



SUBMISSION TO PRODUCTIVITY COMMISSION.

Caring for Older Australians.

*Submitted: 4th August 2010
By: Glenn Bunney – CEO*

“The definition of insanity is continuing to do the same thing in the same manner and expecting a different result”.

Albert Einstein

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Submission Author Biography

Glenn Bunney is an experienced Chief Executive, having held such roles for over 25 years in a range of settings, the last 13 of which have been within our aged care industry. He is the CEO of Sundale, a community-based charitable organisation providing community care, residential aged care, rehabilitation services including a therapy centre and private hospital, retirement living and childcare, on the Sunshine Coast in Queensland. Sundale has been a quality provider of these services since 1963. As a service provider of almost 50 years standing, and holding a diverse and comprehensive range of business portfolios, Sundale is a strong example of a local community group that is both vibrant and viable.

Glenn has been an active member of the aged care community since joining the Aged Care Queensland Board in 1997 and assuming its Presidency in 2000 until 2003 when he was elected as National President of Aged and Community Services Australia. He served as President of Aged & Community Services Australia for four years ending in 2007, is a Director and current Chair of the International Association for Homes and Services to the Aged, was a founding Director of Eden in Oz, a foundation established in 2003 to facilitate the introduction of The Eden Alternative® into Australia and New Zealand, and is a serving Director of the HESTA Superannuation Fund. This latter role provides insight into the challenges faced by employees in the health and community services sector, especially as they prepare for what should be a quality retirement.

His extensive experience at the aged care coal face, along with his involvement at national and international levels provides a unique insight into not only the Australian and global trends in services for the ageing, but in associated and supportive services such as rehabilitation.

INTRODUCTION

The Australian aged care industry is struggling and as a consequence the need and aspirations of older Australians are being compromised. A continuation of the existing regime and legislative framework will commit our nation to failure.

Australia has fallen behind our international counterparts in the planning and structure for services for older people, ironically often on the basis of initiatives that have been formulated by Australian service providers. Political processes ignoring the realities of the situation, or continuing to “shoot the messenger” will not improve the situation.

There have been numerous reports indicating that the manner in which Australia’s aged care services are funded does and will continue to compromise service delivery. At some stage our community has to say that “enough is enough” and pressure the Government to commit the resources necessary to deliver the kind of care that we intend for older Australians, or alternatively embrace a significantly different paradigm in which the community accepts a greater fiscal and care delivery responsibility than it has chosen thus far.

As we face our most significant demographic change in our history, there can be no better time than now to take the essential steps to position Australia for the future. It is not only the needs of our older Australians and their carers at stake, it is indeed the economic viability of the nation in so many ways.


It is a matter of regret that the Terms of Reference for this inquiry have been set in the context of historical thinking. By this I mean that the continued separation of disability services and aged care is a misnomer. Aged care in essence, addresses the disability that comes through the passage of time. The fundamental type of assistance, care and support, is essentially consistent. In spite of this, political expediency continues to “allocate” these services separately, to conveniently hold State Governments accountable for service delivery for disability services, with the Australian Government (as of 2012 as currently planned) being responsible for the full aged care service delivery including HACC. This is an amazing opportunity lost, and is one that as a nation we will regret, as it impedes our ability to truly reform service delivery and innovation across the continuum that is “Long Term Care”.


In preparing this submission we remain conscious of the request of the Commission via conference presentations by Commissioner Woods, for submissions to focus more upon solutions and the future, and less upon the existing system and indeed the past. In preparing this submission however it is acknowledged that we have needed to highlight issues with respect to the current system to emphasise the transition to the new paradigm we are proposing for consideration.

CONTEXT OF THIS SUBMISSION

There has been a plethora of work conducted on the issue of the adequacy and appropriateness of the structure for the provision of aged care services over the last two decades. Successive Governments have not taken decisive action in terms of real reform due to the complexities and potential political impact of policy making in the aged care space. As has been said by more than one politician, “aged care is an election loser, but not an election winner”. This reflects poorly on both the politician but also on the Australian community.

To that end, the focus on aged care policy has historically been aimed at keeping it off the front page of the newspapers and media reports, or at least having the necessary protections to defray responsibility for any adverse events that may arise from time to time – always have someone else to blame! The policy framework to that extent has been one based on two paradigms –


 ***The Paradigm of Prejudice*** – based on the principle that all aged care providers are not to be trusted and have to be subject to severe legislative punishment – the “guilty until proven innocent” approach. To that extent the legislative environment is focused on “**command and control**” mechanisms, not on partnership or mutual trust and respect; and its twin


 ***The Paradigm of Paternalism*** – based on the principle that older Australians are somehow incapable of making their own decisions and choices, and that there has to be a position taken by the Department of Health and Ageing between the consumer and aged care provider. There is no consideration for example, of the reality that consumers may be capable of operating a subsidy budget from the Government to source their own services, something conducted elsewhere in the global community for some years.

On the basis of both paradigms, followed religiously and simultaneously, the whole thrust of the Aged Care Act 1997 and its predecessors is engendered with the ultimate authoritarian twist, which is surely thinking that is inconsistent with the need for forward movement in our policy framework in an ever changing environment. Indeed as was noted by Professor Warren Hogan in his presentations at a number of conference venues, such thinking would not be out of place in Stalinist states, and therefore surely should not be a feature of Australian thinking.




If one was considering the establishment of an aged care system today, would we establish something that

 Has 19 separate “programs” for community care with separate accountability requirements and rules, within the Department of Health and Ageing alone;

 Includes further unrelated programs for community care operated through other Government departments such as the Department of Veteran’s Affairs and State Governments (HACC), albeit that the latter is planned to transition to Australian Government responsibility from 2012 at this stage;

 Sees residential aged care services streamed into three distinct foci of low care; high care and extra service places, the latter being created simply because of a failed policy around capital funding;

 Focuses on “protecting the kids’ inheritance” at the expense of the Australian taxpayer – the only nation in the Western world with such an archaic policy;

-  Reflects a system so complex and confusing to access and operate that a lot of bureaucratic attention is paid to the “interface” between programs rather than truly paying attention to consumer needs and aspirations;
-  Effectively sacrifices consumer choice and preference to the alter of a “one size fits all” approach, whilst simultaneously preaching consumer centric care; and
-  Which requires more than 700 bureaucrats within the Department of Health and Ageing to administer, in addition to ancillary employees across Government owned enterprises.

Or would we hypothetically focus on the needs of the consumer in terms of service provision, treat their needs as a gradated process wherein people move up and down the continuum, and require the Australian taxpayer to only support those who indeed do not have the capacity to support themselves?

It is the intent of this submission to address the issues raised in the context of the Terms of Reference, but additionally to consider the prospect to inform thinking for the future delivery of services within Australia.

It is a matter of fact that within the United Kingdom, United States of America, and many parts of Europe and Scandinavia not to mention New Zealand, that access to taxpayer subsidies for aged care funding are available only after personal resources have been utilised, down to a required level of assets and income. In contrast, our Australian system is characterised by convoluted structures that have the effect of “*protecting the kid's inheritance*” and also effectively has part-pensioners in low care residential beds cross subsidising millionaires in high care residential facilities.

“Perverse” is a description that springs to mind under these circumstances however it seems far too gentle a descriptor.

In its most recent study of the aged care challenge facing Australia, ¹the Productivity Commission concluded that

“Australia’s extensively regulated, highly subsidised and somewhat ‘standardised’ aged care system will come under increasing pressure as a result of population ageing and growing diversity among older people. These pressures will present a number of challenges for the current policy framework and require changes to enhance its effectiveness”.

Consequently even the most recent independent Government initiated inquiry concluded inter alia, **that the Australian aged care system is in need of reform.**

Indeed within the Issues Paper provided by the Productivity Commission for this inquiry² the question is posed “Are there findings or recommendations from previous reviews of aged care in Australia that remain relevant?”. It would simply be easier to describe the reforms introduced as a result of the myriad of inquiries and recommendations already undertaken – effectively none of any significance. If we look at legislative amendments passed over the last four to five year period, almost all such amendments have been focused upon punitive action against service providers and those directly providing the care. At least in that respect we have political bipartisanship, because both sides of politics have failed the Australian people in this policy and reform void.

¹ Productivity Commission 2008 Overview xv

² Productivity Commission Issues Paper – Caring for Older Australians P.5
“Caring for Older Australians”

It is critically important, especially in the context of a post-GFC recovery, that all areas of taxpayer expenditure are reviewed for their effectiveness, efficiency, and value for money. This does not equate to a “slash and burn” fiscal response, but should be more so about new thinking and new directions, building upon what is good and positive and eliminating unnecessary and wasteful regulatory and compliance frameworks.

The fundamental issue is about establishing a consumer-centred vision for the future of aged and long term care that is sustainable and affordable to the Australian economy and appropriate and acceptable to our community. Perhaps this inquiry can be a first step to establishing such vision, and taking the first step to legitimate, substantial, and effective reform.

Perhaps it says much about our political priorities when as a nation we are prepared to spend significantly more to pay for accommodation and care of prisoners and asylum seekers than we are for the care of our older Australians. Most fair minded Australians (the significant majority of our community) would find such a principle abhorrent if they were made sufficiently aware. The practical policy outcome is that those who made this country what it is today, and to whom we all owe a great debt, are less important than those who have either committed crimes against society or those seeking to enter our country illegally. Is this the nature of societal priorities that we truly desire as Australians?

RECOMMENDATIONS

Recommendation 1. The Australian Government should accept the responsibility for providing a sustainable and viable aged care industry, and should not expect service providers to cross subsidise inadequate income streams from other activities.

Recommendation 2. That the Productivity Commission inquiry supports the concept of planning for long-term care rather than separating aged care from other logically aligned activities such as disability services, mental health and primary care.

Recommendation 3. That a dedicated independent review of regulations and legislation be established by way of a future Productivity Commission inquiry to identify and propose elimination of duplication primarily within aged care regulation and legislation where it appears most prevalent. Such an approach would be consistent with the stated intentions of both sides of politics to “cut the red tape”.

Recommendation 4. That the inquiry finds that the Australian Government should not seek to interfere with consumer choice and established contractual arrangements by seeking to focus upon a singular component of the accommodation market, being the retirement village sector.

Recommendation 5. That the Government be encouraged to continue its focus on affordable housing via the Department of Housing.

Recommendation 6. That Government involvement in accommodation selection should remain by way of providing means-tested rental support for those without the fiscal capacity. Such rental assistance should be at a level commensurate with the potential income available to the asset owner by alternative means of tenancy arrangement.

Recommendation 7. That the current model of Accommodation Supplements within the aged care system and requiring a 40% Concessional resident threshold be condensed to a singular payment model without inherent penalty.

Recommendation 8. That the present system of assessment by way of ACAT / ACAS services be replaced by a revised and updated “Comprehensive Medical Assessment” (more aligned to the gradated model of care) prepared by a General Practitioner. This will have the impact of aligning access to aged care and the hospital sector and removing the existing duplication funded by the Australian taxpayer.

Recommendation 9. That where consumers have the financial capacity they should be required to contribute to the costs of service provision, eliminating the existing policy with the effect of “protecting the kids’ inheritance” and bringing a higher degree of equity to the system.

Recommendation 10. That a single gradated system of funding be established across both community and residential care as initially incorporated into the work done by Dr. Richard Rosewarne in the development of the Aged Care Funding Instrument. This will eliminate unnecessary, complicated and duplicative business rules and provide seamless access to funding based on assessed need. It will also eliminate the current practice of individual clients being able to “double dip” into different programs as identified in the AIHW report.

Recommendation 11. That the inquiry proposes, through COAG processes, long term care services be included in consideration around preventative and restorative care, and assist with establishing seed funding for such activities. This will lessen the impact on the acute sector and provide a funding stream to enhance resource capacity and expertise to grow service delivery capacity to the community, save funding in the acute sector (and perhaps impede further avoidable hospital construction), whilst enhancing fiscal viability of traditional aged care providers.

Recommendation 12. That the establishment of a long term care focus structured along the lines of a clinical care team approach, would provide much stronger care linkages and outcomes between primary care and the other essential disciplines. Such an approach has the strong potential to deliver improved clinical outcome at no additional cost to taxpayers. A matrix approach as opposed to silos will optimise the funding available for direct care provision, and facilitate strong collaborative functioning between multi disciplinary teams based on mutual respect for their skills, expertise and professionalism.

Recommendation 13. That, consistent with the myriad of recommendations from previous inquiries, the Government take action to separate policies and funding around accommodation and care, focus scarce taxpayer funding on the provision of care, and leave accommodation decision to consumer choice. This would finally deliver consistency, consumer equity and real choice between traditional community and residential aged care services.

Recommendation 14. Consequent to Recommendation 13 and in conjunction with Recommendation 10 eliminate all existing artificial distinctions between various levels of care across all such care programs.

Recommendation 15. Consistent with the myriad of recommendations from previous inquiries, the Government take immediate action to

- Establish, in conjunction with the industry and appropriate research body, a weighted index based on the value of a basket of goods to identify a baseline cost of care;
- Charge the ABS with the development of a consequential index that can track the movement in this baseline cost of care across time;
- Commit to meeting the indexation increases arising there from, unless offsetting independently verifiable efficiencies are made available by way of regulatory or legislative improvement; and
- Likewise commit to meeting the costs associated with the implementation of any further regulatory requirements.

