding for HACC services currently is allocated to providers on a block grant basis for which providers are accountable to deliver contracted amounts of specified care and support services, which could include domestic assistance, social support, nursing care, allied health services, personal care , meals, home maintenance, respite, assistance with transportation and care coordination and case management. Eligibility for these services is determined by the providers, operating within guidelines set by Commonwealth and State Governments.

A feature of the current funding arrangements, however, is that each of the 3,300 providers is limited to defined service types for which they have obtained funding by tender. This 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 less conducive to innovation in service delivery and workforce flexibility to optimize client outcomes.

[23] A Non-randomised controlled trial of the Home Independence Program: an Australian Restorative Programme for Older Home Care Clients (Lewin G and Vandermeulen S Health and Social Care in the Community 2010)
[24] HACC Annual Report 2007-08 (Department of Health and Ageing)

> "A client who requires something slightly different from the defined HACC service can be denied appropriate services. An example occurred when a family wanted to hire a mobile shower so they could shower their aged parent (the bathroom was upstairs and the gentleman could not manage the stairs without assistance). The family was happy to assist with the showering as the gentleman was a very private person. The family approached us (the service provider) for assistance with the cost of the mobile shower but the constraints on service types did not allow us to offer the support the family required, even though the unit cost of the service provider showering the man was higher than subsidizing the cost of the hired shower. Assisting this family by paying the hire cost would have been cheaper than sending out a carer to shower the care recipient."
>
> Provider

It also requires a large bureaucracy to plan and administer the distribution and allocation of service types amongst the numerous agencies across all regions of Australia.

An alternative approach

An alternative and potentially more effective funding arrangement which would assist a more client-focused approach would be to shift the emphasis from inputs to client outcomes by giving providers greater flexibility to tailor a package of services to meet the assessed needs of each client, giving consumers a choice as to which organization coordinates and delivers their care services, and making providers more accountable in terms of client outcomes.

Such a shift could be achieved by transitioning service provision to a per capita funding model for the less frail aged. Under this model, individuals assessed as in need of community care (by the proposed 'one stop shops') would become eligible to enrol with an accredited community care provider of their choice to receive their care services, and 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 (appropriately indexed) 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).

Under this model, service providers would have greater flexibility to coordinate and tailor services around the assessed short and long term needs of individual care recipients and carers and to innovate around independence models, rather than be restricted to the service types that they have been contracted to deliver. The flexibility would extend to making appropriate use of care coordination to set personal care goals and to support the tailoring of services to the individual, including the capacity to broker services for their clients from other agencies.

A transition to this funding model is likely to see the emergence of more 'portfolio providers' with the capacity to offer or arrange the full range of services to support older people living in the community, or the emergence of partnership arrangements.

Most importantly, the increased flexibility would provide a better platform for community care providers, especially 'portfolio providers', to negotiate partnerships and coordination arrangements with other primary care providers and hospitals because the budget certainty and greater flexibility would better enable them to operate in a more timely and responsive way, including to address the main long term influences on entry into residential aged care such as dependency around activities of daily living,

cognitive impairment, maintaining acceptable body weight and social activity.[25] As noted earlier, the proposed Medicare Locals and Local Hospital Networks potentially provide useful mechanisms to achieve better coordination between the primary care and hospital sectors and age care to increase cooperation between the clinical and community care sectors.

The potential benefits of greater collaboration at the local level that this approach would allow would seem to have been borne out by an evaluation of the Partnerships for Older People Projects in the United Kingdom. A feature of these projects was greater flexibility to access a wider range of services by working collaboratively with local stakeholders and tailoring the services to individual needs and circumstances. As well as improving the quality of life of clients, the evaluation identified reductions in hospital overnight stays and visits to accident and emergency departments.[26]

All individuals assessed by the 'one stop shops' as being in need of community aged care and support would be entitled to enrol for services from a chosen provider. However, unlike the frailer aged where ongoing care and maintenance is likely to feature more prominently in the service regime, an entitlement to individual funding for the less frail aged would be more difficult to sustain given the expected variability in the nature, intensity and duration of the services needed and the administrative complexity resulting from the larger number of potential clients.

Consistent with CHA's view that those that can afford to should contribute towards the cost of their care and support services, it will be necessary to introduce nationally consistent income testing for these services. This would make the provision of these services more affordable for the community, allow available public funds to be directed to those most in need, and would not impede further growth in the private market for these services.

Total funding for a program such as this (which would in turn be translated into the level of per capita funding) would be determined having regard to estimates of unmet need and the outcome of research into effectiveness in relation to improving client welfare and reducing or delaying the need for more expensive high care and hospital care.

