A New Paradigm Needs a New Culture

Response to the Interim Report on the Care of Older Australians

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About the Author

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He was CEO of the national aged care industry peak body *Aged and Community Services Australia* for ten years from October 2000 to December 2010.

Introduction

The Commission's Interim Report (the Report) sets out a new paradigm for the care of older people in Australia. It argues for placing the consumer of services at the centre, for replacing centrally planned and controlled services with ones which are more immediately responsive to consumers' needs and desires and for moving to this new model, progressively, over a five year period[1].

These directions are strongly supported by this submission. Australia can and should do a better job of caring for older people, because they deserve it and because the ageing of our population means there will be a great many more of them – of us – to care for, and our current system is not sustainable.

The Report proposes a five year initial implementation time frame followed by a review to (amongst other things) assess our preparedness for further stages in the reform process[2]. Five years is an appropriate period of time – any shorter and there might be insufficient time to develop properly the proposed new structures and approaches – any longer and there would be an increasing risk of losing momentum and the requisite political will.

Many things will need to change for this vision to become a reality. This submission focuses on things that will need to change within the aged care service provision industry and its culture.[3]

Background

The Industry

The aged care service provision industry has some distinctive features which will influence, and in some cases constrain, its ability to deliver the new paradigm we need for the care of older people. Many of these features are substantially due to the mode of government involvement in aged care, in funding and regulation, up to this point. The conditions that produced them may progressively change but they constitute the starting terrain for the reform journey.

The aged care industry is made up of a large number of separate provider organisations. Some 1,600 organisations operate nearly 2,800 outlets for residential care and a further 4,000 (est.)[4] bodies provide various forms of community care[5]. Few of these operate on a large scale. Many do not offer

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[1] The report covers a lot more than this but these highlighted points are key.

[2] Specifically the removal of supply controls on the number of aged care places is suggested to occur after such a review.

[3] This builds on an earlier article by the author 'Culture Eats Strategy for Lunch' *Agendas* Summer 2010 Aged and Community Services Australia.

[4] The Myer Foundation *2020 A Vision for Aged Care in Australia* p13. DoHA's submission to the current Inquiry (p14) lists 3,334 outlets for HACC services, 1,559 outlets for CACPs and EACHs and 2,783 outlets delivering residential aged care (as at 30 June 2009) The number of outlets is of course greater than the number of organisations. Services funded by the Department of Veterans' Affairs are additional to these totals.

[5] We could also count the 600 villages that are members of the Retirement Villages Association (RVA) though some of these (especially in the not-for-profit sector) are also residential care providers and therefore included in the figures cited above. Not all RVA villages focus on the group of older people who may need care.

the full range of care services, specializing either in residential care or community care, or even a single type of residential or community care service such as high care or meals. Such organisations, on their own, are not well-placed to provide care focused on the whole range of clients' needs.

This is one key reason why a need for external coordination of, and referral to services, such as the *Australian Seniors' Gateway* concept in the Report has been identified in many of the submissions to the Inquiry and reflected in the Report. Residential and some other, aged care providers sometimes object to such ideas, as 'introducing another layer of bureaucracy', but to a substantial degree the architecture of our current system is provider and program centred. To make it client centred, a solution is needed to the problem of inappropriate client capture at the point of service entry[6].

If all providers offered a comprehensive range of service options[7], there would be less need for an external entry mechanism but Australia does not have such architecture across the board in residential or community care. Empowering those organisations that do offer a full range of care services to be entry points is an option that could be considered in the first phase of reform and beyond.

In the current service system, sixty percent of residential care providers and 95% of packaged community care providers are not-for-profit[8], including large, church or community based organisations and small, local services providing region or culturally specific residential care or particular types of community care, for example meals-on-wheels. In the for-profit sector, aside from a small number of large chains, most provider organisations are small, often family-based concerns, comprising fewer than ten homes. It is common for not-for-profit residential care providers to offer other services such as packaged community care, some HACC services and forms of dedicated housing for older people, this is less often the case with for-profit providers. Conversely there are many quite small not-for-profit community care providers offering one or two specific types of service, typically in a local area and only a few that cover the whole range of home-delivered services.[9]

There has been only a small amount of consolidation of residential care providers over the past ten years, though the size of the average residential service outlet, the aged care home, has increased[10]. Several commentators have argued that this persistence of small scale organisations is principally because the licensing of beds and places has acted to perpetuate the dispersed structure of aged care[11].

