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Submission to the

Productivity Commission

Inquiry into Caring for Older Australians

August, 2010
ACAA-SA

Our Association represents Commonwealth-approved residential aged care providers in South Australia. There are 51 residential facilities in our group, operated by 27 different providers, the majority of whom are private organisations.

Our members care for around 3,300 aged residents, 85% of whom are high care.

Endorsement of ACAA Submission

As a member of the federation of state-based associations which comprise ACAA, our Association endorses the submission to this Inquiry made by ACAA.

Therefore, we have not wanted here to duplicate the information, views and recommendations expressed in that document, and have confined our submission to comments which express a slightly different perspective, emphasis or view.

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Bed Licencing

Licencing should continue as a method of regulating the supply of beds, although the present system needs considerable overhaul.

Bed licencing provides some measure of certainty that new facilities will be occupied. This degree of certainty reduces the risk which providers are taking when they invest in new facilities and this reduces the margin they, and the institutions lending them the funds, require. In turn, this reduces the price for the taxpayer and the care recipients.

Considering that average the cost of building aged care facilities is around $200,000 per bed, the risk of building in an unregulated supply environment would be very high, requiring significant risk margin by providers and financiers. The waste of resources from failed operations would be considerable.

Allowing market forces to determine where beds are built, as was allowed in the childcare industry, will lead to oversupply in some areas, and this will lead to the closure of facilities that cannot maintain viable occupancy rates.

The cost of this additional risk would be borne by those who fund aged care, that is the Commonwealth and the care recipients themselves. As well, the inevitable failures would result in service dislocations, causing upset and stress to the elderly clients and their families.

However, the determination of where and how many beds are licenced, and how home care packages are provided for those in need, must be more soundly and flexibly based (see Planning for Future Care Provision).

Community Care Availability

Unlike the provision of residential beds, which is high cost and subject to long lead times, subject to staff availability, changes to the demand for home care can be responded to flexibly and quickly.

However, flexibility of supply is diminished by the current system.

The current system of allocating quantities of packages to approved providers, is inefficient and inflexible, and leads to unnecessary mismatches between service need and service availability.

For example, under the current system a provider may have the capacity to deliver additional packages, there may be unmet demand in the area they service, but if they do not have spare packages which have been "allocated", they are not allowed to satisfy the demand.

Another provider could have an allocation of packages which exceeds their present demand and capacity, but this excess cannot be transferred to another provider.

It seems logical that people who have been approved for certain home care services, should be able to receive those services from an approved provider who has the capacity, or who can readily acquire the additional capacity. The requirement that services can only be provided if the provider has a spare, allocated package, is inefficient, inflexible and is an impediment to older people's access to care.

Therefore, the allocation of community care packages to providers should be abolished, and care should be available to people for whom it has been approved, by any approved provider of their choice who has the capacity to deliver it.

Planning for Future Care Provision

The current system of planning is inflexible, and based on inappropriate targets.

The data is available to produce a detailed profile of those people in the population currently receiving some form of aged care – HACC, CACP, EACH, EACH-D, Residential etc.

Once properly gathered and analysed, the data should be applied area by area, to Australia's population projections. This would enable reliable forecasts of the future demand for the various age care services on, say, a rolling three to five year basis.

Data from this process would be used to allocate residential bed licences, working on a three year lead time from allocation to building completion. The data would be publicly-available to assist providers in their planning.

The publicly-available data referred to above would assist the providers of community aged care services in their planning, however, as stated earlier, there would be no allocation of packages, and approved providers would meet the demand for community care according to their willingness and their capacity.

An important aspect of the planning process would be the deliberate building in, and funding, of an over-supply, or vacancy factor. As an example, for every 97 new beds determined as a result of the planning process described above, 100 beds would be allocated.

The care subsidies provided by the Commonwealth would be based upon the cost of providing the care, and set according to the over-supply factor. This approach would ensure that the system is designed to provide access to residential aged care as and when people need it, which is one of the government's key objectives.

Accessing Aged Care Services

The Commonwealth has announced that it will incorporate all aged care services, including HACC programs, under its direct funding and management. It has also announced the establishment of one-stop-shops, both physical and online, to enable better access to aged care information and services.

These announcements are welcome and should be implemented.

The current system is complex and daunting for families and prospective recipients of care to navigate, and many people wait too long to receive assessment and access to the services available.

As has been noted, access to the provision of home care services is restricted by the allocation of fixed numbers of packages to specific providers so, even after being assessed, people may be denied the care services they need.

With respect to residential services, assessments are currently provided specifically for high or low care. Combined with the practice of allocating bed licences on the basis of high and low care these policies place an unnecessary restriction on people's access to care, and have no purpose other than to maintain an artificial distinction on the classification of people entering aged care, for the purpose of determining how they are able to pay for their accommodation.

We submit that this distinction serves no long-term purpose and that it should be phased out over a period of say five to seven years. For example, if it were over seven years, a facility with 98 low care licences would have 14 become unrestricted per year until all were unrestricted.

This would preserve some stability in the market, and would ensure that business decisions made on the basis of the current rules were not suddenly disrupted.

As well as restricting people's choice, the current licencing policy denies access to the capital funds needed to build and refurbish aged care facilities (see Funding and User Contributions).

Funding and User Contributions

A basic principle for establishing funding levels is they should be based upon a detailed and rigorous analysis of the cost of delivering aged care, in the various community scenarios, and in the residential setting.

