Aged Care Association Australia

Submission to the Productivity Commission

Inquiry into

Caring for Older Australians

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Introduction

Aged Care Association Australia (ACAA) welcomes the Productivity Commission's inquiry into Caring for Older Australians as an opportunity to raise important issues currently impacting on the Australian aged care system that need policy reform to ensure ongoing future maintenance of Australia's aged care system as a world leader in care delivery.

Our ageing population will place ever-increasing demands on residential and community aged care services. The challenge is to respond to these demands in ways which provide a quality service, in a sustainable way.

As the Commission's Issues Paper[1] states, because of our ageing population:

> More older Australians will mean a significant increase in both demand for aged care services and spending on aged care. Using the current targets for the provision of aged care, the National Health and Hospitals Reform Commission[2] forecasts that the number of aged care places will need to at least double by 2030 to meet projected demand. Australian Government spending on aged care is projected to increase from 0.8 per cent to 1.8 per cent of GDP by 2049-50[3].

ACAA endorses the Commission's 2008 finding that:

> A sizeable increase in the required *quantum* of services is not the only challenge in providing aged care services. Over the next few decades, older Australians are expected to become more diverse in terms of their care needs, preferences, incomes and wealth. This will have important implications for the *qualitative* aspects of aged care services (such as the range of services needed and the flexibility of service delivery) and the cost of these services[4].

The Commission is also correct to observe in its Issues Paper that:

> A further challenge will be the need to secure a significant expansion in the aged care workforce at a time of 'aged induced' tightening of the labour market, an expected relative decline in family support and informal carers, and strong competition for health workers from other parts of the health system[5].

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[1] Productivity Commission. Issues Paper. Caring for Older Australians, May 2010.
[2] National Health and Hospitals Reform Commission) June 2009, *A Healthier Future for All Australians*, Final Report.
[3] Treasury, *Intergenerational Report 2010*, Canberra.
[4] Productivity Commission 2008. *Trends in Aged Care Services: some implications*, Productivity Commission Research Paper, Canberra. page XV11.
[5] Productivity Commission 2010, op.cit.

Vision for the Future

The significance of our ageing population to aged care, and to the demand on such services for end of life care, is substantial and will increase with the expected increases in the proportion of the population aged over 65 years. In 1999, 12% of our population was over 65 years of age and 2% was over 80 years. It is predicted that by 2016, 16% will be over 65 years and 4% will be over 80 years, increasing by 2041 to 25% over 65 years and 8.3% over 80 years.[6] For dementia alone the "epidemic" affecting an estimated 162,000 people in 2002 is expected to affect over half a million Australians by 2040.[7]

Our ageing population will place ever-increasing demands on residential and community aged care services. The challenge is to respond to these demands in ways which provide a quality service, in a sustainable way.

As a result, we need to be smarter if we are as a society to provide access to a high quality, viable aged care system into the future. This initial ACAA submission will provide options for developing an exciting new model of aged care which we believe will enable this.

Part of the financial challenge for Government arises from the age of 65 at which entitlement to subsidised aged care currently kicks in.

As our life expectancy continues to increase, as does our quality of life within that longer life expectancy, ACAA would submit that 65 is an increasingly – and unnecessarily – generous base age.

Other countries such as Germany have already started to increase this age of entitlement for aged care services under their social insurance scheme.

Australia has decided to increase the entitlement age to 67 years of age in eleven years time. The average length of life is expected to increase by seven to eight years over the next thirty years. If that is the reality then government support for retirees will still occur over a thirty year period. The cost to the public purse of continued support for an average period of thirty years could well force a future government to consider extending the age at which people become entitled to aged care related services at an age considerably greater than 67 years.

The time for continuing to apply band-aid solutions has passed. Together, we have the opportunity to construct a new aged care system which will allow a smooth transition to a new model which will effectively provide the care needed in 10-20 years time.

ACAA endorses the National Aged Care Alliance's 2009 Vision Statement *Leading the Way: Our Vision for Support and Care of Older Australians* (Attachment A). In particular, we look forward to the aged care system of the future where:

> 'Every older Australian is able to live with dignity and independence in a place of their choosing with a choice of appropriate and affordable support and care services as and when they need them …
>
> People will contribute to the costs of care according to their capacity to pay, and no-one fails to access care because they cannot afford it. The costs of accommodation are separate to care costs and people either purchase or rent, or enter loan/ licence arrangements for accommodation as they choose.'[8]

However, as the National Aged Care Alliance Vision Statement emphasises, we will not as a society achieve this vision by just muddling along.

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[6] J Abbey, 'The reality for aged and community care and end of life'. Presentation to *A Matter of Life and Death: Confronting the new reality*, Canberra, March 2008.
[7] Ibid.
[8] National Aged Care Alliance. September 2009 *Leading the Way: Our Vision for Support and Care of Older Australians*, pages 4, 5. www.naca.asn.au

On the contrary, "fundamental reform is necessary to achieve this vision."[9]

The Australian aged care system needs to migrate from its current inflexible structure to a new, more flexible and viable model which will provide greater choice within a quality system.

Part of this flexibility should do away with the current rigid structures between high, low residential care and rigidity in access to community care and between community and residential care systems.

The provision of services should be driven by demand, rather than supply. Providers should be enabled to provide a range of service models that will provide maximum flexibility and capacity to meet consumers' future choices. The underlying principle of care service provision should be based on the philosophy of an entitlement for all, based on assessed need.

[9] Ibid, page 6.

Long-term funding options

ACAA does not consider that maintenance of the existing high dependency on consolidated revenue is a long term workable solution for long term care service provision. With growing pressure on government funding for health and social welfare resources there is a pressing need to find other forms of financial resources that will support the development of alternate income streams. To this end ACAA and Deloitte Australia have been considering options for a new innovative financial model and have prepared an outline paper titled *Funding Strategies for the Future*[10] (see Attachment B). Features of different models being considered include:

- Using superannuation and other long term saving products to earmark contributions for health and aged care. For example, raise the superannuation contribution by 2% from a particular age (perhaps 40-45), with that being compulsorily set aside for health and aged care services required above the age of 75 years. This additional superannuation contribution would be treated as fully tax exempt.

- Health savings accounts based upon the Singapore model.

- Allowing the service user to pay for the care and accommodation based on the quality of the service provided, with the basic level of service underpinned by some level of government support.

- A social insurance option with the inclusion of an aged care element in the Medicare levy, and resourcing of an increased range of aged care services from Medicare.

- The introduction of long term care insurance to help fund consumers access to aged care services. These products would be offered by private insurers with some initial incentives from government.

- A levy on all income as a type of hypothecated tax preserved for funding aged care services.

    - The Bethanie Group in Western Australia and KPMG have prepared a report into an alternative model of aged care funding. This has identified that an Aged Care Levy on either salaries and wages or total income may be an effective way of funding aged care services into the future.

    - The "Bethanie model" estimates that, when calculated as a percentage of total income, the aged care levy would equate to 1.41% in 2010, rising to 2.32% in 2050.[11]

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[10] Aged Care Association Australia and Deloitte Australia, 2010. *Funding Strategies for the Future.*
[11] KPMG and the Bethanie Group, June 2010. Aged Care in Australia: A Scoping Study, p. 3

Medium Term Reform

ACAA believes that there will need to be long term structural reform decisions flowing from this review and short term system changes which will mainly be targeted at systemic improvement and sustainability while the long term structural reform process is implemented over a five to seven year timeframe.

