5 Assessment of the current aged care system

Key points

- There are many positive attributes to Australia's aged care system, notably the large number of services delivered each day, the range of services that are offered, and the quality of most of these services. However, the system is not functioning as well as it could in many areas.
- Many older Australians have difficulty accessing information, care and support.
  - The aged care system is complex and difficult to navigate.
  - Waiting times for low priority assessment services can be significant.
  - Services, including respite, can be difficult to access in the settings that older Australians and their carers prefer.
  - Access to medical practitioners and allied health professionals can be difficult.
  - Consumer choice and the ability of providers to offer continuity of care is limited by restrictions on the number of bed licenses and care packages and regulations governing the services that providers can offer.
  - There is a lack of continuity of services to respond to changing care needs.
  - There is a lack of incentives for providers to engage in restorative activities to maintain and improve the functional independence of older people.
- The pricing, subsidy and private co-contribution regimes are inconsistent and inequitable for clients both within, and between, care settings.
  - Some aspects of the pricing regime are not sustainable and, as a result, providers are not investing enough in these areas to meet demand — for example, in the provision of new non-extra service high care residential facilities.
- Aspects of the regulatory system are excessive, unnecessary and/or duplicative, resulting in high compliance costs for providers.
  - The focus of the accreditation and quality assurance system emphasises good process rather than good outcomes.
  - Several regulatory initiatives in recent years have imposed significant and avoidable regulatory burdens on service providers.
- Consistent with other reviews and inquiries, the Commission believes that Australia's aged care system is in need of fundamental reform.

The Commission heard from a number of participants to this inquiry that Australia's aged care system is 'world class'. For example, the joint submission from ECH, Eldercare and Resthaven stated:

> International comparisons are often difficult to make but anecdotally at least, Australia is regarded as having one of the best aged care systems in the world. This is perhaps best interpreted in an overall sense rather than a consideration of any one aspect of aged care. … it is fair to say that in Australia, almost every form of care and service is available, or potentially available, to the entire older population, with a markedly high level of quality and affordability. (sub. 453, p. 2)

Similarly, the Australian Association of Gerontology observed:

> … there are elements of aged care in Australia that work effectively to deliver a world class system of care ... (sub. 83, p. 3)

However, many submissions to the inquiry identified significant weaknesses in the funding and delivery arrangements and pointed to where there was scope for improvement.

The chapter does not provide a comprehensive assessment of the aged care system. Rather, it focuses on the areas that offer the highest potential gains from reform. It assesses the system against the criteria of equity, efficiency, effectiveness (including choice, quality and appropriateness) and sustainability as set out in chapter 4. It looks first at access, continuity of care, choice, and unmet demand (section 5.1); then examines pricing, subsidies and co-contributions (section 5.2), and the considers regulation (section 5.3). It concludes with an overall assessment of the scope for improvements in efficiency and the need for further reform for the system to be sustainable (section 5.4).

5.1 Access, continuity and choice is limited

The Australian Government states that it:

> … aims to ensure that all frail older Australians have timely access to appropriate care and support services as they age by providing: information assessment and referral mechanisms; needs-based planning arrangements; support for special needs groups and for carers; a choice of service types and high quality, accessible and affordable care through a safe and secure aged care system. (DoHA 2009e, p. xi)

Over 1 million older people received care and support in 2009-10 (chapter 2). The planning framework for care packages and residential places seeks to ensure that services are geographically distributed and that disadvantaged groups can access care through requirements on providers to meet the needs of particular groups.

However, the Commission heard many reports of people experiencing difficulties accessing and understanding information about the aged care system, and problems in accessing aged care services.

A key challenge in providing aged care services is ensuring that service providers have the flexibility and capacity to meet the level and diversity of demand for aged care services. Currently, the highly regulated system where aged care services are rationed via the planning and allocation system and via an eligibility assessment results in unmet demand for aged care services. In addition, restrictions on the types of services that can be offered in different settings affect the capacity of providers to offer continuity of care, particularly in community settings.

Accessing information and understanding the aged care system

Older Australians and their carers told the Commission that they have difficulty getting comprehensive and timely information about the aged care system, about their rights and responsibilities with regard to the services they can access, and about the level of co-contributions they are required to make. This was confirmed by providers. For example, the Villa Maria Society said:

> A lack of information about aged care is a major barrier to accessing appropriate services. Many people are confused by the various community care programs and how they interact, while others faced with accessing residential care, often at a time of crisis, find the system very complex. Older people and their carers often highlight the following issues:
>
> - Negotiation with a number of service providers
> - Understanding the processes required to receive the services
> - The number of separate assessments that may need to take place to receive different services
> - Understanding the program under which the services are provided. (sub. 395, p. 14)

There is no comprehensive information portal that consumers can access — that is, one that can illuminate the aged care services available and the links between aged care and other welfare support systems. The Health Care Consumers Association of the ACT said:

> The current system is complex. Whether it be the maze of accessing an ACAT [Aged Care Assessment Team] assessment, completing the 26 page Centrelink form, or trying to find providers of in home care, finding the information at the right time in order to make informed decisions is very difficult. Many are defeated by the challenge. We make choices about services without knowing how well they perform or whether they are appropriately located. Information is also difficult to find. Accurate, up to date and

> plain English information needs to be centrally located and easily accessible. (sub. 326, p. 4)

The lack of clear and accessible information also affects the willingness of carers to engage with the formal aged care system. On this point, Carers NSW contended:

> For the Australian aged care system to be accessible, the information needs of carers must be met. The provision of information must be simplified and improved so that older people and carers are informed of what services exist and how to access them. Carers should not have to spend time, energy and resources they do not have to find out what they need, nor should they 'stumble' upon services and supports long after they are first required. Accessing the necessary services should not depend on chance. (sub. 211, p. 7)

Another concern of older Australians from special needs groups, particularly those from Indigenous and non-English speaking backgrounds, is that information about the aged care system is not available in their native language. Dutch Care said:

> Much has been said in recent years on the complexity of the aged care system. For the poor, or non-English speaker, negotiation of the aged care maze is even more difficult. Commonwealth government assistance in this regard is limited. (sub. 128, p. 6)

Waiting times for assessment services

Eligibility for Community Aged Care Packages (CACPs), Extended Aged Care at Home (EACH) and EACH-Dementia (EACH-D) packages, transition care and residential care (including some respite services), is determined through the Aged Care Assessment Program (ACAP). While funded by the Australian Government, state and territory jurisdictions have responsibility for assessments which are undertaken by Aged Care Assessment Teams (ACATs or Aged Care Assessment Services in Victoria) at the local level.

A number of submissions pointed to significant variations in access to, and the timeliness of, assessment services for medium to high level aged care. The Older People's Reference Group, for example, said:

> Delays occur at many points on the hopscotch grid. There is often a waiting time of several weeks, even months, before someone is assessed by an ACAT team. (sub. 25, p. 5)

Similarly, Just Better Care noted:

> In many areas throughout Sydney the waiting time for an ACAT assessment is six to nine months. The ACAT teams have been under-resourced for the past decade to deal with the growing numbers of older people they need to assess and the waiting times are unmanageable. (sub. 131, p. 1)

Access to restorative aged care programs can also be constrained because of delays in receiving ACAT assessments. As outlined by Janine Masso, this can mean an extended stay in hospital:

> There are an increasing number of programs which require an ACAT assessment in order to gain access. This requirement can affect the timeliness of an older person entering the program and delay their discharge from hospital while they await the completion of the ACAT assessment. An example is the Transitional Aged Care Program. A very beneficial program for older people on discharge from hospital to assist in reconditioning and gaining increased strength but limited because of the requirement to have an ACAT assessment prior to admission to the program. (sub. 249, p. 2)

And delays in ACAT assessments can take their toll on both older Australians and their carers. This point was made by the Australian Medical Association:

> In some jurisdictions, difficulty in accessing an ACAT assessment means it can take months before approval for respite care is given. In the meantime, sometimes the only option is to admit the patient to hospital in order to give the carer some relief. This causes great distress for patients and their carers … (sub. 330, p. 3)

Aged care assessments are provided to those older Australians in most urgent need of services as determined by a prioritisation process. Over half of all ACAT referrals are Priority 1 or 2 — that is, the expected timeframe between referral and first intervention is within 48 hours and between 3 and 14 days respectively. While over 83 per cent of first interventions were completed 'on-time' for Priority 1 and 2 referrals in 2007-08, there was considerable variation between jurisdictions at both priority levels (table 5.1).

The most recent data from the National Data Repository (NDR) shows that the average length of time from referral to the first face-to-face contact was 22 days across Australia, ranging from nine days in Tasmania to 31 days in Queensland (table 5.2). Between 2003-04 and 2007-08, the average length of time between referral and first face-to-face contact increased from 18 to 22 days (NDR 2009).