This cost analysis would be graded to account for the increasing costs associated with caring for people as they become more frail, both physically and mentally, and according to the number and type of chronic illnesses they suffer from.

Once measured, the cost of care would be used to set the levels of Commonwealth funding, which would include a sufficient margin to attract and retain provider organisations, and which would be adjusted annually by an index which measured actual changes in the cost of care inputs.

The costing would also consider the additional cost inputs for caring for people suffering from disabilities, mental health issues, severe behavioural or bariatric conditions, and these costs would be reflected in supplements paid to providers.

The costing would also need to account for the range of activities people need to have available, both therapeutic and social, which providers need to provide.

The cost of care analysis needs also to consider the increasing costs of equipment, information technology, and compliance with a range of authorities.

As an example, shower chairs have developed such that basic products which cost $500 - $600 are becoming available with elaborate designs which cost as much as $10,000.
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Industry-specific software can require investments of around $20,000 for a 50-bed facility, and ongoing costs of 15% of the initial amount each year. Software upgrades often require investment in more-expensive hardware to support the new functions.

The need to comply with requirements from an increasing number of authorities adds further to costs, with food safety inspections, and warm water system monitoring and maintenance being two recently added to the list.

A number of rules which currently apply to Commonwealth funding need to be reviewed.

The cap on the Income Tested Fee should be lifted by a modest amount, say 15-20% on the current levels, and then should be subject to CPI increase each year. There should be no clawback of subsidy in respect of this fee and proceeds of this fee should be retained by the provider to assist with capital development and debt repayment.

Under current policy a lower accommodation supplement is paid to facilities unless the proportion of their supported residents is greater than 40%.

The claimed intention of this policy is to ensure equity of access for supported residents, however the policy unfairly penalises facilities which cannot meet the ratio target, and works perversely to restrict access to different potential residents in different situations.

For example, a facility operating close to the 40% threshold may not accept residents who can afford to pay for their own accommodation, in order to maintain the facility’s higher supplement. Conversely, a facility which can never expect to reach the 40% target, because of the socio-economic area in which they operate, may not accept any supported residents, because they will never have enough of them to attract the higher supplement.

We submit that the 40% target is ineffective in achieving its stated goal, and in certain circumstances works against that goal, that it unfairly penalises certain facilities, and that it should be abolished. The payment by the Government in respect of supported residents must be set at a level that is equivalent to the maximum accommodation charge (or its bond equivalent as a daily amount) and this will ensure equity of access regardless of a resident's financial status

Under "Accessing Aged Care Services" we argued that the current restrictions on how people can pay for their accommodation should be lifted.

We propose that, subject to an indexed asset value which would be excluded from any payment, all people entering residential aged care, whether as high or low care recipients, would have the option of paying a refundable deposit for their accommodation, a payment which equates to an agreed deposit, or a combination of these.

The value of this deposit would be negotiated between the provider and the resident or their guardian. Places with higher standards of accommodation and amenity would clearly be in a position to negotiate larger deposits than those with a more modest offering.

This would provide both the funding and the incentive for organisations who wished to attract higher-deposit-paying clients and would provide a viable niche for organisations who wished to offer a more-modest standard of accommodation for clients who paid smaller deposits, or whose accommodation was fully-subsidised.

We do not see the provision of zero or low-interest loans as a viable substitute for a refundable deposit or accommodation charge. However, attractive the terms, a loan would still need to be repaid. A loan cannot substitute for the necessary return on investment and risk required for constructing aged care accommodation.

Retentions:

The fixed quantum of funds retained under the present system is inadequate and bears no relationship to deposit amounts, which vary dramatically across the country.

We have considered alternative options for determining retention amounts, including setting a percentage of the original bond amount, however we believe this would be unfair to those who could afford large deposit amounts and a deterrent to them agreeing to do so.

We propose that the annual retention amount should be set at a maximum of, say, $5,000 - $6,000 per annum, and that the total amount retained over the whole of the resident's stay be capped at 25% of the original deposit amount.

In all cases minimum standards of accommodation would be guaranteed under the Building Code of Australia. The system of Aged Care Certification has served its purpose in lifting the overall standard of accommodation in residential aged care and should now be abolished except for the few cases where facilities do not yet meet the requirements of the 1999 Certification Instrument. Otherwise, it is a costly and unnecessary duplication of regulatory jurisdictions.

With respect to home-based aged care, recipients with the financial means should have the option of purchasing services from their approved provider above and beyond those provided by the funded package which they are receiving.

Accreditation

Accreditation has played an important role in ensuring that aged care providers meet minimum standards in the delivery of a range of services and amenities to their clients, including nursing and personal care, physical environment and lifestyle.

A robust system of accreditation should continue to operate to ensure that minimum standards are maintained, and, importantly, to provide continuing assurance for the Australian community in the quality of its aged care system.

We would, however, propose certain changes:

As is the case in many industries, aged care accreditation should be opened to a competitive system.

The accrediting bodies should concentrate their work on quality assurance, as opposed to the dual roles of assurance and compliance carried by the current accreditation body. Where matters of compliance come to the attention of accreditation auditors, these should be referred in the first instance to the facility's management or, if necessary, to the Department of Health and Ageing.

Also, there must be a stronger nexus between the accreditation standards and the funding system. As an example, accreditation requirements for diversional activities, are not matched by funding for such activities (see Funding and User Contributions)