Business Council of Australia

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Submission to the

Productivity Commission Inquiry

into

Caring for Older Australians

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Summary

The mounting pressures in providing high quality and accessible services for older Australians have been highlighted through a range of reports over the past decade and action can no longer be delayed if adequate services are to be available on an equitable basis. As in the health sector, the increase in numbers of older Australians, their improved life expectancy and the rise of chronic disease means that the range and level of services available to meet the needs of older Australians is inadequate and the current means of financing them unsustainable.

As in the health sector, the changing pattern of demand means that the features of the sector must be reconfigured and expectations of both citizens and providers re-shaped. Governments have the capacity to do this through restructuring the regulatory and governance framework within which the sector operates; setting incentives for both citizens and providers, and ensuring labour market settings result in an adequate and appropriately trained workforce.

A more dispersed ageing-in-place policy that allows a greater breadth of options and choice while at the same time providing greater capacity to support this segment (infrastructure and workforce) is possible through technologies that assist daily living and monitor health to improve the safety of those living independently. But this requires a mindset change from one that adds technology to existing models to one that designs a system of dispersed living and care, enabled and supported by technology.

Specifically the BCA suggests:

- using the functionality that arises from the development of new ICT and telemedicine technologies, the investments in e-health infrastructure and the NBN, to design a system that is based on a continuum of care, recognising the range of services and supporting those who are ageing or suffer from some functional limitation;
- identifying the linked services and supporting infrastructure that exists in other functional portfolios to support healthy living and healthy communities;

- streamlining regulation that constrains the ways in which services are offered and allows the quality, access and efficiency benefits available through new technologies to be captured;

- establishing strong consumer-oriented quality assurance and system governance mechanisms, including access to all relevant information and assistance with system navigation;

- promoting an understanding of the range of services and likely costs associated with ageing within the financial planning sector; and

- developing a new class of financial instruments that can be used to supplement existing mechanisms to help self-fund life-cycle expenses.

Many reviews have established the need for change

First, the BCA notes that all recent major reviews of the sector, including the Hogan Review, the Productivity Commission, the National Health and Hospitals Reform Commission (NHHRC) and the Henry tax review have unanimously recommended the need for substantial structural reform within the aged care industry. The existing model of aged care services is seen to be expensive, inefficient and not capable of meeting the nature, type and level of demand projected for these services in the coming decades, as the population ages, the number of working Australians decreases and the number of carers declines. In summary, your Commission has already found:

- A sector that is characterised by high levels of central planning, excessive government regulation and high levels of public subsidy. 'Governments largely determine how many aged care places are provided, where these places are located, the mix of services, the price of these services and how they are to be modified in response to changing community expectations. Competition and price play little role in signalling to providers the changing patterns of demand and the need to adjust decision-making accordingly.'

- Weaknesses in the system, which were identified as:

  - inequities arising from existing program design;

- inefficiencies stemming from excessive government regulation;
- poor service interfaces within and between aged care services and other systems, including acute care, housing and disability services;
- a limited choice of services for older Australians, as a result of both prescriptive regulation of service models and a lack of coordinated service delivery/information; and
- projected shortfalls in the informal and formal workforce because of population ageing and competitive pressures.

- Proposals previously made by the Commission and supported by those other reviews included:
  - Enhancing efficiency, equity and sustainability by:
    - Unbundling accommodation from daily living services/expenses to allow greater capacity to track prices against underlying real costs of service provision; better targeting of public subsidies to those most in need, and enhancing the ability for providers to deliver a greater range of service elements and, as a result better organise their work processes to allow for best value service delivery by multi-skilled staff.
    - Reforming the dual gate-keeping system by which eligibility for receipt of aged care services is undertaken. Current drivers include a mandatory assessment by government as well as a central planning allocation process in which places to be funded by public subsidy are meted out. A determination of consumer need is therefore controlled by Aged Care Assessment Teams, while ongoing accreditation and quality assurance of services is pursued through a more traditional QA process.
  - Improving the service interfaces between the aged care sector and other services to ensure continuity of care and a more streamlined continuum of care. Healthy ageing and ageing in place require inter-governmental action.
  - Increasing capacity in the sector through productivity improvements. The current regulatory framework discourages or prevents such improvement by restricting returns and service models within the sector. This curbs any incentive for

innovative forms of investment, by limiting new entrants and preventing existing players from investing in new infrastructure, technologies or service models.

Suggested focus for the Current Inquiry

HAS PERFORMANCE OF THE SECTOR IMPROVED?