ACAA together with Hynes Lawyers and PKF Chartered Accountants has prepared a report *Health Reform – the Aged Care Chapter: A review of the Aged Care Act 1997* (Attachment C). The review process included a comprehensive series of consultation with aged care providers and industry stakeholders and the collation of the results of an industry survey. The survey reflects the views of some two hundred approved providers. The consultations and survey were directed at obtaining the aged care industry's views as to the reforms considered necessary to support industry sustainability in the short to medium term.

Set out below are the findings of the review under five major headings:

Capital funding

There is a significant shortfall between the costs of maintaining, upgrading and building residential aged care facilities and the capital contributions that approved providers can obtain from government or residents in the form of accommodation payments.

Approved providers have inadequate access to capital funding because standard high care residents do not have to pay an accommodation bond and the accommodation charge is inadequate. The results of the Survey provide compelling evidence for reform.

- 88% of approved providers surveyed agreed that they should be able to ask any permanent resident who can afford to pay an accommodation bond to do so;
- 84% of approved providers surveyed state that accommodation charges do not provide sufficient capital to maintain existing facilities to community standards;
- 90% of approved providers surveyed state that accommodation charges do not provide sufficient cash flow to build new aged care facilities.

There is a significant difference between the return on an accommodation bond and the return on an accommodation charge with the charge attracting $12,846.00 per resident per annum less than the average bond.

<u>*Recommendation 1*</u>

Extend the right of approved providers to require that all permanent residents (who can afford to do so) pay an accommodation payment, which may be either:
- *a lump sum accommodation payment (accommodation bond); or*
- *a daily accommodation payment (which provides an equivalent financial outcome to the provider as an accommodation bond); or*
- *A combination of a lump sum payment and a daily payment.*

<u>*Recommendation 2*</u>

If Recommendation 1 is not adopted, accommodation charges should be indexed to provide an equivalent financial outcome to the provider as an average accommodation bond.

The 2010 Bankwest Inherited Housing report indicates there is significant wealth being held by ageing Australians, with $400B of housing assets projected to be inherited over the next

fifteen years[12].

An extrapolation of these projections to the fifteen years 2025 to 2050 would indicate that the inherited housing wealth likely to be transferred in this second period would almost double raising the overall wealth transfer figure over the next three decades to an estimated $1200 billion.

With a declining taxation base and escalating social welfare and care costs it is essential that government and community agree on an equitable sharing of this wealth to provide a reasonable inheritance to future generations while ensuring adequate funding is made available for quality care and services for the elderly. Without some reform the likely intergenerational burden born through taxing of the workforce to support the older generation will be substantial and mis-aligned given the expected growth in longevity of the older generation.

Recommendation 3

If Recommendations 1 and 2 are not adopted, the Government will need to fund in whole or in part the capital needs of the industry.

These are estimated at $21B in new building work and a further $15B in renovation and replacement works over the next decade. The expected shortfall under the current scheme is estimated at $5.7B over the next decade. Some options available to government to consider if it decides to take on the main capital funding role are: introduce zero or low interest loans which provide adequate incentives for approved providers to develop and improve high care facilities.

Accommodation supplements

For residents who are unable to make a capital contribution, the government pays an accommodation supplement of up the equivalent of the maximum accommodation charge. The accommodation supplement paid depends on whether the aged care facility meets the Supported Resident Ratio (SRR). The current SRR is set at 40% with a 25% supplement reduction if the aged care provider fails to achieve this level.

- 72% of approved providers surveyed state that there are inadequate financial incentives for approved providers to meet the Supported Resident Ratio.

- 66% of approved providers surveyed agree that the Supported Resident Ratio should be calculated according to the demographics of the area in which the facility is located.

Recommendation 4

Adjust the accommodation supplement to reflect actual hotel and accommodation costs, and change the ratios and penalties to more adequately reflect local service demand.

Operational funding - care subsidies

Funding to meet the direct and indirect costs of delivering care is intended to be derived from:

- resident contributions in the form of a basic daily care fee (BDCF) and an income tested fee (for those residents with capacity to pay); and
- Daily care subsidies and supplements paid by government.

The care subsidy is determined by the application of the Aged Care Funding Instrument which assesses the care needs of a resident at a point in time. The care subsidies range from zero to $213.34 with the mean subsidy being $110.00 per resident per day.

[12] Bankwest. *Inherited housing report 2010*, Bankwest Financial Indicator Series, March 2010.

During the consultation process the following concerns were consistently expressed by approved providers:

- subsidies should be benchmarked to establish the real cost of care,
- the indexation of subsidies should be adjusted to be consistent with the rising costs of care delivery,
- the funding model should provide dedicated funding to meet indirect care costs and ensure that any new regulations or increased training required to perform more complex health care services are funded.

It is proposed that the *Building an Australian Aged Care System: Improving Business Practices* (BAACS) be expanded. The BAACS benchmarking exercise should be expanded to include the collection of data on indirect care costs, cross referenced with the care cost outcomes from the ACFI Review in order to reach a clear understanding of the direct and indirect care costs for the industry.

The benchmarking could be undertaken by the Hospital Pricing Authority which is to be established by the Government as part of its National Health and Hospitals Reform program

Recommendation 5

Benchmark the costs of residential care.

Subsidies are indexed using the Commonwealth Own Purpose Outlays (COPO) index, which comprises 25% Consumer Price Index (CPI) and 75% labour costs calculated using the value of the safety net adjustment.

The primary concern with the COPO based indexation of subsidies is that it does not appropriately account for salary adjustments and is often well below the CPI.

The industry's funding concerns were reinforced this year by the Government's announcement that the 2010/11 increase in subsidies would be 1.7% while CPI to 30th June 2010 was 3.1%, PBCLI 3.4% and minimum wage adjustment 4.8%.

The proposed Hospital Pricing Authority could undertake the task of setting a new indexation methodology which could be one of the following:

- The greater of the CPI and the All Groups Pensioner Beneficiary Living Cost Index for the year ending 31st March each year,
- An aged care specific indexation method

Recommendation 6

Implement a new indexation formula for subsidies.

Additional service charges

Section 56-1(d) of the Act provides that an approved provider may charge additional fees for additional services, if the resident has asked for and agreed to pay for the services in the resident agreement.

- 80% of approved providers surveyed agree that they should be able to levy additional fees for services in addition to those required by the Quality of care Principles 1997.

Recommendation 7

Clarify charges for additional fees for services.

To clarify the situation, it is recommended that the Minister request the Department to:

- Clarify the right of approved providers to charge fees under section 56-1(d) of the Act for services that have been agreed to by the aged care recipient as services in excess of those required by the Quality of care Principles 1997; and
- Differentiate between an extra services fee and fees that may be permitted to be charged under section 56-1(d).

Planning and allocation of places

The majority of approved providers support regulation of the allocation of places, if it is done efficiently. At the same time the majority consider that the allocation process is not responsive to demand.

The Productivity Commission in its 2008 review of trends in aged care services identified that:

- Older people are more likely to use residential aged care facilities for high level care than in the past. Between 1998 and 2007, the proportion of all permanent residents receiving high care increased from 58 to 70 per cent, an increase of 32,000 Australians.[13]

The Productivity Commission has stated that quantity and price restrictions associated with the allocation process:

- ...combine to limit the scope and effective competition between providers, weaken incentives for innovation and delivery, hinder investment decision making, and risk the long term sustainability of aged care services.[14]

- 78% of approved providers surveyed agree that the distinction between high and low care places should be removed and approved providers should simply be allocated 'residential places'.