Data also indicates that some older Australians have to wait extended periods for an assessment after a referral has been made, especially those deemed low priority. High and medium priority referrals (that is, Priority 1 and 2) are attended to relatively quickly with the median length of time between referral and first face-to-face contact being 0 and 4 days respectively (table 5.1). However, non-urgent low priority referrals (defined as priority category 3) may take much longer to progress. These low priority referrals account for around half of all referrals and, if it is assumed that all high and medium priority referrals are attended to in a reasonable length of time, one in five lower-priority referrals take more than 57 days before face-to-face contact is made (table 5.2).

Table 5.1 **Length of time between referral and first intervention by priority category, 2007-08**

	Mean days	*Median days*	*Percentage 'on-time'*
Priority 1 (<48 hours)			
NSW	2.6	0	85.2
Vic	1.2	0	90.0
Qld	3.0	1	79.0
SA	4.8	1	70.2
WA	1.3	0	89.1
Tas	0.7	0	90.0
NT	1.8	0	95.0
ACT	2.7	0	85.6
Australia	**2.6**	**0**	**83.2**
Priority 2 (3 to 14 days)			
NSW	13.0	4	77.3
Vic	5.1	2	92.1
Qld	9.9	6	82.6
SA	11.3	4	85.4
WA	6.4	4	88.3
Tas	6.5	5	88.5
NT	8.7	5	80.3
ACT	4.2	1	95.8
Australia	**9.7**	**4**	**83.6**

Source: NDR (2009).

Table 5.2 **Length of time between ACAT referral and first face-to-face contact, 2007-08**

All referrals

	Mean days	*Median days*	*90th percentile (days)*
NSW	24.8	9	71
Vic	18.4	12	45
Qld	31.1	15	84
SA	22.0	7	48
WA	12.8	8	32
Tas	9.1	7	21
NT	13.6	8	33
ACT	21.5	7	58
Australia	**22.2**	**10**	**57**

Source: NDR (2009).

Although the Australian Government funds the ACAP, it is operated by the states and territories. Such arrangements can create an incentive for the states and territories to give priority in assessment to people who are using their funded

services, particularly relatively expensive and limited acute care (hospital) services. A comment to the National Review of Aged Care Assessment Teams noted that 'many "urgents" are actually urgent for the hospital not the client' (Communio 2007, p. 44).

One of the constraints on the capacity of ACAT teams to undertake assessments is the level of funding allocated to the program. However, if the capacity to undertake assessments was increased without a commensurate increase in aged care service availability, there would be greater numbers of older people on a wating list for approved aged care services.

Access to care services

Most low intensity support services (mainly Home and Community Care (HACC)) are block funded. Providers assess clients for need and allocate services on a prioritised basis within their budget limitations. By contrast, access to community care packages and residential care is restricted by the aged care planning and allocation system and by ACAT-determined eligibility.

While restrictions on the supply of aged care services are a way of managing the Australian Government's fiscal exposure, they can result in older Australians failing to receive the aged care services they require in a timely manner. Submissions from individuals and providers suggest that some older Australians are waiting excessive periods to access the care services they need in both residential and community settings. The Australian Asian Association of Western Australia, for example, said that the availability of beds in residential care in that state:

> … are not at all related to the needs of the ageing which has resulted in both CACP & EACH clients having to wait long periods of time to access any residential care let alone care of their choice. These long waiting periods also means that their urgent care needs are not met with the limited hours and services that can be provided under CACP. (sub. 188, p. 2)

Submissions suggest that waiting times for community care packages are the longest. Willoughby City Council said that:

> … North Sydney has had unmanageable and inhumane waiting times for CACPs, EACH and EACH-D packages. Waiting times range from 6 months to 18 months, with EACH and EACH-D recipients waiting the longest periods.
>
> Due to the lengthy waiting time for packages HACC service providers have been required to continue to provide services to clients who require a higher level of care. Duty of care requirements for HACC staff are often exceeded and older people assessed as requiring a high care level of service are struggling to survive at home.

Many of these people pass away or are forced into [residential] care before their packages become available. (sub. 50, p. 2)

Other participants suggested that ACATs refer people to those services where they know there are vacancies despite the package not meeting the person's care requirements:

ACATS refer clients to those services where they know there are vacancies. For example we have numerous cases where clients are referred for a CACP, yet on assessment it is revealed that they are actually high care and require EACH. We can sometimes go above our benchmarked hours/week, and top them up with NRCP to keep them going until an EACH becomes available, but tight budgets and accountability requirements often do not allow this. Invariably some people are forced to move to residential care. (Provider's comment in Catholic Health Australia, sub. 217, p. 7)

Excessive delays in accessing care and support services undermine the objectives of the aged care system and can reduce the quality of life of older Australians and their carers. However, there are no guidelines on what is an acceptable time to wait to access aged care services after eligibility has been determined by an assessment.

Data indicates that under half of all older Australians accessing aged care services did so within one month of their most recent ACAT assessment in 2009-10 (table 5.3). The only exception is for entry into high level residential care, where 51 per cent of eligible clients accessed this service within one month of their ACAT approval.

Table 5.3 **Length of time between ACAT approval and entry into a care program (residential and community settings), 2009-10**

	High care	*Low care*	*EACH*	*EACH-D*	*CACP*
2 days or less (%)	10.8	5.2	4.3	5.0	*4.4*
7 days or less (%)	24.9	12.0	10.6	12.7	11.4
Less than a month (%)	50.9	32.0	31.5	41.6	38.8
Less than 3 months (%)	76.4	63.3	59.7	70.7	69.7
Less than 9 months (%)	92.3	91.0	87.6	93.7	94.4
Median time (days)	29	61	64	41	45
Total number (program entrants)	**19 726**	**16 426**	**3 459**	**1 863**	**18 890**

Source: SCRGSP (2011).

There is also considerable variation in waiting times between jurisdictions. For example, there are proportionately fewer people entering residential services within one month of ACAT approval in Western Australia but proportionately more entering community care programs, compared to Australia as a whole (table 5.4).

Table 5.4 Proportion of clients entering a program within one month of ACAT approval, 2009-10

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* [a]	*Aust*
High care	52.5	57.8	46.0	45.1	44.3	55.7	34.7	22.1	50.9
Low care	30.4	36.5	32.1	28.6	26.3	48.4	18.4	25.6	32.0
EACH	26.0	25.3	37.0	41.2	29.3	27.2	36.4	66.1	31.5
EACH-D	33.9	32.8	53.2	57.7	33.8	38.8	54.5	66.7	41.6
CACP	27.8	32.7	52.0	60.4	37.2	32.9	37.3	51.8	38.8

[a] NT data are based on the experience of a small number of residents and may not be representative of the experience of NT residents over time.

Source: SCRGSP (2011).

Variations in waiting times are not even uniform between nearby locations. Southern Cross Care (Tasmania) highlighted that:

> As far as Community Aged Care Packages (CACP's) allocations in Tasmania are concerned, some areas continually have empty packages while others have huge waiting lists. Southern Cross Care's north west coast services often have empty packages with no one on the waiting list; yet in Hobart the waiting list for 40 packages is currently 134. (sub. 267, p. 8)

However, this evidence should be interpreted with caution as there may be a number of reasons why older Australians do not enter the services for which they are approved, including:

- the data only includes people who have been allocated a package or place, not those who are still waiting or those who have died before accessing care
- as some ACAT recommendations are only valid for a limited period of time, it is unclear whether the data captures the elapsed time between the initial instance that a person was approved for care and when care is actually accessed
- some people do not accept the first offer of a package or residential care place. In those instances, the elapsed time between the ACAT assessment and placement would include the time people wait for an offer of placement as well as the time people wait for placement with their preferred provider.

It is also unclear whether differences in waiting times for access to aged care services are due to the planning and allocation mechanism, variable conduct of the

ACAP in different regions, or a combination of both. Blue Care explained that the differences in waiting times were the result of a combination of supply constraints and the approach taken by each assessment team:

> ACAT referral processes vary across jurisdictions. Some ACATs 'hold' approved clients until a local service provider has the capacity to take the new referral. In contrast, other ACATs simply complete the assessment and notify multiple service providers, who then collectively 'hold' the new referral themselves until a place is available. (sub. 254, p. 58)

Restrictions on the supply of aged care services create inefficiencies beyond aged care, particularly for the health care system. For example, the *National Health and Hospitals Network: Further Investments in Australia's Health* reported that:

> In 2006, about 2,400 patients eligible and approved for aged care and no longer requiring care in hospital were waiting in a hospital bed for an aged care place to become available ('Long Stay Older Patients'), with 63 per cent waiting in hospital for more than 35 days. (Australian Government 2010b, p. 68)

Access to respite services

Respite enables carers to have a break from their caring role. Having access to respite services, particularly emergency respite, is an important factor in the decision of many carers to continue in this role. Carers of older Australians and consumer advocates indicate that they have difficulty in accessing appropriate and timely respite services. For example, Eva Gross noted:

> In terms of carer support, residential respite care is often not easy to access unless well-planned in advance, though the need often tends to arise suddenly (e.g. the carer suddenly becomes unwell), due to the limited number of beds set aside for respite purposes. In terms of community respite, demand way outstrips supply and waiting lists tend to be extensive. Whilst carers wait for relief, via residential or community respite, the risks of them burning out increases. (sub. 435, p. 7)

The relative inflexibility of programs designed to support informal carers may also restrict access to respite.

