A proposal for a new tier of Community Care Intermediate Packages between CACPs and EACH/EACH-D

The aims of this proposal are:

1. To give a clear signal of the Government's commitment to expanding aged care, particularly community care.
2. To respond to the call for restructuring Care Packages and give an additional step in package funding over the period until recommendations from the Productivity Commission Inquiry are implemented.
3. To contribute to maintaining overall provision and address the persisting and potentially increasing shortfall between approved and operational places for residential care.

What is needed?

A new tier of Community Aged Care Packages intermediate between CACPs and EACH packages - I-Packages - is required to make for a more even graduation of care services to address three major problems in the system that have exacerbated over time:

- The need for providers to juggle funding for clients who are between the current two levels. Package clients now are often having to 'top up' their package with HACC services, particularly where they need nursing but also for extra hours of day care and personal care. The outcome is considerable additional strain on HACC.
- The considerably larger number of HACC clients on CACP- equivalent and higher levels of services than there are on CACPs. These Package-equivalent clients do not transfer to a package because: no package is available, CACP funding is too low to meet their needs, they are receiving nursing care which is not covered in a CACP, they do not want to change from their HACC provider, and in some cases, higher user payments for a Package.
- An intermediate level of funding would see most of the additional funding go to direct care services rather than more case management. Case management and administrative costs have absorbed an increasing part of CACP funding and reduced hours of direct care. I-Packages funding would add value for clients by providing more direct care, including nursing, building on the base of existing case management.

Who would be eligible for I-Packages?

Two groups of clients would be eligible for I-Packages, subject to ACAT assessment.

1. Clients who had already been on a CACP and who were using additional HACC services to meet their care needs, especially nursing.
2. HACC clients receiving levels of service equivalent to or exceeding CACPs funding.

Moving these two groups of clients on to I-Packages would relieve pressure on both CAPCs and HACC. Access to services at I-Packages level would also control upwards 'bracket creep' as a step between CACPs and EACH would mean that clients would not have to jump to an EACH Package. The new packages would specifically include nursing care, but eligibility would not be restricted to clients receiving nursing.

Why is the time right for a new initiative now?

Outlays on aged care are set to moderate for another three or four years due to relatively low growth of residential care places from 2008-09. The increase of only 2,818 operational residential places in 2008-09 was due largely to the low number of approvals in 2006-07.

The number and balance of residential and community places in ACARs has fluctuated from year to year instead of growing steadily as would be expected in line with growth of the population aged 70+. Averaging approvals and additional operational beds over the five years 2004-05 to 2008-09 smoothes the effects of these fluctuations in approvals and the 2-3 time lag for approvals to be realized. (see detailed figures in Table 1, p. 5 over)

Notwithstanding the increase in approvals each year since 2006-07, the average of 4,300 additional beds per year is just under 70% of the average 6,000 approvals, a shortfall of 30%. The cumulative effect of under-realization over 5 years is a shortfall of close to 9,500 beds. These are 'ghost beds' that have been approved but never become operational. The gap between the number of packages approved and becoming operational is negligible, and on average, close to 90% of approved packages become operational.

While it can be argued that the annual shortfall in RACH places can be made up in extra allocations over 1-2 years, the cumulative shortfall is much harder to make up and many factors suggest that it is proving difficult to overcome. This persisting under-realization can be attributed to a combination of several factors:

1. Some beds take longer to come into operation and some are never constructed, with reallocated bed licences adding to approvals in each ACAR.
2. Some loss due to closures; it is likely that closures may have peaked in the lead up to the final round of higher standards required for certification by 2008 and reduced since then, and the proportion of all beds that are now very old stock has diminished considerably since 1997.
3. The impact of the GFC on access to borrowings; this effect appears to be continuing.
4. High building costs and delays in construction due to competition in the building industry.
5. Provider uncertainty in anticipation of the outcomes of the numerous reviews since the Hogan review in 2004; none of these reviews have resulted in increased funding for the accommodation component of residential care. The Productivity Commission Inquiry has extended this climate of uncertainty and may see low interest in the next ACARs.
6. Delays in both calls for applications in ACARs and in announcing approvals.
7. Evidence of vacancies in residential care, especially Extra Services Homes, due to increased community care and also increasing alternative accommodation options, including serviced apartments in retirement villages.