There is a role for rehabilitation oriented services for the frailer aged as well. These would be enabled if community care package providers and residential aged care providers had greater capacity and flexibility to include allied health services such as physiotherapy, occupational therapy and speech pathology amongst the range of services they can provide, or they had better access to expanded Day Therapy Centres. This is discussed further below.

Transition Care

A consequence of the rationing of aged care services is that many older people remain in public hospitals after a hospital episode while awaiting placement in a community or residential aged care service.

At the same time, there has been an under investment in sub acute care and rehabilitation services in most regions of Australia designed to maximize a person's functionality and independence after a hospital episode, and to reduce their dependence on aged care.

[25] A study by Kendig H, Browning C, Pedlow R, Wells Y and Thomas S *Health, Social and Lifestyle Factors in Entry to Residential Aged Care: an Australian Longitudinal Analysis* (Oxford University Press March 2010) concluded that 'overall...the findings suggest that comprehensive health promotion and care through later life are likely to yield benefits in assisting older people in staying in their own homes as well as improving survival and quality of life.'

[26] Windle K et al National Evaluation of Partnerships for Older People Projects Final Report (The Personal Social Services Research Unit December 2009)

There have been attempts to deal with this situation over the years, partly in response to the cost shifting inspired 'bed blocker' jibe. The most prominent attempt at the Commonwealth level has been the introduction of the Transition Care Program in 2005. Under this program, aged care places from within the provision target ratio have been allocated to the States and Territories to provide flexible care to older people at the end of an inpatient hospital episode (subject to eligibility assessment by an ACAT), including low intensity therapy and nursing support or personal care. The care provided is intended to be time limited, therapy focused and necessary to complete the care recipient's restorative process in order to optimize their functional capacity and assist them and their families to make long term arrangements for care.

An evaluation of the Transition Care Program found that while at the individual level positive outcomes were being achieved, the level of access to rehabilitation and geriatric beds in a region influenced recipient selection and in many cases the Transition Care Program appeared to be fulfilling the traditional role of rehabilitation services. Hence, while the program was not intended to be a substitute for rehabilitation services, it appeared to take on this role, and with limited success. Comparisons between the Victorian Geriatric Evaluation and Management units (GEM units) and residential-based transition care found that the GEM units admitted more disabled patients and achieved functional improvements more rapidly.[27]

This situation seems to suggest that the most appropriate response to older people languishing in public hospitals after a hospital episode is to increase investment in sub acute care and rehabilitation, rather than divert scarce resources away from aged care.

The need for increased resources for sub acute care has been recognized by the Commonwealth who, as part of the National Health and Hospitals Network, has agreed to provide $1.6 billion to the States and Territories to deliver 1,316 new sub acute beds or bed equivalents nationally by 2013-14 (focusing on rehabilitation, palliative care, mental health and geriatric services), and $122 million for sub acute beds in Multi Purpose Services in rural communities. Pending the full implementation of these services, the Commonwealth is also providing $280million over four years under the *Aged Care Act 1997* to compensate the States for the cost of long stay older people in public hospitals.

Against this background of increased investment in sub acute care and rehabilitation services and the fine line between these services and transition care services, CHA considers that transition care funding should be redirected to expanding independence and wellness services such as Day Therapy Centres to support older people living in the community and their carers.

Day therapy centres

Day Therapy Centres in Australia are a hangover of the in house therapy centres that were present in a small number of nursing homes at the time they were being 'deficit funded' by the Commonwealth. Because only a few of the nursing homes had such therapy centres (approximately 130), their funding was not incorporated into the national funding arrangements for nursing homes (CAM and SAM)that replaced deficit funding in 1987. Instead, a separate program of annual grants (Day Therapy Centres program) was established to support their continued operation. Aside from a modest expansion of 12 centres in 2002, the program has been effectively warehoused. Contracts are renewed on an annual basis and funding is indexed under COPO, which means that real funding levels have declined and the Centres have not been able to keep up with the movement in salaries for allied health professionals.

The 139 Day Therapy Centres currently in operation provide physiotherapy, occupational therapy, podiatry and speech therapy services to frail older people designed to help them maintain, or recover, a

[27] National Evaluation of the Transition Care Program (Commonwealth, State and Territory Governments May 2008)

level of independence that will enable them to remain in the community or low level residential care. However, because of their small number relative to the (growing) potential target group, and their random distribution, community access to these services is very uneven.

An independence focus referred to earlier would be further assisted by increasing the funding for, and national reach of, Day Therapy Centres, including by locating these services with those 'portfolio providers' that emerge as a result of the proposal to fund community care providers for the less frail aged on a per capita basis. In due course, it may also be possible to incorporate funding for these centres in the proposed per capita funding model.