> The greatest problem is that some frail seniors are not able or do not wish to access day respite programs that provide socialization because they have received EACH or [CACPs] packages and are not allowed access to the HACC funded service. Domestic care such as cleaning, laundry, shopping and help with meals and personal care … (help with dressing, eating and toileting) are prioritized ahead of social participation as would be expected. The pity is that social participation provides many health benefits that may require less reliance on medication and personal care. (Sherwood Respite Services, sub. 399, p. 2)

Further, Alzheimer's Australia expressed concerns about respite for informal carers of people with dementia:

> One of the main barriers to accessing respite services is a lack of flexibility and choice. This includes flexibility in when the respite is available, where the respite is provided, and what types of activities are included in the respite care.
>
> ... there is a need for specialist dementia respite care services that respond flexibly to the needs of both people with dementia and their family carers at any stage of the dementia journey. (sub. 79, p. 18)

Indeed, the Department of Health and Ageing (DoHA) acknowledged that there are some issues with the current suite of respite supports. For example, a

> … situation can arise that a client of a respite provider may seek additional respite from their provider, but the provider is unable to meet this need even though they have spare capacity, because that spare capacity is related to a separate funding initiative with a different target group. This is clearly suboptimal for both the client, who cannot access the respite they need, and the provider, who is required to return the funding for the unused respite to the Commonwealth while meeting the fixed costs of operating their service. (sub. 482, p. 49)

Choice in relation to services

Many participants pointed to the lack of choice and flexibility resulting from the rationing of care places under the current planning ratios. The Victorian Government called for the planning process to be:

> … more responsive and flexible to reflect demographic changes and changing client needs, as well as changing sector demands. … Commonwealth planning and allocation processes for all aged care services need to be reviewed to ensure there will be sufficient supply and an optimal mix that can meet forecast need, recognising both the growing demand for community care and the importance of avoiding unnecessary admission into residential aged care. (sub. 420, p. 22)

Perth Home Care Services argued that the planning ratios were 'outdated':

> The methodology of population ratios used for planning is outdated. It was developed on the basis of two residential service types i.e. hostel and nursing home. Over time it has expanded to 4 service types, CACP, EACH, Low Care and High Care but these are still based on residential care. It is recognised that aged care is a continuum from low level community care to high level residential care with many points along the way. Ageing in place is a fundamental principle and is not consistent with the 4 service types named in the ratio model. People move in and out and up and down the continuum. (sub. 398, p. 3)

Baptist Village Baxter highlighted the implications for care recipients of a shortage of care places:

> The client, if they wish to receive subsidised care services, firstly must satisfy the eligibility criteria established by the Government (through the Aged Care Assessment Teams) and then find a care provider willing to admit them into residency. The willingness of the provider is based upon current waiting lists, ability of the person to contribute to the capital costs (through payment of an accommodation bond or meet 'exempt bed' requirements), the level of care to be delivered and other stipulations. In reality, the consumer has little effective choice in this process as most aged care providers have few vacancies, which results in the client placing their name on many waiting lists, often far removed, from their ideal location.
>
> If the client chooses to receive care in their existing home, again they must approach the approved providers of community based services in the region and (often) place their names on a waiting list. (sub. 170, p. 3)

Potential care recipients seeking a care place or package, especially at the high level end of care, often do so following an event or sharp deterioration in functionality. As such, finding a place or securing a package often involves a sense of urgency. And, for those seeking residential care, the search is usually confined to a particular geographical area. With high occupancy rates (in excess of 90 per cent) common in residential aged care facilities, care recipients can have very few options available to them.

Under the current planning ratios, just 22 per cent of Government-subsidised aged care places are for care services delivered in the community (DoHA 2010n). According to Catholic Health Australia, this compromises care recipients' choices:

> The rationing of overall places means that not all older people assessed as being in need of aged care have an equal opportunity for timely access to services. Also, the current regulations which limit the choice of community aged care to 22 per cent of the aged care places provided under the planning ratios means that older people are effectively being denied equal opportunity to choose whether they receive care in their own home or in an aged care home, or the security of knowing that as their care needs change, they will have the option of continuing to receive care in their own home. (sub. 217, p. 7)

And, the evidence suggests that demand for formal care packages in community care is higher, relative to residential care, from those older Australians assessed as eligible for care. Across Australia, only 32 and 22 per cent (respectively) of the number of people approved for CACP and EACH packages were admitted to a package compared to 35 per cent and 49 per cent for low and high level residential care respectively in 2008-09 (table 5.5). This comparison of admissions in the following year relative to approvals over the previous 12 month period suggests that there is significant unmet demand for aged care services, notwithstanding the

limitations of using ACAT approval data as a measure of unmet demand (chapter 3).

The current rationing of care places also reduces the incentives for providers to innovate and to respond to demand more generally. This will become more pronounced as the Australian population ages and the demand for aged care services increases significantly. As discussed in chapter 3, the baby boomer generation will have the financial capacity and the inclination to demand greater control and choice of aged care services.

Table 5.5 **First-time admissions as a per cent of first-time ACAT approvals**

2008-09 admissions as a per cent of 2007-08 ACAT approvals

	Community care			*Residential care*		*Total*
	CACP	*EACH*	*EACH-D*	*Low care*	*High care*	
NSW	27	19	63	35	50	36
Vic	45	23	54	37	49	42
Qld	33	22	41	33	47	37
SA	28	22	36	28	55	36
WA	30	24	44	34	41	35
Tas	47	38	76	56	53	53
NT	29	88	85	52	32	38
ACT	24	21	33	32	44	31
Australia	**32**	**22**	**51**	**35**	**49**	**38**

Data sources: NDR (2009); SCRGSP (2010b).

While a gatekeeper plays an important role in controlling access to public subsidies, aged care services should be targeted to those with assessed needs, not wants. But within this there is scope to do better to match the preferences of older Australians, particularly for remaining independent and living in their own home. Constrained competition and restricted choice for care recipients can be addressed by reducing and ultimately removing controls over the number of community care and residential places. A number of recent reviews have argued the need to remove the restrictions on the number of community care and residential places (box 5.1).

Reforms aimed at increasing consumer choice, flexibility and access are discussed in chapters 7 and 9.

Continuity of care

Restrictions on the number and scope of services that providers can offer also reduce the capacity of providers to offer continuity in care service delivery, particularly in community care. The result is a care system that is fragmented and constrained in its ability to meet the aged care needs of older Australians. Some older Australians are forced to change care providers to access higher levels of care if their current provider cannot offer the service or does not have a place available.

Box 5.1 **Limiting supply of care places comes at a cost**

Limiting the supply of care places, while helping to manage fiscal risk for government spending (notwithstanding the gatekeeping role performed by ACATs) also limits competition which in turn reduces choice for users and dampens the incentive for providers to operate efficiently and to be innovative. Recent reviews point to the benefits of removing supply constraints on aged care places.