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[6] There can also be problems with residential care providers 'cherry picking' new residents on the basis of their ability to pay a large bond or attract a large subsidy. Some check on this is warranted though in time the Report's other recommendations would remove many of the perverse incentives in the current system. We should not allow a system to develop which requires people to buy their way into care, as occurs to some extent currently.

[7] And if governments took care to avoid setting perverse incentives in pricing.

[8] Many packaged care providers purchase services from for-profit 'sub-contractors'. This brokerage model was intended to reduce the risk of inappropriate client capture.

[9] We should not forget that aged care services are also provided by State and Local Governments. The nature of these is quite diverse.

[10] Only 12.1% of homes now have fewer than 40 beds, compared with 53% in 1998 and 34% in 2007

[11] For example Professor Warren Hogan who conducted the Review of Pricing Arrangements in Residential Aged Care (Department of Health and Ageing 2004)

The People

Little is known systematically about the skills and qualifications of aged care managers, CEOs or Boards. Neither of the two workforce censuses that have been conducted by the National Institute of Labour Studies for the Department of Health and Ageing, in 2004 and 2008, included senior management in their scope and, in any event, a listing of formal qualifications may not be much of a guide. In 2001 the then federal Minister (Bronwyn Bishop) identified deficiencies in this regard as an issue and commissioned some work intended to boost management and governance capacity, however it is no longer prominent as an issue on recent Government agendas. The not-for-profit sector recruited professional managers heavily from other industries in the 1990s[12], including both senior managers and people with specific skills such as financial management or accountancy. There are many such recruits among the ranks of current industry CEOs, but there is no quantitative data in this area that the author is aware of.

Industry associations, faith-based peak bodies, commercial event managers and the Aged Care Standards and Accreditation Agency offer conferences and seminars to expose people in the industry to the latest thinking and senior management in the industry attend these but not much is known about the penetration or impact of such activity.

One other feature of the aged care management echelon that stands out is the longevity of tenure of many of its CEOs. Many current CEOs have been in their roles for well over a decade, this would be considered unusual in many industries or in government. This is intrinsically neither a strength or a weakness in terms of the industry's capacity to manage change, longstanding incumbents are not *necessarily* resistant to change and newcomers are not necessarily innovators, in practice it is likely to be a risk factor.

Many provider organisations have a relatively 'thin' management structure as a result of their small size. All have operated in an environment of government-regulated supply and government 'guaranteed' income for all, or practically all, of their existence[13]. Aged care senior managers, though it may not feel like it to them, are used to stability and to incremental rather than transformational change.

What Does this Mean for the Future?

It is inaccurate and unhelpful to use data such as this to characterise aged care as a cottage industry and that is not the purpose of the preceding sketch[14]. What is relevant to note is that the features outlined pose challenges for achieving the vision for aged care set out in the report. Strategies for dealing with them will need to be developed, by governments, by the boards or owners of aged care services and by the management they employ.

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[12] Prompted in part, it has been suggested, by the Industry Commission's report *Charitable Organisations in Australia* 1995.

[13] Some church and community-based services have been involved in caring for older people since before there were government subsidies ie. in a purely charitable mode but their recent history has been one of government funding and regulated supply. The fact that a flow of funds from the Government is assured does not mean that it is necessarily sufficient for all desirable purposes.

[14] This was a popular negative stereotype in the first part of the previous decade.

The challenge, in a nutshell, is to move from a service provision industry structured along program and service type lines to one built around the needs of consumers. It is to ask a ten billion dollar industry with a history of government-protected stability, with a thinly-stretched leadership capacity and unknown depth of talent, to transform itself. It is important to recognise that this is a do-able, but significant, task.

