CATHOLIC HEALTH AUSTRALIA

ECONOMIC IMPLICATIONS OF AN AGEING POPULATION

SUBMISSION TO THE PRODUCTIVITY COMMISSION

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Catholic Health Australia – Background

Catholic Health Australia (CHA) is the largest non-government provider grouping of health, community and aged care services in Australia, nationally representing Catholic health care sponsors, systems, facilities, and related organisations and services.

The sector comprises providers of the highest quality care in a network of services ranging from acute care to community based services. These services have been developed throughout the course of Australia's development in response to community needs. The service providers carry on centuries-old traditions of bringing Christ's healing ministry to those who suffer – the ill, the disabled, the elderly, the disadvantaged, the marginalised, the poor, serving those that others with a profit motive do not. The services return the benefits derived from their businesses to their services and to the community; they do not operate for profit; they are church and charitable organisations.

The Catholic health and aged care ministry is broad, encompassing many aspects of human services. Services cover aged care, disability services, family services, paediatric, children and youth services, mental health services, palliative care, alcohol and drug services, veterans' health, primary care, acute care, non acute care, step down transitional, rehabilitation, diagnostics, preventive public health, medical and bioethics research institutes.

The Sector Snapshot

17,500 residential aged care beds
5393 independent living and retirement units
4,651 Community Aged Care Packages (CACP) and thousands of people are assisted through the Home and Community Care Program (HACC) and other community care support
65 hospitals
8,500 hospital beds
45 privately funded hospitals
20 publicly funded hospitals
7 teaching hospitals
8 dedicated hospices and palliative care services

The Catholic health, community and aged care ministry is defined by these interrelated foundational principles:

Dignity: Each person has an intrinsic value and inalienable right to life. Everyone has a right to essential comprehensive health care.
Respect for Human Life: From the moment of conception to natural death, each person has inherent dignity and a right to life consistent with that dignity.
Human Equality: Equality of all persons comes from their essential dignity. While differences are part of God's plan, social and cultural discrimination in fundamental rights are not part of God's design.
Service: Health care is a social good. It is a service, not a commodity used for maximising profit.
Common Good: Social conditions should allow people to reach their full human potential and to realise their human dignity. Equitable access to care, developing research and training, and conducting professional inquiry into the social, ethical and cultural aspects of health, builds social conditions and communities that respect human life and allow people to realise their potential.
Association: Every person is both sacred and special. How we organise society – in economics, politics, law and policy – directly affects human dignity and the capacity of individuals to grow in community.

Preference for the Poor: Priority must be given to the needs and opportunities of the poor and disadvantaged. This encompasses economic, cultural and individual notions of poverty and disadvantage.
Stewardship: Health resources should be prudently developed, maintained and shared in the interests of the community as a whole and balanced with resources needed for essential human services.
Subsidiarity: The identified needs of individuals and the community are best addressed at the level where responses and resources are available, appropriate and effective.

CHA's policy proposals for an Ageing Population

In recent years, CHA has given consideration to the future health and aged care needs of Australia's older population and has developed a range of proposals to meet these care needs into the future. CHA considers that while the Government has a primary responsibility for meeting the care needs of older people, there is a balance to strike between the contribution made by the government and an expectation that individuals will need to make some contribution to these care costs.

CHA's overarching view is that the Government has an obligation to provide high quality support and assistance for older people. Put simply, older people have made a significant contribution to their communities through their support of families, their community involvement, their work and study, their volunteering, their caring roles and their years of contribution to all levels of government through various forms of taxation. As a society, older people should expect to be adequately cared for when and where they need it. To meet these obligations, CHA has proposed two measures to simplify and extend the support provided to older people. These measures are:

1. An Aged Care Benefits Schedule; and
2. Medicare Seniors Plus

Given fiscal restraints and the growing numbers of older people, it is not realistic that the public system will pick up the full cost of all health and aged care needs for all people. A level of user contribution for some services depending on capacity to pay is generally acceptable. However, under existing policy parameters, individuals are being asked to provide a greater contribution to their health and care costs whether this be through co-payments for GP and diagnostic services, private health insurance and contributions for residential and community care services. Besides superannuation, there is little incentive or support for people to save for the contribution they will be expected to make for their health and care costs when they are older. To overcome this policy gap, CHA has advocated another policy measure:

3. Health and Aged Care Savings Accounts.

These three measures are outlined in more detail below.