Industry surveys, such as those conducted by Deloitte and Grant Thornton confirm the continued financial underperformance of the aged care sector[1]. Ongoing low returns, barriers to entry and limitation on prices and the range of service models deter expansion and investment in a sector that, conversely, faces unprecedented demand. These reports also confirm the distortion in economic incentive structures for providers, which currently favour the development of low care beds at a time when the presenting demand is increasingly for high care (but high cost) beds. Although more options are being developed to support assisted living in the community, these do not offset the need for more residential high care places.

The limited consolidation within the sector, which has been driven by the poor investment returns, has meant that the 'cottage industry' nature of the sector has remained unchanged. As a result, there is, at the broadest level, a striking underinvestment in information and communication technologies and other infrastructure that might improve efficiency and productivity. Demand for labour continues to be high and the recent partial compensation for statutory wage increases have exacerbated cost pressures. This will be an ongoing pressure point if the current equity pay claim is successful, or if staffing ratios are imposed and additional funding is not provided. Although funders may seek to exert pressure on providers to capture some of the efficiency gains that previous reviews have highlighted, this is unlikely to occur while there exists a 'cottage industry' management culture. In turn, this mindset is likely to persist until regulatory change allows greater returns in the sector and encourages new entrants.

[1] See Deloitte, *Annual survey of into the Australian Aged Care Industry 2010* and Grant Thornton, *Aged care survey 2008 – Second Report January 2009*.

THE CONTINUING TREND TO AGEING-IN-PLACE

Despite the inherent funding flaws associated with residential aged care, the government's preference for funding of community care packages over residential aged care places does recognise and support most people's preference to be supported to stay in their family home. What has not been considered, however, is that the expansion of retirement villages can represent an alternative or supplement to independent living and increases the range of residential options available to older people. Their consistent take-up by consumers confirms the stated preferences by seniors groups for ageing-in-place policies and the synergies with aged and community care should be explored.

Despite the successful pilots of community care packages in retirement villages[2], there is concern that the different regulatory arrangements across jurisdictions for retirement villages may present a barrier for some companies to the national expansion and integration of retirement villages and aged care. Minter Ellison has called for uniform legislation to regulate the industry and suggests that consistency and certainty are critical to a sustainable industry[3]. Onerous requirements that separate villages from aged care make seamless transition along a continuum of care problematic.

WHAT DO SENIORS WANT AND NEED?

The Commission's existing recommendation that services be unbundled from accommodation, so to allow a more flexible approach to service delivery and encourage new entrants, stands. The following points provide support for this idea as well as a general guide to design principles.

[2] See AIHW, 2006, *National Evaluation of the Retirement Villages Care Pilot – Final Report*.

[3] The New Lawyer, 2009, 'Minters drives retirement overhaul', Available at: http://www.thenewlawyer.com.au/article/minters-drives-retirement-overhaul/505872.aspx.

A continuum of care – seamless movement between residential settings and ageing in place

Seniors groups have consistently argued for the development of a sector that provides a continuum of care as depicted below, with a consistent focus on choice across the spectrum of care needs, and takes into account a person's capacity to pay.

This continuum implicitly recognises the changing mix of services required to support personal care and daily living activities, including domestic assistance, home modification and assessment, security and nursing support.

The Australian Institute of Health and Welfare (AIHW) evaluation of community care packages in retirement villages found that a more tailored approach to care packages could delay the need for entry into residential high care. This also potentially reduces demand for Emergency Department services and acute care through more regular monitoring of health and, in particular, medication use. Mistakes in medication or failure to take medications have been shown to cause a significant number of preventable hospital admissions and/or increased levels of disability as noted throughout this submission.

The pilot programs recorded high levels of support from both residents and their families, and feedback indicated that more of their needs were being met than in care packages previously provided. The pilot also highlighted a lack of access to packages, which occurs when specific guidelines are not met (e.g. exclusion from eligibility to Home and Community Care packages on the basis of residential arrangement).

The pilot also highlighted the differences between those for whom no informal carer was available and those for whom one was, and the influence this had on people's choice of residential setting. Those without informal care were more likely to reside in retirement villages. While much has been made of the growth in aged cohorts, the projections of single person households are also relevant because of the dependence in current models on informal carers.

The Productivity Commission has already highlighted the vulnerability of current models of aged care to any shortfall in informal carers over coming decades. The projections show large shortfalls both in the potential pool of carers and as a result of the competition for these people within the workforce leading to increased pressures for self-funded retirement.