- **Recommendation 16.** That Government, in conjunction with the industry, investigate the overseas experience of Consumer Directed Care by way of vouchers, and develop policy and timing to introduce the CDC concept within Australia.

Recommendation 17. In conjunction with vouchers being introduced, align regulation to ensure consistent regulatory treatment of both informal and formal carers in terms of require qualification, experience, reporting and accountability requirements and insurance coverage.

Recommendation 18. Depending on the capacity of the Productivity Commission to broaden the definition associated with this inquiry to long term care, stretch the concept of long term care provided

- Service delivery across all areas is based upon assessed need;
- There are no artificial barriers able to be applied via contorted “business rules” between aged care and those living with the impact of non-aged related disability.

Recommendation 19. However if a broader definition is not open to the Productivity Commission, propose an immediate adjustment of the service planning regime based on 1,000 people aged 85+ years, and rebalance the weighting between community and residential care based on consumer preference advice.

Recommendation 20. Establish a transitionary period of not less than 5 years using the projections based on Recommendation 19 to inform planning for the immediate future and deliver short term certainty to the community.

Recommendation 21. That the Australian Government assume responsibility for long term care incorporating aged care; disability services; primary care and mental health – encapsulating for the first time all consistent aspects of chronic disease management.

Recommendation 22. That subsequent to Recommendation 21 a matrix approach be established across these areas to replace the siloed thinking that currently permeates policy development. This would introduce common standards where relevant, and avoid unnecessary duplication; whilst enhancing policy and regulatory interoperability.

Recommendation 23. That the Government embark on a genuine reform of re-regulation of the industry, based on a true risk management approach. Accountability is critically important however “obsessive and oppressive” regulation must be removed from the system.

Recommendation 24. That the Government adopt the approach of a minimum data set (such as the InterRAI used in the U.S., Europe and Scandinavia) against which audits could be conducted by Government based upon benchmark irregularities, providing the basis of a risk based approach. This would provide accountability for the industry; enhance confidence from the Australian community; and importantly provide a basis for the international benchmarking of the Australian industry.

Recommendation 25. That the Government ensure and insist (consistent with its own policies) that no regulation is introduced that does not carry with it an independently verifiable regulatory impact statement which has received industry input.

Recommendation 26. That the industry be charged, with the support of appropriate research resources and ancillary support, to develop role based definitions and skills requirements, acknowledging the shortfall anticipated in future years. Such skill profiles should be used to influence the education curriculum for enhancing workforce planning and capacity building.

Recommendation 27. That specific funding be made available to enable the industry, (perhaps through the Aged Care Industry Information Technology Council) to investigate and establish a list of products and suppliers to readily access such devices.

Recommendation 28. That once such a product list is available, that seeding grant funds be made available in a single year to enable service providers to purchase and deploy such equipment, the requirement being reporting on its success (or failure) as an end of year report.

Recommendation 29. That the Australian Government take whatever steps necessary to establish an electronic health record capacity in Australia in a timely manner, recognising the urgent nature of this fundamental reform. In the absence of such capacity real efficiency and collaboration leading to substantial improvement in care outcomes will continue to elude Australia.






Recommendation 30. That the Australian Government recognise that with a clientele of over 1,000,000 Australians, and touching pharmacy; hospitals and primary health; the aged / long term care sector should be the priority area for the application of the electronic health record.

AUSTRALIAN AGED CARE – CONTRIBUTION AND ACHIEVEMENT

The Australian industry has much of which it should be proud, but so too should our community. The industry is a reflection of our Nation, providing services to a wide range of Australians from many ethnic as well as social and disadvantaged backgrounds. The industry services major metropolitan centres, regional areas, and even very remote regions of this vast land.

It is a testament to the dedication of the people within the aged care industry, that in a financial environment that has seen real fiscal productivity improvements since 1997 in excess of 2% per annum that the service delivery has been able to be continued. Regrettably, 2008 proved to be a watershed wherein aged care services seriously started to crumble under the weight of excessive regulation; insufficient funding; and a lack of vision and preparation for the needs of older Australians, with such trends only exacerbating since that time. The time is well past for tinkering at the edges, with serious reform a critical priority. It is time for a blank sheet of paper rather than the self-interested protectionism that pervades existing regulatory thinking. True reform will not be possible regardless of multiple inquiries and recommendations, without the Government of the day ensuring that new thinking is facilitated within the bureaucracy. There is a clear and present moral hazard when those most affected personally by major reform, are the very same people who have the capacity to stand in its way. Experience has shown this to be a pervasive truth in relation to the Department of Health and Ageing. Any review of recommendations for change, and their acceptance or rejection, provides a clear platform for understanding why significant evolution of policy frameworks has not occurred for more than a decade.

Quality care for older Australians should be a given, as should the resources to deliver same. It is said that a measure of the quality of a society is in how well it cares for its most vulnerable. In that sense Australia stands with a proud reputation historically, however our place in the world ranking has slipped over recent years. It is important to reflect on exactly what is delivered by the aged care industry, although some of the following data represent estimates only. The Australian aged care industry –

-  Provides residential aged care to in excess of 170,000 people;
-  Provides in-home care for over 900,000 people;
-  Employs in the region of an estimated 400,000 people, and is at least the 5th largest employer group (and growing) in the country;
-  Provides services that enable Australian workers to engage in paid employment rather than remaining as informal carers, thus contributing much needed taxation income to the nation and providing a sense of wellbeing for the individual, thereby contributing positively to GDP; and
-  Reflects less than 20% of the Australian Government outlays on Health and Aged Care, at around 0.7% of GDP, yet attracts significantly disproportionate regulatory interdiction.

By any measure, the aged care industry is a major contributor to the economic, social and infrastructural fabric of our community. The industry has historically been referred to as a “cottage industry” however its emergence over the last 10 years in an ever-evolving constant state of change, has delivered an industry poised by its own actions and preparation for future sustainable activity.

As a consequence of this increased level of commercial professionalism, many in the industry have made the decision that residential aged care under the current regulatory framework is not sustainable and have voiced this view. Such a view has not only been voiced, but acted upon, with now several thousand residential aged care bed licences not being taken up in the ACAR rounds. At a time in our history when demand will escalate, the current policy framework is failing older Australians, their families, and indeed the Nation.

A new report recently launched³ includes a comprehensive modelling for residential aged care which concludes that the existing capital and recurrent funding structure will not deliver sufficient returns to even meet the financing costs associated with borrowings. Consequently financial institutions have walked away from lending for residential aged care facilities in the absence of collocated profitable activities. What this means of course is that the service provider assumes additional risk by adding legislative risk rightly belonging to the Australian Government. The inherent presumption⁴ in questions from the Senate inquiry in 2009 suggested that aged care service providers should cross subsidise aged care services from other activities including retirement village activities. This approach amounts to forced nationalisation or profit transfer at Government insistence – something we hear about in third world nations, but certainly not in modern progressive economies such as Australia.

Recommendation 1. The Australian Government should accept the responsibility for providing a sustainable and viable aged care industry, and should not expect service providers to cross subsidise inadequate income streams from other activities.

In the absence of significant and true reform, Australia stands poised to be the first modern western democracy that has failed to prepare for the demographic challenges that we have known and talked about for years.

³ Health Reform – the Aged Care Chapter – ACAA; PKF; Hynes Lawyers. August 2010 Pp.13 - 15

⁴ Senator Gary Humphries – Senate Inquiry – Residential and Community Aged Care 2009

“Caring for Older Australians”

Submission to the Productivity Commission.

CARING FOR CARERS

Whilst not specifically covered in the Terms of Reference, I felt that it was essential to raise with the Committee the issue of caring for those who give so much of themselves in their role as carers. In that sense I refer to both informal (family and friends) and formal (those who have chosen the profession of caring) at all levels.

Currently our Australian system lacks the true recognition of carers, and indeed under many circumstances, actual abuse of carers is not unheard of in the pursuit of ever escalating regulatory regimes. I can almost hear the reaction of Commissioners now, presuming that this statement is a gross exaggeration and could not possibly be true.

In clarifying my point, may I please take you back to the twin paradigms mentioned earlier in this submission? The Paradigm of Prejudice is alive and well, and resides quite contentedly within the Aged Care Act 1997 and all of its associated Principles and **enforcement** (the word used in the Act) provisions. The inherent assumption is that those who provide the care somehow have a covert and evil intent to do wrong when caring for older Australians. Within the very same Department of Health and Ageing, when considering acute (hospital) care, such a presumption would be considered scandalous and completely unacceptable. If the base legislation sets the framework for its application, then the Act indeed incites disrespect and maltreatment of people working within aged care services, under the guise of “protecting vulnerable citizens”.

The complexity and ever burgeoning regulation within the aged care industry is driven in no small part by the inefficiencies of the regulatory regime itself. Indeed Professor Warren Hogan made it clear in his report that regulation is at the heart of much of the inefficiency within the industry, and a section has been devoted in this submission on this matter. Although his report is now some six years old, the only thing that has changed is that there is now even more regulation to drain the available care funds. His fundamental recommendation to develop an indexation based on a basket of services remains ignored, and the 1.75% Conditional Adjustment Payment has been withdrawn without the countervailing indexation development. Although Professor Hogan quite actively agitated for renewed thinking and action in partnership with the aged care industry, his recent passing has meant that he will not see such reform.

Consider the situation for someone working in an aged care service, (currently for the moment, residential care), where the existing interdictions occur (although it appears to be intended to seek to perform the same kind of function in community care services). Given the vagaries of those for whom we provide care, days wherein things run smoothly are few and far between – such is the nature of “human services”.

Suddenly, just after you've finished breakfast for the elders, and probably being in the middle of assisting with medication, two assessors or investigators (depending on the relevant Department but they always travel in at least pairs) appear at the front door, flashing their cards, and proceed to dominate the scarce time resources available to the carer, nurse and manager of the facility for the full day (at least). During this time those present are interrogated by the assessors / investigators, often treated with intimidatory tactics and disrespect, and left drained and harangued by the end of the day, and wondering why they bother to submit themselves to such treatment. In some cases, that is the last day of their employment in aged care. And what about the elders and their needs on that day?

The draining of resources is ironic when one considers that such interdictive action is justified on the basis of “protection of the elderly”.

It is critical if we are to stem the flow of resignations of qualified and experienced people from the aged care industry, that a paradigm of respect for carers be adopted by those representing the Australian Government, in whatever their responsibility. Carers are critically important to our ability to provide quality services to older Australians, and those younger Australians living with a disability. Indeed we already know that in our future there will be insufficient numbers of carers to meet such demand under the existing service delivery model.

We need to stem the outflow of such carers as a logical first step of being able to sustain services into the future.

SERVICE DELIVERY FRAMEWORK

Anecdotally today's consumers do not want nursing homes – they have said loud and clear that they wish to remain at home (whatever that means for them) and have services brought to them by way of a menu of choices from which they exercise their choice. Successive Australian Governments to their credit have acted upon such preferences by way of establishing “packaged care” services to build upon the Home and Community Care program.

Regrettably the system is fraught with duplication, inconsistencies and excessively expensive reporting and compliance mechanisms. Although community care is regarded as homogeneous, each program has its own reporting requirements, there are different contracts, and indeed separate data compilation requirements. Why are these aspects so inconsistent? That's actually an easy question to answer – each is a “program” and is overseen by a different group of bureaucrats, making different decisions without even contemplating how “the system” outside of their corner of it, could operate more efficiently and effectively.

When we consider residential care, although there is a singular system of legislation, reporting and accreditation, the myriad of “business rules” overlaying the system are duplicative and extreme. Previous inquiries have covered this subject more than adequately, including the most recent inquiry into the functioning of the Complaints Investigation Scheme (C.I.S.). Further, in the context of residential aged care the legislation seeks to cover virtually every aspect of facility operations, save one, the determination of the staffing levels, effectively ignoring the most significant cost aspect in such services, and consequently being able to disregard such a significant cost in contemplating indexation.

Indeed perhaps it is opportune to ask why do we always talk in respect of community care and residential care as if they were two separate coins, when indeed at worst they represent the flip sides of the same coin.

In its report, the National Health and Hospitals Reform Commission spent scant time on even considering the importance of long term care services to the overall health system, although it would not be presumptuous to say that without the long term care sector, the acute sector would clog and grind to a halt on so many dimensions.

For the long term care industry to be effective and continue to contribute positively to the care needs of those it serves; and continue to contribute so positively and comprehensively to the Australian economy; the service delivery framework of the future must seek efficient and effective consumer choice based care.

Recommendation 2. That the Productivity Commission inquiry supports the concept of planning for long-term care rather than separating aged care from other logically aligned activities such as disability services, mental health and primary care.

Consumer Protection

Much is made within the Aged Care Act about protecting Australia's most vulnerable citizens, and this is something that appropriately Australians would expect – it is fundamental to our national psyche. However one should ask whether the DH&A is the appropriate body to take responsibility for such consumer protection.

Across all states for example, we have the department under the Minister for Consumer Affairs (howsoever called) and certainly in Queensland we have the Health Quality Complaints Commission overseeing health related complaints.