These factors are likely to continue, and there is a real risk that the Government could be caught out by low provider interest in residential care places in the next ACAR, and then have to react after the event by approving more CACPs and EACH/D places.

Introducing I-Packages as a purposeful new initiative would instead put the Government on the front foot and place it in a pro-active position in leading reform. I-Packages would reshape the aged care system in line with the directions that are widely called for by consumers and providers, and consistent with the recommendations of the Productivity Commission Draft report. Current conditions however mean that I-Packages can be

introduced now rather than having to wait for the Government's response to the Commission's report and subsequent action.

Finally, I-Packages could contribute to overcoming an emerging level of 'ghost beds' and pre-empt 'ghost beds' becoming the political issue that they were in 2007.

How would a new package tier fit with the planning ratios?

The introduction of a new tier of packages would be highly consistent with several recent trends:

1. Maintaining the overall ratio of provision by approving additional package places to make up for shortfalls in RACH places. The average number of approvals and average number of beds coming on line per year over the last five years are well below the 9,000 beds indicated for the 2010-11 ACAR when the 2008-09 ACAR approvals were announced. Instead of making another *ad hoc* downwards adjustment in beds number balanced by an increase in packages above the indicative figure of only 1,298, a formal change to the ratio could be sequenced with the introduction of I-Packages. Approval of 5,000 beds would be a much more likely, and preferable, outcome of the next ACAR. An increase to 6,500 packages could then be divided between 2,500 CACPs, 1,000 EACH/D and an initial large allocation of 3,000 I-Packages.
2. A steady decline in the age specific rate of use of residential care for over a decade; that is, the proportion of each five year age group living in residential care has fallen. Over the last decade, there has been a decline of around 20% in the rate of use of residential care by each 5 year age group from age 70. Without this decline, the ageing of the older population would have seen a substantially larger number needing residential care. The decline in use can be attributed to improvements in life expectancy and related factors and the trends is unrelated to trends in bed provision.
3. A strong preference of clients and providers for community care and ACAT approvals for community care packages far in excess of available places.
4. Analysis by the Allen Consulting Group and others showing the need for an intermediate level of packages to take up HACC clients at package equivalent and high levels of care. This group of clients who use high levels of HACC services impose a disproportional demand on HACC.

Rather than making further *ad hoc* adjustments in the ratio and increases in package approvals, it is timely to make a formal adjustment in the ratio. As of mid 2009, provision of 110 places per 1000 aged 70 and over was divided between 87 residential care places, 20 CACPs and 3 EACH/EACH-D. These figures compare to the target ratio of 113 places divided between 88 residential places, divided evenly between high and low care, and 25 community care places divided between 20 CACPs and 4 EACH/EACH-D per 1000. Although recent figures suggest that the target ratios may be achieved, there is still considerable uncertainty about the rate at which beds are coming on line, and the target ratio allows for only a minimal increases in packages.

Even if the proposals of the Productivity Commission to relax planning controls are accepted by the government, some form of ratios will be required to monitor assessments and access in relation to provision and expenditure, and to plan for the changes envisaged in community care. Adjusting the ratios now would give a strong signal of the likely direction of future moves and initiate changes ahead of, but in line with, action likely to follow on the Commission's recommendations. It will be around three years before any action is taken on the Commission's recommendations, and an adjustment of the ratios could be planned for

over say five years. As I-Packages would be relatively less costly than further EACH/EACH-D packages, the total ratio could be increased as well as the balance between different services changed, without an increase in outlays. The number of residential care places has been propped up artificially by the planning ratios, and evidence of vacancy rates in both high and low care point to lower need. A small downward adjustment in beds could be phased in over 5 years to achieve a new target ratio of 115 places by 2015, divided between

- 82 residential care places,
- 20 low packages,
- 10 intermediate package and
- 3 high packages.

How should the level of funding be set?