Integration with the health system

In drawing this continuum, however, it is important to recognise that an individual's medical needs will vary markedly across those stages. The design of an aged living system therefore needs to be blended with a seamless health service. This is not just about designing a system that recognises the complex health needs of those who only present when they require residential high care, but takes the more comprehensive view that there are likely to be services and supports required at each stage, not to mention preventative health and lifestyle options which can be of benefit.

In its final report, the NHHRC recognised the need for both systems to be designed together if dys-functionality was to be avoided for individuals and unnecessary imposts made on the health sector. This was demonstrated through the AIHW evaluation of retirement villages care packages, which found that better tailoring of care packages potentially reduces demand for Emergency Departments service and acute care through the regular monitoring of health and, in particular, medication use[4].

It has previously been estimated that 86% of those aged 65 and over use two or more prescription medications simultaneously[5]. In 2008 the AIHW released a report addressing the movement of patients between residential aged care facilities (RACF) and Hospitals. This report showed that of the 39,466 people admitted to hospital from RACFs, 30% were admitted as a result of adverse medication events, of which up to 75% were potentially preventable[6].

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[4] AIHW, 2006, *National Evaluation of the Retirement Villages Care Pilot – Final Report.*

[5] AIHW. *Older Australia at a Glance*, 3rd edn. Canberra: AIHW & DOHA, 2002. Report No.: AIHW Cat. No.: AGE 25.

[6] AIHW, Movement from hospital to residential aged care: preliminary results, 2008, AIHW Data Linkage Series Cat. No CSI 4.

Healthy living – cross government and portfolio

Just as policy attention is turning to greater efforts at prevention for the population at large, so too should it turn to promotion of healthy living for ageing Australians. Preventing or managing chronic disease and limiting disability are vital elements in managing the demand for care and health services and for improving the quality of life of both the ageing and their carers[7].

This necessarily requires consideration of all the elements of wellness as well as access to ongoing physical and mental activity; social connection; cultural activities and transport for all services. The successful management of these issues is critical to achieving healthy living and healthy communities and crosses a range of portfolio responsibilities and all levels of government. For this reason, the BCA has been pleased to see the development of the Health-in-all Policies approach adopted in South Australia.

TECHNOLOGY AS AN ENABLER

Current trends show, on the one hand, increasing demand for more and better quality aged care services but on the other, a model of current service provision that is fixed and incapable of growing to meet the quantum of demand, let alone any variation on the type of demand. The trend to a more community-based set of services is strengthening, but is being curtailed by existing regulations that ration and control the type of services provided and limit opportunities for the innovation and productivity improvement essential to accommodate projected needs in an affordable and equitable way.

As noted by the Productivity Commission, the percentage of people of pension age receiving a full pension in 2007 was 55.1%, with this figure projected to drop to 35.8% by 2047, in tandem with a growing pension age population[8]. The challenge then is how to increase the capacity of the sector and deliver a greater range of services within a limited capacity to pay. Current models are designed to achieve economies of scale and cost effectiveness through aggregation of the most needy into centralised facilities, with a

[7] See *Australian Unity Wellbeing Index 2007.*

[8] Productivity Commission 2008, *Trends in Aged Care Services: some implications, Commission Research Paper*, Canberra, p.xix.

dispersed model of care dependent on informal carers, supplemented by some support services for the rest.

Public administration traditions exacerbate this by dividing programs according to functional portfolios. This means that citizens or their carers must navigate between portfolios to find appropriate support services and undertake the necessary integration of service provision themselves. As Alan Miliburn has remarked:

> On their own governments cannot meet the environmental crisis or the pensions crisis any more than they can bring about better health or lower crime. That requires actions by individuals not just governments. And it calls for reforms to the old paternalistic relationship between State and citizen. A grown up relationship is what is required in which as much power as possible is moved outwards and downwards from centralised states to individual citizens and local communities.[9]

In the absence of an alternative approach to government service provision, ameliorating this integrative task can be achieved through electronic sharing of information. For example, the adoption of unique health identifiers and electronic sharing of health information – the current e-health measures – are fundamental to making the provision of health and aged care services seamless while improving quality and patient safety.

International evidence suggests, however, that existing and emerging technologies can provide benefits that extend beyond sharing patient/consumer/resident information across sector boundaries. They can also enable greater capacity in the aged care sector itself, extending the range of residential options and leveraging the workforce. By supporting ageing-in-place, the need for significant new physical infrastructure is reduced (by extending use of existing private residential settings and by reducing the need for care by improving health status, or delaying its deterioration).