1. Aged Care Benefits Schedule

Rationale

There is much commonality in the care needs of older people irrespective of whether the person receiving care is in their own home or whether they are in a residential aged care facility. Similar services are provided to older people in their own homes to the services that are provided in aged care facilities. For this reason CHA considers that Australia would benefit from a more integrated model which provides care services under one system irrespective of where the care is provided. In other words, care and accommodation are separate issues and can be treated as such. This is not to suggest that there are not links between care and accommodation particularly where people are choosing or are required to enter a residential aged care facility. However, the model of care provided should be able to stand-alone regardless of where the person is living.

There are many reasons why an integrated care system which could operate through what CHA has named an Aged Care Benefits Schedule makes sense. Firstly, the assessment processes that are used to determine a person's care needs whether they are in their own home or at a residential care facility are linked and often the same. Aged Care Assessment Teams (ACATs) currently make these assessments for residential aged care residents and for many users of community care programs and services. An Aged Care system that integrates care for people regardless of where they are living could continue to use ACATs or their equivalent to assess the care needs of a person and determine the specific care requirements needed for that person having regard to the living circumstances and support structures they have access to.

Secondly, an integrated care system would be transferable and portable. If a person is living in their own home with care services provided, their eligibility for care assistance would be maintained if their circumstances change and they are required to move – whether that be to move into other private accommodation, or to move in with family members/carers or to move into a residential aged care facility. In these circumstances the care requirements may be exactly the same, so the trauma of having to move may be lessened by the fact that the person retains consistency in their care. However, if the reason that the person has to move has come about because their care needs have changed, this would be accommodated by another assessment of the person through the ACAT (or its equivalent) and possibly aged care providers. In such circumstances, the ACAT would use the existing care assistance eligibility to reassess what additional assistance the person may now need and be eligible to access.

Thirdly, an integrated care assistance program funded through an Aged Care Benefits Schedule would address some of the inequity which currently exists in the aged care system. Under the current system, people in aged care facilities receive a higher proportion of government assistance to meet their care costs compared to those people who are receiving care in their own home. In residential aged care there are varying care subsidy levels whilst in community care, regardless of the differing levels of care provided, there are flat rate payments for Community Aged Care Packages (CACPs) and for Extended Aged Care in the Home (EACH). Further, the residential aged care subsidy includes notional non-care cost components such as hotel services and return on investment.

In addition, because package-level community care is generally under-funded, with evidence of unmet need there are more issues of inequity in the system. Those with more assets and income can supplement their package by privately funding some

services such as buying extra domestic assistance. People with more meagre resources exist on very basic services which do not always meet their full needs and are unable to purchase supplementary services privately. An Aged Care Benefits Schedule would address this inequity by providing more consistent care arrangements regardless of where the person is living.

What would an Aged Care Benefits Schedule include?

An Aged Care Benefits Schedule would be separate to – but could build on – the Medicare Benefits Schedule (MBS).

The MBS model could certainly be used as a basis for setting up the infrastructure necessary to establish an Aged Care Benefits Schedule. In particular, the Aged Care Benefits Schedule would be similar to the MBS in that care needs will determine entitlement, and as care needs change, so will entitlement provisions.

The difference between the MBS and the Aged Care Benefits Schedule is that while the MBS would continue to list and provide medical treatments and interventions requested and performed by GPs and specialists for all Australians, the Aged Care Benefits Schedule would include a list of care and support services that could be accessed by older Australians. These services are generally not provided by GPs or medical specialists (although there may be some exceptions); rather they are services provided by nursing and personal care staff, allied health professionals and domestic, domiciliary and maintenance staff.