CACPs, EACH and EACH-D were introduced on the arbitrary basis of equivalence with residential care funding. There was no collection or analysis of data on community care service use or costing, and there has been little since.

It is thus reasonable to set funding at an intermediate point between CACPs and EACH packages, around $24,000 a year. Each I-Package would provide for two clients for every additional EACH or EACH-D client and so give twice as many clients access to a package than would expansion of EACH. EACH-D are aimed at very selective client group and the evaluation of EACH-D showed only ambivalent outcomes, with the interventions often being seen to be too late.

I-Packages could make a larger contribution to maintaining the overall planning ratio than EACH/EACH-D for the same budget outlays, and also compared to residential care in which average Australian Government funding for care per place is now around $40,000.

When and how could I-Packages be introduced?

An announcement of the intention to introduce a new tier of packages, and anticipated adjustment in the planning ratio, could be made as soon as possible, and with consultation with the sector. Applications could then be called for in the 2010-11 ACAR.

Further, to avoid delays in announcing outcomes of the 2010-11 ACAR, approvals could be announced in two stages. A two stage approval process would allow for interest in the new tier of packages to be assessed and for adjustment of the number of residential places approved in the event of low interest. The formal adjustment to the planning ratios could be made when the second stage of approvals is announced and in the light of responses to I-Packages. The high level of applications for Packages in recent ACARs suggests I-Packages would be similarly well received.

There is ample precedent for changes to the planning process and the ACAR. Both CACPs and especially EACH/EACH-D were introduced to make up for shortfalls of residential care places and in response to demand for increased community care, and to maintain the total level of funding going to aged care. CACPs and EACH/EACH-D initially grew very slowly, but increased over time. As clients, carers and providers are now familiar with package approaches, a larger number of I-Packages could be introduced more quickly to achieve substantial provision in 5 years. The start-up costs of packages are low, approvals come on line in a short time and almost all approved places become operational.

Starting with say 3,000 in the first year, then increasing by 1,000 a year over the next 5 years would bring provision to 25,000 in 5 years. This outcome would see I-Packages reach close to half the projected number of CACPs by 2015, and approach the target ratio of 10 places per 1000 aged 70 and over. Setting a target five years out will allow for some adjustment in the rate of phasing in over that time.

This initiative would give a very clear signal of the Government's commitment to aged care and responsiveness to provider and community preferences.

Table 1: ACAR approvals and actual increases in residential aged care places and packages, 2004-05 to 2010-11

As at June 30	ACAR Approvals (1)							Actual increase (2) (nett of closures)		
	RACH			Community Packages			Total RACH + Com			
	Low care	High Care	Total	CACP	EACH/D	Total		RACH	Packages	Total
2004-05	5,315	3,590	8,905	2,020	900	2,920	11,825	5,185	2,723	7,908
2005-06	3,099	2,129	5,228	4,307	1,567	5,874	11,102	4,526	5,918	10,444
2006-07	2,692	2,043	4,735	1,975	1,202	3,177	7,912	3,780	4,006	7,786
2007-08	2,110	4,415	6,525	2,377	1,616	3,993	10,518	5,401	3,950	9,351
2008-09	1,983	3,765	5,748	2,944	1,755	4,699	10,447	2,818	853	3,671
5 year total			31,141			20,663	51,804	21710	18204	39,914
5 year annual average			6,228			4,133	10,361	4342	3641	7,983
Realisation rate: Actual/Appr								70%	88%	7,7%
Current Allocations and Projected Outcomes (3)										
2009-10			5,463	2,408	4,221	6,629	12,092	4,342	3,940	8,282
2010-11 Indicative only (4)			9,076			1,298	10,374	4,603	4,176	8,779

Data from AIHW Statistical Overview 2008-09

(1) Table A1.1, (2) increases calculated from year to year changes in operational places detailed in Table 2.1

Places allocated for Transition Care are not included; some of the residential TCP places have been established in existing beds and so have in effect reduced available places, and there has also been a loss from closures.

(3) 2009-10 outcomes estimates at average of previous 5 years and 2010-11 at 6% growth.

(4) Indicative figures advised with 2008-09 ACAR