The National Health and Hospitals Reform Commission (NHHRC) recommended:

> … that the current restrictions on the number of aged care places an approved provider can offer be lifted. This means good aged care providers will be able to take as many people as wish to use their services, and older people will no longer have to accept the only place they can find. Aged care services will compete with each other to attract older people. Older people who are unhappy with their care will find it easier to shift to a different service. (NHHRC 2009, p. 109)

The Productivity Commission (PC) in *Trends in Aged Care Services: some implications* said:

> The planning and allocation system effectively lessens competition between providers, thereby reducing incentives for cost consciousness, efficiency improvement and innovation in service delivery. Relaxing this barrier to entry would create more competition in the market for aged care services. (PC 2008, p. 190)

And, in the *Annual Review of Regulatory Burdens on Business: Social and Economic Infrastructure Services*, that:

> … the Government should consider possibilities for relaxing supply constraints in the provision of aged care services as a means of improving the quality and diversity of services and reducing the reliance on regulation and the need for price controls in areas where there is effective competition. (PC 2009a, p. 30)

The *Review of Pricing Arrangements in Residential Aged Care* noted:

> Restraints on the allocation of bed numbers reflect also a fiscal restraint designed to reduce a government's exposure to unbounded future expenditures. The effect is to limit severely the choice of facilities available to users of services. When the industry operates at about 96 per cent of its capacity as measured by beds occupied, as it does at present, there is no more than 'Hobson's Choice' around Australia for users of services. (Hogan 2004b, p. 19)

The Commission heard of some care recipients choosing to receive inappropriate aged care services because they were reluctant to change personal carers — for example, some people stay on HACC when they are eligible for CACP or EACH(-D). As a result, HACC providers may experience increased demand for services if older Australians are unable to access high level community care services, are unwilling to change carer, do not wish to pay higher co-contributions or are unwilling to enter residential care (where a community care place is not available). Redfern and Inner City Home Support said:

> The Interface between HACC and CACP can be difficult. Clients who receive a range of HACC services are often reluctant to go on to a CACP because they lose the social aspects of their care. They lose the community relationships that have been fostered through HACC services. (sub. 348, p. 2)

Community care packages are only available in discrete blocks which often do not reflect the level of an individual's need. Many participants spoke about the affect of the gap between CACP and EACH packages on continuity of care. For example, Shirley Anderson said:

> CACPs packages provide around 5–6 hours of direct assistance per week. EACH packages provide between 15–20 hours of assistance. I do not find the CACPs quite enough assistance, but it does not seem logical to jump from 5–6 hours of care and then to suddenly seek 15–20 hours. Deterioration is often a slow process. I think what really happens is that carers really struggle for too long on the CACPs package. (sub. 60, p. 2)

The South Australian Government argued:

> … there needs to be improved coordination and integration in policy and service system development between the various programs (i.e. Home and Community Care (HACC), National Respite for Carers and other Commonwealth carer support initiatives and Commonwealth packaged care) … The lack of continuity in care between HACC, Community Aged Care Packages (CACP), Extended Aged Care at Home (EACH and EACH D) is perhaps the most significant issue for community care. (sub. 336, p. 4)

Continuity of care is less of a problem in residential care where the Australian Government has introduced 'ageing in place', whereby low care residents can remain in the same facility as their care needs change (depending on the capacity of the provider to meet these increased care needs). However, there are other aspects of care continuity, such as high staff turnover, that may result from inadequate funding or poor management practices.

Restrictions on the capacity of providers to offer greater continuity of care can affect other service interfaces, including through inappropriate admission to acute care and/or premature admission to residential care, resulting in inefficient use of resources and a reduction in the wellbeing of care recipients.

Lack of incentives for restorative care, rehabilitation and maintenance

One of the objectives of the *Aged Care Act 1997* is to provide aged care services that maintain and increase functional independence in older Australians. Many participants, however, argued that under current arrangements there is little focus on early intervention and the promotion of independence (box 5.2).

Box 5.2 **Participants said a greater focus on early intervention and promotion of independence is needed**

Occupational Therapy Australia:

> Systems currently focus on people at risk of hospitalisation or admission to residential care. This results in reactive rather than proactive approaches to triage and management of wait lists. Interventions which enable consumers to remain active and independent generate downstream cost benefits and are a worthwhile investment. Occupational therapists strongly advise that responding to people's needs as they begin to develop activity restrictions and participation limitations is necessary, in addition to focussing on people with high support needs. (sub. 203, p. 11)

Bega Valley Meals on Wheel Plus:

> The wellness or re-enablement model has been part of the Victorian HACC system for several years. For service users this may be a better model for providing choice and the possibility of leaving the HACC system if possible. Service users once in the system tend to stay, and this leads to dependency, lack of choice and an emphasis on their failings. (sub. 51, p. 4)

Meals on Wheels Association:

> … a strategic shift in funding to prevention and early intervention and support will both delay and reduce absolute costs for both residential and acute care. (sub. 209, p. 1)

City of Port Adelaide Enfield:

> As with other human services and health services, prevention and early intervention, is the most cost-effective way of providing effective services that contain costs for future generations. Provision of accessible community-based services is a cost-effective way of managing and delaying the demand on hostels and nursing-home beds, as well as medical services. (sub. 32, p. 1)

Further, there is little incentive for providers to invest in activities that promote the restoration of health and functional independence in care recipients as restoration generally results in a reduced care subsidy, particularly in residential aged care. As a general practitioner (GP) said:

> … the current scramble that goes on in nursing homes to fudge figures so that patients can be classified with as many diseases as possible to get maximum funding is both an insult to the patient and an insult to the medical profession who it is expected will provide the evidence … The patient 'who has more wrong with them' is more valuable to the institution in which they are being cared. (Peter Winterton, sub. 41, p. 2)

The Australian Nursing Federation (Victorian Branch) also indicated that:

> There is a conflict of interest between aged care accreditation standards which encourage independence and ACFI [Aged Care Funding Instrument] which allocates funding based on dependence. (sub. 341, p. 116)

Similarly, S. Van Deventer noted:

> The ACFI funding tool, contradicts the aged care accreditation standards. The standards require that we maintain a resident's independence for as long as possible, which often involves more time by the staff. It takes longer to walk with a resident (thus maintaining his independence) than what it does to transport a resident in a wheelchair, yet we are funded at a maximum for the wheelchair, rather than for supervising the ambulant resident. Therefore, this may not always be happening, as facilities do not have the staff to do this. (sub. 109, p. 1)

Others participants considered that greater emphasis on assistive technology and home modification services was required, as these services have the potential to assist older Australians to remain in community settings for longer periods than might otherwise be the case. According to the South Australian Government:

> There is a focus and culture of providing maintenance and support in community care rather than the provision of adequate support for people to regain function and maximise independence. An increased focus on prevention, capacity and restorative approaches is essential, including an emphasis on assistive technology, equipment and home modification. This can be achieved through clearer service contract specification, reporting and building in financial incentives for preventative and restorative services. (sub. 336, p. 4)

The lack of emphasis on restorative care and maintenance, and prevention more generally, can be inefficient. That is, the return to public funding from such investments may more than pay for themselves in lower future costs of acute and aged care. There is emerging evidence that this is the case (chapter 6).

Difficulty accessing general practitioners and other health services

Strong relationships with the primary health system are important to providing quality aged care services. However, a number of submissions indicated that some older Australians, living in residential care facilities or in the community, have difficulty in attracting GPs to deliver services in these settings. The Australian Medical Association argued that GPs are reluctant to provide services because GPs:

> … are the primary medical care providers for older people living in the community and form long term relationships with their patients and their families. They play a crucial role in managing and coordinating care for an older person. However current Medicare benefit arrangements do not reflect the time it takes to provide care to older people with chronic long term conditions and do not cover the costs of delivering medical care

outside of the doctor's surgery. As a result, home visits no longer feature in general practitioner care as much as they once did…

Adequate incentives must be developed, and access to nursing and allied health services must be improved, to support the medical workforce to provide medical care to older Australians living at home and in aged care facilities. (sub. 330, p. 1)

Aged care service providers and older people also indicated that they experienced difficulties accessing and attracting the services of physiotherapists, podiatrists, dentists, dieticians and other allied health professionals (Consumers Health Forum of Australia, sub. 287; General Practice South Tasmania, sub. 278). For example, the Victorian Day Therapy Centres Network said:

In Victoria DTC's have historically had difficulty attracting appropriately qualified Allied Health Professionals. Current funding means agencies that run DTC's are not able to offer salaries that are comparable with public health services and current market demand. (sub. 448, p. 2)

Some participants argued that part of the problem in accessing the allied health services is related to Medicare benefits restrictions. For example, the Dieticians Association of Australia stated:

The current chronic disease Medicare items are inadequate. Australians with a chronic disease can access five visits to allied health practitioners per year. These limited item numbers are currently shared across allied health professionals. People with a chronic disease often require multiple visits with a number of allied health service providers to achieve improved health outcomes and better management of their chronic condition/s. (sub. 371, p. 5)

Incentives to increase access to allied health services are inequitably aimed towards low care residents. As the Australian General Practice Network explains:

… a number of GPNs [General Practice Networks] following consultation with local aged care facility providers have directed their local implementation of the ACAI [Aged Care Access Initiative] towards supporting better access to dental care for residents, by brokering access to dental assessment and in some cases treatment for low care residents in RACFs. Dental Staff visiting facilities and GPN staff have noted the inequity in providing access to this vital service to only low care residents, when many facilities are unable to effectively do so for high care residents due to workforce shortages of dentists and dental hygienists and limitations in getting dental staff to travel to provide assessments of residents in the facility. (sub. 295, p. 7)

Poor access to medical and allied health services affects the capacity of the aged care sector to deliver timely and appropriate care, and can result in unnecessary pressure on other parts of the health system (chapters 9 and 10).