It is also worth noting that an effective Aged Care Benefits Schedule may lead to cost reductions in the MBS. Access to quality care services is likely to lead to less GP consultations and emergency and acute sector admissions.

Some potential examples of where there may be a direct link between the types of services offered on the MBS and the Aged Care Benefits Schedule include the Enhanced Primary Care (EPC) items for case conferencing and contributing to care planning and new Medicare provisions to enable General Practitioners to undertake comprehensive medical assessments for new and existing residents in residential aged care facilities.

These items demonstrate a link between the MBS and what might be included on an Aged Care Benefits Schedule. However, this link may best be achieved by using these new MBS items as another means of referral and assessment of eligibility for older people to access services on the Aged Care Benefits Schedule.

The Aged Care Benefits Schedule would include a list of care categories and within each of these categories there may be a spectrum of care need ranging from basic to very complex. So, for example, each area of care might have up to three or four levels of remuneration based on the intensity of care needed.

The categories and levels of care within categories could translate into item numbers on the Aged Care Benefits Schedule with appropriate funding attached. A person would be assessed to determine what items of care they are eligible to receive. To determine what categories of care should be included and the respective levels of care within each category would require further research, analysis and development work.

There is already a vast array of high quality Australian and overseas research that could be considered further in terms of how it could contribute to the structure of an Aged Care Benefits Schedule. Some of this work includes:

- The work undertaken for the Department of Health and Ageing to revise the Resident Classification Scale (RCS) questions;
- The HACC Program National Minimum Data Set; and
- The InterRAI Method[1]

These and other sources of research would provide a useful start to developing the care categories and the assessment tools for the Aged Care Benefits Schedule. As examples, it is envisaged that the care categories would incorporate areas such as:

- Mobility
- Personal Hygiene
- Toileting
- Problem Wandering
- Challenging Behaviour (Verbal, physical disruption)
- Behaviours of Concern (Emotional Dependence, Danger to Self/Others, Other Behaviour)
- Medication
- Nursing Procedures
- Self care (motor) functioning

Additional supplements would be included for palliative care, people living in rural and regional Australia and providing care for homeless people.

Benchmark of Care

CHA has also argued in other forums and submissions that aged care services and support should include a benchmark of care. CHA has stated that a benchmark of care should determine an appropriate level of staffing and skill mix to deliver appropriate care and quality of life to older people. As such, CHA maintains that any costings associated with an Aged Care Benefits Schedule would need to be considered and assessed against benchmarks of quality care. The person's eligibility for these services would therefore entitle them to the funding associated with the relevant items included on the Schedule. The person may receive all the assistance through the one aged care provider or they may have different providers assisting with the various categories of assistance. Further details about how payment operations could operate are outlined below.

How would the person and provider access funding under the Aged Care Benefits Schedule?

To be eligible for assistance through the Aged Care Benefits Schedule, a person would be assessed by an ACAT (or its equivalent) using an established assessment methodology. If necessary, appropriate medical practitioners will assess any specialist needs such as palliative care.

The infrastructure established to administer Medicare payments, namely through the Health Insurance Commission (HIC) could be utilised to administer the Aged Care Benefits Schedule. The ACAT will advise the agency administering the Aged Care Benefits Schedule - assumed to be the HIC – of the Schedule items that the person is

[1] See website: www.interrai-au.org/downloads.

eligible to access. This information could then be captured and included on the person's Medicare records.

Approved Aged Care Providers would be provided with software to enable them to access the information which identifies what level of assistance the person is eligible to receive. The individual care items would attract a specific subsidy. The software provided to Aged Care Providers would also enable them to process claims for payment. That is, the infrastructure would enable the provider to determine the entitlements of the person and to process claims for payment. It would be a very streamlined and simple process for the user of services and very convenient for providers to ensure swift and accurate payments.