That provides in Queensland at least two state bureaucracies to whom complaints or concerns can be taken, although there are others such as the Adult Guardian which can also take action. Added to this mix we have the Department of Health and Ageing. If the health industry in its broader context (including long term care) is to be streamlined, would it not make sense for it to concentrate on those areas not already being done effectively by others, rather than building parallel layers of bureaucracy and absorbing precious resources in the process.







Recommendation 3. That a dedicated independent review of regulations and legislation be established by way of a future Productivity Commission inquiry to identify and propose elimination of duplication primarily within aged care regulation and legislation where it appears most prevalent. Such an approach would be consistent with the stated intentions of both sides of politics to “cut the red tape”.

Housing

Safe and affordable shelter is the most fundamental element required by human beings. In its absence there are detrimental impacts upon health, wellbeing, and social interaction. In that context it is interesting to note in the terms of reference to this inquiry that the Commission has been asked to consider the role of retirement villages.

Much has been said of this issue by senior managers within the Department of Health and Ageing over recent years. It is an area where there appears to be the view that an opportunity exists for the DH&A to extend their legislative reach to encapsulate retirement villages on the basis that they are focused upon the elderly, and by extension could well come under the purview of the DH&A. If this sounds overtly critical of the intentions of the Department, one could reasonably ask why retirement villages in isolation have been singled out when there is no consideration of social housing, affordable housing, the general rental market, caravan parks (home for many older Australians) or indeed the general issue of affordability in the freehold or rental markets.

The retirement villages industry, whilst referred to generically, indeed is a stratified industry, covering the following inexhaustive list:

-  Mobile home parks;
-  Rental villages;
-  Loan license villages;
-  Freehold villages;
-  Strata titled villages; and of course
-  Mixed villages encapsulating aspects of some or all of the above.

From a pricing perspective, there is likewise a myriad of considerations within the industry ranging from rental (as noted above), all the way through to villages with units costing in excess of A\$ 1.5m. The operators of these villages vary greatly also, as does the corporate structure of these organisations. They range from family owned business or partnerships; private companies both small and large; church organisations; community groups; and publically listed corporations – they may be a small local organisation, right through to national operations incorporating thousands of units across the nation.

Generic terminology perhaps – but homogeneous this industry definitely is not.

As for the role that such villages provide with respect to providing services to older Australians, they provide the most fundamental service – safe and appropriate housing. By and large the units built in this sector consider the ongoing needs of the older person and encapsulate aged-friendly design. Ironically aged-friendly design criteria are suitable for any age, and would add minimal cost to built form construction.


In contrast, the design criteria established by the Department of Health and Ageing in addition to the requirements of the Building Code of Australia adds substantial cost to building residential aged care places, indeed making it some of the most expensive construction in Australia at around \$ 230k per bed, about twice the cost of a four bedroom brick house in terms of construction cost.

As previously noted, appropriate housing is a fundamental tenet as the very core of health and wellbeing. This is evidenced by organisations focusing on the care needs of those suffering homelessness, such as Wintringham⁵. As noted by the Wintringham CEO, Bryan Lipmann AO, following admission to services the health state of many residents improve simply because there is a safe environment and a roof over their heads. I do not seek to trivialise the needs of the homeless here, but merely to reinforce that appropriate, safe, secure and affordable housing is the basis of all health and wellbeing.

The historical housing design principles, it would be fair to say have been based upon Mum, Dad and 2.4 kids. The needs of such a cohort are quite substantively different to those of someone of 85 years of age with mobility limitations, where stairs are not only a challenge but can be, at the extreme, a matter of life or death. A set of stairs with no alternative access can lead to abject social isolation, health deterioration, otherwise avoidable hospitalisation, and / or premature admission to residential aged care. It would not be an exaggeration to say that there are a number of elders within residential aged care services today who, given more appropriate housing access, could or would probably still be living in the community.


So a critical issue revolves around housing and the policies that apply thereto. The Australian Government is addressing this within its policy framework around both the National Rental Affordability Scheme (NRAS) and the policy pertaining to the Stimulus Housing Program. If all housing under these programs were stipulated to be aged-friendly in addition to being required to be environmentally sustainable (this is an existing requirement), this additional housing stock of an estimated 50,000 homes would go a long way to addressing some of the housing needs of older Australians, and provide an enhanced resource to support the principles around community care. It could also assist in reigning in rental costs and improve affordability across the nation.


Consequently there are some basic considerations in relation to housing, some of which could be interpreted as -

 The issue around housing should fundamentally be one about choice. Older Australians have exercised freedom of choice, and balanced their purchasing decisions between aspirations and fiscal value and reality all of their lives.

⁵ Wintringham is a specialised service in Victoria focused on the specific needs of the Homeless. www.wintringham.org.au
“Caring for Older Australians”

Amongst other things Australia has often been described as a consumerist society. Why should these same principles not apply when it comes to long term care?

 Not every older Australian has the financial capacity to do other than rent a home, but surely the location, features and bedroom configuration should be their choice also, however

 If others have the capacity to own their own home, what right does anyone have to tell them they now have to move because their care needs have changed?

Government involvement in the decisions related to housing or accommodation choice for older Australians should be one of facilitation, not direction, with existing social support by way of rental subsidies continuing to be made available for those most in need.

Recommendation 4. That the inquiry finds that the Australian Government should not seek to interfere with consumer choice and established contractual arrangements by seeking to focus upon a singular component of the accommodation market, being the retirement village sector.

Recommendation 5. That the Government be encouraged to continue its focus on affordable housing via the Department of Housing.

Recommendation 6. That Government involvement in accommodation selection should remain by way of providing means-tested rental support for those without the fiscal capacity. Such rental assistance should be at a level commensurate with the potential income available to the asset owner by alternative means of tenancy arrangement.

Recommendation 7. That the current model of Accommodation Supplements within the aged care system and requiring a 40% Concessional resident threshold be condensed to a singular payment model without inherent penalty.

Accessing the System

It would be difficult to describe the process of accessing services for aged care as being simple. Indeed if we just reflect for a moment on the process for accessing hospital services, it is a relatively simple matter – you can be sent to hospital via a referral from a General Practitioner. In essence, the professional judgement of a GP enables any Australian to access both public and private hospitals (the latter dependent on holding health fund membership or being willing to self-fund), constituting a cost to Government some fourfold that applying to aged care. Consequently the practice of referral to hospital is essentially a one-step process.

Accessing the aged care system starts at the same point – a GP referral. However at this time such a referral does not lead a consumer to service provision – instead it leads them to an “Aged Care Assessment Team” (ACAT or ACAS depending in which state you live).

This team then conducts an assessment to determine your care needs (already done by the GP potentially under an MBS Item payment for a Comprehensive Medical Assessment), and decides what level of care you need based on this time limited assessment, and whether you require community or residentially based services, and the level of these services. Try as they might with the very best of intention, the snapshot of the individual and their needs must be an incredibly difficult activity for the members of these teams. Alternatively the GP has probably known the individual and their family for a number of years, knows and understands the clinical issues they face and probably has a very solid grasp of the level of deterioration over time along with understanding the impact on partners and family.

It is only after the ACAT assessment that as a consumer you can start to identify service providers, and later to access them, and ultimately the services they provide.

Anecdotally within the industry it is often noted that the ACAT assessment of care need is correct roughly 50% of the time. Given that the same outcome probability can be achieved by way of tossing a coin, one has to seriously consider if the investment in such infrastructure is indeed “value for money”, especially when the taxpayer is essentially paying twice for such services. There is a significant investment in the ACAT infrastructure, along with payment to General Practitioners for Comprehensive Medical Assessments. Process substitution under such circumstances surely makes logical and policy sense.

Recommendation 8. That the present system of assessment by way of ACAT / ACAS services be replaced by a revised and updated “Comprehensive Medical Assessment” (more aligned to the graduated model of care) prepared by a General Practitioner. This will have the impact of aligning access to aged care and the hospital sector and removing the existing duplication funded by the Australian taxpayer.

Equity of Access

A study conducted by the Australian Institute of Health and Welfare showed that users of the aged care system were in many cases, accessing multiple programs simultaneously. The study was based on 2003 / 2004 data and showed that

⁶Some care programs can be accessed simultaneously. Six months after assessment:

- Nearly 8% of the cohort who were still alive were recipients of a Community Aged Care Package; of these, nearly 30% were also using services from other programs.
- Around 40% of people who were clients of Veterans’ Home Care were also accessing services from the large Home and Community Care program.
- 13% of those using Home and Community Care were also accessing other programs.
- More than half of the people in residential respite care 6 months after assessment were accessing a community care program when they were at home.

The data also showed a significant finding in that the majority of those accessing ACAT assessments did not access services at all even after 2 years, although some customers had passed away in the intervening period.

⁶ AIHW Pathways Through Aged Care – October 2009. Page 2.
 “Caring for Older Australians”
 Submission to the Productivity Commission.

Table 6: Time to use of ACAT-dependent programs, PIAC new-pathways cohort (per cent)

Time after completion of reference ACAT assessment	Started on a CACP			Admitted into permanent RAC		
	With HACC/VHC before	No previous care	All	With HACC/VHC before	No previous care	All
Within 91 days	7.2	5.0	6.2	19.6	18.4	19.1
92–183 days	2.6	1.9	2.3	7.1	5.5	6.4
184–274 days	1.4	1.2	1.3	4.8	4.0	4.4
275–365 days	1.1	0.7	0.9	3.9	3.0	3.5
<i>Within 1 year</i>	<i>12.3</i>	<i>8.8</i>	<i>10.8</i>	<i>35.5</i>	<i>30.8</i>	<i>33.4</i>
366–456 days	0.8	0.6	0.7	3.4	2.6	3.0
457–548 days	0.7	0.6	0.6	2.8	2.4	2.6
549–639 days	0.5	0.4	0.5	2.5	2.0	2.3
640–730 days	0.6	0.4	0.5	2.3	1.8	2.1
<i>1 to 2 years</i>	<i>2.6</i>	<i>2.0</i>	<i>2.3</i>	<i>10.9</i>	<i>8.7</i>	<i>9.9</i>
<i>Within 2 years</i>	<i>14.9</i>	<i>10.8</i>	<i>13.1</i>	<i>46.4</i>	<i>39.5</i>	<i>43.3</i>
No event	85.1	89.2	86.9	53.6	60.5	56.7
Total	100.0	100.0	100.0	100.0	100.0	100.0
Total (people)	42,920	34,428	77,348	42,920	34,428	77,348

Notes

1. Table excludes 89 records with a pathway that indicated death before receipt of care because this implies linkage errors.
2. The reference date is the date of the end of the first completed ACAT assessment in 2003–04.

One is lead to the obvious question as to how effective is the existing process via ACAT, and is there a better way. How can we best deliver value for money to the Australian taxpayer?

Recommendation 9. That where consumers have the financial capacity they should be required to contribute to the costs of service provision, eliminating the existing policy with the effect of “protecting the kids’ inheritance” and bringing a higher degree of equity to the system.

Care Delivery

The extensive and productive work that was done on the Aged Care Funding Instrument (ACFI) ⁸ and in particular the consultation leading up to and incorporated into its development, has not been taken to its potential benefit. The concept within the development of the ACFI was to have a graduated scale of subsidies based directly upon the identified care needs of the person, effectively moving from (0,0) to (100,100) in an index sense. The essential idea was that a person could move both up and down this scale dependent on their needs, and it took account of the fact that needs are indeed changeable.

In principle there is no reason why this scale should have been regarded as applying to residential aged care alone, as this was not its intention.

⁷ AIHW Pathways Through Aged Care – October 2009. Page 12.

⁸ This work was undertaken by Dr. Richard Rosewarne, Managing Director – Applied Aged Care Solutions. “Caring for Older Australians”

Additionally the complication surrounding the ACFI was brought about by the “business rules” introduced by the DH&A, not inherent to the instrument itself. Perversely the stated intention of the ACFI was to streamline what was the Resident Classification Scale (RCS), which in practical terms due to the application of the business rules “streamlined” 8 classifications into 63, and remains focused upon residential care alone at this juncture.

Within Community Care services, funding bears no relationship with the funding mechanisms established in residential care. It is as if there is an inferred variation based upon where you live rather than your care needs as an older Australian. As noted in the NH&HRC Report⁹,

- The level of funding support for people receiving aged care services in the community is ‘locked’ into different packages, rather than being based on a scale where need for services might increase incrementally. That is, a Community Aged Care Package (CACP) provided an average of about \$12,684 annually to support care. The next ‘level up’ is an Extended Aged Care at Home (EACH) package that provides over \$42,000 annually. There are no middle tiers of community care for people requiring more than a CACP, but less than an EACH package.

Consequently the level of funding available within packaged care results in a staccato effect. Clients must remain on one package for an extended period of time – probably much longer than is appropriate to their care needs, until their needs advance so significantly to get them up to the next level. One is left to wonder at whether if more could be done sooner even at a modest additional cost, would the care need progress to the same extent. In other words, rather than seeing Government outlays in absolute terms of expenditure, a rethink around “investing in care” might deliver dividends in both care outcome and fiscal terms.

