Response to the

Productivity Commission Draft Report:

Caring for Older Australians

March 21, 2011

HammondCare

An independent Christian charity

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HammondCare's Response to the Productivity Commission Draft Report: *Caring for Older Australians*

1. Introduction

HammondCare is an independent Christian Charity, established in 1932. Today HammondCare ranks in the top 50 of Australian charities (by revenue) with FY11 revenues in excess of $130 million. We serve people with complex health and aged care needs, regardless of their circumstances.

We are acknowledged both nationally and internationally as Australia's leading provider of dementia-specific services. In 2008, HammondCare acquired a network of sub-acute hospitals and related health services: these services are focussed on palliative care, rehabilitation and older persons' mental health. This merger of these two services – health and hospitals and aged care - was made because we believe that critical to caring for older Australians is the concept of breaking down the divisions between health and aged care silos. Older Australians who need 'aged care' support are not simply 'residents' or 'clients': they are invariably also someone's 'patient'. However, the current systems mitigate against improving those linkages.

HammondCare welcomes the Productivity Commission's Draft Report. Indeed, we believe that those interested in caring for older Australians should celebrate the breadth and direction of the Report's recommendations. Our response should be read in this light: we seek to note those areas which would benefit from further consideration or where we believe there will be unintended consequences.

2. Separation of funding componentry (6.1)

HammondCare strongly supports the proposal that the Commonwealth should separate funding of care, living expenses and accommodation. By doing this, the Government will lay the foundation for better integration of aged care and ageing-associated healthcare services, in particular sub-acute care. However, to refine this recommendation, the PC should consider:

- The need for parallel structural reorganisation around health and mental health, to ensure that individuals diagnosed with dementia come within the scope of a single administrative and funding arrangement which is fully integrated with the aged care system. This is necessary for both formal and informal care support, given that dementia is the most prevalent and significant disability associated with ageing: to this end, it is efficient to classify dementia as an impairment leading to a disabling (and often

relentless) reduction in ADL-capability. It is not simply another chronic disease.

- As a corollary to this, and recognising that in Recommendation 6.2, universal funding for healthcare is separated from at least partial responsibilities for other components, dementia and other age-related chronic diseases, and support of their consequent disability should be considered for a separate universal funding guarantee;

- In this separation, there needs to be a clear and predictable arrangement for individuals for whom relative poverty and/or absence of informal care arrangements makes the prospect of genuine care inseparable from their need for specialised accommodation;

- HammondCare believes that residential services should be arranged about the clinical and social needs of the resident, not based on their finances. Because of this, HammondCare is concerned that this separation does not lead to inappropriate accommodation decisions that are made on the basis of finances, as opposed to the best place to support someone. For example, we firmly believe that best practice residential care for people with dementia is achieved where it is possible that residents with similar profiles can co-exist.

  This focus is important for workforce education and increasing expertise which in turn leads to better outcomes for residents. Dementia, as a disease, is no respecter of socio-economic status: you can be rich or you can be poor and you can have dementia. Currently, programs such as 'extra service services' have been hostile to this approach, wanting those who can afford ESS to be placed in one location and those who can't in another, ignoring totally the clinical and social needs of given individuals.

3. ***Removal of regulatory restrictions on licences (6.3)***

HammondCare supports this proposal, not least because it creates a policy indifference to residential *vs*. home or other external care. We further believe that, while other providers and consumer groups might disagree, a five-year transition is very reasonable. Anything more than a five year transition puts off reform, yet again, into the 'never-never'.

Another reason HammondCare supports this proposal is that it actually diminishes risk. In the past the propensity of the Government has been to 'spread bureaucratic risk' by allocating sector needs service providers who have scale and resources, more than ever before. Since 1995 HammondCare has grown at 20% compound. In 2011, that growth has delivered in scale and internal capability that was simply absent when we had 250 beds and $8million in revenue. Safety, quality assurance and innovation require scale and predictability, and therefore we believe that any measure that encourages rationalisation in this sector should be encouraged. We support the consideration of a tender for market participation, as discussed on Page 177.