5.2 Pricing, subsidies and co-contributions are inequitable and distort investment

The Australian Government sets most of the prices that can be charged by providers, the level of subsidies and rates of private co-contributions. Providers have flexibility on the amount they can charge for accommodation bonds.

There are a number of inequities in the different pricing regimes between types of services and between care settings. Some violate the principle of treating people with the same capacity to pay equally, while others introduce distortions in choice. The levels of personal co-contributions are different for different services, people may pay different co-contributions for the same service despite having the same capacity to pay. For providers, the pricing of some services does not cover the cost of those services. This is a particular problem for accommodation charges and retention amounts, the behavioural domain under the Aged Care Funding Instrument (ACFI), and indexation of public subsidies for personal care.

Different levels of private co-contributions for services

Under the current pricing regimes, the Secretary of DoHA sets the private co-contributions guidelines for care services delivered in community settings and for accommodation, everyday living expenses and care services in residential settings.

Co-contributions across community care services are inequitable

While the Government does not set fees for community care packages (CACP, EACH and EACH-D), it does set a maximum level that providers can charge — all care recipients can be asked to pay a fee equivalent to 17.5 per cent of the single age pension. Recipients can also be asked to pay an additional fee of up to 50 per cent of their income above the pension. This contrasts with services under the HACC banner, where providers can charge users a small nominal fee (or even nothing if transactions costs of collecting the contribution are significant). These inequities have led to a number of participants urging a review of fee structures, including Southern Cross Care (Tasmania) which highlighted:

> Contributions by the consumer to the cost of providing community care services needs urgent review. HACC and Veterans contributions have remained at a base level of $10 per week since inception while other programmes such as Community Aged Care Packages (CACP) and Extended Aged Community at Home (EACH) Packages have a different fee structure. Often the level of care is the same but the fee structures bear no resemblance to each other. (sub. 267, p. 14)

The inconsistent requirements for co-contributions for equivalent services may result in older Australians being reluctant to move into formal aged care packages that better suit their needs, particularly if the co-contribution is likely to be higher (as may be the case if their income is significantly above the basic rate of the Age Pension). Baptistcare (WA) explained the reaction of consumers to the inconsistent pricing of community care services:

> The complexity of the aged care system … has lead to a plethora of programs which overlap with differing eligibility criteria and differing levels of direct cost to the consumer … this negatively influences client decisions regarding entering programs, based on solely economic considerations (lower fees) rather than need ... complaints arise when people move from HACC to Community Aged Care Packages (CACP) and sometimes result in people not accepting a CACP, which includes a 'care' element, in part because of the higher contribution. In maintaining their HACC services which might only provide 'domestic' services, they thereby deny themselves the 'care' that they are assessed as needing. (sub. 426, p. 2)

Different co-contributions for care in residential and community settings

Another inequity under the current pricing arrangements is that full–rate age pensioners in receipt of community care packages are asked to contribute to the cost of their care (as opposed to accommodation and everyday living expenses) while full-rate age pensioners in residential settings are not.

As noted, age pension recipients of formal community care packages may be asked to contribute up to 17.5 per cent of the basic Age Pension to cover their costs of care. Accommodation and everyday living expenses are paid from the balance of their pension and any other income or welfare support they receive.

By contrast, full-rate age pensioners in residential settings are not required to make any contributions to the costs of their care. The 'basic daily fee' of 84 per cent of their age pension is only a co-contribution to their everyday living expenses and accommodation. They cannot be charged any contribution to their personal care costs, even if they have equity in assets that could be drawn down.

Residents pay for different services depending on their care classification

Another inequity exists where the classification of residents between high and low care means that providers can charge low care residents for some care services and consumables that providers are expected to provide free of charge to high care clients.

St Johns Village Wangaratta noted that:

> Cost of care services are different, for example, a resident in low care pays for allied health services compared to a resident in high care where facilities pay for the allied health service. (sub. 404, p. 3)

Low care residents are also expected to pay for incontinence pads and other aids and equipment that they require for their care while high care residents are not charged. These charges are levied regardless of the resident's income.

Different co-contributions for accommodation in residential settings

One of the most inequitable co-contribution issues is the variable pricing of accommodation services in residential settings.

Residents who enter as low care and all residents receiving extra services (regardless of their care needs) can be asked to pay an accommodation bond of any amount provided they are left with a minimum asset amount (currently $39 000). The level of the accommodation bond is based on a resident's assets and does not necessarily relate to the quality of the accommodation.

The average level of accommodation bonds charged by providers exhibit substantial variations (table 5.6). However, these variations do not necessarily reflect the underlying costs of providing the accommodation. Not-for-profit (NFP) providers historically charge high extra services bonds but only operate a limited number of these beds.

Non-extra service high care residents, regardless of their means, do not pay an accommodation bond but contribute an accommodation charge which is currently capped at $30.55 per day irrespective of the quality and location of the accommodation. As explained by a care recipient in the Catholic Health Australia submission:

> I was assessed as needing to go into high care and the need was urgent. Despite the fact that I was living alone and wanted to have my own room and bathroom, I was told that I had to go into a four bed room. I subsequently found out that I had to pay the same for my bed with shared bathroom as my friend in a single room with an ensuite.
>
> The DON [Director of Nursing] explained that the government sets the maximum price and it's the same for all residents regardless of the room configuration. (sub. 217, p. 8)

Table 5.6 **Average new accommodation bond, by sector and extra service status, 2007-08 to 2009-10**

	2007-08	*2008-09*	*2009-10*
	$	$	$
Residents taking up non-extra services places			
Not-for-profit	169 608	194 758	209 797
For-profit	205 217	221 041	237 099
Government	135 122	164 951	162 559
All sectors	*176 625*	*200 362*	*215 175*
Residents taking up extra services places			
Not-for-profit	313 649	256 973	334 715
For-profit	230 709	259 037	281 070
Government	—	170 727	259 383
All sectors	*246 755*	*257 796*	*292 744*

Source: DoHA (2010h).

As bonds are not capped, many care recipients who pay large bonds contribute far in excess of the cost of the accommodation that they use — bonds in excess of $1 million are not unusual. In many cases, providers use this revenue to cross-subsidise high care residents who make accommodation payments that are less than the cost of providing newly constructed accommodation. These arrangements are irrespective of the resident's capacity to pay (chapter 7).

The current arrangements make many older Australians feel financially exploited on entering residential aged care. For example, a participant who did not wish to be named said:

> I don't feel it is fair for villages [residential aged care facilities] to charge people on the basis of their assets with no limit as to what they can charge. It is contrary to the usual way in which our society operates. I am sure we would think it very strange if we went into Harvey Norman to buy a heater and the salesperson asked us how much money we had before he answered the question. (sub. 58, p. 2)

The inequitable pricing arrangements for accommodation services also mean that wealthy older people with an ACAT assessment can effectively 'buy' their way into residential care, particularly extra services high care, in a relatively timely manner when those with less means have to wait for a place to become available.

Co-contributions for formal community care programs are not capped

Older Australians receiving formal community care services whose income is above the basic Age Pension rate may be asked to contribute up to 50 per cent of this

additional income (after tax and the Medicare levy have been deducted) (DoHA 2010c).

Effectively, this means that a client's contribution towards the cost of their care is not capped and not limited to the cost of the care that they receive. These design features for wealthy community care recipients are inequitable. By contrast, residential care contributions are capped at around half the maximum care subsidy and service recipients are not required to pay more than the cost of their care.

In reality, community care recipients have been able to negotiate a price with their service provider, so payment above the cost of the service would be rare. However, as information about co-contributions for formal community care services is not collected by governments, it is not known how many formal package recipients are contributing more than the basic age pension contribution and how many are contributing more than the cost of the services that they are receiving.

Pricing of services

Providers argued that some of the prices for aged care services set by DoHA are not adequate to cover costs. The result is that some providers are particularly reluctant to invest in maintaining and building capacity in the sector.

Accommodation charges and retention amounts

Many residential aged care providers advised that the maximum price set for the accommodation charge and public subsidies for accommodation in non-extra service high care do not cover the financing cost and depreciation of buildings and maintenance. Access Economics (2009a) estimated that accommodation charges need to be at least 50 per cent higher in order to cover these costs (that is, around $43 per day compared to then current maximum charge of $28.72). This situation has arisen because the maximum price and subsidy for ordinary high care accommodation has not been indexed at a rate that reflects increases in building costs for residential aged care.