It is on this basis that there should be one singular gradated system for long term care, based on assessed need. Such a gradated system should, as the nomenclature implies, recognise the need for incremental funding in response to assessed need, replacing the existing system that via complex and unnecessary business rules and structure requires additional unfunded care resources to be provided until such care needs literally “crash or crash through” the next artificial barrier.

Recommendation 10. That a single gradated system of funding be established across both community and residential care as initially incorporated into the work done by Dr. Richard Rosewarne in the development of the Aged Care Funding Instrument. This will eliminate unnecessary, complicated and duplicative business rules and provide seamless access to funding based on assessed need. It will also eliminate the current practice of individual clients being able to “double dip” into different programs as identified in the AIHW report.

⁹ A Healthier Future for All Australians – NH&HRC Interim Report December 2008.
“Caring for Older Australians”

Preventative and Restorative Health

Whilst outside of the scope of the inquiry, the role of preventative health cannot be underestimated in terms of its contribution to the health and well being of older Australians. Although traditionally thought of in terms of the scope of General Practitioners, it is also in the realm of allied health professionals and nurses.

A more effective methodology of managing chronic disease would have the potential to save the Australian economy substantial costs, most directly to the health budget, but also to the PBS and in terms of direct economic contribution. Long term care is, in its broadest sense beyond lifestyle, and is about the management of chronic illness. It is something that the long term care industry does extremely well, and could be engaged at a much more systematised manner rather than establishing duplicative services. To that end incorporating General Practices within aged care services could provide mutual benefit and enhance service delivery to the community.

The additional funding streams would assist long term care providers in maintaining the skills and expertise required to focus upon their specific client base whilst expanding the scope of practice to create a more enjoyable and rewarding work environment for those directly involved.

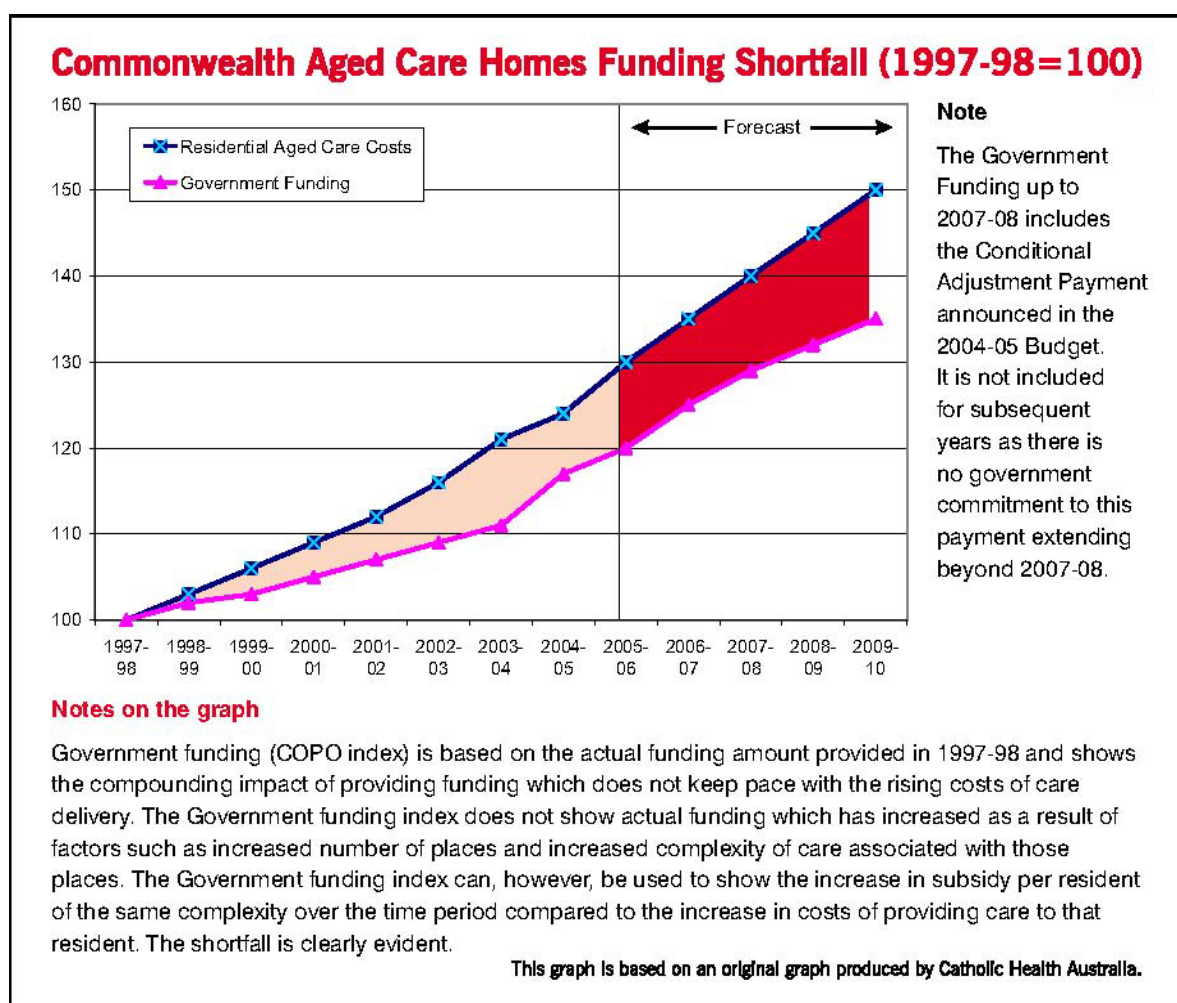
In the same manner, restorative health (rehabilitation) could be considered as another logical construct, with similar benefits. Under the current system Day Therapy Centres deliver some of this benefit to a very limited extent, and yet again it is limited due to the constraints placed upon them by way of funding and contractual restraints.

Recommendation 11. That the inquiry proposes, through COAG processes, long term care services be included in consideration around preventative and restorative care, and assist with establishing seed funding for such activities. This will lessen the impact on the acute sector and provide a funding stream to enhance resource capacity and expertise to grow service delivery capacity to the community, save funding in the acute sector (and perhaps impede further avoidable hospital construction), whilst enhancing fiscal viability of traditional aged care providers.

Recommendation 12. That the establishment of a long term care focus structured along the lines of a clinical care team approach, would provide much stronger care linkages and outcomes between primary care and the other essential disciplines. Such an approach has the strong potential to deliver improved clinical outcome at no additional cost to taxpayers. A matrix approach as opposed to silos will optimise the funding available for direct care provision, and facilitate strong collaborative functioning between multi disciplinary teams based on mutual respect for their skills, expertise and professionalism.

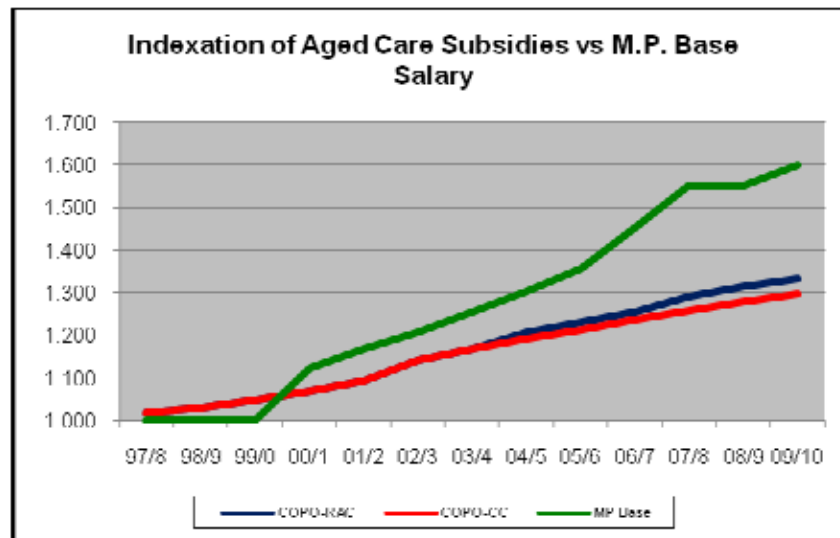
FUNDING AND REGULATORY ARRANGEMENTS

Many reviews have pondered the question of funding adequacy, and none have concluded that funding is sufficient to meet the true costs of care, and indeed many have recommended increases in funding. Interestingly the Aged Care Act 1997 binds service providers with continued and ongoing service responsibilities, however nowhere within the Act is there any direct responsibility or accountability on behalf of the Australian Government to fund that care. This situation is made even more perverse when one considers the myriad of unfunded regulatory impacts just in the recent few years including Police Checks; Mandatory Reporting; the introduction of the Complaints Investigation Scheme et al. The following graph was prepared by Catholic Health Australia and developed further by Aged Care Industry Council leading up to the 2007 election campaign.



The profile remains accurate to the extent that the Rudd Government extended the Conditional Adjustment Payment for the 2008 / 2009 year, but eliminated it thereafter. The shortfall clearly is increasing and has already to in excess of 15% over the last 10 years in residential care, and indeed the gap is far greater (approximating 23%) for community care, to which the Conditional Adjustment Payment was not extended when introduced in 2004.

When we consider, for example, that Parliamentary wage increases are determined via an independent body that considers the cost pressures relative to general cost escalations, we see that aged care subsidies are significantly behind such cost increase trends.



The variation on this basis is in the realm of some 30 basis points (~20%) represented by the gap between the lines to 2009/2010 and may have increased again over the last 12 months. It is implicitly interesting to consider this being the case in spite of there having been two “wage freezes” on Parliamentary salaries in this time period – one under Prime Minister Howard and the second under Prime Minister Rudd – and even with that backdrop the fact that there can still be a disparity of this magnitude says much about the shortfall in aged care funding.

When considering the nature of cost escalation with respect to aged care services, it is informative to reflect upon comments from previous inquiries into the industry.

¹⁰ *“The indexing arrangements that would continue to apply under the coalesced regime are deficient in that they are not directly related to movement in industry-specific costs”.*

¹¹ *“Wage costs are fundamentally influenced by pay outcomes for nurses in the acute care sector”.*

¹² *“Moreover, funding methodology should build on periodic reviews of change in the nature of residential aged care and the expectations of residents. Examples include the need to make provision for the purchase of improved incontinence aids, and for the lower number of beds per room that will be required as accreditation and certification progresses”.*

Remarkably, although these statements from independent reviewers were made up to 10 years ago, nothing has changed in terms of the lack of realism attached to the indexation processes relative to aged care funding. The COPO (Commonwealth Own Purpose Outlays) index by its very nature and construction, will always deliver an outcome that is less than CPI, and not address wage rate increases or wage parity.

COPO is calculated by taking 75% of the CPI and 25% of the national wage case (base wage rate movement). Such a calculation will always result in a sub-optimal increase in subsidy rates.

Indeed in its 2008 report,¹³ the Productivity Commission noted that the Conditional Adjustment Payment (CAP) was recommended by Professor Hogan as a temporary measure pending the establishment of new funding arrangements.

¹⁰ Nursing Home Subsidies, P. 81, and Productivity Commission 1999.

¹¹ The Hogan Review

¹² Ibid. P. 81

¹³ Trends in Aged Care Services, P. 100, Productivity Commission 2008
“Caring for Older Australians”

The Commission went on to note that the inter-departmental review of the CAP does not encompass the broader issue of the effectiveness of the current indexation arrangements. Predictably, that inter-departmental review recommended the elimination of the CAP but failed to recommend any changes to the indexation formula, thereby condemning the aged care industry and those for whom it provides care, to continued fiscal abuse sponsored by the Australian Government.

In its previous report ¹⁴ the Productivity Commission recommended that

“Basic subsidy rates should be adjusted annually according to indices which clearly reflect the changes in the average cost of the standardised input mix, less a discount to reflect changes in productivity. Revised indexation arrangements should be introduced as soon as possible.”

It is informative to consider where such reviews make recommendations that reduce bureaucracy they are rejected by the DH&A ¹⁵ however when any mention is proposed to entrench bureaucratic duplication and inefficiency it is pounced upon by the DH&A with voracity and self-interested zeal.

It is crystal clear therefore that for true reform to be undertaken, the work to be done must not be lead and directed by the DH&A. If we seriously wish to position Australia for the future; streamline policies and processes; create access and equity for older Australians corresponding with their needs and aspirations, the time for action is now!

It is absolutely essential that the DH&A be involved in this reform process, however under no circumstances should the DH&A be positioned as a filter or editor of the report outcomes. Our aged care system needs to be dragged, kicking and screaming if necessary, into the 21st Century, without being burdened or restricted by way of moral hazard.

¹⁴ Nursing Home Studies, Productivity Commission 1999

¹⁵ Banks Review 2006 suggested the removal of duplication of certification and that accreditation be contestable. Both rejected by DH&A. However DH&A grabbed with both hands the recommendation of the ANAO 2008 contending continuation of the obvious duplication of the Certification requirements, in spite of acknowledging that it had established a whole new industry of consultants and expensive professional advice.