4. The Australian Seniors' Gateway (8.1)

HammondCare supports a single national gateway for the provision of relevant and timely information and support in decision-making to communities and individuals in relation to their aged care needs - a multipurpose gateway for promotion, information, screening and basic referrals.

HammondCare does not support the proposed second level of the Gateway System (Specialist Care Assessment Service) as proposed on page 239 for two main reasons:

i. **Understanding the primary motivation of the Gateway**
We believe the proposed second level of the Gateway System (i.e., charging that system with a dual responsibility) is likely to exacerbate further one of the main tensions in the aged care system - that is, considerations around the cost of care interfering with decisions around the care needed. What will the primary motivation of the proposed Gateway be? Will it be to control the overall aged care spend, or to assess and map the care needs of older Australians and ensure they receive optimal care? If fiscal oversight and care sit under the single umbrella, how will this balance be kept in check? Do we want a system where the Gateway is a single point of failure?

Under the current residential system, we have ACATs as an initial gatekeeper, a good funding tool in ACFI and a robust independent validation system that manages this balance. HammondCare believes the value of this system should not be lost in any reform.

ii. **Inadequate assessment opportunity**
HammondCare believes that good assessment is rarely achieved in a single visit or phonecall. It is our understanding that responsibility to assess and determine entitlement would sit with the Gateway and we are gravely concerned about this aspect. We don't believe there will be adequate time for the Specialist Care Assessment Service to acquire sufficient understanding of the client's needs in the timeframe available and this would result in a level of funding which is not aligned with the person's needs. In addition, aged care providers will be reluctant to embrace clients who appear underfunded, which will further slow the system down.

Case Study
The husband of a lady with dementia contacts the Gateway for guidance. The Gateway Assessor meets the couple in their own home in the morning. On this particular morning the lady is lucid and calm. The husband, in an effort to preserve his wife's dignity, acknowledges her memory problems, while denying she has problems with incontinence or dementia-related challenging behaviour. The Assessor, in their hour long visit, determines the lady is entitled to a lowish level of care and recommends a list of at home care services and providers.

On presenting to the preferred provider, the level of care appears to be greater than that which can be managed at home and there is clear gap between the original assessed need conducted at 10am and the actual need. In fact, the lady needs residential care and is rejected by the service provider because the allocated funding will not cover the cost of her care.
What happens then? The husband and wife return to the Gateway and the process is repeated, or, she goes downhill because of the lack of care and ends up in hospital.

It is our experience that care needs as assessed by ACAT often vary significantly from care needs assessed over the first month of care delivery in situ. We would like to see the Gateway used in a longitudinal manner to screen for needs rather than determine assessed needs at a single point in time. This will enable more accurate and dynamic assessment to happen over a longer period of time and in the context of a relationship of trust being developed between the provider, the individual and their carer(s), and will ensure more appropriate care is delivered promptly.

We are concerned that the system proposed in the draft report will further complicate the client's already complex journey of care, increase the bottleneck that currently exists waiting for an ACAT assessment and result in increased unnecessary hospital admissions.

5. ***New payment arrangements for residential accommodation (6.4)***

HammondCare supports:

- approval for bonds without retention amounts (which should significantly reduce concerns around bonds);
- removal of increasingly insignificant high/low-care distinctions; and
- removal of extra service as a classification (6.8); and flexible but related payment options;

Some issues here for further consideration include:

- The PC's draft report seems to infer that bonds earn interest when, in fact, for new developments they are crucial in repaying debt. Our new developments rely on a discounted cashflow (DCF) that sees the receipt of incoming bonds approximating two-thirds of the initial development costs including interest charges within the first two years. If lump sum bonds were not available or were practically discouraged, this might exacerbate the problem for building more residential aged care: banking institutions may well refuse to debt-fund new developments, unless the daily charges were substantially more.