The Myer Foundation's 2002 report *2020 A Vision for Aged Care in Australia* put it thus:

Substantial reform of the current industry structure is required if a system of more continuous care for older people that meets their changing needs is implemented. Critical issues to be resolved include:

- *Achieving a balance between the concentration and amalgamation of provider organisations to increase efficiency, while ensuring the necessary geographical spread of services to meet the needs of a more spatially diverse older population*
- *The distribution of types of services across regional areas*
- *The mix of service types offered by any one provider and the cross service linkages to acute health and other health and support services*
- *The patterns of specialisation and focus in regional plans that will be needed to maintain, and provide access to, high-cost specialty services*
- *The most desirable mix and appropriate roles for public and private sector providers*

Some of the change required may occur as a result of the freeing up of supply - to the extent that the ensuing competition between providers results in consolidation, the creation of larger, more comprehensive service providers and the ability to deepen management structures. As the Report put it:

This opening up of supply, and creation of a responsive and competitive market, will require providers to change their business models and will test the management skills of some. However, the transition must be orderly, to ensure the ongoing delivery of safe quality care to older people and viability of the aged care industry— although not necessarily the viability of all current providers

p xxx

As suggested, competition implies winners and losers to some degree and a potential risk to service continuity if some providers go out of business rather than merge or be taken over. Even when the relaxation of supply controls increases the amount of surplus capacity in the system (and engenders greater choice for consumers) aged care consumers are not like shoppers in a mall who can simply walk into the shop next door. They have a long term professional service relationship with their care organisations and for 200,000 of them[15] it is their home[16]. It may also result in outcomes that, because they are unplanned, or because there are limitations to the fully-effective operation of markets[17], are sub-optimal in terms of the comprehensive care of older people, including effective links with other care services. A risk management strategy[18] to contain any potential harm to

[15] Roughly the number of people receiving residential aged care in a 12 month period.

[16] As Braithwaite notes in *Regulating Aged Care* this fact also places limits on the ability of competition to ensure service quality, I would add '...at least on its own.'

[17] Notwithstanding the role of Gateways, information asymmetry is unlikely to entirely dissolve and, as stated there may be a high price for consumers to exercise choice in many instances.

[18] Or perhaps more pertinently a set of local risk management strategies since it is specific services that may fail.

consumers including a capacity for active intervention in the event of a service failure needs to be part of the change management plan.

To ensure that each region provides access to a full range of aged care services and not just good choice between the most lucrative ones for providers, some form of service planning is likely to be needed to complement market forces.[19] Aged care services are not simply a consumer good or a lifestyle choice, though both of these are important considerations, they are also part of an overall system of care including health services. Some sort of template against which to assess the range of services available in a region is suggested. Providing incentives or issuing selective tenders or simple negotiation with services to encourage them to fill gaps is likely to be an ongoing role for the funding Department at the regional level. As the Report notes 'insufficient and inadequately funded restorative and rehabilitative care, and insufficient funding for palliative and end-of-life care' are existing shortcomings[20].

It is important to note that service mix and availability must be considered at the specific local level. Ensuring an adequate supply of each key service Australia-wide, or State-wide etc. does not help actual consumers who live in specific suburbs or towns, not in statistical abstractions. The implementation process, and scrutiny of it, will need to extend to a fairly granular level to ensure that real benefits accrue to real consumers.

Action Required

What can we do as a nation to address the various risk factors suggested above and ensure that the benefits of aged care reform will be achieved? Recognising the challenge is a first step as is maintaining a determination to achieve reform goals in the face of it. More specifically, the following actions are suggested.

Action by Governments

Governments need to provide a framework to nurture the transition to more market-driven, client-responsive services without perpetuating the status quo. Relevant measures in this regard include:

- Establishing a capacity for averting service discontinuity from market failure including a rolling fund to acquire[21] failing services if their clients can't be accommodated by other local services.
- Developing a planning template for each region[22] to monitor the adequacy of the range of available services and introduce appropriate strategies including incentives if corrective action is suggested.
- Making resources available to provide advice and assistance to service providers to achieve the reform goals.