These pricing restrictions are causing some providers to delay the building and/or refurbishment of non-extra service high care facilities. Others are not applying for new licenses to construct and operate ordinary high care beds because it is not viable to make such investments under the current pricing regime. For example, Catholic Health Australia noted that there:

> … has been under allocation of residential high care places in recent Aged Care Approval Rounds (ACAR), and the handing back of allocated places (bed licenses). The under allocation of residential places in the 2009 ACAR was 1,915 places or 25%

of residential places advertised (5748 allocated compared with 7663 places advertised). (sub. 217, p. 9)

In the 2009-10 aged care approval, only 5643 of the 8140 proposed residential aged care places were allocated. The shortfall was made up by increasing the allocation of CACPs, EACH and EACH-D (DoHA 2010a; DoHA 2010p; Elliot 2010).

For services that charge accommodation bonds, pricing restrictions and time limits on the size of the retention amount can affect the capacity of some providers to cover the costs of depreciation and capital replacement.

Aged Care Funding Instrument (ACFI) domains

The introduction of the ACFI in 2008 was an important step in seeking to better align the residential aged care pricing and subsidises with the broad areas, or domains, for which older Australians require care. The three domains — activities of daily living, behaviour and complex care — are each funded at a low, medium or high level. DoHA determines the range of needs for each level, the scope of services required to meet these needs, and their cost of supply.

While the ACFI has generally been welcomed by industry as providing a sustainable funding platform for service delivery, the funding of the behavioural domain has been highlighted in some submissions as an area of concern for a few providers. As Mercy Aged Care explains, in relation to people with a disability who are ageing:

> Funding under the aged care funding instrument (ACFI) does not recognise the complex clinical, behavioural and support needs of this population. This support often involves long periods of one on one staff time. The current (maximum) behavioural supplement of $30 per resident per day provides less than one hour of direct staff time per resident per day associated with the management of behaviour and emotional support. Most residents in this group have significantly higher support needs. (sub. 221, p. 5)

Underpricing of the behavioural ACFI domain is particularly a problem where a service caters specifically for older Australians with behavioural issues but who do not have significant difficulties with activities of everyday living or do not require complex care. Wintringham, an NFP provider of support and aged care services to the homeless or those at risk of becoming homeless, have encountered an adverse experience with the transition to the ACFI:

> The ACFI in its current guise acts as a powerful disincentive to any provider wishing to care for the elderly homeless … Behavioural issues, which resulted in high overall RCS [Resident Classification Scale] claims, are not able to be claimed at the same rate under ACFI. Behavioural issues require vast amounts of staff time and patience, these care

requirements then 'leech' into the care provided in the other two ACFI domains, to an extent, governing how care is provided overall. The three ACFI 'silos of care' do not allow this to occur – for example, should resident be reluctant to shower, this is classified as a behaviour and can only be claimed in this silo … In addition, in comparison to the other two ACFI silos (ADLs and Complex Health Care), the … [ACFI] Behaviour 'silo' is poorly funded and cannot be easily adapted to acknowledge the high cost of catastrophic behaviours. (sub. 195, pp. 9-10)

As a result, Wintringham and other providers who deliver aged care services to older Australians with significant behavioural problems claim that it is increasingly difficult to operate sustainably under the current scheduled price in some ACFI domains.

Indexation

One of the factors influencing the viability of providers in residential and community settings is the level of indexation of prices and subsidies. A number of submissions claim that current base indexation levels for residential and community care services have been consistently less than the increase in the cost of providing services.

Residential care

Some of these cost pressures have been ameliorated in residential settings by a conditional adjustment payment. Yet even with this top-up payment, some providers, such as Catholic Health Australia, indicated that the arrangements are not sustainable:

The cost pressures facing nursing and personal care as the result of COPO [Commonwealth Own-purpose Outlays] indexation of the *basic care subsidy* and care-related supplements are reflected in financial performance surveys which show that margins are declining and a large proportion of providers are operating at a loss. (sub. 217, p. 10)

Other policy changes, such as Award Modernisation, have also affected the cost of providing services. As Kincare described:

The Award Modernisation process and recent pay rises have introduced new and challenging dynamics to this process. It is bringing better pay and conditions to employees in the industry which will help make the industry more attractive to staff. However, it has increased costs for community care providers by up to 10–15%. This is in stark contrast to indexation of around 1.7% in an industry already under strain from years of indexation not keeping pace with costs. Wages are the major input cost of community care. An increase of this size, this quickly, is impossible for organisations to absorb and will inevitably result in reduced services and further financial strain on providers. (sub. 324, p. 26)

Community care

A number of providers argued that, as a result of sustained underfunding, the number of hours of direct care delivered to clients under community packages has been reduced. According to Aged Care Queensland:

> In community care, the hours of care being provided to clients have reduced significantly because funding levels no longer cover the true costs of care. The daily funding amounts for CACP's were first determined in the early 1990's and have only been subject to inadequate COPO indexation since that time. As a result CACP providers have gradually been forced to provide less hours of support. The average Community Aged Care Package previously provided 7 hours or more of support each week but now only delivers 5. (sub. 199, p. 14)

To the extent that indexation is insufficient, there will be pressure on providers to keep wages low, which is a major contributor to the unattractiveness of working in the aged care sector compared to health and other services sectors. Concerns in regard to the sustainability of the aged care workforce are dealt with in detail in chapter 14.

Differences in the taxation treatment between for profit and not-for profit-providers

The Commission's study *The Contribution of the Not-for-Profit Secto*r (NFP Report) (PC 2010b) identified differences in taxation treatment between community service providers who were for profit and those that were NFP or government owned. For aged care, the Australian Government has recognised the differences in payroll costs faced by the for profit provider, with a subsidy to offset the costs of payroll tax. However, no adjustment to prices and subsidies is currently made for the differences in fringe benefit tax (FBT) treatment.

Most NFP providers are able to offer their workers a FBT free package of up to $30 000 in non-salary benefits before these forms of compensation are subject to FBT. In addition, they can offer a meal entertainment exemption, which is uncapped. A number of submissions raised the inequity in the treatment of FBT as an issue of concern — Aged and Community Care Victoria (sub. 408), Cook Care Group (sub. 10), Martindale et al. (sub. 304), Pakary, Yalding and Hahndorf Holdings (sub. 308), Spakia (sub. 306), Salisbury Private Nursing Home (sub. 310), Tickled Pink Aged Care (sub. 301) and Woodville Nursing Home (sub. 298).

The NFP Report concluded that the FBT treatment did violate competitive neutrality principles in certain competitive human services areas including hospitals and aged care. Subsequently, the *Australia's Future Tax System* review recommended that FBT concessions for NFPs be phased out over 10 years (Henry

Review 2010). The Australian Government rejected this recommendation (Rudd and Swan 2010).

The extent of the competitive advantage provided by the different treatment for FBT is unclear as take-up rates by aged care workers are not known. The Commission reiterates the conclusion of the NFP Report that the FBT concessions should be phased out slowly to provide the sector the opportunity to adjust. Importantly, such a phasing out should be accompanied by government recognition of the full costs of providing community services, and that the benefits foregone should be redirected to the sector in more appropriate ways. In the event of a significant increase in aged care salaries, the efficacy of the FBT concession should be re-examined.

5.3 Regulatory burdens are excessive

The aged care system is characterised by high levels of government intervention and associated regulation. Restrictions on the planning and allocation of aged care services together with restrictions on prices, subsidies and co-contributions have been considered in previous sections. This section focuses on other regulations and associated burdens placed on providers in the delivery of aged care services, including accreditation and quality assurance.

Regulatory oversight is essential to protect older Australians, many of whom are vulnerable, and to ensure that public subsidies are not fraudulently claimed. However, some of the regulations imposed on the sector provide relatively little gain compared to the costs they impose. Costs arise where regulations reduce the efficiency of service providers or where they distort the nature of the services provided in ways that do not benefit the clients. The Commission's *Annual Review of Regulatory Burdens on Business: Social and Economic Infrastructure Services* report (PC 2009a), which looked at the community services sector including aged care, and the NFP Report (PC 2010b) both identified a number of excess regulatory burdens in the aged care sector. In particular, efforts to reduce risk to residents, often in response to a single unfortunate (but well publicised) incident, have added to monitoring and reporting costs and constrained the nature of the activities services are willing to offer their clients.

Getting the regulatory balance right is not easy, but there is a strong case that in some areas the balance has tipped too far toward over-regulation to the detriment of the efficiency and effectiveness of the system.

Accreditation — focus on process rather than outcomes

One of the strengths of the Australian aged care system is that it is considered by both stakeholders and international peers to generally provide good quality services. The accreditation and quality assurance system is important in ensuring that care standards are maintained and improved.