Means Testing and Co-payments

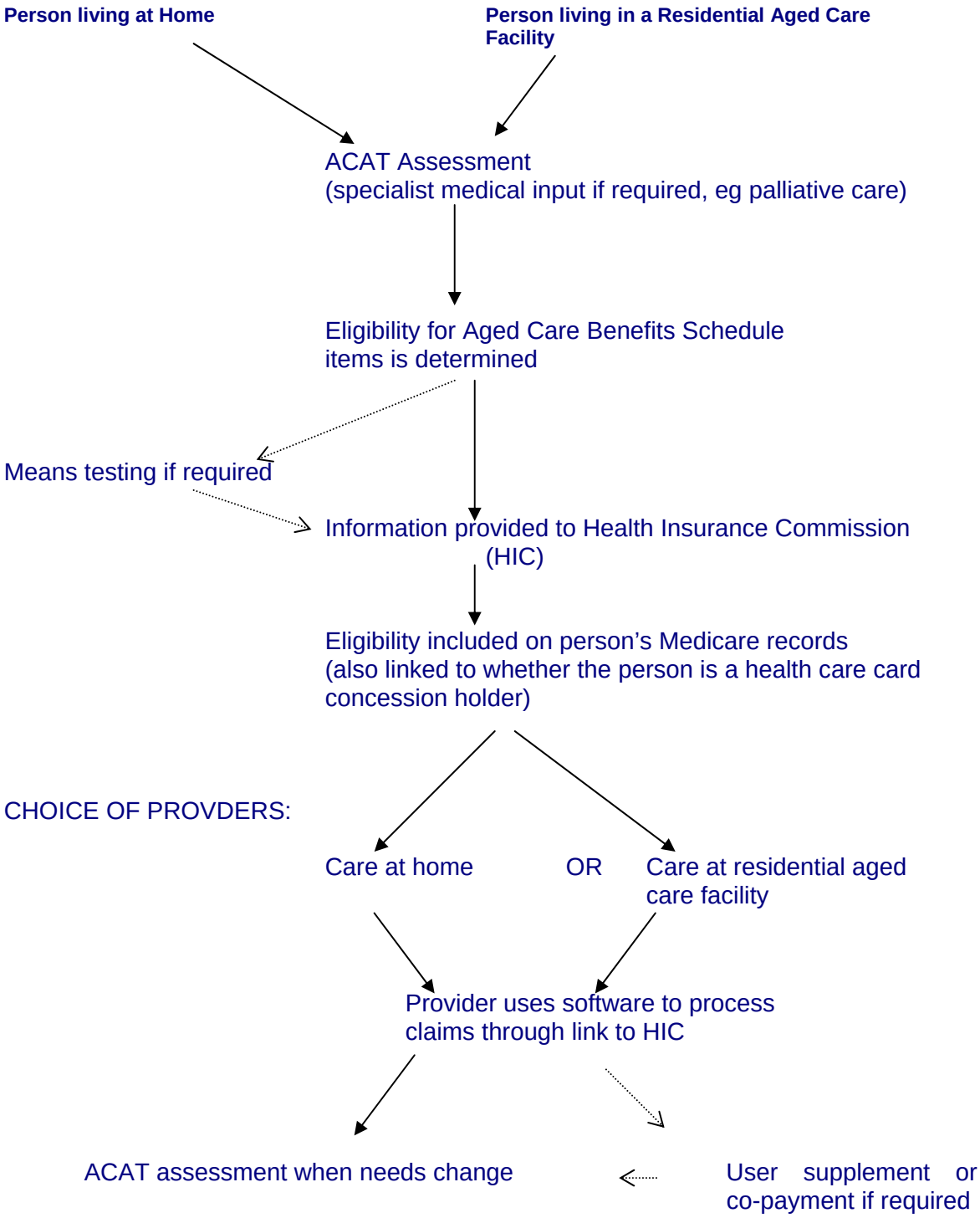
The Aged Care Benefits Schedule would principally be an entitlement scheme. However, it is acknowledged that there may need to be some rationing of resources through means testing and co-payments.