Recommendation 8

Replace existing residential allocation categories with one allocation category for permanent residential care.

Current issues contributing to the increasing lack of viability of providing residential aged care include:

- The allocation process is inflexible.

- There is no current mechanism which enables an increase or adjustment in the supply of places based on market indicators identified at local level.

- The extra service ratios do not reflect community preferences.

- At present only 15% of residential care places in each state, territory or region can be extra service places. This rigid cap denies ageing Australians choice of services.

- Limiting the extra service places was originally predicated on concerns that an unlimited supply of extra service places may result in an unreasonable reduction in access to standard services for aged care recipients unable to afford extra services.

[13] Productivity Commission. *Trends in Aged Care Services: some implications*, September 2008: 30
[14] Productivity Commission. *Annual Review of the Regulatory Burdens on Business: Social and Economic Intrastate Services*, Commonwealth of Australia, 15 September 2009 23.

- 82% of approved providers surveyed agree that all aged care providers should be able to offer extra service equivalent hotel and accommodation services in response to market demand.

Recommendation 9

If recommendation 8 is not adopted whereby approvals are for places then increase the current 15% extra services ratio to 30% and apply a state based cap.

If the existing approvals process is maintained approved providers should be able to apply to the Department for additional places outside of the ACAR.

An ongoing approvals process would enhance the flexibility of the allocation process by enabling the department to immediately increase the supply of places if there is evidence of demand in a particular region.

In considering whether there is unmet demand for services the Department should be required by the Act and the Principles to consider market research.

Recommendation 10

Establish an ongoing approvals process that enables additional places to be distributed in response to demand.

The ACATs role should be limited to determining whether an aged care recipient needs permanent residential care, community care, respite or flexible care.

This process is inefficient. It necessitates the assessment of a resident's needs by two separate entities under different criteria. These assessments can reach different conclusions which increase the administrative burden and create planning and resourcing issues for approved providers.

The ACFI assessment provides a more accurate representation of a person's level of care as the ACFI assessment process is much more detailed than the assessment undertaken by an ACAT.

Recommendation 11

Adjust the role of the ACAT to approve the type rather than the level of care.

The aged demographics on which the ACAR are based are inaccurate.

Further analysis should be undertaken by a pricing authority to better understand the probable impact on the provision of services and costs if the planning demographics are changed from 70 years to 75, 80 or 85 years

Recommendation 12

Review the demographic age on which the planning ratios are based.

The aged care industry has mixed views about the abolition of the ACAR.
While the current process is inflexible, the Survey results show that aged care providers are uncertain about the impact abolition of the ACAR would have on their operations.

- 52% of approved providers surveyed state that full deregulation of the allocation of aged care places may have a negative affect on their balance sheets.

Recommendation 13

Undertake a cost benefit analysis of abolishing the ACAR.

Accreditation

The results of the consultation process and of the Survey indicate that approved providers regard the following areas of the accreditation process as those in most need of urgent reform:

- The performance indicators of quality and regulatory performance;
- The frequency and timing of unannounced visits;
- The review rights of accreditation decisions; and
- The qualifications of the assessors performing audits.

- Only 36% of approved providers surveyed consider that the Accreditation Standards are specific enough to allow an objective and consistent assessment of compliance.

- 70% of approved providers surveyed supported the introduction of a minimum data set to establish clear indicators of quality and regulatory compliance.

The current accreditation process imposes a significant administrative and financial burden on residential aged care providers.

Recommendation 14

Introduce an agreed minimum data set.

- 80% of approved providers surveyed state that unannounced visits impose a significant administrative burden on approved providers.

- 61% of approved providers surveyed state that unannounced visits have a significant financial impact on approved providers.

- 61% of approved providers surveyed do not agree that unannounced visits have improved the quality of care and services provided to residents.

The Government policy requiring the Agency to undertake at least one unannounced visit per year at each residential facility should be amended. A revised policy should be implemented that requires the Agency to apply a risk assessment framework to determined frequency and timing of unannounced visits in a more targeted fashion.

Recommendation 15

Adjust the policy for undertaking unannounced visits.

While most accreditation decisions are subject to reconsideration by the Agency and can be reviewed by the Administrative Appeals tribunal (AAT) some decisions such as a decision not to vary the period of accreditation or a decision not to accredit a home, are only reviewable by the Agency.

- 96% of approved providers surveyed agree that all decisions relating to compliance with the Accreditation Standards and the period of accreditation should be reviewable.

- 91% of approved providers surveyed agree that they should have a right to apply to the AAT for the review of an accreditation decision.

Recommendation 16

Permit the AAT to review any decision made by the Agency.

- More than 60% of approved providers surveyed state that they do not regard Assessment Teams as being appropriately qualifies or competent to assess compliance against the Accreditation Standards.

Recommendation 17

A registered nurse should be required to participate in all audits where clinical expertise is relevant to the Accreditation Standards being reviewed.

Complaints Investigation Scheme (CIS)

The results of the consultation process and the Survey demonstrate that approved providers have significant concerns about:

- The qualifications and competence of CIS investigators;
- A chronic failure by the CIS to manage complaints in an effective and timely manner;
- A lack of transparency and public accountability of CIS;
- The manner in which compulsory reporting is administered by the CIS; and
- The Aged Care Commissioner's powers or lack thereof.

- Only 25% of approved providers surveyed regard CIS investigators as being appropriately qualifies to determine compliance with the Act;

- Only 29% of approved providers surveyed regard CIS investigators as being competent to determine compliance with the Act.

The Walton Review found that the training provided to CIS investigators is inadequate. It also identified that approved providers are concerned that CIS investigators do not have a good understanding of the aged care industry or the ageing process, particularly in relation to dementia and mental illness.

Recommendation 18

Require CIS investigators to undergo compulsory orientation and ongoing training, competency based assessments and accredited mediation training.

During the consultation process, approved providers consistently reported that many complaints are minor complaints that should (and could) be resolved between the facility and the complainant but that the CIS does not promote the local resolution of complaints.

The Survey results are consistent with the concerns expressed by Associate Professor Walton who stated:

> Many complaints are not appropriate for the standard investigation track and are better managed by the provider, the care recipient and the family or advocacy group without the involvement of the CIS.[15]

- 62% of approved providers surveyed agree that the majority of complaints investigated by the CIS were found to be without merit.

Approved providers expressed dissatisfaction about the level of feedback provided by the CIS. Approved providers stated they were often uncertain as to whether the complainant was satisfied with the outcome of the complaint. This creates challenges where an ongoing

[15] Walton, Associate Professor Merrilyn. *Review of the Aged Care Complaints Investigation Scheme*, October 2009: 33.

relationship with the resident is required.

Recommendation 19

Expand the grounds on which the CIS can decline or cease an investigation or mediation.

This report recommends that section 16A7 of the Investigation Principles 2007 be amended to enable the CIS to decline or cease to investigate a complaint:

- Until the complaint is put in writing, unless after consideration of the complainant's capacity and circumstances, such a request would be unreasonable;
- Where the Department is satisfied that the approved provider has investigated, or will investigate the action complained of at a level at least substantially equivalent to the level at which CIS would investigate the complaint;
- Where the nature of the complaint is such that it would be reasonable in the circumstances to require the person in the first instance to attempt to resolve their concerns with the approved provider;
- Where the complaint is of a type that the CIS can direct that the parties attempt alternative dispute resolution; and
- Where the investigation, or the continuance of the investigation, is unreasonable given the resources of the CIS and the nature of the complaint.