One of the three reasons cited for the move from the Resident Classification Scheme funding model to ACFI was to reduce the level of documentation (DoHA 2009g). However, submissions indicated that there is still excessive reliance on documentation, which reduces the time staff can spend with the older Australians they care for. For example, the Council on the Ageing (Australia) (COTA) argued that:

> … the accreditation process should not require substantially more paperwork than is required for normal business, clinical and care management needs. We have some sympathy with the view that quality accreditation processes in the health and aged care sectors have placed too much emphasis on excessive paper trails rather than on actual outcomes being achieved. (sub. 337, attachment 6, p. 7).

In a similar vein, UnitingCare Australia (UCA) (sub. 369) suggested that the system for accreditation and quality control be redirected away from a heavy focus on processes and inputs towards one which places greater weight on outcomes for older Australians. Similarly, the submission by Aged Care Crisis states:

> A system which takes staff time away from residents in order to complete a myriad of bureaucratic tasks fails both residents and staff. Currently, documenting the minute details of a person's life seems to have become more important than actually helping them live their lives. Documentation and the keeping of records is an important part of care — as is developing well-formulated care plans. However, the current system is out of balance and the staff time spent on documentation rarely, if ever, appears to result in improved care. (sub. 433, p. 4)

In addition, Maree Bernoth wrote:

> The way the accreditation process works currently, the aged care facilities that are delivering high quality care are disadvantaged because the process does not recognise this just as it does not recognise when poor quality care is given. Most facilities pass accreditation because managers and staff know how to subvert the process. It is not about care given, it is about having systems in place and on paper. It is irrelevant whether or not those systems are functioning because the real, tangible outcomes are not looked at, that is, the actual care delivered (or not) in the bathrooms and the bedrooms. (sub. 253, p. 22)

Too much emphasis on process and documentation adds to costs without commensurate benefit. Moreover it can 'crowd out' time and resources which could be devoted to other aspects of caring which enhance the wellbeing of older

Australians receiving aged care services — such as allied heath services, music therapy, nutritional care (Dieticians Association of Australia, sub. 371), and grief counselling and spiritual support (Villa Maria Society, sub. 395).

Excessive paperwork was also cited as an impediment to attracting and retaining staff who are attracted into the industry by the opportunity to provide care, not to undertake clerical tasks (chapter 14).

Other excessive regulatory burdens

Over the last five years, there have been a number of government initiatives which have imposed significant burdens on aged care providers including, mandatory police checks, reporting of missing residents, and mandatory reporting of assaults. Like unannounced visits by the Aged Care Standards and Accreditation Agency (ACSAA), these may be part of a well functioning regulatory environment, but how they have been implemented is raising costs unnecessarily and limiting innovative alternatives. There are clear links between some of these regulatory imposts and high profile incidents that have seen highly prescriptive and onerous regulation introduced for all industry participants, regardless of whether the risk is systemic (could apply across all providers) or idiosyncratic (arising from the behaviour of a few providers).

Some providers were critical of what they perceive as an excessive regulatory regime and the associated compliance costs. For example, Blue Care said:

> The Commission is well aware of industry frustrations with the inefficient and burdensome regulatory regime currently in place, and the corresponding suggestions from the industry to standardise quality/accreditation frameworks. For a large organisation like Blue Care, tapping into a multitude of government subsidies enables us to provide an extensive range of care options, but each funding program applies a separate set of standards, which amplifies our burden of compliance. Many of our community services are accountable for regulatory compliance under four external funding programs (i.e. HACC, DoHA, DSQ and DVA), and sometimes, accreditation is even applied at the sub-program level. The inefficiencies of managing our compliance activities across multiple programs are enormous. (sub. 254, p. 58)

The appropriate response to risk depends on the overall risk posed, the nature of the risk and whether it can be managed, and the consequences of failure to manage the risk. While any incident that negatively affects vulnerable individuals (and their families) is regrettable, a judgement must be made about whether the risk can be reduced and at what cost. Idiosyncratic risks are often best managed through an effective complaints mechanism that allows clients, their families and staff to raise concerns. Systemic risks are generally better managed through regulation, but the

costs need to be explicitly considered as do the benefits of reducing the risk. In the aged care sector, it seems that successive Australian Governments have tended toward a 'zero tolerance to risk' approach rather than adhere to the principles of good regulatory practice, including undertaking Regulatory Impact Statements to develop appropriate risk management regimes (PC 2009a).

Unannounced visits by the ACSAA

Some submissions from providers indicated that unannounced visits took up significant amounts of senior staff time at very little notice. For example, Southern Cross Care noted:

> Spot checks are a serious cause of emotional worry to staff … three assessors arrived at our Rosary Gardens facility without any warning at 9.15 am and remained there until approximately 5.00 pm. This sudden visit took up the time of senior staff at this aged care facility for the whole of the day. The unannounced visit was a 'routine' inspection and not related to any issue of concern. (sub. 267, p. 18)

DoHA signalled (in the Walton Review (2009)) that it will give consideration to changing the visits program as part of its broader review of accreditation processes.

Overlapping and duplicative regulations

Under the current regulatory system there is also a large amount of duplication, both within the Australian Government (between agencies) and between jurisdictions. Particular areas were highlighted by the Commission's Regulatory Burdens report (PC 2009a).

In the case of complaints investigations, it is not uncommon for ACSAA and DoHA to undertake concurrent investigations into the same incident. Some of this duplication arises as both agencies have different responsibilities for ensuring the delivery of quality aged care services (PC 2009a). However, this split of responsibilities appears inefficient and there may be opportunities to streamline these processes.

While ACSAA (sub. DR763, p.11) accepts there is some confusion about the roles of ACSAA, DoHA and the Complaints Investigation Scheme (CIS), it also notes that it is appropriate that it receives information about a complaint when the CIS 'believes the issue they are investigating may reflect a broader systematic issue' in relation to accreditation. In 2009-10 ACSAA received 2138 referrals from DoHA.

There are also significant overlaps in regulatory requirements between ACSAA and state and territory governments, primarily over infectious disease outbreaks, occupational health and safety, food safety, nursing scopes of practice and building certification (PC 2009a). While overlapping regulations are inefficient, inconsistent regulations can create serious problems for providers.

The Australian Government has accepted that the burden from overlapping and duplicative regulation should be reduced, and has implemented the recommendations on fire safety declarations (chapter 12; Australian Government 2009a). However, it has yet to announce any other significant initiatives in this regard. Further discussion on duplicate and overlapping regulation is in chapter 15.

5.4 How much reform is required?

As outlined in previous sections, there are many aspects of the Australian aged care system that do not measure up well against the criteria of equity, efficiency, effectiveness (choice, quality, and appropriateness) and sustainability outlined in chapter 4. A summary of how the current system is performing against the criteria is given in table 5.7. The summary provides a broad indication of several areas where there is scope for reform. But perhaps the major challenge is the sustainability of the system in its current form.

Is the current system sustainable?

There is some evidence that the system is currently under pressure, raising questions about its long term sustainability. Rationing of supply means unmet demand, while underfunding puts pressure on providers, and those people providing informal care. These problems will only be exacerbated with the ageing of the Australian population and growing diversity of demand (chapter 3). The sustainability of funding for what is largely a publicly funded aged care system is discussed in chapter 6.

Table 5.7 **Performance against the proposed objectives of Australia’s aged care system**

Objectives		*Areas for improvement*
To promote the independence and wellness of older Australians and their continuing contribution to society	→	There is little incentive for providers to engage in activities that promote the restoration of health and functional independence in care recipients as restoration generally results in a reduced care subsidy, particularly in residential aged care Access to home modifications is limited
To ensure that all older Australians needing care and support have access to person-centred services that can change as their needs change	→	There are significant variations in access to, and timeliness of, assessment services for medium to high level aged care. Delays in assessment for restorative aged care programs and respite care are a particular concern Restrictions on the number and scope of services that providers can offer reduces their capacity to offer continuity in care service delivery, particularly in community care Some older Australians, living in residential care facilities or in the community, have difficulty in attracting general practitioners (GPs) to deliver services in these settings. This is also the case for some allied health services
To be consumer-directed, the system should allow older Australians to have choice and control over their lives and to die well	→	Regulations and planning ratios can limit the capacity to providers to offer greater choice. Older Australians may be unable to access the services of their choice, such as accessing care in the community rather than entering residential care
To treat older Australians receiving care and support with dignity and respect	→	The Australian aged care system is considered by both stakeholders and international peers to generally provide good quality services. But emphasis on process and documentation to enforce standards reduces time available for greater face time with clients
To be easy to navigate, with older Australians knowing what care and support is available and how to access those services.	→	Reports of difficulty in getting comprehensive and timely information about the aged care system, understanding their rights and responsibilities with regard to the services they can access, and the level of co-contributions they are required to make
To assist informal carers to perform their caring role.	→	Carers of older Australians and consumer advocates indicate that they have difficulty in accessing appropriate and timely respite services
To be affordable for those requiring care and for society more generally. To provide incentives to ensure the efficient use of resources devoted to caring for older Australians and broadly equitable contributions between generations	→	Co-contributions vary across the different programs and can vary across clients with the same need and capacity to pay. Accommodation bonds and uncapped contributions to community care programs are inequitable and can exceed the cost of the service