There is also scope to include/extend a low intensity therapy focus within existing day respite services so that, as well as providing a break for carers, respite services are also able to assist clients with independence objectives. Administrative benefits and advantages for consumers may also be possible through collocation or greater integration of Day Therapy Centres and Day Respite Centres, including incorporating funding into the proposed per capita funding model.

Assistive technologies

Another feature of the current community aged care system is the absence of comprehensive and affordable access to assistive technologies to support independent living. The development of a national scheme (means tested) to facilitate reliable and easy access to aids and appliances and emerging assistive technologies would provide a major support for both care recipients and carers and improve the effectiveness of models of care designed to encourage independence.

11. Quality assurance and accreditation

Allowing older people and their families to choose whether they receive aged care and support services in their own home or in an aged care home, and the prospect that more will choose the former than current regulations allow, will increase the focus on the appropriateness of the current quality assurance arrangements applying in community aged care.

A related issue which may arise for some is how much competitive advantage may accrue to community care if the quality assurance arrangements are less effective (and less onerous) than those applying in residential aged care.

A distinction that can be drawn between care received in a person's own home and in an aged care home is that the latter entails the management of the aged care home accepting responsibility for the care and wellbeing of each resident for 24 hours/day. On the other hand, receipt of care services in a person's own home suggests that the care recipient and family/carers are taking some responsibility upon themselves. The current quality assurance arrangements which apply differently in residential and community aged care recognize, inter alia, this distinction.

Nevertheless, with the prospect of more people receiving higher levels of care and support in their own homes, and the necessity for there to be effective quality assurance arrangements to underpin the more flexible aged care arrangements envisaged in the reform proposals, it would be prudent to review the current quality assurance and accreditation arrangements for community aged care.

The recent assumption of full Commonwealth responsibility for aged care would also make such a review at this time opportune so that the arrangements are appropriate to the needs of the full spectrum of aged care service types.

A matter that would warrant serious consideration as part of such a review is the possibility of the Aged Care Standards and Accreditation Agency having responsibility for accrediting all community and residential aged care providers (though this does not mean that the accreditation standards and processes would be the same for both community and residential aged care). Such an arrangement would address the conflict of interest avoidance principle which favours the functional separation of funding, regulatory and accreditation responsibilities.

The transition period for the implementation of the reforms should be used to undertake such a review.

Consistent with the above, CHA also supports the creation of a separate Aged Care Complaints Commission to administer aged care complaints investigation processes, as recommended by the Walton Review. The creation of an independent Commission would address the perception that as funder and regulatory, the Department of Health and Ageing is not the appropriate body to administer complaints investigation processes because of a perceived conflict of interest.[28]

12. Retirement villages and other service integrated housing

In its initial submission, CHA recommended that people assessed as eligible for aged care assistance under the *Aged Care Act 1997* should be able to choose whether they receive care and support in an aged care home or in their own home with community aged care. CHA also noted, inter alia, that the certainty that people could exercise a choice to 'age in place' would be likely to stimulate further development of innovative housing options for people in later life, including various forms of retirement villages and service integrated housing.

It is also the case that even given the current policy settings concerning residential and community aged care, and with the minimal involvement of Australian Governments, Australia has seen the emergence of a substantial service integrated housing sector for older people.

This is comprehensively addressed in a recent AHRI report which estimates that service integrated housing accommodates approximately 130,000 people, mainly in retirement villages, but also other forms of housing for older people such as independent living units, serviced apartments and assisted living facilities.[29] Most of this housing has developed privately, with a smaller proportion being a legacy of since discontinued public housing programs for older people developed in partnership with the religious and charitable sector.

Quality assurance issues

From an aged care perspective, the various forms of service integrated housing are not significantly different in concept to older people living in their family homes with the support of Government subsidised community care services (depending on availability) or who purchase support and care privately. Where care recipients are eligible to access Government subsidised community aged care and support services, their provision should be subject to the same quality assurance arrangements and standards as would apply to Government subsidised services delivered to a person residing in the family home. Privately purchased services should continue to be the responsibility of the purchaser, backed by the normal community consumer protection laws.

[28] Review of the Aged Care Complaints Investigation Scheme (Walton M October 2009)
[29] Service Integrated Housing for Australians in Later Life (AHURI Report No 141 January 2010)

The regulation of retirement villages and other forms of service integrated housing should remain the responsibility of existing State and local government authorities. CHA would support, however, greater harmonization of regulatory arrangements and consumer protections across the States and Territories, especially regulations designed to protect the financial interests of older people.