Recommendation 20

Incorporate more robust alternative dispute resolution mechanisms into the Act and Principles.

This report acknowledges the Walton Review's recommendation to establish a new Aged Care Complaints Commission to:

- Facilitate greater independence between the CIS and the Department; and
- Increase transparency and more effective management of complaints.

This report recommends that the Act and the Investigation Principles 2007 be amended to:

- Establish key performance indicators for the CIS that encourage the timely assessment and resolution of complaints: and
- Provide that the CIS must publish data demonstrating their performance in the management of aged care complaints.

The performance indicators may include:

- Timeframes for assessing and resolving complaints;
- The outcomes of any quality checks undertaken by the Commissioner; and
- Releasing feedback data provided by complainants and approved providers on the performance of the CIS.

Recommendation 21

Establish key performance indicators for the CIS and make the performance data publicly available.

Approved providers are mostly supportive of the concept of compulsory reporting of physical and sexual abuse, even though they largely do not regard compulsory reporting as having created a safer environment for residents living in residential aged care facilities.

- 59% of approved providers disagree with the proposition that compulsory reporting of 'reportable assaults' has created a safer environment for residents living in aged care homes.

Approved providers stated during the consultation process and in the Survey that the administrative burden associated with meeting the compulsory reporting requirements has imposed a very significant drain on their already limited resources.

This report recommends that the current compulsory reporting regime be reviewed. The review should consider:

- The effectiveness of the 24 hour reporting timeframe;
- The nature of the incidents that are being reported, including the number of resident on resident assaults being reported outside the discretion not to report;
- The time spent by approved providers on meeting their compulsory reporting responsibilities;
- The rights of residents and their family not to have matters reported;
- The police response to compulsory reports;
- The number of notices issued and whether the notices are proportionate to the breach identified; and
- The number of charges laid by the police and successful prosecutions as a result of the compulsory reporting legislation.

Recommendation 22

Review the regulatory impact and effectiveness of compulsory reporting of abuse in residential aged care.

A clear consensus was expressed amongst approved providers consulted that the Commissioner's role was of little value and did nothing more than add to the existing regulatory burden.

- Only 23% of approved providers surveyed regard the Commissioner as playing a useful role in the industry

- 58% of approved providers surveyed agree that the Act should compel the Department to implement the Commissioner's recommendations.

Recommendation 23

Provide the Commissioner with determinative powers.

Associate Professor Walton has proposed that section 16A.21 of the Investigation Principles 2007 be expanded to enable any person who makes a complaint to request a review of the outcome of that complaint by the Commissioner.

If this amendment were implemented it would grant staff and members of the public the right to apply to review a decisions about the care and services provided to any aged care recipient. Such pesons are currently provided limited information on the outcome of an investigation so as to protect the personal information of the aged care recipient. The only person who should have the right to appeal a decision about the care provided to a named aged care recipient, should continue to be the aged care recipient or their representative.

Recommendation 24

Reject Associate Professor Walton's recommendation to enable any person who makes a complaint to request a review of the outcome of their complaint by the Commissioner.

Building Certification

Residential aged care facilities built after May 2005 are built in accordance with Building Code of Australia (BCA) Class 9c Building Standards, which are specifically designed for aged care buildings. The BCA sets the minimum community standards for safety, health and the amenity

of buildings.

In 1997, prior to the development of the BCA Class 9c Building Standards, the Department established its own certification process. The BCA Class 9c Building Standards largely duplicate the Department's certification process. The only notable exception is the Department's privacy and space requirements which are not covered by the BCA Class 9c Building Standards. The Department's privacy and space standards impose restrictions on the number of residents per room and the number of baths and toilets per resident.

The Government in response to the Productivity Report on Regulatory Burden 2009 has agreed that the requirements in respect to space and privacy be referred to the BCA for incorporation within the 9c Building Standards. This report recommends that a better course would be to include the space and privacy requirements with the Accreditation Standards.

- 81% of approved providers surveyed agree that many of the certification requirements imposed on approved providers under the Act are already imposed by other regulations.

Recommendation 25

Incorporate the privacy and space requirements into the Accreditation Standards and remove certification requirements from the Act.

Consumer Choice

It is now a standing public policy that the average Australian has a strong preference for maintaining their independence in the home of their choice for as long as possible during the individual's lifetime.

A second tenant of modern public policy in the aged care service delivery environment is the desire by consumers to be supported to achieve maximum choice in services and support which will sustain the objective of life time independence.

Alongside these two objectives rests the need for a holistic system that provides equitable and fair access to all within a fundamentally financially sound and robust aged care system that will ensure maximum choice to consumers while retaining system efficiency and economies of scale.

Effective choice and service options are best achieved when there is some level of market driven outcomes which are sufficiently adaptable to respond readily to changing consumer wishes.

As an underlying parameter of reform ACAA believes that future aged care structures should be predicated on systems that will achieve the greatest level of consumer choice while retaining a robust service provider platform.

Recommendation 26

It is recommended that the Productivity Commission maintain a strong focus on how any future reform recommendations can deliver system reform that will support the highest level of consumer choice achievable.

Community Care

An effective community care service system

As the Australian population ages over the next forty years strategies for maintaining independence and access to home based person care will become critical to how Australia manages its fiscal exposure to an ageing population. Without well integrated low cost home based services, Australia will find the proportion of GDP and Government outlays being expended on social welfare, health, housing and aged care will impact on the fiscal balance in the Australian economy.

Community care services – such as home help, home modification, assistance with showering and nursing – support older people to retain their independence at home, help to prevent the need for more expensive services (such as hospital or residential aged care), and help people return home more quickly after a stay in hospital.

In 2007, the Australian Institute of Health and Welfare (AIHW) reported that 1,004,400 Australians aged 65 years and over needed some form of assistance to help them stay in their own homes. More than 330,000 of these people indicated their care needs were being met only partially, and over 50,000 indicated that their needs were *not being met at all.*[16]

In attempts to meet this demand, community care services are being rationed and spread thinly with approximately a quarter of a million older people receiving an average of just 31 hours domestic assistance per year (or 35.7 minutes per week) and 80,028 very frail clients receiving an average of 54 hours of personal care (showering and shaving) per year (or 62 minutes per week).[17]

Community Aged Care Packages (CACPs) five years ago provided 7 hours of care per week but now deliver only 5 hours per week on average.[18] Extended Aged Care at Home (EACH) packages have experienced a similar decline in hours.

All community care services, including packaged care, have for years only received COPO indexation, the CAP was never extended to community care. This means that the price per package is far below the cost of delivering the services. This situation is compounded each year by inadequate indexation.

Recommendation 27

ACAA recommends that a new aged care indexation methodology or price fixing review be undertaken by the Hospital Pricing Authority and should apply to the full range of community care services.

Essentially there needs to be more community care available, paid at a price (per unit of service) that supports quality service delivery as well as greater flexibility for services to meet the increasing needs of clients. Getting the unit prices right will be an important step to ensuring further effective reforms, including providing consumers with greater choice.

The decision earlier this year to fully integrate the Home and Community Care program under Commonwealth financial and service delivery responsibility in all states except Victoria and Western Australia is a welcome move towards a better integrated community care service offering.