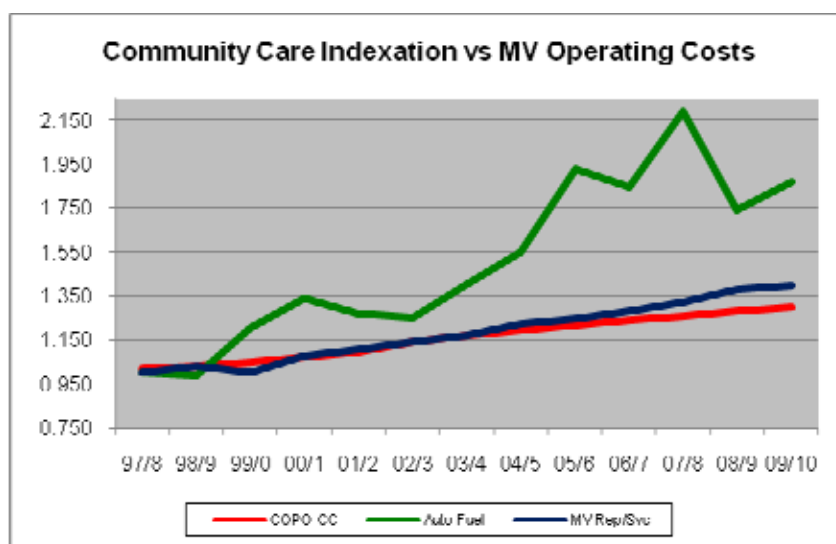
“Caring for Older Australians”

Submission to the Productivity Commission.

Community Care

Whilst the main focus in terms of aged care appears to be on residential services, there is no doubt that the preference of older Australians is to remain at home as long as possible, and indeed to make the ultimate life transition from home if at all possible. Public policy that responds to these aspirations is absolutely appropriate and successive Governments have sought to rebalance such service delivery.

In considering these particular preferences and aspirations, issues around travel time and cost are critical matters, none of which have been reflected in the subsidy levels over time. Community Care subsidies have lifted in the realm of 2% per annum over recent years, whilst ¹⁶ABS data indicates clearly that the price of automotive fuel, and the costs associated with motor vehicle repairs and servicing, a significant cost component in community care, outstrips indexation by 60 and 10 basis points respectively over the last 12 years of the current Act. Meeting such cost means a reduction in client contact time. The elastic band ultimately snaps and someone gets hurt.



Another significant aspect of the economic pressures on Community Care services relates to the lack of consistency in fees applied across the various programs. For example, in Queensland the Queensland Government both overshoots and competes with private providers in the community care space via the HACC program.

Indeed it has been reported that on the Sunshine Coast in Queensland, an abnormal level of vacancies in relation to Community Aged Care Packages (CACP) and Extended Aged Care at Home (EACH) Packages is driven by ACAT on the basis of a belief that HACC services carry a lower cost to the consumer than CACP or EACH.

Whilst taking a position of advocacy for consumers is admirable, this does result in cost shifting behaviour between State and Commonwealth and threatens the financial viability of service providers. On that basis such a position is not in the long term interests of consumers or the industry. It is understood that the Sunshine Coast is not the only ACAT taking such a view.

Consequently the aged care industry is being squeezed between not only restrictive and capped income with substantially increasing costs, but Government action via taxpayer funded ACAT activities is also impacting upon demand.

¹⁶ ABS 6401.0 Consumer Price Index, Australia, 2010 Series A2328636K (Fuel); A2328771A MV Repairs & Servicing. "Caring for Older Australians"

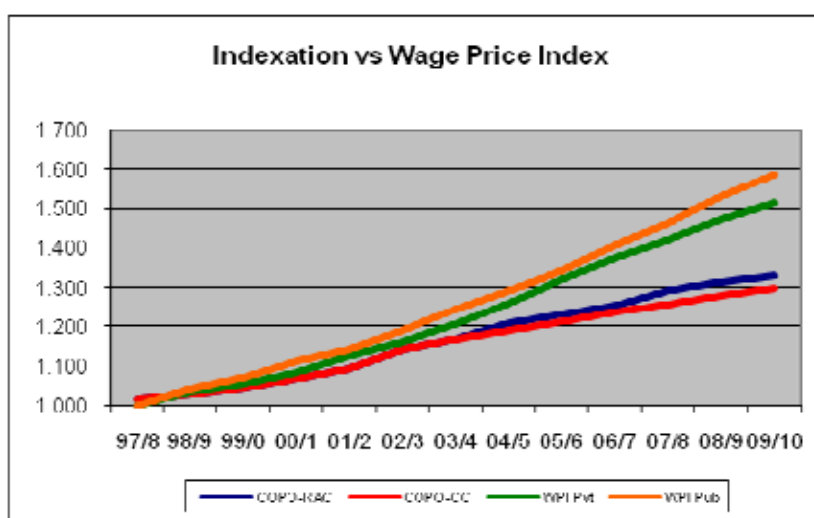
The Effectiveness of COPO Indexation

The current indexation method is “Commonwealth Own Purpose Outlays” (COPO), or COPOUT as it is better known within the aged care sector. COPO is calculated by taking 75% of the CPI and 25% of the national wage case (base wage rate movement). Such a calculation will always result in a sub-optimal increase in subsidy rates, especially when it effectively and directly discounts both elements of cost increases by its formula construction.

There is a range of cost escalation indices being produced by the Australian Bureau of Statistics currently across many sectors of the Australian economy. If we take a few examples, just for the sake of the exercise and compare increases in actual cost escalation to the COPO (self calculated) adjustments, we will see that COPO falls well short against every single measure. I have taken the relative data from the nominated ABS Reports and calculated the index based upon the increases in the ABS data for the relevant period.

The purpose of these comparisons is two fold –

1. To indicate the cost movements within the economy with which the aged care industry must cope based on the COPO indexation; and
2. Indicate that these costs affect aged care services in the identical manner that they impact other businesses. Shortfalls in funding as against cost increases logically, as noted by the Productivity Commission, will result in shaving costs and quality will ultimately be impacted. Government decisions dictate control of income, but they do not control costs.

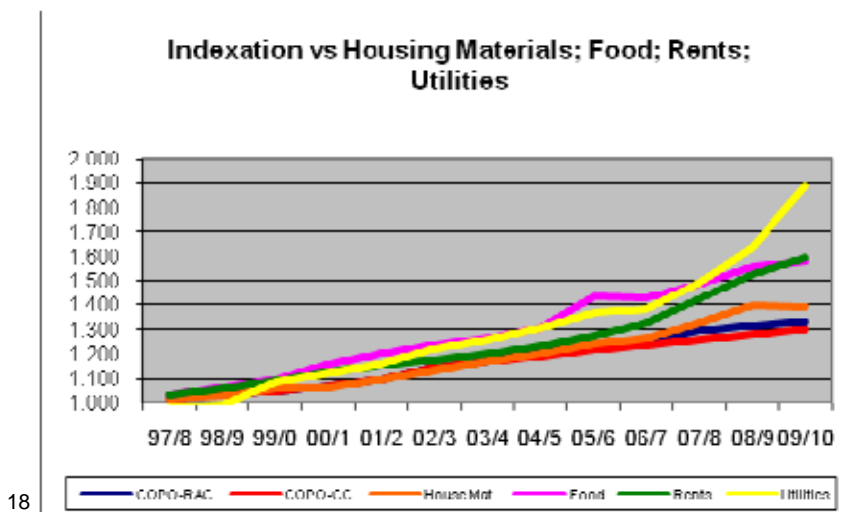


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The comparison shows how labour prices have moved in the health and social assistance (aged care and presumably disability service sector), and indicates that over the period the indexation for aged care has a shortfall of some 22 and 29 basis points to the private and public prices for the overall sector (17% and 23% respectively). Put another way, given the comments made by both Ministers Julia Gillard and Justine Elliot that aged care providers should pay their employees at the same level as the public sector, differentials of this magnitude make this an impossibility and highlights the political avarice towards the aged care industry. This comparison clearly impacts on the ability of the industry to compete for labour resources, in a very labour intensive activity.

¹⁷ ABS 6345.0 Wage Price Index Ordinary Time – Healthcare and Social Assistance - Hourly Rates of Pay Excluding Bonuses. Series A2603879J Public; A2602929A Private.

It was acknowledged by Professor Warren Hogan that unlike the acute care industry, the very nature of aged care services makes input substitution (technology for labour for example) of limited capability or benefit. Aged care workers need to pay their bills, and have a feeling of self achievement free from bureaucratic abuse and intimidation. Even for people in aged care however, as committed as they are to the elders they serve, altruism has its limitations.



The cost of materials comparison reflects the effective cost of materials and building maintenance in comparison to the increases brought about by indexation for residential aged care. It is clear that the indexation has not recognised the substantive increase in rents charged across the economy reflective of the costs of maintaining and funding accommodation maintenance. The food price inflation brought about by recent drought impacts have been exacerbated more recently by the diversion of food production to alternative fuel applications, whilst we are just starting to see the enormous impacts of utility prices as an early indication of what we will experience under a future Carbon Trading Scheme.

The inherent assumption that aged care services are protected from the general price escalations across the economy is naïve at best and negligent at worst. Is there really an expectation within Government(s) that somehow such substantial cost increases can be ignored, and then not expect deterioration in care standards as the income is stretched beyond capacity?

It is clearly recognised that the various components incorporated above have a differing proportionate impact on the costs of delivering services, but even with accepting that this is the case, none of the cost lines have followed a similar cost escalation history in comparison with the indexation of aged care subsidies.

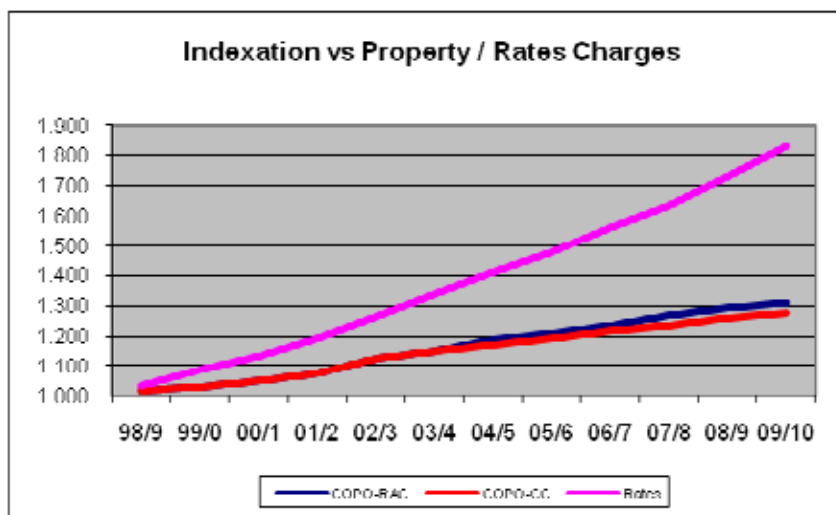
Whilst ever the Government wishes to completely control every aspect of a service providers' income, and dictate the standards to be preserved, there is an indicative moral hazard shared between the Government and the service provider in the event that the elastic band of available funds breaks. To date the Government(s) have avoided the repercussions of this moral hazard, however this is likely to change given the increasing number of services that are indeed collapsing across the nation. Most have been absorbed by other organisations and kept out of the media.

¹⁸ ABS 6427.0 Producer Price Index 2010 All Groups. Series 2390558X Materials Used in House Building.

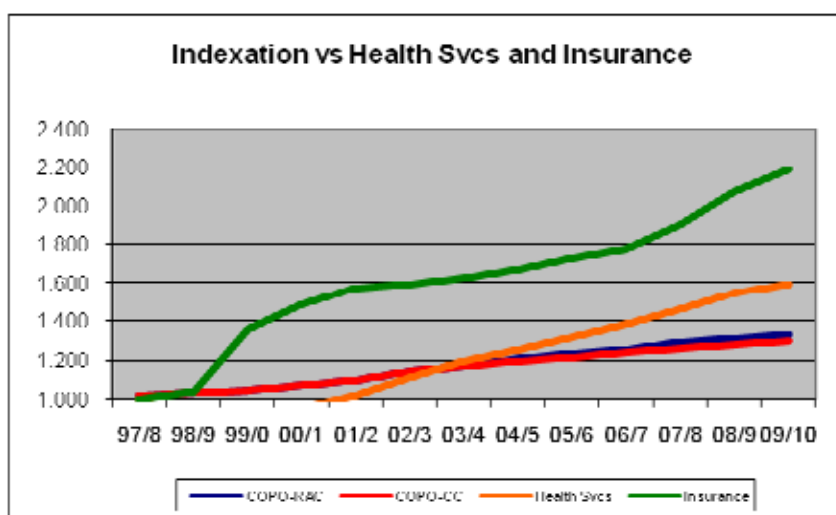
ABS 6401.0 Consumer Price Index 2010 All Capitals. Series A2325891 Food; A2331876F Rents; A2326521X Utilities.

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In the absence of an appropriate pricing index acknowledging the realities of cost escalation, or alternatively an acceptance by Government that the individual is responsible for meeting service costs where they are able, this price shortfall will continue.



¹⁹Property Rates and Charges are applied by local Government. On this basis residential aged care services and community care services are impacted in the same manner as the rest of the community. Again any inherent assumption that this is not so is clearly misdirected and unrealistic.