Barriers to housing innovation

There is a strong case for the Commonwealth to sponsor the development and adoption of universal housing design principles through the Building Code of Australia to support the construction of dwellings which are suited to the needs of people as they age in order to forestall the need to change dwellings for this reason alone. In this regard, CHA welcomes the announcement that the Commonwealth, the housing industry and the disability sector 'have agreed to an aspirational target that all new homes will be built to disability friendly Livable Housing Design Standards by 2020', supported by voluntary guidelines for housing that will be used to inform consumers and the housing industry about universal housing design.[30]

The development and uptake of housing more suited for people in later life could also be assisted further by reducing transaction costs such as stamp duty. An expansion of privately funded age appropriate housing would complement a community preference to live independently for as long as possible with the support of community aged care, reduce the need for purpose built aged care homes and enable the recycling of housing stock to meet life cycle needs of different age cohorts. The New South Wales Government's recent announcement to relax stamp duty requirements for older people is an example which other States and Territories would do well to follow.

Social housing for people in later life

Governments in recent years have renewed their involvement in social housing, targeting those who are disadvantaged in the housing market, including the homeless and those at risk of homelessness. Recent Government social housing initiatives include the National Rental Affordability Scheme (NRAS), the National Partnership Agreement on Homelessness and the National Partnership Agreement on Social Housing.

The need for publically supported housing, however, is not unique to older people as the need can arise at any stage of a person's life cycle, quite unrelated to the frailty of older age. As a result, the need for public housing assistance often predates the need for aged care services, but the possibility that aged care needs will emerge later in life should be taken into account when designing and providing public housing. In this regard, public or social housing should be developing housing solutions which would allow residents the option to age in place for as long as possible with the support of community aged care services should the need for aged care and support arise.

Nevertheless, housing stress can, and does, coincide with the onset of age related frailty, such as pensioner renters with limited assets occupying inappropriate housing or who find rental accommodation unaffordable, but who could otherwise continue to live independently. The housing needs of this group should be a priority for public housing agencies, working in partnership with community housing bodies and non government organizations. Again, the housing should be designed to allow for 'ageing in place' with the support of community aged care services.

[30] Promoting Liveable Housing Design in Australia (Media Release Bill Shorten MP July 2010)

13. Aged care/disability interface

The interface between aged care and disability care services is currently characterized by overlapping Government programs spread across both Commonwealth and State Governments.

CHA suggests that there are two basic options to address the current overlap and fragmentation. The effectiveness of either option, however, would be compromised without adequate funding to meet need which avoids the necessity to ration services. The two options are:

a) Create a national aged care and disability program which would cover all people with long term care needs irrespective of age and the cause of frailty and disability.

b) Create two national parallel programs to address disability and aged care services separately, with the former designed to ensure lifelong care and support for people with congenital or acquired disabilities, and the latter designed to ensure care and support for people assessed in need of care due to frailty as a result of ageing.

Currently Australia operates a hybrid system. While there are separate disability and aged care programs, there are also some programs which cover both groups, with overlapping responsibilities between the Commonwealth and the States/Territories. Added to this is the significant complication that disability programs are even more underfunded than aged care programs. As a result, some younger people with disabilities are still being cared for, as a last resort, in aged care homes which are often not appropriate for their needs.

CHA supports the use of parallel programs to support disability and aged care services. An advantage of this approach is that it would provide the opportunity to create a universal entitlement-based national disability scheme which has nationally consistent needs based assessment and funding entitlements, consistent eligibility criteria, consistent client contribution policies based on standardized capacity to pay criteria and consistent quality assurance, accreditation, reporting, transparency and accountability arrangements, to mirror that which is more evolved in the aged care sector under the *Aged Care Act 1997*.

The distinctive care and support needs and characteristics of the various sub-groups within the disability community and the lifelong need for support and care would mean that their requirements could not easily be accommodated within the current regulatory and funding structures in aged care. For example, the current funding levels under aged care's Aged Care Funding Instrument (ACFI) would not be appropriate for many younger people with disabilities, many of whom need much higher levels of care and support than provided under the ACFI. A regime of supplements would be required which would add complexity for clients and program administration.

A national disability program, however, would need to ensure lifelong care and support as people's needs change, including due to ageing, whether administered at the State/Territory level, as agreed by COAG, or at the national level.