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[19] The Report acknowledges that market forces alone will not suffice in eg rural or remote areas. I am suggesting that there is also a *risk* in metropolitan regions that may need to be managed. Service planning may well be a background activity and a transitional need.

[20] p. xxiii The solution proposed in the Report, to encourage hospitals to purchase such services using case mix funds is a good example of one type of intervention mechanism.

[21] And subsequently dispose of.

[22] The appropriateness of the current planning regions for this purpose may need to be reviewed. Some may be too large geographically for a meaningful assessment of local service delivery capability.

- Consideration should be given to the development of an 'industry plan' as a guide to industry re-structuring at the national and local level in both residential and community care.
- Linkages between aged care services and other parts of the care system such as primary care services and hospitals need to be systematically facilitated. The "Medicare Local" structure may be a vehicle for this but might need to be modified to take on this function, or a new mechanism developed.
- Implementation of the reforms needs to be resourced if it is to be successful.

Aged Care Services

The Boards and owners of aged care services will need to take stock of the changes emanating from the reforms and plan appropriate responses. These may include:

- Revising the assumptions of which strategic plans are based to include a more market-based, competitive, client centred model.
- Determining the extent to which they aspire to be a comprehensive or a niche provider.
- Establishing the potential for strategic alliances with other providers.
- Conducting a skills audit of existing management and taking the necessary recruitment or development action.
- Communication with existing clients and their families
- Forging effective links with other parts of the overall system of care, to the extent to which these are not in place currently.

Action by Industry Associations and Peak Bodies

A potential role exists for these bodies in providing information, discussion forums and feedback as part of an overall implementation communications strategy. Providers may use such organisations as feedback channels to the government bodies charged with the reform process. Along with other stakeholders, the associations and peak groups will need to do what they can to support the will to change.

In passing we may note that, to the extent to which competition between aged care providers becomes a feature of the system, aged care industry associations may need to re-visit their internal protocols. Like the rest of the industry they have not had to deal with a competitive service environment and have, for the most part, been able to advocate to their monopsonist funder on behalf of all with relatively few tensions. The range of views expressed in submissions to this inquiry and in subsequent forums suggests that it may be difficult to continue this without adjustments to their governance rules, policies and strategies. In a climate of 'winners and losers' the associations may have to may have to back one group of members over another or stand back from the debate to some degree[23].

Action by All Stakeholders

The first hurdle for aged care reform is political. Aged care stakeholders have been supportive of the broad directions set out in the Report, though appropriately noting differing views on some specific points, but will need to maintain this and to work on building broader support for the reforms in

[23] The example of the tax treatment of charitable providers, dealt with below, may be an early example of this dilemma.

order to sustain and bolster political backing for them. This is not a slight task. It is good that bodies such as the National Aged Care Alliance support the reform agenda but this is unlikely to be sufficient to ensure its passage through the political and bureaucratic minefields.

Aged Care and e-Health

The report alludes to the importance of e-health – communications and assistive technology – in a number of contexts including workforce efficiency and it is agreed this is a key agenda. There is also a need to support service linking and coordination. From the consumer's perspective even categories as broad as 'aged care' are arbitrary silos. If they need care, it is likely to span what we call aged care; GP and other primary care services, including pharmacy; and hospitals. Using modern information technology to support such care trajectories is a must.

The level of information technology capability in aged care is growing but from a low base. The introduction of the new ACFI funding tool in 2008 is credited with being a catalyst for many residential care providers to move to on-line claiming of subsidies often using computerised care management software as a base. A relatively modest injection of funds by the Australian Government at the end of the 2004-05 financial year no doubt helped these developments.[24] In community care there is a small number of highly IT sophisticated agencies, many that share an IT base with the residential care services provided by the same organisation and still more whose capacity is not well-known. Developing the IT capacity of aged care providers, not least to enhance their capacity to operate as part of a service system that is more seamless to consumers, is a priority.

Aged care needs to be part of e-Health[25]. Initiatives such as the Personally Controlled Electronic Health Record are particularly relevant to people with chronic, multiple and overlapping health and care issues - such as many older people.