²⁰Aged care is a critical component of our overall health system and has the capacity, if properly funded, to relieve pressure from our hospital system, deliver better health outcomes for older Australians, and save considerable Government investment in hospitals and associated facilities.

When one considers the accepted reality that older people within our aged care services as clients today reflect an increased level of frailty and a higher level of complex care needs, the exorbitant manner in which health and insurance costs have screamed away from subsidy payment increases does not deliver an efficient or effective alternative to the acute sector.

It is widely accepted that older people should be kept out of hospital as much as possible. The fiscal strangling of the aged care industry means that significant cost saving opportunities are being lost to the Australian economy. The comparison of existing daily rates in hospitals as opposed to aged care services are a nonsense as they assume that the rate for aged care services are appropriate and correct. The same person in a public hospital bed receiving taxpayer funding of over \$ 1,100 per day, will receive a maximum of \$ 162.89 in residential aged care. And yet we are expected to employ similar skill sets at parity wage rates and provide lifestyle.

¹⁹ Ibid. Series ID. A2329986C

²⁰ Ibid. Health Services Australia Series ID. A2326836T – Insurance Series ID. A2332011L
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Indeed the same person in a public hospital bed in some cases could receive **no taxpayer contribution at all in a residential aged care bed**. Where is the equity?

Making the System Equitable

The existing capital funding system is structured in such a way as to have part pensioners in low care facilities (hostels) potentially cross subsidising millionaires in high care. This is a societal disgrace, especially since the only reason for the differentiation between the two is political. This represents a prime example of how politics and dogma have driven inefficiencies, threaten fiscal viability, and short changes the Australian taxpayer.

If indeed there was any doubt around the voracity of this assertion, one only has to be aware that “Extra Service” places are a mechanism by which high care services can attract accommodation bonds. It recognises a failed policy framework and makes a substitution creating effectively a segregated industry, making a mockery of claims that the aged care policy framework wishes to avoid a two-tiered model – it already exists by way of this service paradigm.

It is informative to consider that Australia is the only country that has a policy that “protects the kids’ inheritance”, at the expense of the taxpayer. Every major nation with mature aged care services requires anyone with the means to do so, to self-fund their care until such time as their resources are reduced to an established safety net level. Other nations likewise take the view that the individual is responsible for their own accommodation costs, with Government only focusing on a safety net for those who do not have the resources to self-fund, but instead focuses on the care required and how best to facilitate this.

The inequity can be addressed in the following manner –




The Government should remove itself from consideration of accommodation for anyone other than those who need a safety net. This reflects the reality of those in receipt of community care services, and would bring equity and social justice to all consumers seeking to access aged care services. It would also introduce a competitive structure to aged care services based upon consumer choice that does not exist under current legislation.



The Government could focus on the provision of funding for the delivery of care services, thereby being in a position to stretch limited resources across more episodes of care, benefitting more older Australians than is currently possible.



The legislative structure that segregates low and high care, which is unique to Australia, complicating legislative and regulatory environments, creating inefficiency in service delivery, and maintaining social inequities, should be scrapped immediately. The accommodation choice for older Australians should be just that – their choice. If the older person or their family would prefer a single ensuited room and are prepared to pay the relevant cost, or alternatively wish to share accommodation and maintain social interaction with others, then again that should be their choice. Currently this choice is removed from them via the Paradigm of Paternalism within the Aged Care Act 1997, referred to in earlier comments.

 Establishing, as part of the consideration of the establishment of an appropriate indexation based on ABS data, to establish such an index for all services, including those in specialised (NESB; Homeless) segments or indeed those operating in rural or remote locations.

Recommendation 13. That, consistent with the myriad of recommendations from previous inquiries, the Government take action to separate policies and funding around accommodation and care, focus scarce taxpayer funding on the provision of care, and leave accommodation decision to consumer choice. This would finally deliver consistency, consumer equity and real choice between traditional community and residential aged care services.

Recommendation 14. Consequent to Recommendation 13 and in conjunction with Recommendation 10 eliminate all existing artificial distinctions between various levels of care across all such care programs.

Recommendation 15. Consistent with the myriad of recommendations from previous inquiries, the Government take immediate action to

- Establish, in conjunction with the industry and appropriate research body, a weighted index based on the value of a basket of goods to identify a baseline cost of care;
- Charge the ABS with the development of a consequential index that can track the movement in this baseline cost of care across time;
- Commit to meeting the indexation increases arising there from, unless offsetting independently verifiable efficiencies are made available by way of regulatory or legislative improvement; and
- Likewise commit to meeting the costs associated with the implementation of any further regulatory requirements.

Service Planning

If we were to ask people about whether they wanted, when their time came, to enter a nursing home, the majority would answer in the negative. People wish to remain at home as long as possible, and this aspiration has been reaffirmed repeatedly.

Once again our aged care service structure is driven by “programs” and not by consumer need and preference. There are no such considerations in the establishment of hospital services, with the risk being left up to the service provider, to succeed or fail based on their market knowledge and appropriate investment in services that are reflective of consumer preferences.

Perhaps it is time that Australia seriously considered the option of the provision of vouchers for older Australians and leave the sourcing of services of their needs to them. There is substantial talk around the concept of consumer directed care, however the legislative and regulatory structure we have in place currently runs completely counter to such philosophies. It is informative that in spite of such systems being operational across the globe, in Australia we have just seen an announcement of designated Consumer Directed Care community care packages on a trial basis. There seems to be a reluctance to learn from other nations, with a preference to consume precious resources on trials and relearning.

As noted by the Productivity Commission ²¹ under their consideration of Quality and Choice, the pressure for publically funded goods and services to be more responsive to consumer preferences is not unique to aged care.

“Over the last two decades, reforms across a wide range of industries have sought to strengthen the role of consumers through removing regulatory constraints on choice and competition”.

There is no doubt that such a substantive change in policy direction will have its share of complications. However experience from overseas initiatives have shown clearly that such changes result in



Greater autonomy for older people and enhanced feelings of independence (independence is an objective of the Aged Care Act 1997);



Decreased perceived unmet needs and care related health problems because it is the client who makes the priority decision leading to an enhanced feeling of wellbeing; and



Increased satisfaction with overall care arrangements and life more generally.

Are these outcomes not what we aspire to as an Australian community? It will no doubt be difficult for Government to consider the significant review of the Aged Care Act 1997 that real consumer choice will bring, but we need to remember that the fundamental work on the Act was done in a Departmental report produced in circa 1975 – an entirely different time and place to the modern Australia of today, let alone that of the future.

The result of this complicated and control-centric legislation is that so-called “reforms” take an eternity and then rarely deliver what was sought by the industry or consumers. A prime example is “The Way Forward”, released in 2004 which sought to reform the Australian Government funded community care service, to rationalise the 19 programs, and streamline access and efficiency.

²¹ Trends in Aged Care Services, P. 103. Productivity Commission 2008
“Caring for Older Australians”
Submission to the Productivity Commission.

Children were conceived and born after this policy was announced with great fanfare, and are now at school, whilst “The Way Forward” remains a **policy objective** and apparently an ongoing “work in progress”. Australia cannot wait for further delays as the resultant outcomes would be delivered once again in a time and place that is substantively altered compared with when the objective was launched.

Recommendation 16. That Government, in conjunction with the industry, investigate the overseas experience of Consumer Directed Care by way of vouchers, and develop policy and timing to introduce the CDC concept within Australia.

Recommendation 17. In conjunction with vouchers being introduced, align regulation to ensure consistent regulatory treatment of both informal and formal carers in terms of require qualification, experience, reporting and accountability requirements and insurance coverage.

Service Planning Ratios

The allocation process is evidence of inappropriate modelling. This is obvious as the planning is based on a “per thousand people over the age of 70 years”. The average age of admission into residential care is around 83 years, often referred to as the “older old”. The higher the proportion of people over 85 the more likely they are to enter residential aged care.

Similar age groups apply to community care services delivered through the Australian Government packaged services. Any planning model that is based upon demographic groupings of 70+ years of age, when the customer of the services is over 80 years of age, will never align demand and supply.

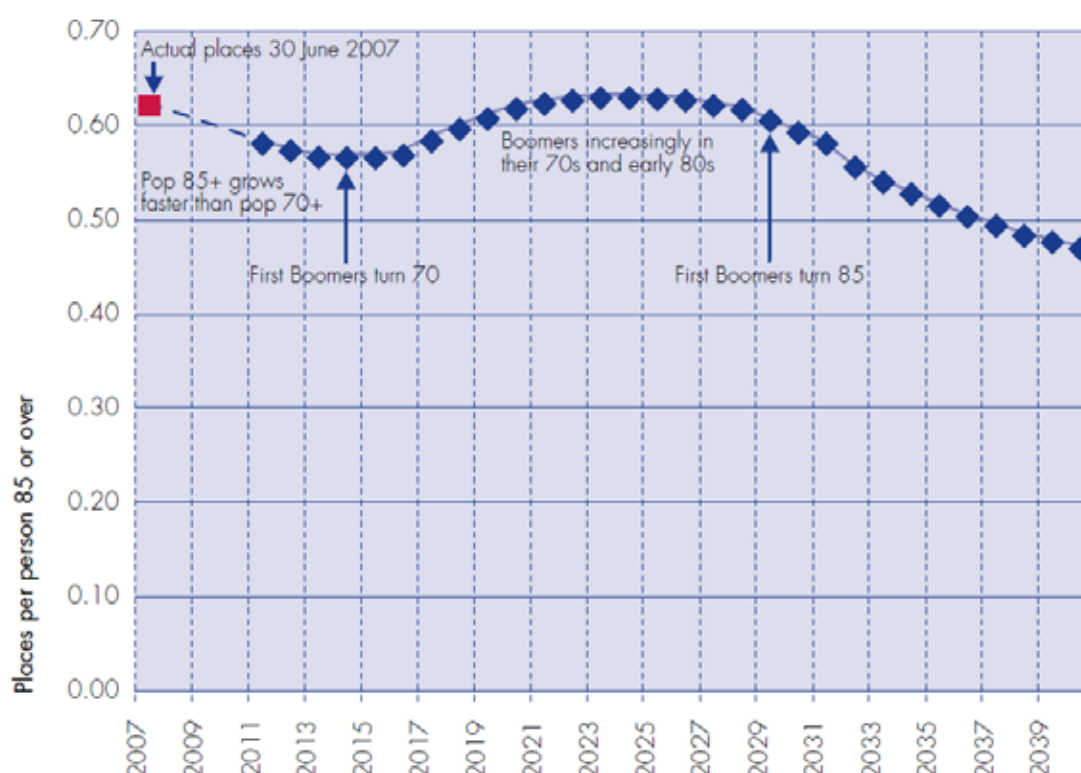
Whilst in opposition the current Australian Government committed to reviewing the planning process, and we are yet to see this piece of work commenced.

In contrast however, perhaps this is a prime opportunity for Australia to move beyond old habits and move towards aligning the aged care industry to the same operational environment as other industries such as hospitals and child care services. In these sectors the service provider takes the commercial risk intentionally. Under the Aged Care Act 1997 the service provider not only takes the risk of their own commercial decisions, moreover they also are impacted by the risks of any errors or omissions within the current planning scheme and Government decisions. The Government on the other hand carries no such commercial risk, especially given that subsidy and accommodation payments are only delivered on the basis of an occupied place.

Given this situation it would be more appropriate to allow the service provider to undertake the entire commercial risk free of the added dimension of carrying Government decision risk as well. If we consider for example the following chart published in the ²²NH&HRC report we are struck by two important elements – firstly that service planning should logically be carried out based upon a population aged 85+ years – and secondly even on such an improved basis, this graph shows clearly the relative short-term nature of the “Baby Boomer Phenomenon”. Based upon the restrictive prescribed nature of residential aged care under the current regime, thereby making such buildings useless in terms of alternative applications, why would any organisation invest in building residential aged care facilities today for a life expectancy that could be as short as 20 years? From the perspective of fiscally responsible decision making, placed up on Directors of organisations today under Corporate Law, such action simply does not make sense.

²² A Healthier Future for All Australians – NH&HRC Interim Report December 2008.
“Caring for Older Australians”
Submission to the Productivity Commission.

Figure 6.4: Using the current planning ratio there will be fluctuations followed by a long-term decline in aged care places per person aged 85 or over.



Source: Australian Bureau of Statistics (2008), Population Projections Australia, series c and places ratio of 113 per 1000 people aged 70 or over

Recommendation 18. Depending on the capacity of the Productivity Commission to broaden the definition associated with this inquiry to long term care, stretch the concept of long term care provided

- Service delivery across all areas is based upon assessed need;
- There are no artificial barriers able to be applied via contorted “business rules” between aged care and those living with the impact of non-aged related disability.

Recommendation 19. However if a broader definition is not open to the Productivity Commission, propose an immediate adjustment of the service planning regime based on 1,000 people aged 85+ years, and rebalance the weighting between community and residential care based on consumer preference advice.

Recommendation 20. Establish a transitional period of not less than 5 years using the projections based on Recommendation 19 to inform planning for the immediate future and deliver short term certainty to the community.