A recent KPMG report summarises the opportunities for better resource usage and the increasing demand for IT-based resources by residents themselves:

> Assisting the sector to take advantage of broadband and IT, while not solving all the myriad challenges, can provide residential facilities with tangibly increased capacity to manage limited resources more effectively and free up staff to deliver enhanced care. In

[9] Alan Miliburn address to The Global Foundation, Sydney, 2 May 2006.

> short, technology can play a major role in helping administrators, carers and the many health care providers involved in the sector to improve efficiency, quality of care and importantly, improve the experience of both residents and staff.
>
> …If residents are not requesting computer access, their family members are. It is a vicious cycle. The facilities know they can benefit from IT implementations, but finding the time, resources and expertise to make it happen, is a major barrier.[10]

The financial benefits of telemedicine for remote chronic disease management and assistive living flow both within the traditional aged care sectors and to the health sector itself. In 2003, the United States Veteran's Health Administration introduced a national home telehealth program to coordinate the care of veteran patients with chronic conditions with the aim of avoiding unnecessary admission to long-term institutional care. In the first four years of the program there was a 25 per cent reduction in the number of days of bed care and a cost per patient of $1,600 per annum compared to over $13,000 per annum for home-based primary care[11].

Concerns that a dispersed aged care system could not be achieved cost-effectively should be allayed by the results of overseas programs such as this one. Rural area patients accounted for 37% of a total of over 36,000 patients and there was an average satisfaction rating of 86%[12].

Another study in the United States by the New England Health Institute in 2007 compared the cost of remote monitoring of patients with congestive heart failure to disease management and standard care. There were estimated savings of $400 million per annum for those patients in the seriously ill categories[13].

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[10] KPMG 2009 *Golden Opportunity – How information technology can rejuvenate the aged care sector,* http://www.kpmg.com/AU/en/IssuesAndInsights/ArticlesPublications/Documents/Golden-OpportunITy.pdf

[11] Darkins et al., 2008, 'Care Coordination/Home Telehealth: The Systematic Implementation of Health Informatics, Home Telehealth, and Disease Management to Support the Care of Veteran Patients with Chronic Conditions', *Telemedicine and e-Health*, December 2008, pp. 1118-1126.

[12] Ibid.

[13] New England Healthcare Institute. 'Remote Physiological Monitoring', *NEHI Research Update*, January 2009.

Within the residential aged care sector itself the opportunity to use new assistive and monitoring technologies to relieve staffing pressures and improve safety for residents is evident. As noted previously, the AIHW has found a significant percentage of hospital admissions for patients in aged care facilities are caused by preventable adverse medication events. A current project auspiced by the Aged Care IT Council on electronic medication management seeks to address this challenge. However as KPMG points out , the state of readiness within the sector is low with small amounts available for investment and staff skills needing upgrading:

> Some aged care facilities and the people within them, have already made positive progress in implementing IT. However, for the most part, the sector has found this step to be an extremely difficult one, particularly in small and regional facilities where resources are stretched and IT expertise is limited. In the vast majority of Australian aged care facilities, the reality is that the level of technology is minimal. Typically, a small number of unconnected computers are shared across an entire facility. Often, staff are not proficient at using them to their full capacity, furthermore many residents have limited or no access to computers.[14]

To date the role of technology in the sector has been limited by viewing it as an add-on rather than as an enabler in the redesign of the system of services to be provided. Dr Paul Gross has identified five kinds of barriers to the greater adoption of telemedicine: conceptual; financial; technical; legal and political[15]. In undertaking its work the BCA urges the Commission to re-think the design of the services required by people as they age and to challenge assumptions that current constraints about cost-effectiveness can only be achieved through centralisation and physical aggregation.

CONSUMER INFORMATION, QUALITY ASSURANCE AND FINANCIAL PLANNING

The current aged care industry is fragmented and complex, and requires the involvement of all three levels of government. The recent COAG reforms promise to rationalise these in most States. But even within these reforms those measures that extend to healthy

[14] KPMG, op. cit.

[15] Dr Paul Gross, Address to the Second Annual National Telemedicine Summit, 24 March 2010.

living are excluded and Australia is yet to adopt a public policy framework that consistently addresses the needs of its citizens in a holistic way.

The current regulatory frameworks are heavily influenced by a desire to provide consumer protection and to control public expenditures. These objectives remain important but we would argue that they can be achieved through alternative and separate means. We have argued elsewhere that, if people are being asked to take on more responsibility for their own support and health they need more information to enable them to do this and to make informed choices about what services they seek.