The formalization of the two parallel programs approach, however, would not of itself resolve ambiguities over responsibility for the care needs of younger people with disabilities as they age. COAG, in the context of the National Health and Hospital Network, has recently agreed to implement arrangements which are designed to clarify responsibilities in relation to this matter. In particular, COAG has agreed that the Commonwealth will assume responsibility for funding aged care services for all people aged 65 and over (and indigenous people aged 50 and over), and the States and Territories will be responsible for funding

care services for younger people - such as younger people with disabilities - where ever they are receiving care.

CHA supports this aged-based clarification of funding responsibilities between the Commonwealth and the States as it is a practical administrative response to the problematic issue of apportioning dependency and frailty between ageing factors and acquired and congenital related factors. The policy could be accommodated under a parallel programs structure by Governments annually compensating (invoicing) each other under the National Disability Partnership for costs incurred on behalf of each other without the need for any disruption for the care recipient or the care provider.

The compensation arrangement would need to apply irrespective of the settings in which the care is provided. Accordingly, disability services would need to embrace 'ageing in place' principles which would allow people to continue living in their current accommodation as their needs change, but also allow people to choose to move to other settings if appropriate and preferred. The latter could include residential aged care services or services which are collocated with 'mainstream' aged care homes in order to share common support systems.

Importantly, with funding certainty, the administering State/Territory authority would have the flexibility to allow care recipients and their carers to plan for and exercise choice of care setting and providers that best meet their needs, thereby ensuring continued quality care and support for people with disabilities as they and their carers age. It would also allow care providers the flexibility to tailor their services to meet client preferences.

To be effective, however, a national disability program would need to be underpinned by a nationally agreed funding system, such as a form of social insurance which is presently being examined by the Productivity Commission. The comparative inability of the disability community over the years to compete for priority in the annual Budget formulation processes, as evidenced by the current degree of unmet need, presents a strong case for more certain funding arrangements such as compulsory community-wide social insurance.

14. Financial risk to the Commonwealth Budget

CHA's initial submission identified that the proposal to fund aged care for the frailer aged on an entitlement basis according to assessed need poses a potential fiscal risk for the Commonwealth Budget if not managed appropriately.

Moreover, CHA identified that:

- much of the regulatory framework currently surrounding the provision of aged care services in Australia is driven substantially by the Commonwealth's over arching policy objective of managing its fiscal risk by rationing the supply of subsidised services through a population based provision ratio, rather than meeting the care needs of all who are assessed as in need of aged care and support; [31] and

- while providing Budget certainty, this policy comes with a considerable cost to those Australians needing aged care, and their carers, and to the efficiency and effectiveness of aged care services.

[31] A key point identified by the Productivity Commission in its *Review of Regulatory Burdens: Social and Economic Infrastructure Services* (Productivity Commission, September 2009)is that the 'Aged care industry is characterised by centralised planning processes ...... without tackling the underlying policy framework that stifles competition it is unlikely that the regulatory burden can be substantially reduced.'

Background to fiscal risk concerns

The fiscal risk arises from a concern that an entitlement based approach for the frailer aged may lead to both a supply (or provider) induced demand as providers seek to maximize the market for their services by providing services to people not in need of services, and also a consumer driven demand for services. It is considered that this is more likely to occur if entitlement and choice is extended to community aged care because people may be more likely to seek or accept assistance while living in the family home, whereas the act of relocation and separation from the family home to an aged care home serves as a natural barrier to accessing services. Accommodation copayment arrangements also act as a disincentive to unwarranted demand for residential aged care, as is the rising acuity of residents which has changed the atmosphere in aged care homes.

This concern in part reflects a reaction to the circumstances which prevailed prior to the introduction of a provision ratio in the 1986-87 Budget.

Prior to 1972, there was no eligibility assessment for receipt of Commonwealth nursing care subsidies. As a result, there was evidence that many older people were living nursing homes unnecessarily. Between 1972 and 1986, admission to a nursing home required a certificate of approval from a medical practitioner, which was also subject to endorsement by a Commonwealth Medical Officer in order to address fears that some private doctors who were also owners or part owners were admitting patients to nursing homes without justifiable reason.[32] In effect, therefore, eligibility was largely decided by the family doctor who exercised this responsibility without the support of effective national assessment tools and performance management and monitoring processes.

In 1987, responsibility for eligibility assessment was passed to State/ Territory administered Aged Care Assessment Teams (ACATs). As the Commonwealth's influence on the performance of ACATs was indirect, the Commonwealth introduced the added security of a population-based provision ratio (which was also seen to have the funding advantage of linking aged care places growth to growth in the aged population).

A feature of the above eligibility assessment arrangements is that, in one way or another, they could not be relied upon to perform a fair and reliable gate keeping role to manage the financial risk to the Commonwealth.