The current step between the low level community care offered for a CACP and a high level EACH package is too large. The NHHRC report has recognised this and recommends the

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[16] AIHW *Older Australians at a Glance* (November 2007): 102-104.

[17] HACC MDS Statistical Bulletin 2006-07: 13-14 http://www.health.gov.au/internet/main/publishing.nsf/Content/hacc-pub_mds_sb_2006-07.htm~hacc-pub_mds_sb_2006-07-3.htm

[18] Productivity Commission, Report on Government Service Provision 2009.

introduction of more flexible funding arrangements suggesting that an additional five pay points may be required. ACAA proposes that the various programs (HACC, CACPs, EACH and EACHD) be merged, under the jurisdiction of the Commonwealth Government, to create one program with a range of flexible funding levels to meet an individual's needs. This would create administrative savings which would be better invested in delivering care to older people.

Recommendation 28

ACAA recommends that the Productivity Commission support increased funding for community care services to pay an appropriate (unit) price and enable the level of care provided to better meet existing client needs.

Recommendation 29

ACAA recommends that future access to community care be better integrated through common assessment processes that support the client to seamlessly access services as and when required.

Recommendation 30

ACAA recommends that all persons approved for community care services should have the support of a case manager who would assess the person's needs and secure the most appropriate available service from an approved service provider.

One of the most difficult aspects of delivering efficient services to an individual's home is the loss of human resource efficiency due to time taken to travel, individual residence variability, social framework of each contact and clinical data management.

A second issue that impacts upon the capacity of service delivery in domestic settings is the availability of voluntary carers. The availability of voluntary carers as a proportion of the community care workforce will decline rapidly from 2017, which is likely to have a significant impact on the demand for higher levels of paid workers to support home based care recipients.

As the average length of life continues to grow and the number of divorced, separated or unattached persons enter older age the number of persons without a family member or spouse to undertake the voluntary carer role is likely to diminish. The one small countervailing factor is the current trend for the male average length of life to gradually move closer to the female average length of life.

Recommendation 31

That Australia adopts an annual health and welfare annual check up for all people older than 75 years. The service would be voluntary and would undertake an annual home visit for every person who met the aged criteria.

Recommendation 32

That Commonwealth Government support a marketing campaign focused on asking older Australians to consider housing options that might better suit their individual circumstances and support more appropriate service delivery to sustain an efficient community based care program to the individual's home.

Retirement villages and independent living units

The aged profile of the entrants into retirement villages and independent living units is approximately 80 years of age - not significantly younger than the age of entrants into residential care which is currently approximately 83 years of age.

Villages and independent living units are gradually becoming the aged care hostels of the

nineties. With some coordination and minimal domestic support and clinical input a person can be retained in this setting for most if not all of their life.

Such settings have the benefit of achieving greater efficiencies for home based community care programs.

Recommendation 33

A future aged care system should aim to provide effective coordination between community care, seniors housing of various types and residential care. Packages of housing, care and accommodation need to be seen by the consumer as a continuous service offering, with the consumer not having to negotiate multiple service providers over time as their service needs and requirements change.

Community care services can be considerably enhanced by well networked and integrated telephony, information support systems and home based assistive devices and technologies.

Such technology effectively deployed can provide systemic improvements in efficiencies to both paid carers and medical professionals. Monitoring devices can provide support to voluntary carers or remote family worried about safety and security.

Devices effectively deployed can offer greater freedom and safety to the individual which can enhance a person's well being and life style.

Social isolation can to a large extent be avoided with astute use of communication systems that support ongoing contact with family, friends and acquaintances.

Silverchain is the largest community care service provider in Western Australia and has demonstrated substantial productivity gain among staff and service delivery improvement among care recipients through the effective use of a range of communication tools to assist staff with their daily work schedule and to transmit client data both prior to and after a consultation.

Recommendation 34

That the Productivity Commission support the development of a single integrated national community care service capable of delivering the full range of supports that will maintain a person's independence, in their own home setting.

Recommendation 35

That the Productivity Commission support financing and deployment of a range of communication, information technology and assistive devices which are geared towards improving and sustaining a person's independence in the home setting of their choice for as long as possible.

Workforce

The 2006 National Institute of Labour Studies (NILS) survey of the aged care workforce revealed a highly motivated workforce, dedicated to the provision of high quality care. However, the survey also clearly indicated a workforce demographic which is ageing rapidly. Unless solutions are found soon to alleviate the attrition from an ageing workforce the problem will become endemic. The survey demonstrated that particularly among registered nurses, the major deterrent to working in the sector is the volume of red tape with which nurses must contend.

Other parts of the Australian health care system with much larger government outlays do not have imposed upon them the type of highly intrusive, subjective and inspectorial processes currently applied to aged care.

Indeed ACAA does not believe that aged care workforce attraction and retention issues are likely to be resolved unless and until there is a complete overhaul of the existing compliance and inspectorial function currently the responsibility of the Department of Health and Ageing.

In this regard ACAA has long argued that there needs to be an executive exchange program between aged care providers and the Department of Health and Ageing. The executive exchange program would involve 10 to 12 senior executives from DoHA and industry spending one or two weeks on secondment in the other's work place each year. The intention is to create a stronger working relationship between both entities and to ensure a much better understanding of the environment in which each operates.

Recommendation 36

The Productivity Commission endorse the creation of an executive exchange program between aged care providers and the Department of Health and Ageing.

While ACAA recognises that workforce planning is not a short term issue, it is unlikely that the status quo will deliver the necessary staff with the appropriate skills mix for the future.

ACAA recognises the significant difficulties that will be faced by many providers in coming years to attract and retain sufficient skilled staff to meet the needs of staffing in both residential and community settings unless workplace re-design occurs now.

Aged care is a hands-on service delivery environment. There are limited opportunities for gaining significant efficiency improvements due to the heavy dependence on manual service provision.

The Department of Health and Ageing in its second submission to the 2008 Senate Enquiry into Residential and Community Care submitted their assessment of the industry's productivity improvement during the ten year period up to 2008. The Department in their submission estimated that the industry achieved a 17% productivity gain over this period or 1.7% per year.

Much of this productivity gain has been achieved through workforce restructuring and re-design. The NILS report referred to above clearly indicates the industry's pressures through registered nurse number decline, while gross client throughput increased.

ACAA is of the view that in an industry such as aged care the capacity to continue to extract efficiency gains is not inexhaustible and that the efficiency gain capacity has probably been achieved.

Clearly the industry has had to achieve these results to maintain viability while maintaining quality service provision. This outcome has also been achieved while living with an insufficient annual index, competing with escalating public sector wages, meeting staff requests for wage increases and a government requirement to meet numerous compliance and administrative

requirements from within existing resources.

One example of a system improvement without any recognition of cost changes is the introduction of disposable incontinence aids. This was not a mandated requirement from government but the use of disposable incontinence aids is now industry standard practice and a facility supplying re-usable product may struggle to meet compliance obligations.

This system change has been highly beneficial for all involved. It produces a better quality outcome for consumers, an easier management environment for staff and improved staff/client relationship. All round an extremely positive outcome.

Only one problem: disposable incontinence aids actually cost considerably more to purchase even when you include laundry, handling and linen costs. Given the high dependence on government funding, the system rarely recognises the implications of quality and system improvement possibilities from deploying best practice products or services. It becomes the norm and providers are expected to find additional resources from within to achieve an undoubtedly better outcome.