Transfers between different parts of the care system, or alternative to transfers such as the 'in-reach' services suggested in the Report should be facilitated and supported by twenty-first century technology, as is the work of other industries for example, banking. Using technology to support remote service delivery, for example using remote monitoring, is particularly useful to people with limited mobility, due to physical or financial limitations or for whom a visit to a clinic for a half hour consultation can take up one or more days due to the distance involved[26].

Aged care's capacity for e-health needs to be nurtured and strategic investments made in infrastructure to support it. An investment of public funds in this area would pay dividends.

The Role of Charities

The Report makes a recommendation[27] in the area of charitable tax concessions which warrants further consideration. This is the recommendation that the FBT concessions granted to charitable

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[24] $150 million was made available on the basis of $1500 per bed.
[25] This point was made in the Bennett report on health reform and in the Report. It isn't disputed by policy makers or NeHTA but is worthy of being re-emphasised.
[26] The submission from Aged and Community Services Australia makes this point.
[27] pp.118-119

providers of aged care services be gradually phased out as the Government recognises the true costs of providing care. A number of submissions from for-profit providers and one from a state-level industry association are cited in support of this as are the recommendations in this area (rejected by Government) of the Henry Tax Review.

The argument, from for-profit providers, that a supplement should be paid to non-charities to level the tax playing field with charities is not supported by the Report which suggests instead that the tax advantages made available to charities should be gradually removed. The suggestion is made that 'the benefits foregone should be redirected to the sector in more appropriate ways'. There is no acknowledgement that charitable providers might add special value to aged care services[28] and it is not clear that the proposed 'redirection' would reflect this ie. would flow to charities rather than across the board. Given the comments in the report about competitive neutrality it is inferred that charities would not continue to be distinctly recognised.

A tax concession that recognises the added value of charities but does not specify how this should be applied is preferred over yet another form of tied or grant funding, if this is what 'other ways' turn out to be. The essence of charitable work is that it proceeds from the benevolence of the charity rather than from the funding of an external provider and this creative force should not be lost from aged care in the interests of achieving a 'level playing field'.

However the notion that charities should be accountable in some way for the taxation benefits they enjoy is a valid one, the current system contains no such discipline and it may be that some charitable organisations in aged care return little to the community that would distinguish them from any other organisation, this has been suggested by some commentators[29]. A reporting requirement, such as a statement in the organisation's Annual Report could be introduced to address this.

The idea that the recognition of charitable status and in particular its financial recognition should be reduced is rejected. Removing them by the stealth of failing to index them[30] is dishonest and the value of the FBT concessions agreed by the Australian Government in 2000 should be restored by increasing the ceiling on FBT-free fringe benefits for charities from $30,000 to $50,000. It is noted that this, as well as the idea of reporting requirements, is a Government-wide issue that is unlikely to be resolved in the context of aged care alone.[31]

Removing FBT tax concessions to charitable aged care providers is not supported.

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[28] This has been argued in the context of the Howard Government's *Charities Definition Inquiry* and in submissions to the Commissions own study *The Contribution of the Not-for-Profit Sector* (2010) by many organisations including, in the aged care context, Aged and Community Services Australia, the organisation representing not-for-profit aged care providers.

[29] The empirical basis of this critique is not known to this author.

[30] A promise to review the $30,000 ceiling made by the Treasurer in 2000 has not resulted in any change.

[31] This would be in scope for the currently proposed single regulator of charities.

Conclusion

Transforming the culture of the diverse, fragmented but large industry that cares for older Australians from its current provider centred, sheltered and funding silo culture to one built around the needs of consumers, that provides them with genuine choice and that is subject to competition will take time. It will present challenges to governments and to the boards and management of aged care services all of whom have ‘grown up’ in the current paradigm.

It will require a degree of political resolve and maturity from Australia’s politicians, to see and pursue the big picture rather than attempt to score points in matters of detail. It will require investment in strategic areas and recognition that high quality services cost money.

In return for greater choice and services which respond more flexibly to their needs some consumers of aged care services will need to pay more for them. Their families will need to be clear about whose needs the care system must meet first.

It will require patience and persistence and a good deal of hard work to achieve this transformation.

It will be worth it.