An alternative approach

As indicated in the initial submission, CHA considers that a more appropriate means for managing fiscal risk, while at the same time ensuring that care is available for all frailer aged people in need of care and avoiding the perverse consequences of rationed supply, is to put in place a comprehensive and fair national 'gate keeping' process to ensure that only those assessed as in need of care attract means tested care subsidies. The 'gate keeping' arrangements would have to be based on nationally consistent assessment tools administered by trained and accredited personnel that can be supported by performance monitoring and management processes such as inter- rater reliability comparisons of assessment decisions. The delegates can be supported in exercising their powers by contracting in clinical assessments and diagnoses.

The Commonwealth's decision to assume full responsibility for aged care and to establish 'one stop' eligibility assessment and information centres is the ideal platform to put in place such arrangements. As noted in our initial submission, robust 'gate keeping' needs to be in place before supply controls are lifted.

[32] The Commonwealth Department of Health and Family Services reported in its submission to the Productivity Commission Inquiry into *Funding Methodologies for Nursing Home Subsidies* (September 1998) that in 1970 '25% of nursing home residents did not really need to be there on medical grounds'.

Feedback from our members suggests that there is considerable scope for improvement in the consistency of eligibility assessments.

> "Our organisation provides community packages across a number of ACAT regions and we are experiencing considerable variability in ACAT assessments for packages across the regions. As a result we have underutilised packages in some areas and waiting lists in others. This suggests that there is considerable room for improvement in the consistency of assessments."
>
> Provider

Demand for aged care services can also be influenced by fees policies. The 1997 reforms introduced more comprehensive income tested care fees for residential aged care. It is important for demand management and equity reasons that income testing and fees policies are consistent across residential and community aged care.

It is also noteworthy when considering the risk of supply induced demand that, compared with the arrangements that existed prior to the 1997 reforms, providers of care for the frailer aged today must undergo searching checks to gain approved provider status and must comply with rigorous regulatory arrangements such as accreditation standards, key personnel checks, complaints procedures and building standards where non compliance is subject to onerous sanctions. These arrangements would act as significant deterrents for opportunist providers wishing to exploit the system.

It is also relevant that the provision target today has reached 113 per 1,000 people aged 70 and over, compared with the target of 100 which prevailed prior to 2004. This recent increase in supply could be expected to have reduced the level of unmet need, thereby moderating the extent of the fiscal risk. The increased cost of meeting any unmet need should also be offset against the cost of more expensive hospital episodes and emergency department visits by older people who are not having their care needs appropriately met under a system of rationed aged care.

The National Health and Hospitals Reform Commission proposed that the twin objectives of managing the Commonwealth's fiscal risk and increasing consumer choice and competition could be achieved by limiting the number of people at any time receiving subsidised care and at the same time lifting restrictions on the services that providers could offer. Under this arrangement, there would be a provision target ratio managed by ACATs, whereby ACATs could have a maximum number of approvals for care that could be in effect at any one time for people living within a planning region.[33] [34]

The continued rationing of services on this basis would secure Budget certainty and generate some competition between community and residential aged care providers if accompanied by consumer choice of care setting (though this would be moderated because many providers operate in both sectors). However, the overall impact on increasing consumer choice and responsiveness and competition between providers would be diluted because provider service development decisions would still be constrained by knowledge of the capped availability.[35]

[33] A Healthy Future for All Australians (National Health and Hospitals Commission June 2009)
[34] The National Health and Hospitals Reform Commission recommended that the provision target ratio be based on the number of people aged 85 and over, rather than the current 70 and over, as this was more reflective of the average age of new aged care recipients. As a second best to an entitlement approach, CHA would support this change to the provision target ratio.
[35] Review of Regulatory Burdens: Social and Economic Infrastructure Services (Productivity Commission, September 2009)

15. Funding options and intergenerational issues

The Productivity Commission's Issues Paper invited discussion on the appropriateness of requiring current taxpayers to subsidise the costs of caring for older Australians under a 'pay-as-you-go' system, particularly given the projected increase in aged care needs over the next 40 years and the significant shift of income from taxpayers to aged care recipients that this entails.

'Pay-as-you-go' is effectively the current system whereby current taxpayers (mainly in the labour force) are meeting approximately 70% of aged care costs, with the balance comprising user contributions towards the cost of accommodation and, to a lesser degree, care.

Voluntary private insurance and savings accounts

Alternatives to 'pay-as-you-go' include various forms of voluntary private insurance arrangements, including aged care savings accounts, designed to induce some form of pre-payment by individuals to take the pressure off current taxpayers.