- HammondCare's average concessional ratio is about 40%. The accommodation standard that we provide is the same for those who are financially disadvantaged and those who are not. This, we contend, is one of the strengths of the Australian system that we should not discard. However, we can only do this if some bonds – or bond equivalents – are greater than the actual cost of accommodation.

- We presume that – regional variations aside – the subsidy will not vary according to the charges and service levels of the program, but will be a voucher related to the location and wealth of the resident;

- The proposal (p.178) that there be a similarity of funding for respite or sub-acute healthcare to match ordinary healthcare is attractive, though there is an associated need to consider how this would work where transitional specialised care is provided to individuals already in residential care. More detail is required here.

6. ***Concessional Targets (6.5)*:**
It is HammondCare's view that the willingness to provide a minimum ratio of those who are currently considered concessional residents should be a requirement for participation in the otherwise competitive market under the tender system. This has the attractive feature that growth in 'semi-private' care would necessitate growth in genuine 'public' care for those who are financially disadvantaged. There is a danger here that the middle may be squeezed out as providers seek high-return patients to subsidise their necessary quota, and this will need more detailed modelling.

7. ***Public Equity Release Scheme (7.1)*:**

We have some concerns, based on the very real historical experience, which the Department of Health and Ageing will share, that payment of aged care fees through home equity release will lead to a strong community backlash against reform. Accordingly, HammondCare would recommend that:

- The introduction of non-retention bonds should precede for some years the introduction of home equity release;

- Some detailed modelling should be undertaken to identify how the relative costs and risks (to both income and capital) vary between:

  i. A capital bond;
  ii. A rented bond;
  iii. A reverse mortgage (essentially home equity release); and,
  iv. A daily fee;

  It is our view that providing better understanding of the interchangeability and relative risks of these instruments is more useful than insisting on a superficial parity between fees and bonds;

- There needs to be a significant community education campaign to address the actual and perceived information asymmetries (see pp.211-12).

8. Sub-Acute and Aged Care Linkages (8.2 and 8.3)

As a provider that is attempting to integrate sub-acute and aged care services, this is the area that HammondCare has greatest interest in. Today there are far too many regulatory impediments and jurisdictional divides that are hostile to best practice care.

The Interface between Mental Health and Aged Care. In the area of mental health, the needs of individuals with severe and challenging behaviours are not best served because there are jurisdictional divides between limited State-funded programs, the availability of specialist mental health services for older people, and the fact that ACFI is not suitable for these individuals. In this regard we refer to the principles recommended in the *Report to the Minister for Ageing on Residential Care and People with Psychogeriatric Disorders*. The measures recommended in this Report can not only improve the lives of those people with challenging behaviours but other older Australians in residential care as well.
***The Interface Between Palliative Care and Aged Care* (8.3)**

It is HammondCare's view that this recommendation is unnecessarily ambitious in seeking to find a 'casemix' approach to palliative and end-of-life care. In place of this, we would contend that it is better to:

- Encourage co-location of palliative care residential aged care places with sub-acute palliative care units by removing the regulatory impediments in the Aged Care Act, including issues as building certification. At the moment,

older patients who no longer need to be in a palliative care unit but, for whatever reason cannot return home, often go to a nursing home which may have expertise in palliative care – or (more usually) may not. There may be no other residents at that nursing home who are receiving palliative care. This means that 'in reach' palliative care expertise is not as readily available as it could be. Co-locating palliative care nursing home beds with a palliative care sub-acute hospital unit will immeasurably improve the available expertise to support the primary and general care staff in supporting people at the end of their lives.