Recommendation 37

That the Productivity Commission support the creation of innovative service and product funding pools that will assist aged care providers deploy a range of best practice products and services in various settings across community and residential aged care.

The industry average expenditure on salaries and wages is approximately seventy percent of all expenditure. A rough approximation for salary and wage costs is the aged care subsidy which also approximates 70% of all income.

Until aged care facilities are receiving the appropriate levels of funding, wage rates in the sector will suffer. While this is the case, highly skilled nursing staff will not be attracted to work in aged care.

ACAA believes that nurses and carer workers require competitive remuneration in recognition of their unique skills. The aged care sector must have the financial strength to offer competitive wages to nursing staff. There will continue to be an overall shortage of registered nurses in the industry until this objective is achieved.

Recommendation 38

That the Productivity Commission recognise the high dependency of the industry on government funding while operating in an environment which directly competes for registered nurses with the acute hospital sector, and that current funding levels do not provide sufficient financial capacity in most jurisdictions to compete effectively with acute sector pay rates.

Aged Care Career Pathways

The Aged Care Career Pathways scheme has proved effective in supporting undergraduate and post graduate first year employees to obtain positive clinical placements and workplace experience in aged care settings.

ACAA believes this type of program needs to be created in all states and territories and across most regions.

Aged care needs to distinguish itself by providing high level support during clinical placements and making post graduate employment an attractive experience.

The 2010-11 budget allocated funds to commence better deployment of this type of program, however ACAA believes the program requires considerable expansion.

Recommendation 39

That the Aged Care Career Pathways program be extended nationally.

Medical Workforce

It is generally recognised that securing sufficient GPs to visit aged care residents is problematic in many parts of the country.

There are a variety of problems ranging from small client numbers, poor remuneration, lack of consultation facilities, lack of GP confidence in treating the very old and lack of coordination of consultation times.

ACAA considers that a complete rethink of the current arrangements is required with a sample of options being tested to determine best performance outcomes.

It is vital for us to achieve improved integration between the health and aged care sectors involving a cooperative, multidisciplinary approach involving GPs, other medical specialists including geriatricians and palliative physicians, nurses, and allied health professionals, other health professionals, and carers.

Most GPs do not provide services in aged care homes. There are many barriers which act as disincentives for GPs, and other medical specialists from operating in the aged care sector. These disincentives include:

1. inequitable means of payment;
2. the large number of non-face-to-face administrative tasks and red tape expected of GPs and other health professionals;
3. the lack of integration of medical services in the aged care system; and
4. the absence in many care homes of consultation rooms with adequate treatment facilities and computer facilities which can link to their computers and computer records, which would facilitate access to patient records for all visiting health professionals, and would save duplication of records.

The Howard Government's Medicare Plus program included funding for GP panels and for GPs to provide services such as participation in medication management review panels.

ACAA commends consideration of this sort of model as a way to engage GPs who will accept responsibility for providing a full range of medical services, including consultations, in aged care homes.

The issues of red tape and integration of medical services in the aged care system are broad issues which ACAA has partly addressed with the Commission, and would be keen to pursue further during the Commission's inquiry.

The issue of information technology has been making strong strides by the aged care industry, and is the subject of a separate section within this report.

Recommendation 40

ACAA recommends that the Productivity Commission support the introduction of funding of aged care service providers to enable engagement of GPs and other medical specialists including geriatricians and palliative physicians to provide integrated services within the aged care environment.

Recommendation 41

ACAA recommends that the Productivity Commission support Government funding of various trials to test better GP service arrangements including:

- *cashing out Medicare rebates*
- *aged care facilities contracting service provision with GP group practices*
- *funding of GP coordinators who will liaise between GPs and aged care facilities about consultation and appointment times*
- *Capital grants to aged care providers to assist with provision of clinical consultation rooms.*

Leadership

The aged care industry has a relatively large number of managers but because of the many individual sites organisational structures mean that management structures are very flat.

Within aged care homes the local management team even within large group operators is crucial to the operations of each facility and to the maintenance of long term quality service management.

When there is facility failure it is often found to relate in some way to the local management group.

At the same time the industry employs in excess of 6,000 managers in this type of crucial role, though as an industry we provide little or no training, support, or mentoring of these managers. More particularly, most of the industry does not engage in a leadership career path nor succession planning arrangements for future managers.

ACAA, the Royal College of Nursing Australia and Australian Catholic University have supported the development of an industry managed clinical leadership program which once developed should be deployed nationally for all aged care providers providing leadership training and mentoring for current and prospective clinical managers in the aged care system.

Recommendation 42

That the Productivity Commission support the need for the industry to have an integrated clinical leadership program to support clinicians currently involved in leadership roles or contemplating a career path involving such roles.

Aged care is unfortunately one of the sectors most burdened with oppressive regulation, red tape, and paper-based systems in the broader health system. It is essential that if aged care is to become an attractive workplace environment, in particular for younger workers, that aged care reduce the red tape to secure a more streamlined, paper-free environment that frees workers to undertaken explicit care and services for care recipients.

Aged care providers provide 570 million medication administration events each year, with each residential care recipient in receipt of nine medications per person on average.

This is an enormous task and should receive maximum electronic assistance to ensure the most secure and safe systems are deployed to achieve the best quality outcomes for care recipients.

Recommendation 43

That the Productivity Commission recognise the very heavy burden aged care staff undertake in achieving high levels of medication administration for care recipients that receive medications, and that if aged care is to become an attractive employment option information technology must be used to change the current system so that much of the unnecessary red tape can be removed.

Aged Care Information Technology

Over the past decade, aged care provider use of IT has improved rapidly and now more than half of the industry uses some form of IT support system to better manage clinical information and data.

The transfer of the payments system to Medicare Australia, and the introduction of the Aged Care Funding Instrument (ACFI) which can be lodged electronically, along with the need for continuous quality and efficiency in care and administration has driven this rapid improvement. While there are many areas of operation that could be improved by further application of technology, there are some specific gains to be achieved in medication management.

There are nearly 570 million medications administered per annum during the 70 million days of care (approx) provided in residential care homes. Each resident is, on average, taking 9 medications. There are over 30,000 admissions to hospitals each year from residential care and according to the AIHW at least 8,000 of these admissions are preventable, many due to adverse medication administration events.

Medication management issues are a major cause of older people having to go to hospital. In addition, the inefficient systems used to administer medications result in aged care staff, GPs and pharmacists spending considerable time and effort on prescription writing, (including chasing new prescriptions when the current ones expire), owing prescriptions and double handling of excessive paperwork. Clearly this is an area for potential and significant productivity improvement for all three stakeholder groups.

In recognition of this, the Aged Care Industry IT Council (ACIITC) has been working toward the establishment of a whole of industry electronic medication management solution, which will support e-prescribing by GPs, e-dispensing by pharmacists and electronic medication administration by aged care staff. The intent is to raise the capability of all aged care providers within four years to support e-transactions and e-health more generally. This is in line with the NHHRC emphasis on the importance of e-health in delivering a better and more efficient health care system.

To date, this project has included substantial consultation with a broad range of health industry stakeholder organisations and a business case submitted to the Department of Health and Ageing.

A significant investment is needed to support this project. However, the investment will be offset by reductions in service demand in other parts of the acute health setting. For example, if the medication management system reduced or removed the 8,000 preventable hospital admissions (from residential aged care) a saving of $24M per year would result. In addition, the industry plans to use the deployment of IT support systems to work towards reducing the total number of medications per resident from nine to seven with an estimated annual saving of $23M.