It is accepted by many that voluntary savings accounts dedicated to aged care are unlikely to be an effective or efficient way of helping to fund the future cost of providing aged care services because of the considerable unevenness in the incidence of needing high care services across the older population. While the likelihood of ever needing care is fairly high, and likely to increase with longevity, the duration and intensity of that care need varies greatly. As a result, not only would people not be inclined to save for the eventuality of needing care (especially if there is a Government safety net which provides a high level of care and a rationing system which constrains choice), but also this uncertainty would likely result in either over or under saving.

Ergas [36] sums this up as follows:

> These variations in hazard rates imply considerable unevenness in the distribution of expected care costs within the elderly population. Given that unevenness, a pure savings scheme would either result in savings that are inadequate to cover care costs (if most households saved less than the risk that they were exposed to), or alternatively, if large numbers saved enough to cover potentially high exposures, the elderly would be forced to make larger bequests (and hence have lower lifetime consumption than they desired).

Practical difficulties also present themselves with voluntary private aged care insurance. As a result, international experience shows that the widespread development and take up of private aged care insurance for long term care is limited, and covers only a relatively small proportion of the population. [37]

Ergas lists the following practical difficulties:

- The complexities involved in devising and properly pricing long term care insurance products which take into account, for example, correlated risks such as medical technology having a similar affect on a large part of the insured group which limits the scope for intra and inter generational risk pooling, and the difficulty of factoring in the availability of informal care.

[36] Providing and Financing Aged Care in an Ageing Society (H Ergas 2008)
[37] Productivity Commission Submission to the *Review of Pricing Arrangements in Residential Aged Care* June 2003

- Demand side constraints arising from the likely unaffordability of premiums for older cohorts who have never had long care insurance (the position facing Australia's baby boomers as they approach retirement), and reduced incentives for take up because the Commonwealth ensures access to aged care through safety net arrangements.

- Transition issues affecting intergenerational equity which would arise because the younger insured would not only contribute to their long term care insurance but would, as taxpayers, also contribute towards the cost of (previously uninsured) older people who, because of their age, are uninsurable.[38]

Consequently Ergas concludes that experience to date is not encouraging as regards the development of effective voluntary forms of pre-payment for aged care. Nevertheless, CHA considers that individuals should have the option of taking up private insurance for their long term care needs if insurers are prepared to make products available.

Social insurance

The alternative to voluntary private insurance is compulsory social insurance for the total population, similar to the Medicare Levy concept. This approach has the potential to secure greater certainty about the level of government funding for aged care but poses similar inter generational equity issues as a pay-as-you-go approach.[39] As well, as noted by the Productivity Commission in its submission to the Hogan Review, there are design issues surrounding the size of the levy and management of any surpluses or shortfalls, and concerns for Governments about the loss of Budget flexibility. It is instructive that the size of the Medicare Levy remains at legacy levels and covers only a small proportion of total Commonwealth health outlays.

User charging

Under either a pay-as-you-go arrangement or compulsory social insurance, there is a case for these funding avenues to be complemented by user charges for care recipients who can afford to contribute towards the cost of their accommodation, living expenses and care.

In this regard, the 1997 reforms introduced income tested fees for care in aged care homes. This measure, along with a tightening up of income testing rules, has resulted in a sustained increase (13.5% annually since 2004-05) in the contribution by residents towards their care costs. [40] This trend is likely to increase as the Superannuation Guarantee Scheme arrangements mature and community wealth increases.

Accommodation copayments (accommodation bonds and accommodation charges) also apply for those that can afford to pay them, using the rationale that older people who choose to receive their aged care in an aged care home should continue to contribute to the cost of their accommodation as they would if they remained living in the community.[41] This approach also implicitly recognizes the concessional treatment afforded the family home under Australian housing and taxation policies which have

[38] The report *Careless: Funding Long Term Care for the Elderly* (Featherstone H and Whitham L Policy Exchange 2010) estimated that the annual voluntary premium for the 65+ cohort needed to cover care in the UK would be 40,000 pounds.
[39] The Japanese social insurance model attempts to lessen the impact on intergenerational equity by requiring mandatory contributions from the working population between the ages of 40-65 only, with a 10% copayment from the State. Overall, 50% of funding for aged care still comes from the taxation system.
[40] Report on the Operations of the Aged Care Act 1997 2008-09 (Commonwealth Department of Health and Ageing)
[41] The ABS Housing Occupancy and Costs 2007-08 data released in October 2009 indicates that home ownership (overwhelmingly outright ownership) for the 65-74 and 75+ age groups was 84% and 82% respectively.

contributed to wealth accumulation in this form. It has been estimated that tax expenditures on owner occupied housing currently amount to about $20 billion per annum.[42]

Copayment policies, however, have to take into account that the lifetime savings of most Australians are in the form of home ownership.[43] The illiquid nature of this asset can constrain payment options for individuals, with potentially adverse financial consequences if lack of flexibility does not allow choice of payment arrangements that suit personal financial circumstances and objectives.