- Have a specific funding mechanism and program for palliative care, to fund both residential and in-home care options, separately from Medicare, aged care or hospital funding programs. While this would replace the healthcare component of aged care funding, it should not necessarily replace either residential or ADL-support (care) components, thereby creating policy indifference between residential, home or hospital stay (as may be medically most appropriate). Cf. the goals of Recommendation 6.1 here;

The Interface Between Rehabilitation and Aged Care (8.3)

Like mental health and palliative care, the linkages between rehabilitation and aged care need to be strengthened. From an economic and a social point of view, slow stream rehabilitation and similar restorative care programs can play an important part in Caring for Older Australians in short-stay residential care.

At present, when an older individual comes to the end of an episode of hospital care, they face three main choices at discharge:

1. return home, with or without extra support/therapy services. For most people, this requires the presence of ready access to a well-committed carer. Given that many older Australians live alone, this standard transitional care option is either not realistic, or not safe as a discharge option. If (in our currently risk-averse health environment) discharge is not considered safe, the individual will remain in hospital for a longer period of time, either in a formal rehabilitation setting, or (less obviously) in a general medical/geriatric hospital setting, to try and improve their functional status so return home becomes safe to contemplate;

2. placement in ongoing and permanent aged care accommodation;

3. respite/convalescent care in an aged care setting, in the pious hope that time, medications and nursing care alone will heal and improve the individual's functional abilities. For more than half a century, it has been clear that functional improvement will not occur without rehabilitation and restorative therapy interventions.

A fourth option should be encouraged and tested for efficacy and efficiency – residential transitional care between the end of hospital admission and return to independent living at home. In this model, rehabilitation medical, nursing and

therapy staff input is provided to individuals staying for limited periods of time in residential aged care settings, with programs having clear goals and functional outcomes for resumption of safe independent community living. If hospital and residential care services are directly and organisationally linked, individuals will benefit from earlier transitions along a clear continuity of care, reducing hospital stays, providing restorative care in less costly settings than subacute hospitals, but with appropriate specialist supervision that will ensure safer outcomes and less risk of re-admission.

9. *Block Funding (8.4)*: While HammondCare appreciates the argument around block funding, we would seek assurance that this will not affect funding of sub-acute service capability, which remains somewhat ambiguous under the NHHN arrangements.

10. *In-reach options (8.5)*: HammondCare, as an integrated health and ageing provider, strongly supports the prospect of in-reach multi-disciplinary aged-care health teams. However, we believe there should be recognition that:

    - To deliver suitable population density to make this type of approach work, there is particular merit in the specialist dementia residence – an area in which HammondCare is a leader;

    - Given that investment in such services delivers concomitant savings around health and disability care delivery, we believe some consideration should be given to outperformance or specialisation payments for such innovation.

11. ***Non-aged care housing (specifically 10.4)*:**

    We believe that the separate regulation of retirement villages and other post-home housing by State Governments creates two problems, viz.:
    - It conflicts with the smooth pursuit of community care goals, particularly the reduction of 'windscreen time', (travel time by community care workers) which requires at least the prospect of regulated 'ageing in place';

    - Similarly the finance of the aged care system will clearly benefit from increased density in ageing locations, not least for the planned collocation of associated healthcare services. This would benefit from common oversight.

12. ***Volunteer remuneration (11.5)*:**
    There is economic evidence that the offer of funding for volunteers in healthcare environments has a 'crowding-out' effect and may actually reduce participation. This bears further consideration.

13. Policy Implementation: Translating Policy into Practice

As we said earlier, we welcome the direction of the Productivity Commission's Draft Report. One matter that the PC might want to consider is that so often good policy is interpreted by Departments into Program Guidelines which are in turn are interpreted into contracts for Government-subsidised services. Too often

the result is that these contracts bear no relation to effective delivery of services nor, indeed, the intent of the original program. At this stage, Service Providers are then obliged to squeeze what needs to be done into the program guidelines and the related contract.

We would urge the Productivity Commission – and the Australian Government – to consider this issue. Once policy has been determined, it is vital that potential service providers be engaged to develop workable and effective program guidelines and contracts rather than being obliged to 'shoe-horn' effective programs into inappropriate guidelines and contracts.