The complexity of the current arrangements and the likely ongoing complexity suggest that consumer information and system navigation aids are going to be essential. While supporting the need for unbundled services for both equity and efficiency reasons, the BCA stresses the need to help citizens navigate the various services available, subsidised and unsubsidised, which means more publicly available information on availability, outcomes, quality and pricing. There is a case then for strong quality assurance and information provision by government. However we also believe that alternative models to bureaucratic quality control have been successfully implemented in other sectors, such as the financial services and consumer sectors. These models provide greater capacity to support innovative service models that can adapt to changing consumer preferences than bureaucratically driven input focused models.

There is also a strong case for greater navigational aids and for extending the range of professionals able to assist beyond the limited case workers currently available, particularly since these cross health and aged care boundaries and levels of government. With some 45% of Australians now covered by health insurance funds, many of which are actively supporting a greater focus on prevention and healthy living, there is potential to add this group of organisations to the pool of systems navigators.

Importantly these need to be available to assist with the financial planning that is now encouraged for retirement incomes. If people are to be encouraged to progressively make provision for their care, they need to understand the financial implications of this earlier than is currently possible (i.e. at the point at which care needs suddenly or drastically change). Many of the limitations on structural reform in the sector arise from the lack of transitional planning opportunities. This has then acted to limit the financing mechanisms

available for funding service provision. Financial and estate planning therefore needs adequate lead times to allow for alternative financing streams.

SOCIAL INSURANCE

The concept of social insurance is increasingly promoted as a solution that will smooth the financial demands across a person's life cycle and across pools of people. The NHHRC canvassed the adoption of a version of social insurance to fund health costs. A proposal for an unemployment insurance scheme linked to superannuation has arisen in the context of seeking to balance the need for employment security with workplace flexibility. A national insurance scheme to fund disability support has also been promoted. Education bonds to provide for educational expenses and access to superannuation to fund first homes have in common a desire for new financing mechanisms that smooth financial pressures across an individual's life cycle and lessening pressures on public expenditure. Again, the BCA suggests that in considering the specific proposals for the aged care sector, the Commission looks to the design of a new class of instruments.

BEYOND AGED CARE

Many of the challenges faced by aged care services are replicated for other segments of the population. For example, the level of physical and mental disability is rising across the population and is not confined to older age groups. The needs and capacity limits that have characterised the preceding discussion of the aged care sector are repeated in the experience of other groups requiring support, care and health services.

If we are able to design a dispersed system for those who are ageing, then conceptually that system should be generic enough for all those who suffer disability or limitations in their capacity to function independently to access the services they need, regardless of capacity to pay and irrespective of their need for varying levels of services (such as access to education and employment). Specialist residential care units may be needed to supplement these but they are not different in concept from the specialist units still envisaged for some aged care.

RE-VISITING SECTOR REGULATION AND PRODUCTIVITY IMPROVEMENT

The need for productivity improvement across the economy has been generally accepted. So too has the need for productivity improvement in particular sectors, especially those

that face unprecedented rises in projected demand and significant constraints on supply. What has struck us in reviewing sectors, such as health and aged care, is how they are heavily regulated and only a limited number of policy levers are used to shape the provision and demand for services. The lens of microeconomic reform has been largely absent. The regulatory frameworks have accumulated over time and often in response to particular issues; incentive structures have not been updated to reflect changing demands and policy aims.

We suggest therefore that the Commission consider whether it would be appropriate for responsibility to be assigned to a government agency, such as the Commonwealth Department of Innovation, Industry, Science and Research (DIISR), to take a specific lead both in encouraging new productivity-boosting investments in such sectors and in identifying regulatory barriers to market performance and perverse incentives that undermine the public policy objectives sought.

DIISR's current responsibility is to deliver policies and programs in partnership with stakeholders to encourage the sustainable growth of Australian industries. Creating sustainable health and ageing industries must be a priority industry in this context. DIISR, or an appropriate body under its portfolio, could encourage investment in the health and ageing industries and drive productivity improvements by coordinating the various levels of government and portfolios to bring about the right regulatory, infrastructure, policy and funding settings for the long-term sustainability of the sector.

A model similar to that applied by Invest Victoria may be useful in facilitating and coordinating these connections for those companies interested in investing in the sector to partner with government to meet the investment and productivity challenges. This would involve an extension of the department's current responsibility but would provide a cross-government productivity focus for the sector and act to validate anticipated regulatory burdens made through the Regulatory Impact Statements from the perspective of actual users and potential investors.