> "I am a full pensioner widow who, on entering a high care home, needed to sell my home. So as to preserve my pension, I wanted to pay a bond but was told by the provider that this was not allowed by the Government. I had to pay an accommodation charge instead.
>
> As a result of selling my home and placing the proceeds into a managed fund, I lost my pension, became a tax payer and was required to pay the maximum income tested care fee. The Global Financial Crisis then reduced the value of my managed fund investment."
>
> Care recipient

Accordingly, CHA's initial submission advocated a transition to more flexible arrangements for accommodation payments across both low and high care provided in a more open market, including a deferred payment option for high care supported by a Government sponsored deferred payment scheme, as proposed in the recent UK white paper on long term care.[44]

In the Australian context, a deferred payment arrangement would not be dissimilar to the innovative concept underlying the Higher Education Contribution Scheme (HECS). Whereas under HECS tertiary education costs are recovered from future earnings, care recipients would have the option of having their aged care accommodation costs recovered under the scheme from their estate. As one option for meeting aged care accommodation costs, a deferred payment scheme would have the advantage of allowing people to access residential aged care without the stress of selling the family home or making alternative financial arrangements, often at short notice and potentially at a financially inopportune time.

CHA notes that arrangements which require user contributions towards accommodation costs generate concerns about diminished inheritances for current taxpayers. The alternative for these taxpayers would be to contribute to aged care accommodation costs through their current earnings (taxes) instead.

Means testing

Means testing of care recipients for aged care assistance should be consistent between residential and community aged care, while distinguishing between the components of care ie living expenses, health care and assistance with personal care, and accommodation costs.

[42] Tax Expenditure Considerations for Owner Occupied Housing (Audrey E Pulo Commonwealth Treasury Economic Roundup Issue 2 2010)
[43] Baby Boomers – Doing It Themselves (AMP.NATSEM Income and Wealth report Issue No 16 March 2007)
[44] Care, Support and Independence : Building the National Care Service (HM Government March 2010)

CHA also agrees that, as stated in *Australia's Future Tax System*, means tested charges for costs of care should be set so they do not harm income adequacy in retirement and are consistent with pension means testing. This entails taking into account the effective tax rate already applied to private income through the pension means test and income taxes, so that the total effective marginal tax rate is less than 100 per cent of income, but all the while limiting the charge to the cost of care and ensuring that the total taper on private means does not remove all incentive to maintain savings.[45]

The application of this approach is particularly relevant with regard to how the current income tested fee arrangements can impact adversely on couples where one member needs to enter residential care. The combination of the resident's basic daily fee of 84 per cent of the basic pension plus the income tested fee and, in the case of high care, the accommodation charge, can leave the remaining spouse at home with insufficient disposable income to continue living in and maintaining the family home.

CHA considers that aged care means testing arrangements should be reviewed in the context of the principles outlined in the report on *Australia's Future Tax System*, and also be taken into account when consideration is given to any reforms flowing from the report to ensure that means testing arrangements are fair and consistent.

16. Transition arrangements

CHA's initial submission highlighted that its proposals for increased consumer choice of aged care services involved a significant relaxation of the current regulatory arrangements governing the provision of aged care services which, if not carefully managed and implemented, could pose risks to the continuity of services for care recipients.

It is worth restating here the essential elements of a transition strategy that would be required to minimise the risks to care:

- Allow for a gradual realignment of the balance of care types in favour of community care before the overall provision target is removed (noting that this realignment will occur against a background of further growth in overall places as a result of the combined effects of the provision target and the structural ageing of the population, including increasing demand for high care residential places).

- Maintain controls over accommodation payments in high care until the market deepens (occupancy levels may be a suitable indicator of market deepening), but lift accommodation payments in high care during the transition period to levels which support investment in new and rebuilt high care homes.

- Allow time for the implementation of other risk mitigating and reform enabling measures before supply and demand controls are lifted, including robust 'gate keeping' arrangements (the 'one stop assessment shops'); alignment of the subsidies and fees across residential and community aged care; and introduction of Special Purpose Financial Reporting and other financial data arrangements to support cost of care and financial performance assessment by an independent party (the National Hospitals Pricing Authority) and the rebasing of the ACFI.

The details around the transition arrangements need to be developed in consultation with consumer and provider peak groups.

[45] Australia's Future Tax System (Australian Government December 2010)