GOVERNMENT ROLES AND RESPONSIBILITIES

It is clear that as Government faces tightened fiscal circumstances, a feature that will sustain beyond the current post-GFC phenomena, priorities will need to be established between what the Australian taxpayer can afford and personal financial responsibility. As this reality evolves, the role and responsibility of Government must evolve accordingly.

Should we be able in Australia to create policy frameworks to create an evolving industry, focused on consumer choice and the delivery of high quality outcomes, this must present a significant opportunity to downsize the bureaucracy currently oversighting the various duplications and individual programs within the existing service offer. A growing proportion of the funding for aged care is absorbed by such oversight activities and if the whole system is to become increasingly efficient and effective, the bureaucracy should not be exempted.

Contemplation of the features of a system of “long term care” as opposed to “aged care” delivers a variety of options that are similar in some ways and diverse in others.

A system of long term care under the regulatory and funding authority of a single level of government (preferably the Australian Government to avoid the moral hazard of subsidies being lost into consolidated revenue for the States), would result in the responsibility assumption for aged care, disability services, primary care, and mental health. By definition and characteristic, these all feature disease or illness management of a chronic nature, and all lend themselves potentially to both preventative and restorative approaches and attention. A level of functional independence is possible across all such groups, which when harnessed effectively could lead to substantial savings to the acute sector which currently carries a significant level of the consequential fiscal burden.

The assumption of responsibility across these areas with a matrix rather than a siloed approach would provide a basis for interoperability and streamlining that we have hitherto not seen in Government programs.

From a Government oversight perspective it is a regulatory disgrace that new regulations brought into aged care (e.g. the introduction of police certificate; mandatory reporting et al) were exempted from the Government’s own policy requiring Regulatory Impact Statements. Instead, questionable DH&A advice was provided, without substantiated evidence, that these changes did not represent a material impact upon the aged care industry. Such assertions were clearly not developed in conjunction with the industry and were clearly inaccurate and misleading.

The existing monopoly on quality accreditation services within the residential care sector, along with the unique “program based requirements” within community care should be eliminated. The requirement for independent accreditation should be retained aligning such requirements to the health sector standards – viz – accreditation being required to be held by way of a recognised quality framework. It seems incongruous that an industry is expected to become more efficient when every program has a separate and distinct set of different and inconsistent requirements, thereby removing the very core capacity that is fundamental to the achievement of any semblance of efficiency.

The amount of existing resources that are wasted within the current framework representing approximately 20 different accreditation schemes should be eliminated consistent with the recommended streamlining based upon a graduated funding model. Such an approach would be entirely consistent with that adopted for hospitals; pharmacists and general practitioners.

Recommendation 21. That the Australian Government assume responsibility for long term care incorporating aged care; disability services; primary care and mental health – encapsulating for the first time all consistent aspects of chronic disease management.

Recommendation 22. That subsequent to Recommendation 21 a matrix approach be established across these areas to replace the siloed thinking that currently permeates policy development. This would introduce common standards where relevant, and avoid unnecessary duplication; whilst enhancing policy and regulatory interoperability.

Recommendation 23. That the Government embark on a genuine reform of re-regulation of the industry, based on a true risk management approach. Accountability is critically important however “obsessive and oppressive” regulation must be removed from the system.

Recommendation 24. That the Government adopt the approach of a minimum data set (such as the InterRAI used in the U.S., Europe and Scandinavia) against which audits could be conducted by Government based upon benchmark irregularities, providing the basis of a risk based approach. This would provide accountability for the industry; enhance confidence from the Australian community; and importantly provide a basis for the international benchmarking of the Australian industry.

Recommendation 25. That the Government ensure and insist (consistent with its own policies) that no regulation is introduced that does not carry with it an independently verifiable regulatory impact statement which has received industry input.

WORKFORCE REQUIREMENTS

The workforce requirements inherent in a new paradigm will be impacted across the long term care sector in varying ways. Residential care capacity will always be required however the nature and scope of its activities will alter quite substantially as it becomes far more of a palliation and behavioural management model, and features shorter average length of stay coupled with significant increases in acuity and co morbidity. This will lead inevitably to a requirement for higher level clinical skills, and more limited need for lifestyle related activities. In effect, residential aged care will become more like a hospital case load with the resultant impacts on the essential workforce profile. This will place further stress on the availability of professional and registered personnel such as nurses and allied health professionals, both of whom are already in short supply.

Counter balancing that to some extent, will be the increased use of personal carers within the community setting, with enhanced clinical oversight support necessary. The customers in such a setting will require a higher level of chronic disease management, with remote monitoring and electronic health records being a principal feature. A focus on preventative and restorative care will bring with it a higher level of monitoring and reporting capability that will inevitably mean higher levels of information and communications technology adoption. In turn, unless such ICT services are accessible by way of cloud computing or the like, significant investments in an effective ICT internal workforce will be essential.

Whether we like it or not, and whether industrially palatable or not, the synergistic impacts of higher demographically driven demand; a reduction in the availability of informal carers; and a paid Australian workforce under extreme demand pressure (therefore being priced accordingly into the future as competition increases for available resources) – will all lead us inexorably to a need for independent and remote monitoring, where contact is prioritised and made as needed by way of monitoring evidence. This will by its very nature change the way in which we deliver in-home care services as well as residential care. If we accept that the future paradigm is a significant uplift in the number of people seeking in-home or community care services at the expense of residential care, going forward we will need to be able to rationalise the service structure for the episodes of care.

Within such an environment there will be a real need for more highly qualified generalists (carers under current terminology) supported by highly skilled clinical consultants (nurses, allied health and medical). The construction and maintenance of such a workforce requires real investment in systems and structures, information and communication technology (covered separately in more detail), a clearly articulated and recognised educational program, and sufficient funding to enable those professionals to be paid at a level commensurate with their peers in other industry streams.

Recommendation 26. That the industry be charged, with the support of appropriate research resources and ancillary support, to develop role based definitions and skills requirements, acknowledging the shortfall anticipated in future years. Such skill profiles should be used to influence the education curriculum for enhancing workforce planning and capacity building.

REFORM OPTIONS AND TRANSITIONAL REQUIREMENTS

The reform options are outlined within the context of the various recommendations made throughout this submission. What we have attempted to paint is a picture of where the system must head, conscious of the desire for Government priority setting. However the “do nothing” option will lead Australia into further economic malaise through the withdrawal from the workforce those who need to provide care for their loved one.

The essential question to Government is – can you afford **not** to act now? After more than a decade of inquiries and trying to shuffle the issue off to someone else to delay decision making, the time to act is now. The impact in terms of electoral cycle is now only two cycles away to see the first Baby Boomers entering the life phase for care. This group has shown itself to be self-centric and maintains an extremely significant voting bloc. It likes choice, represents the ultimate consumerists, and is used to getting what it wants. Should the next Australian Government simply pay lip service to aged care policy and fundamental reform, it does so at its own political peril. A solid platform and vision must be established in the next election cycle, and not left until the Nation is in complete crisis.

That means not simply providing platitudes or acting to “look tough and make no apologies for it” – the Australian community needs stability and confidence in the future direction. None of that will come in the absence of addressing fundamental financial shortfalls in the current system, and with limited funds priority areas must be struck, with Government reducing the scope of its legislative coverage, not increasing it unnecessarily.






THE CONTRIBUTION OF TECHNOLOGY IN A 21ST CENTURY SERVICE

Assistive Technology

There is a range of assistive technology that should be utilised to enhance the independence and dignity of our customers, and increase efficiency within the service delivery network. As outlined in the section on Workforce, Australia has no option than to improve its technical capability especially in the area of remote and unobtrusive monitoring.

Assistive technology should also be made available to consumers, possibly as part and parcel of their funding package, based on their personal preferences and choice. Much of these items are capable of retrofit and ease of removal from homes when no longer required. A range of such products are already utilised within the disability sector.

The following list is not by any means exhaustive, however could include

-  Assistive or adaptive devices – something as simple as a tool to make turning taps on and off easier;
-  Continence aids with transponder advice – avoids unnecessary “checking” of continence aids and automatically establishes a continence pattern for the individual. This would lead to an enhanced continence management program rather than simply resorting to continence aids;
-  Medication reminders;
-  Automated switching – reed switches on doors; automatic lighting; stove auto shut off devices; exit from home sensors – all of these could be established around the individual’s personal routine, and if out of the ordinary, send notifications to nominated persons (could be a neighbour or family member – it doesn’t have to be a paid service).
-  Mobility aids; special eating cutlery; more appropriate seating including wheel chairs – all have the capacity to enhance independence and improve lifestyle.

Recommendation 27. That specific funding be made available to enable the industry, (perhaps through the Aged Care Industry Information Technology Council) to investigate and establish a list of products and suppliers to readily access such devices.









Recommendation 28. That once such a product list is available, that seeding grant funds be made available in a single year to enable service providers to purchase and deploy such equipment, the requirement being reporting on its success (or failure) as an end of year report.

Information and Communication Technology

ICT relates more to the infrastructure to enhance the transmission and management of information. Existing technologies exist to enable remote monitoring of health related issues within a person's own home, using Bluetooth technology via a home telephone. The challenge becomes how to develop appropriate notification software to affect the maximum benefit from such technology. Some progress has been made on this front however there are opportunities for further enhancement and for the establishment of interoperability capacity similar to the work being done in the United States via the ²³Continua Alliance. This focus means that regardless of the specific items used in the personal health space, that equipment should work with equipment from alternative suppliers (provided they are members of the Continua Alliance). Membership involves the largest health solutions suppliers from around the globe. The principle is the same as "The Button Plan" for the automotive industry in Australia – rationalise componentry as much as possible to reduce overall capital and recurrent costs.

Continua was established by way of the network associated with the Centre for Ageing Services Technology, an affiliate organisation with the American Association for Homes and Services for the Ageing, the American not for profit aged care industry association. It is entirely appropriate that Australia should not reinvent the wheel in this technology space, and that formal linkages be maintained with what is developing overseas.

The opportunities of mobile solutions apply just as strongly within the community care and residential sectors across the whole long term care continuum. The whole gambit of

-  Remote monitoring;
-  Mobile technology – providing real time updates and safety support for community care workers;
-  Telehealth capacity;
-  Cloud computing and with it shared access to software programs;
-  Access to open source software;
-  Wireless networks;
-  Broadband / greater bandwidth access;
-  Social networks for access to information;

all contribute to the collage that is the future of ICT. All of this technology however loses its greatest potential in the absence of an electronic health record. To date hundreds of millions of dollars have been expended through NEHTA without an appropriate outcome, and Australia remains significantly behind in this area compared with other western countries. We are told that even several years down the track, we remain between five and eight years away from a solution. This is simply too far away and in spite of a significant commitment in the last budget from the Australian Government for in excess of \$ 400m, Australia continues to appear to wish to create its own solution, at an anticipated cost of some A\$ 1.5bn.

²³ Continua Health Alliance is a not for profit collaboration of 200 technology companies aimed at achieving interoperability for personal health solutions. www.continuaalliance.org
"Caring for Older Australians"

Recommendation 29. That the Australian Government take whatever steps necessary to establish an electronic health record capacity in Australia in a timely manner, recognising the urgent nature of this fundamental reform. In the absence of such capacity real efficiency and collaboration leading to substantial improvement in care outcomes will continue to elude Australia.

Recommendation 30. That the Australian Government recognise that with a clientele of over 1,000,000 Australians, and touching pharmacy; hospitals and primary health; the aged / long term care sector should be the priority area for the application of the electronic health record.

EFFICIENCY IN THE AUSTRALIAN AGED CARE INDUSTRY CONTEXT

Efficiency – Context, Consequences and Challenges.

In any consideration of the efficiency mentioned within the Hogan Report ²⁴ it is essential to understand the context in which the review was conducted, and under which the recommendations were made. All who are involved with aged care services in Australia understand that the data upon which the review worked was for the fiscal period 2002 / 2003, now a full five years out of date. Within that context, with respect, any review must consider the current environment for aged care services to even begin to consider “efficiency” issues and consequences.

The CAP has enabled the industry to go some way to being able to cope with substantially increasing cost profiles over recent years. The Centre for Efficiency and Productive Analysis was commissioned to examine the efficiency of the residential aged care sector in Australia and to provide such input to the “Hogan Review”.

It is indeed insightful to consider some of the comments made in the CEPA report, with such observations that maintain their relationship with our present day circumstances. In reviewing the issue of output variables of ACFs, it was noted that “it is fairly clear from these studies that an ACF resident is not a homogenous item”²⁵. Since such residents are not, in the common vernacular, “like pumping out sausages in a sausage factory” one needs to remember that people are all different – that’s what makes our society so incredibly amazing in its scope and responsibility. Any assumption that arises from the principle that the provision of aged care can follow a “one size fits all regulatory approach” whilst preaching services focused on the individual needs and aspirations of residents, is an assumption that is doomed to moral hazard wherein regulation and the imposts it represents and people centred service provision come from two distinctively different perspectives.