Investment in the project would be used in 2010-11 to complete the technical systems design for whole of industry deployment which would commence in 2011-12 and continue over a three year period.

Deployment at this level will result in a significant improvement in industry IT capability which would, if deployed across the industry, develop an industry capable of considerable systems improvement including GP interface, sharing clinical records, creating an electronic health record, providing a new system for accreditation, a different method of ACFI validations and a health record for long term chronic disease older care recipients.

Recommendation 44

ACAA recommends that the Productivity Commission support Government investment in the development and deployment of an electronic medication management solution for aged care

initially targeted to residential care.

Complex care

Increasing acuity and complexity of care

Increasingly, aged care, both residential and community, cares for people with complex, chronic conditions.

The increasing acuity of recipients of care in residential and community contexts is stretching workforce capacity to manage effectively and safely in what is rapidly becoming a sub-acute treatment service.

Currently, some real weaknesses persist with the Aged Care Funding Instrument (ACFI) not being relevant to what is actually occurring around resident needs for chronic and palliative care.

Despite increasing trends for hospitals to discharge terminally ill patients to aged care if they are aged over 55 years, ACFI does not adequately cover the frequency and skill intensity of care and treatment needed for palliation to be effective.

These weaknesses need to be resolved in readiness for a rapidly ageing population which will place greater demands on aged care residential and community services.

Palliative care

The significance of our ageing population to aged care, and to the demand on such services for end of life care, is substantial and will increase.

For older people, death commonly occurs while receiving aged care, both residential and community, unless the patients are transferred to acute care facilities. However, there are barriers, including inadequate pain relief and symptom management, in aged care – both residential and community – preventing people being able to receive quality, seamless end of life care for their complex health needs, in the setting of their choice.

The World Health Organisation's definition of palliative care is used worldwide including in Australia[19]:

> Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Palliative care:
>
> - provides relief from pain and other distressing symptoms;
> - affirms life and regards dying as a normal process;
> - intends neither to hasten or postpone death;
> - integrates the psychological and spiritual aspects of patient care;
> - offers a support system to help patients live as actively as possible until death;
> - offers a support system to help the family cope during the patient's illness and in their own bereavement;
> - uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;
> - will enhance quality of life, and may also positively influence the course of illness;
> - Is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

All of this applies in aged care, both residential and community-based.

[19] World Health Organisation (WHO), http://www.who.int/cancer/palliative/definition/en/

Accordingly, it is both a short-term and a long-term strategic planning need for resourcing to support aged care facilities to work towards providing quality care for these people, including appropriate palliation, pain and symptom relief.

Currently, the Aged Care Funding Instrument (ACFI) does not adequately support resident needs for palliative care.

In particular, ACFI does not adequately cover the frequency and skill intensity of care and treatment needed for palliation to be effective.

Even with an ACFI of HHH or HNH such residents are not well funded as having complex care needs. The current ACFI subsidy is around one third of the amount that specialist palliative care services receive in state and territory jurisdictions. An additional ACFI supplement is therefore needed.

Recommendation 45

ACAA recommends that the Productivity Commission support changes to the Aged Care Funding Instrument (ACFI) to better support the provision of complex and palliative care within aged care services, e.g. by making the ACFI subsidy for palliative care services more equivalent to the amount that specialist palliative care services receive in state and territory jurisdictions.

To a significant degree, aged care is already a palliative care service. The final report of the National Health and Hospitals Reform Commission recognised the need for, and made a number of recommendations to improve, palliative care services in residential and community aged care settings[20]. These recommendations were:

- NHHRC recommendation 55. We recommend strengthening access to specialist palliative care services for all relevant patients across a range of settings, with a special emphasis on people living in residential aged care facilities.

- NHHRC recommendation 56. We recommend that additional investment in specialist palliative care services be directed to support more availability of these services to people at home in the community.

- NHHRC recommendation 57. We recommend that advance care planning be funded and implemented nationally, commencing with all residential aged care services, and then being extended to other relevant groups in the population. This will require a national approach to education and training of health professionals including greater awareness and education among health professionals of the common law right of people to make decisions on their medical treatment, and their right to decline treatment. We note that, in some states and territories, this is complemented by supporting legislation that relates more specifically to end of life and advance care planning decisions.

In addition, the following NHHRC recommendation deals with medical care for people with terminal conditions.

- NHHRC recommendation 54. We recommend building the capacity and competence of primary health care services, including Comprehensive Primary Health Care Centres and Services, to provide generalist palliative care support for their dying patients. This will require greater educational support and improved collaboration and networking with specialist palliative care service providers.

So far, the response of the Government has been to keep referring to the allocation in the 2010-11 Budget of $1.6B over 4 years for "sub-acute beds" which the Government says is not

[20] Australian Government, 2009, *A Healthier Future For all Australians,*

restricted to hospitals, but can mean places in the community, or in residential aged care. While this is a potentially important means of ensuring that aged care can play an active role in providing seamless care services to older people with sub-acute care needs, there is long way to go in having this recognised in practice. One of the problems is having this recognised and supported by the States and Territories who are recipients of this funding.

Long Term Structural Reform

If aged care is to meet the needs of an ageing population, there is a need to consider the fundamental reforms the system will need in order to align prospective demand with level and type of services that will provide the highest level of choice to consumers and the flexibility and capacity to change the service offering over time.

To achieve these objectives, some of the rigidity within the current system has to be changed, with the system framework reconfigured to support innovation, flexibility, client choice and certainty, for consumer expectations to be met.

In addition to the long term funding suggestions outlined in Attachment B and the medium term reforms outlined in attachment C there is a need to plan for longer term structural reform which will allow the industry to migrate from the current scheme to a more market oriented customer focused system over a manageable period of time.

The reforms that would need to be considered in this context are summarised in the table in the next section under Transition Arrangements. These suggestions are predicated on an agreement that long term structural reform will be needed by the industry in order to create a financially viable and sustainable system.

National Health and Hospitals Reform Commission

The NHHRC made a number of recommendations that would ultimately deliver major reform to the industry. A number of the NHHRC recommendations raised questions about likely impact on the system's viability.

ACAA is of the view that further work needs to be undertaken to better understand the likely impact of recommendations such as changing the planning ratio and allocating places to ACATs. The aged care system is a finely tuned industry with limited margins. Precipitate actions that could change lending patterns and erode borrowing capacity need to be thoroughly understood prior to major reform announcements.

That said, there appears little doubt that the current scheme can not deliver the growth and choice desired without some fundamental structural reform.

Single Government Responsibility

ACAA has been supportive of a single level of government taking financial responsibility for the delivery of aged care services. Following the 2010 COAG agreement, it appears that this will now occur in all but two Australian jurisdictions over the next two to three years.

This will now provide the Commonwealth with the opportunity to integrate HACC, community care and residential care into a seamless service offering.

Recommendation 46

ACAA supports the development of a seamless aged care system where clients are not forced out of one program into another because the funding or administration of the program comes from another level of government.

Consumer Information

Finding your way around the aged care system is ridiculously complex.

Completing documentation for every step along the service trail can be even more complex. 90% of persons entering residential care are either full or part pensioners. Therefore between Centrelink and Medicare there is a very substantial database on each person's history, domestic status and financial circumstances.