CHA is not commenting in this paper on whether means testing should be included, or if it is, how it should be assessed. However, under the model proposed, it would be possible to incorporate a component of user charging or co-payments if this was required.

Using the model outlined above, a person's eligibility for care after any means testing exercise was undertaken would be captured on the person's Medicare records. Each person would be provided with an outline of the services they are entitled to receive and any co-payment that the person is required to contribute. When an Aged Care Provider is processing the person's care claim, the software system would allow the provider to process the claim against the Aged Care Benefits Schedule and identify any supplement or co-payment that is required to be paid by the person directly to the Aged Care Provider.

The following diagram demonstrates the process for how the Aged Care Benefits Schedule could work:

The Aged Care Benefits Schedule Process



Enabling user control and choice

One of the advantages of the Aged Care Benefits Schedule is that is will enable a greater degree of user control and choice. In the current aged care system, such autonomy is not possible.

The portability of the services funded through the Aged Care Benefits Schedule would enable people to move across Australia and retain their eligibility for care services. Because the person would have a complete picture of their eligibility for certain categories and levels of service, it would enable the person and their family to ascertain which providers could best meet their particular needs. As the funding would be attached to the user themselves, and not to the provider *per se*, more control is given to the user. This meets CHA's criterion that health and aged care funding and models of service must be *person-centred* and not *industry or provider centred*. There would be greater incentives for providers to ensure their services are high quality and meeting the needs of the older population.

The ability of older people to transfer their eligibility for care services provided in their own home to an aged care facility (if this becomes necessary), and the potential for continuity in care provision will reduce much of the stress and concern currently associated with this kind of move for older people and their families.

Further, as older people will be assessed to see which types – and level - of care they need and this assessment will be matched by appropriate levels of funding, it will also minimise the current disincentives in the aged care system which lead some providers to "cherry pick" the least disabled or frail. Providers would be aware that funding will be provided for the services they deliver which will match the specific needs of older people.

Some Necessary Safeguards

As with any funding and service delivery initiative, there will need to be safeguards built into the system to ensure its integrity and to ensure that it is meeting the needs of those it is being established to assist.

Planning/forecasting of service demand

The Government will be required to ensure adequate planning and forecasting of the demand for services and to ensure that there are adequate numbers of community care and residential aged care providers throughout the country to meet the needs of older Australians.

It will not replace the need for a care plan

While the assessment process which will form the basis of the Aged Care Benefits Schedule will be a useful guide to the specific care needs of a person, each person will still require their own Care Plan. A Care Plan will still be required to outline the tailored support measures that a person needs to help them in their daily lives. The Aged Care Benefits Schedule will provide a guide to the overall types and level of care that needs to be provided, but only a Care Plan will reflect the individual, specific activities and services that a person needs. The Aged Care Benefits Schedule could however, incorporate a system to validate care provided based on the Care Plan documentation. This could also be linked to a mechanism which would allow adjustments to eligibility should the person's situation deteriorate or should the initial assessment be inappropriate.

Funding will need to be appropriately indexed

One of the current problems which plagues the aged care sector is the inadequate indexation formula used to support the sector. The current indexation factor used by the Commonwealth fails to recognise and fund the rising care cost factors in aged care services.

An Aged Care Benefits Schedule will also be subject to the same rising care costs currently faced in the sector. The indexation formula used on the Aged Care Benefits Schedule must be appropriate and reflect the true cost of providing quality care.

It is important to note that the MBS is also currently underfunded as the indexation arrangements in MBS have not kept pace with rising costs. CHA stresses that the Aged Care Benefits Schedule will only be effective if the funding attached to the Schedule is indexed at a rate which keeps pace with the real costs of providing care.