In summarising the efficiency of the sector ²⁶ Professor Hogan noted that

“.... aged care operators look to meet demand at the lowest possible cost, taking advantage of the fact that some inputs can be substituted for others. In effect, they seek the cost-minimising combination of factor inputs required to produce aged care at a given level of quality. That said, many operators are currently operating well within the ‘efficient frontier’ of production at minimum cost”. The point missed in the analysis is that in the main the “top quartile” performers were limited to those providing extra service places, a market segment that is not reflective of simple translation to all services, or indeed those facilities still operating four-bed wards. An argument made by the DH&A that “if the top quartile can make positive returns then the rest of the industry should catch up” proffers support for an aged care system that has two distinct streams – extra service at one end; and four-bed wards at the other.

He goes on to note that this focus on cost minimisation occurs but is subject to a series of regulatory constraints imposed by the Australian Government, through the Department of Health and Ageing et al. Consequently it was observed that the regulatory issues at that time (which have been extended since by subsequent Ministers) included:




²⁴ Pricing Review of Residential Aged Care – Professor Warren Hogan, 2004

²⁵ Efficiency of Aged Care Facilities in Australia – The Centre for Efficiency and Productivity Analysis, Queensland University 2.5 Output Variables P.12

²⁶ Ibid 4.2 Efficiency of the Sector – CEPA analysis P. 73

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-  Quality standards set by the Government;
-  Government commitment to equity of access resulting in sub optimal sized facilities in rural and remote areas (and also to a different extent for ATSI and CALD specific services); and
-  The various requirements of state and territory governments as well as the role for local governments.

It was clearly noted that the regulatory structure within which any industry operates is a major driver of cost structures. There is also a principle of natural justice that costs associated with meeting regulatory imposts should be recompensed. This is evidently not the case for the Australian aged care industry wherein substantive regulatory imposts have not been accompanied by the corresponding fiscal support.

The inherent limitations of the analysis of efficiency in relation to the lack of real consideration of quality is encapsulated in the CEPA report wherein it notes that

“quality of care provided to the residents is an important variable influencing the efficiency score. It is possible that an ACF that provides high quality care may use more measure inputs and may therefore be regarded as more inefficient...”²⁷.

Moreover, even given that the Hogan Review was labelled a “pricing review” it bore little consideration of the actual price paid for inputs, a point not lost by the CEPA report ²⁸. In that report it states “in other instances, some aged care facilities may be disadvantaged by their location and service provision may be more costly due to higher prices – this is particularly important in this project since no explicit account is taken of spatial difference in prices paid by ACFs located in different areas”.

Technical Efficiency

The report states that ²⁹ “the input-oriented technical efficiency of an aged care service measures the extent to which a service can reduce its input usage and yet produce the same level of outputs”. When one refers to the actual report produced by CEPA, it is made clear in that report that the measurement of technical efficiency bears no consideration whatever to the issues of quality, which is so important in any human service environment.

Indeed the CEPA report states ³⁰ “Cost reduction and containment in the provision of residential care for the ageing population is essential in maintaining the level and quality of care necessary to service an ageing population. The current *study of efficiency is geared towards the identification of sources of cost inefficiency* (emphasis added) and to finding strategies for achieving cost savings” which leaves no doubt whatsoever that quality is not a dimension given substantial consideration within the evaluative study.

One of the more obvious changes since the time of the report in terms of efficiency, relates to the comment made that the output levels of aged care services are not generally a decision variable. Indeed it goes on to say that “the number of consumers is determined through budgetary constraint, and demand generally exceeds supply, as indicated by the occupancy rates³¹”.

²⁷ Efficiency of Aged Care Facilities in Australia – CEPA 4.2.4 Environmental Variables P.38

²⁸ Ibid.












²⁹ Ibid 4.2.1 P. 74

³⁰ Ibid P. 101

³¹ Pricing Review of Residential Aged Care 4.2.1 Technical Efficiency P. 74
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Occupancy rates in the current context indeed as a general rule, no longer remain as high as when the review was conducted. Certainly in the context of rural and remote facilities, occupancy is not usually at the high levels found in metropolitan services, so an industry wide assumption of demand exceeding supply is unrealistic as it treats the industry as homogenous, which it certainly is not. Indeed it is no more homogenous than those it serves.

Returning briefly to what the report described as **drivers of inefficiency** in a regulatory sense, based on the correlation of various factors in the CEPA study, we find the following.

Regulatory Contributor to <u>Inefficiency</u>	Changes Since the Review
 Government policy to equity of access leading to sub optimally efficient services	 Allocations have continued to be made based on this policy parameter, meaning that this impact has only exacerbated since the review.
 Residential care services with higher certification scores tend to be more inefficient; and in a related context  Services with more beds per room tend to operate more inefficiently due to higher maintenance costs and poor design.	 The residential aged care industry, at the behest of the policy on certification, has continued to build services consistent with the expectations built by Government communication to the community. Older facilities with multiple people to a room are being replaced at great cost with more inefficient buildings with higher certification scores.
 ATSI or CALD services have a higher cost base due to the need to provide culturally appropriate care.	 This issue has not changed since the review, although any extension of such specialist services would exacerbate inefficiencies in the industry.
 Services with higher proportion of concessional residents appear to be more efficient due to more homogeneous services.	 Due to the 40% cut off many facilities are working to the absolute minimum concessional resident base to improve income.
 Those services deemed to “cut corners” on quality may appear to operate more efficiently.	 When efficiency is not linked to quality, this is an obvious outcome of the policy.

Scale Efficiency

This measure relates to how well a service could improve productivity by changing its scale of operations to the optimal scale. The review concluded that although there is an economic argument to support such an assertion, it was unlikely that services in rural and remote areas are likely to achieve optimal scale, and further it is evident that in determining the “optimum” there was no consideration in relation to land or construction costs and the consequential viability of the resultant facility from a capital perspective. It is unreasonable to consider efficiency solely in the context of “outputs” (i.e. bed days available) without considering the impacts on getting to that point.

It was also determined that there does not appear to be any appreciable difference between chain and non-chain ACFs³². Accordingly the presumption that seems to have been inherent in policy pursuit that consolidation of the industry in Australia would lead to improved efficiency is not borne out through the outcome of the study. Indeed for industry practitioners, this outcome is self-evident. When one considers that the level of direct costs within residential aged care is extensive with labour alone between 70% - 80% of income, there is very limited potential to achieve cost savings by simply having more and more facilities. The actual cost of linkages and management oversight indeed has the high potential to produce diseconomies of scale.

The principle that consolidation of the industry will somehow drive efficiency presupposes a high level of administrative overhead, which is not a feature of the Australian aged care industry.

Allocative Efficiency

Allocative efficiency is a measure as to whether the observed input-mix is optimal. One measure is the economies of scope within a service’s operation. The review made the logical observation that services providing an array of services (accommodation; personal care; nursing; and dementia) are likely to achieve better economies of scope and therefore achieve higher levels of allocative efficiency. There would be no residential aged care service in Australia that does not reflect at least three of the nominated domains in its service delivery, hence the finding is a statement of the obvious.

Regulatory Inefficiency

Professor Hogan describes regulation³³ as any restriction on voluntary action, and notes clearly that such action distorts and / or restricts the operation of the market (viz leads to inefficiency). We would offer not only that this is evidently the case in residential aged care, but moreover that the view that should regulation be necessary then the cost of meeting it should be the responsibility of the regulator, leads one to conclude clearly that the escalating regulatory requirements within the aged care industry has substantially and further eroded the funds otherwise available for the delivery of care.

There is an absolute irony in that context, with the more regulation about the care of older Australians, the less funds are actually available to provide that more, and the more likely that a failure in the system will occur, requiring, in the view of the bureaucracy and / or Government, that more regulation is required.

³² CEPA Report P. 46


³³ Pricing Review of Residential Aged Care 4.2.4 Regulatory Inefficiency P. 79
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Hence the circle of regulatory diseconomies of scale continues until and unless the cycle is broken by substantive reform of the system, not seen to date nor anticipated under the existing policy circumstances.


It is clearly acknowledged that while the inefficiency associated with certain forms of professional regulation (licensing) that have the undesirable effect of reducing contestability and therefore leading to inefficient markets, are being considered by the new Government, such impacts have yet to be considered in the context of the residential aged care industry.


As Hogan outlines³⁴ “the regulation of residential aged care services can be a slippery slope, with an act of regulation not only decreasing the overall efficiency of the sector but also leading to further inefficiency sapping regulation”.


He goes on to nominate a number of specific features of the aged care financing and funding arrangements that lead to market failure and hence to inefficiency in the industry.

 Supply is heavily constrained which potentially results in the stifling of innovation and decreases consumer choice. As mentioned previously the increased vacancy rates in residential aged care have moved this dynamic further since the time of the report and demonstrate an increasing regulatory driven inefficiency since that time.

 Private price is likewise heavily constrained. This leads to an unreasonably and unjustified level of Government contribution to the aged care system at an unnecessarily high level.

 Hogan notes that it is indeed possible to use mechanisms to protect residents while allowing service providers to set market based fees. This should be especially possible in an environment wherein consumers have a choice of accommodation options to suit not only their fiscal capacities but also their personal preferences and choice driven by their aspirations. Currently there is no choice within the residential aged care system for consumers to seek arrangements outside of the tightly constrained determinations under the Aged Care Act 1997 except through alternative providers who are inexperienced and fall outside of the tight legislative regime. Effectively therefore is that through a rather paternalistic approach to legislation, residents and their families are being denied true consumer choice which should be regarded as an anathema within Australian society.

 The merit good nature of aged care militates against the Government’s ability to exercise its purchasing power. Concomitant on the Government’s role as monopolistic purchaser is the moral pressure to accept responsibility for increasing costs.

 The purchaser / user disjunction gives operators and consumers incentives to incur costs that they should not have to bear.

³⁴ Pricing Review of Residential Aged Care 4.2.4 Regulatory Inefficiency P. 81
“Caring for Older Australians”
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Comparative Efficiency

The CEPA report is also quite telling with respect to the comparative efficiency of the Australian residential aged care industry, when held up against the available literature.³⁵ The authors note that as an outcome of their review of available literature the “average technical efficiency (TE) scores range from 0.57 up to 0.89, with most clustered around the 0.80 level”. The CEPA report noted on the other hand, that the Australian industry average (TE) score was 0.87³⁶.

Regrettably this measure was touted at the time as meaning that the Australian residential care industry had the potential of increasing its efficiency by some 13%. The truth however was that the industry, even at that time, was operating far more efficiently than similar services across other parts of the western world.

In terms of comparability, it is also instructive to consider the finding in the CEPA report with respect to high care facilities, especially when one considers that high care residents now constitute almost 70% of all residents within residential aged care facilities. The CEPA report found that³⁷ “Potential efficiency gains are marginal in the case of high care ACFs. Operating income and expenditure are identical for the ACFs. A majority of homes that are scale inefficient appear to be “too large” and are operating in decreasing returns to scale part of the production frontier”.

The new funding instrument ACFI, has resulted in between 70% - 80% of existing residents relying upon the grand parenting arrangements just to maintain current funding which has already been effectively reduced through inflation operating at 4.8%. Clearly the business rules have excessively complicated the ACFI translation and resulted already in fiscal uncertainty.

A major environmental impact that has been exacerbated since the report was prepared, is that the availability and therefore price of land upon which residential aged care facilities can be built, has increased substantially since the report was finalised. During that same time period, the availability of capital funding has dramatically decreased in real terms, a matter that is dealt with specifically elsewhere in this submission.

Conclusion on Efficiency Considerations

Any consideration of efficiency is incomplete in the absence of any serious inclusion considering issues of quality; capital and individual prices of inputs, is and always will be, inadequate and produce unrealistic outcomes. The provision of the Conditional Adjustment Payment of 1.75%, including its extension into the 2008 / 2009 by the current Australian Government, has produced evidence of enhanced efficiency due to the overall indexation (inclusive of CAP) not maintaining pace with the real price escalation confronted by the industry over recent years.

The contribution to inefficiency by regulation has been exacerbated since the time of the Hogan Report. We have seen additional regulatory impost, again without the funding necessary to meet such imposts, since the time of the Hogan Report.

Indeed the ability of the Australian residential aged care industry to continue to produce increased levels of bed days attests to its growing efficiency.

³⁵ Ibid P.2

³⁶ Ibid P. 97

³⁷ Ibid 5.7 Conclusions P. 103

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The elimination of the CAP payments without a realistic indexation in place will lead to substantive service failure with existing resident displacement, whilst preventing service access to new consumer need.

Although the analysis of the 2005 / 2006 fiscal performance data produced in response to some of this new regulatory requirement indicates that some 40% of ACFs are operating in deficit, we are yet to see substantial failure with organisations “falling over” even under such circumstances. We have however seen over recent months continued reporting of an increasing number of facilities in financial trouble, and some being closed as a result. It is suggested through this submission, that since the CAP be removed, such failure will be a continued and escalated feature of the Australian aged care industry. The result of this phenomenon is that older Australians will be denied access to services into the future, with additional risk to both service providers and political reputation.

In spite of the intimated inadequacies of the COPO reflected by the Hogan Review especially with the additional payment represented by the CAP, we have yet to see any review or the production of an adequate recurrent indexation formula. The COPO is an entirely inadequate index which has produced facility failure when combined with rising regulatory impositions, and will continue to do so unless and until it is replaced with an indexation method which reflects the actual movement in costs of providing services.