There is a unique opportunity to establish systems which integrate this information and share it among the various funding or service provider agencies to try and avoid both the excessive red tape that follows and the constant intrusion into the individual's affairs. A sufficiently robust system should be deployable to safeguard privacy while permitting the sharing of information among the various entities.

Recommendation 47

ACAA supports a simplified data collection and information exchange between government agencies and approved service providers.

Allocation Rounds

Residential care currently maintains an occupancy level of approximately 93% which in many parts of the country is providing consumers considerable choice. However this is patchy and in areas such as Far North Queensland there are long waiting lists and excess demand over supply.

The increase in total places during the past seven years to 113 per 1000 persons over 70 has been accompanied by this declining occupancy in most parts of the country. Unfortunately, there is little evidence to indicate whether this changing occupancy status has been caused by the increase in total allocations, declining demand, increased place allocations to reach the 113/1000 target, or other factors.

There is certainly a need to make a connection between the number of places being allocated in each domain and whether other factors are impacting on demand. As 50% of all hostel residents are now classified as high care it would seem logical to move to a future where service providers could elect to convert low care places into either high care or extra service places dependent upon the prevailing local circumstances.

If providers were permitted over time to transfer low care places into community care or high care places in a controlled timeframe it must raise the question at the end of that process of what will be the continuing function of the allocation process, or should approved providers simply be permitted to deliver services in a residential or community setting dependent on local service need?

Recommendation 48

That in a controlled process, residential low care approved providers be permitted as demand changes to convert existing places to high care or community care places.

Capital Servicing

The section of this submission dealing with medium term issues makes specific recommendations regarding reform to the industry's capital raising capabilities.

It is worth re-stating here that this issue must be dealt with prior to any substantive change to the allocation process or the allocation formula, as the industry is already struggling to meet the investment requirements that future growth projections are indicating as desired.

Any further erosion in industry confidence in this regard, or weakening of the existing poor return on capital, is likely to drive the industry into withdrawing even further from the investment in new building stock that will be needed over the next two decades.

ACAA has calculated that over the next 20 years the industry will need to invest approximately $51B in new building works and approximately $40B in renewals and replacement building works. Annual investment today is approximately $3B leaving a potential shortfall of $30B over the 20 year cycle.

As the number of low care places declines it will be essential that a replacement capital stream capable of supporting this level of investment is devised, otherwise the customer choice will evaporate.

Recommendation 49

Allow future residential care clients a variety of options for contributing towards their hotel and accommodation services including accommodation charges and lump sum contributions or a combination of both.

Recommendation 50

Initially increase the accommodation supplement and charge to reach at least 80% of the average lump sum accommodation payment in the previous financial period.

Recommendation 51

Undertake an in depth analysis of the cost of capital. Once this task is complete, move to uncap the accommodation charge with the existing safety net maintained and the accommodation supplement being paid at 80% of the market rate.

Another source of capital other than land is Personal Property Securities such as shares, intellectual property, receivables, contract rights, machinery, and crops. The new national Personal Property Securities system to begin operating in May 2011[21] will provide more certainty and should make it easier for older people to raise money through liens against their non-landed property assets for use as aged care bonds, without having to dispose of the assets.

Recommendation 52

ACAA recommends that the Productivity Commission support the use of the new national Personal Property Securities system and make it easier for older people to raise money against their non-landed property assets for use as aged care bonds, without having to dispose of the assets.

Operating Income

As recommended under the section on medium term reform, aged care requires a new funding formula that recognises the real cost of care. Pending these recommendations being implemented ACAA would support the continuation of the Conditional Adjustment Payment additional annual index previously set at 1.75% in addition to the COPO annual index.

Recommendation 53

Continue the Conditional Adjustment Payment (CAP) until a new aged care specific index is developed.

Recommendation 54

Extend the CAP to Community Care pending the finalisation of a new aged care specific index.

Aged Care Industry/Government five year agreement

ACAA believes that Government should consider introducing an Aged Care Industry/Government five year agreement which sets an agreed series of activities that the industry and government agree to work on over the next five year cycle.

[21] Personal Property Securities Reform, Attorney-General's Department, http://www.ag.gov.au/www/agd/agd.nsf/Page/PersonalPropertySecurityReform_PersonalProperySecurityReform

This could be an important vehicle for introducing phased transitional changes.

There is inadequate medium to long term strategic planning in aged care, especially combined Industry/Government work on current trends, future directions and strategic vision with a ten to twenty year horizon.

Recommendation 55

That the Productivity Commission support the creation of a government/industry five year agreement.

Transitional arrangements

To ensure that the migration to a new model of aged care does not cause disruption to the provision of high quality services, there needs to be transparent transition arrangements with appropriate, staged phases, and a reasonable period for adjustment for all involved – industry, consumers, workers, and government.

The following is a timeline of transitional arrangements which could achieve the objective of transparent process pending modification based upon the Commission's final report and government response to the recommendations.

2010	Australian Government assumes responsibility for funding aged care.
	Increase accommodation charge in high care; increase the accommodation supplement to 80% of accommodation charge.
	Allow high care residents flexibility in how accommodation payments are made, including capped accommodation charge, (uncapped) refundable lump sum, and deferred payment.
2011 - 2012	Allow flexibility for providers to convert low care residential places to community care and high care residential.
	Change provision ratio from places to care recipients.
	Continue CAP annual increment (or equivalent) and extend to community care packages.
	Develop, consult on, and introduce a Benchmark of the Costs of Providing Aged Care.
	Establish an independent aged care pricing authority (or establish this function within the proposed Hospital Pricing Authority) to develop an appropriate and viable aged care funding index.
	Introduction of funding of aged care service providers to enable engagement of GPs and other medical specialists including geriatricians and palliative physicians to provide integrated services within the aged care environment.
	Align subsidies and fee policies and levels in community and residential aged care (including HACC).
	Allow all care recipients choice of care services and provider.
	Allow community care recipients to transition to higher entitlement as their needs increase, based on ACFI (modified as necessary to accommodate increasing chronic and palliation care needs) assessment.
2012 - 2014	Increase accommodation charge in high care and the accommodation supplement to a level at least 80% of the lump sum accommodation payment value of the previous year.
	Allow high care residents flexibility in how accommodation payments are made including the accommodation charge, the refundable lump sum, deferred payment or combinations of all three.

	Uncap accommodation charge and apply independent capital valuation assessment with the accommodation supplement being set at 80% of the market rate.
	Funding to residential care providers to access primary care services, geriatricians and palliative care specialists.
	Expand Home and Community Care Program (HACC) to achieve continuum of services within the broader aged care program.
	Set clear targets for increased provision for sub-acute services.
	Review need for transition care in context of increased investment in sub-acute services.
	Continue capital grants program to support residential care services for special needs groups and rural and regional communities.
	Maintain viability supplement for rural services.
	Remove provision target controls on supply (including extra service).
	Continue balance of care ratios.
2015 – 2017	Integrate community service provision, seniors housing and residential care into a seamless service offering for future care recipients

Recommendation 56

ACAA recommends that the Commission deal with a structural reform of this magnitude through a transparent plan of action that clearly details the milestones in the reform process and ensures whole of industry readiness to make the necessary changes in an orderly and timely fashion.

Conclusion

The Productivity Commission has the opportunity to help create a quality and viable aged care service that will serve Australia well into the future.

Aged Care Association Australia looks forward to working closely with the Productivity Commission during the course of this inquiry.