Ongoing Auditing and Accountability

The current aged care system includes provisions to ensure assessment processes are reviewed for accuracy and consistency. Aged Care Providers are also subject to auditing and monitoring requirements to ensure appropriate levels of service are being provided and there is no evidence of fraud or mismanagement.

A new system using the Aged Care Benefits Schedule would also be subject to such monitoring and examination. There would need to be checks to ensure that the ACATs were appropriately and consistently assessing people's eligibility for care services. There would also need to be checks to ensure the software system used to process payments and any co-payment arrangements were being undertaken with integrity and without any fraudulent activity.

Summary of the Aged Care Benefits Schedule

The Aged Care Benefits Schedule is a model of care funding which could take Australia into the future and would provide a more comprehensive and integrated model of funding to meet the care needs of Australia's older population. It's key features are:

- The use of standardised assessment processes to identify the types of care needs of older people including a spectrum of care need ranging from basic to complex;
- The care provided through the Aged Care Benefits Schedule would generally be provided by nursing and personal care staff, allied health professionals and domestic, domiciliary and maintenance staff;
- It would be separate to the Medical Benefits Schedule but would be similar in that there would be item numbers which have appropriate levels of remuneration attached. It could also build on Medicare infrastructure including payment options through the Health Insurance Comsssion; and
- Once care needs were identified, the Aged Care Benefits Schedule would fund the care to older people irrespective of their accommodation and living arrangements.

2. Medicare Seniors Plus

CHA proposes that Medicare incorporate a new dimension – "Medicare Seniors Plus" - which would increase the level of entitlement and access that older people have to health services. The health system is failing older Australians and this will potentially worsen with an ageing population. Older people have more complex health and care needs and in the public system, there can be unacceptable waiting times for what should be considered basic health care services, whether this be dental treatment through to surgery and therapeutic interventions that would assist their recovery after a medical event. The effects of long waiting times can be particularly distressing for older people and their families and carers.

Under Medicare Seniors Plus, people 75 years and older (and Indigenous people over 55 years) will be eligible, similarly to veterans, to access private health services, paid for by the Commonwealth. This new scheme will be the responsibility of the Commonwealth to ensure that older Australians receive accelerated access to essential care. The Catholic hospital system could be a major partner in this initiative. In addition to accessing essential surgery, providing greater access to the over 75 year olds (and Indigenous people over 55) will also require improved funding and service delivery for the care of complex and chronic medical conditions.

Medicare Seniors Plus would alleviate some of the pressure on private health insurance and potentially lead to a reduction in premiums as some of the higher users of private health will have their health needs met through the Medicare Seniors Plus arrangements.

Medicare Seniors Plus could expand on other existing programs which meet some specific needs of older people such as the Commonwealth Hearing Program. In a similar vein, access to essential dental treatment should be part of the entitlement of Medicare Seniors Plus. Access to rehabilitation services after a period in hospital for medical or surgical procedures should be included as an essential entitlement if such care is recommended by medical practitioners. A greater investment in rehabilitation will not only give older people more confidence and peace of mind, but it will minimise the numbers of older people needing to go back to hospital or enter a residential aged care facility.

Medicare in its current form is already failing some older people and will fail more people in the future unless steps are taken to more specifically meet the health needs of older people.

3. Health and Aged Care Savings Accounts

In recent decades, Governments have given more attention to policies and options to assist people save more for their retirement, particularly through more flexible superannuation options.

CHA considers that there are other broader issues that need to be considered in assisting people to plan for older age and retirement. In recent years, there has been an increasing trend in both health and aged care to shift costs to users. Increasing fees and charges have been part of the health and aged care political landscape for some time. While not condoning this trend, it is likely that this trend is going to continue. It is not reasonable to assume that all people will have adequate assets and superannuation to meet the increasing user charges in health and aged care for older people in older age.

For this reason, CHA advocates for a policy initiative to introduce a Health and Aged Care Savings Account which is dedicated to helping people meet their out of pocket expenses related to health and aged care.

The changing demographic of Australia's population needs to be reflected in the Commonwealth Government's commitment to aged care funding. An older age demographic should lead to a commensurate increase in funding for all services provided for older people. As the population ages however, on current trends the total number of users contributing to the costs of their care will increase and Australia currently does not have the infrastructure to support them meet these costs. Further, health and aged care needs are often greater when incomes are lower and assets harder to redeem (such as the family home), that is, if there are any assets to draw upon. Currently in the residential aged care sector, residents contribute about one-third of the full costs of care and accommodation. This equates to about $2 billion user charging and this figure is rising each year.

A recent report by NATSEM and AMP found that many people between 50 and 69 years of age are approaching retirement carrying higher levels of debt than the previous generation and that superannuation is being used to pay off this debt – houses, cars, credit cards etc.[2] In other words, there is less funding available to actually support living costs in retirement years. This does not bode well for people being able to meet unexpected health and aged care costs.

There are a number of options for introducing a form of Health and Aged Care Savings Account or Scheme. Health and Aged Care Savings Accounts could be facilitated as an add-on to superannuation and managed in the same framework with a separate component for private contributions dedicated specifically to building up a reserve for meeting health and aged care costs. In this respect, the funds could accumulate with unused funds becoming part of the person's estate. Another policy response is to supplement the existing superannuation levy by another 2-3% for this purpose.

Health and Aged Care Savings Accounts are not intended or likely to replace health insurance. Rather their role would be complementary and in practice would cover the user charging costs of residential and community care which are not covered by insurance. Potentially the Health and Aged Care Savings Accounts could also be used to assist meet private health insurance contributions which can be a substantial proportion of older people's yearly expenses.

Another option to consider is to enhance the existing Medicare Levy to allow for increased health and care costs in older age. This measure would focus less on saving for user charges, but rather would increase the revenue available to governments to contribute to health and aged care costs. As stated by Gray and Kendig:

[2] NATSEM/AMP, 7 March 2004, "The Lump Sum: Here Today, Gone Tomorrow", *AMP.NATSEM Income and Wealth Report Issue*.

> Popular support for a mandatory, public style approach might be enhanced by wide recognition of a need to increase funding, to have an entitlement to care in the community as well as the residential setting, and by an appreciation that sharing of risk is desirable.[3]

In summary, CHA reiterates that the Commonwealth Government has the primary responsibility to provide and fund high quality aged care programs and services. It is also recognised that increasing costs will also in part be borne by users of services. Where reasonable fees are charged people with a capacity to pay should have been given the capacity to save. What is clear is that if extra measures are not taken now, users will pay more than they need to in the longer term. As highlighted by the Access Economics/ASFA Report on Intergenerational Modelling for Australian Families "essentially, rising aged numbers and health prices will hurt both public and private pockets, but the public pocket must be replenished from the private one".[4]

Finally, CHA would like to point out that any measures adopted by the government to increase private savings including the adoption of a Health and Aged Care Savings Account must make provisions to ensure that people on low incomes are not in any way disadvantaged in being able to access high quality care and health services. In a wealthy country such as Australia, there is plenty of capacity for the government to provide and fund the highest quality care for all its citizens. Within these parameters, there is also potential for those people who have access to greater resources to contribute to some of these costs, and they should be given the infrastructure and support to do so.

Conclusion

CHA offers these three policy proposals as solutions to the issues arising from an ageing population. These measures provide responses to community care, residential care, medical and surgical treatment and also offers a fiscal option to assist older people save to meet the health and aged care costs they may incur as they age.

The attached appendix provides further insight and analysis about the issues arising from an ageing population and strategies to ensure equity and commitment in meeting the needs of Australia's population into the future.

[3] Gray, L. & Kendig, H. (2002), *Paying for Aged Care*, The Myer Foundation, p11

[4] Access Economics/ASFA (22 April 2004), *Intergenerational Modelling For Australian Families*, p7.