There is evidence of underfunding

Concerns about the adequacy of care subsidies and the effectiveness of the current indexation arrangements were raised by care recipients, their families and providers. Consumer representatives have argued that the level of government funding is insufficient. For example, Carers Australia argues:

> Caring is not financially sustainable for many carers and this is just one of the pressures that can increase the difficulty of providing care in the home. Carers currently carry an unfair burden of the cost of care for older people comparative to government expenditure on supporting their needs. (sub. 247, p. 16)

While COTA said that:

> At the micro-economic level it is also becoming increasingly clear that there will need to be a significant increase in the resourcing of both community and residential care if the industry is going to be sustainable and if Australia is to continue to have good quality support and care that everybody can access … Indexation of government subsidies [is] consistently below price inflators for both wages and goods and services, with almost no means for this to be compensated for by providers as user charges are tightly government regulated. (sub. 337, pp. 10-11)

According to a number of providers, inadequate subsidies mean that they struggle to provide quality care for residents and to attract and retain appropriate staff to provide the care expected. They also expressed concern about the ability of their staff to provide the social and emotional support to residents that is important to maintaining the quality of life of residents (funding is not provided for social and emotional support for residents and their families). And, as discussed above, the current system of indexation applying to public subsidies for aged care is regarded by many participants as failing to cover the cost increases faced by the industry.

Providers, if they are to remain in the industry, need to be adequately compensated for the cost of providing care. As the Victorian Government said:

> Like any market, the ‘price’ paid for aged care services needs to be sufficient to both stimulate capital investment and meet the full, ongoing costs of operating services. (sub. 420, p. 5)

Blue Care also said:

> Under-funding and inadequate indexation of subsidies has occurred for many years and can only continue for so long. In the long term, unless providers are compensated for the full economic cost of provision of service to supported residents, supply will be eventually withdrawn. (sub. 254, p. 10)

Blue Care estimated that residential care is currently under funded by $15 per resident per day. Based on the current population in residential care and allowing

for income tested fees they estimated the underfunding to be around $900 million annually (sub. 254).

If care subsidies are currently under-funded, ensuring subsidies accurately reflect the cost of supplying care would mean a larger public aged care bill. Funding must be adequate, but generous funding can reduce the incentives for providers to be innovative and continuously look for ways to reduce costs without compromising quality. It can prop up inefficient providers who may be providing poor quality care services. It also puts pressure on the Commonwealth budget as well as on individuals paying co-contributions.

The level of unmet demand is not known but could be high

The rate of approvals for residential care services exceeds the number of admissions, suggesting unmet demand for these services. However, assessments can be based on prospective (rather than current) need especially for those at the low care end of the spectrum whose needs are expected to accelerate with time. Howe et al. (2006), from an analysis of ACAT assessments, report that while the number of clients recommended for high level residential care is close to the number of admissions, the number recommended for low level care is almost twice the number of admissions.

In community care the evidence suggests a shortage of places — the 2008-09 funding application rounds for community care packages were oversubscribed, with the (then) Minister, Justine Elliot, reporting that the ‘aged care sector has sought 27 039 community care places for the 2784 places on offer’ (Elliot 2009, p. 1). Providers receiving HACC funding are required to ration their services to the available budget.

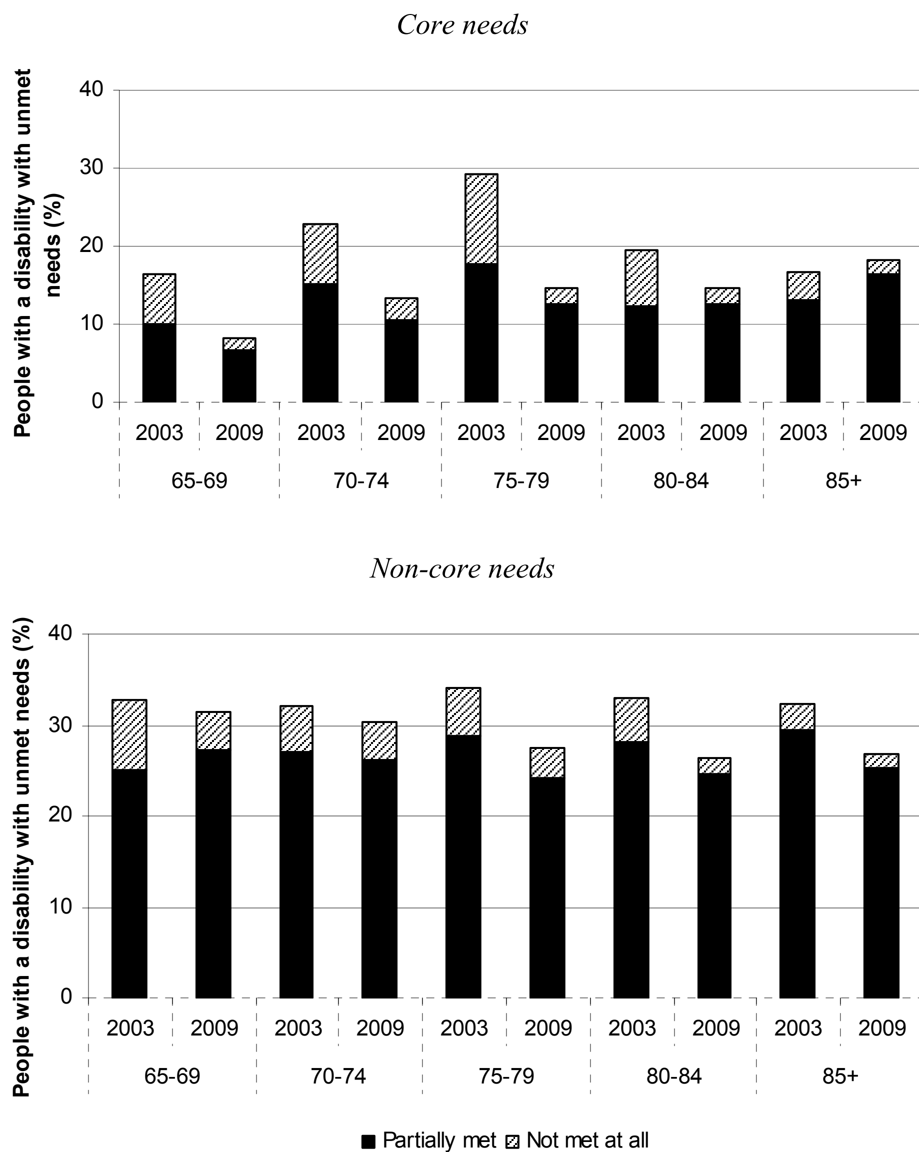
The Australian Bureau of Statistics (ABS) Survey of Disability Ageing and Carers (SDAC) reports on the extent to which people who are living in households and have care needs, consider that their needs are met. The ABS seeks separate information on needs arising from a person’s ‘core’ and ‘non-core’ restrictions. Core restrictions are those that affect an individual’s ability to communicate, be mobile and care for themselves, while non–core restrictions affect an individual’s ability to participate in work ,schooling and social activities.

Generally, the level of unmet need that older Australians reported fell between the 2003 and 2009 SDACs (figure 5.1). The share of people whose needs are completely unmet has fallen across all age groups, both for people with needs relating to their core and non-core functions. However, the same trend is not as pervasive for people with partially met needs. Overall, the only group of older

Australians experiencing a rise in people reporting their needs to be partially or full unmet is for those aged 85 years or older with care needs arising from their core restrictions. This indicates that while the aged care system has improved access to almost all aged care services since 2003, it is not able to provide adequate levels of service to those older Australians aged 85 years and over with core needs, arguably the group most in need.

Figure 5.1 **Proportion of older Australians with a disability who have unmet needs**

Core and non-core needs by age



Data sources: 2003 & 2009 ABS Survey of Disability, Ageing and Carers CURF files.

Is there scope to improve efficiency?

There is significant scope to reduce the cost of providing aged care services through reducing excessive red tape and other regulatory burdens as discussed above. Such changes can provide a one-off reduction in costs. However, to promote on-going improvements in efficiency, providers need incentives to seek better, and lower cost, ways of doing things.

As noted earlier in the chapter, many of the current arrangements, such as supply constraints, do anything *but* encourage competition between providers or provide incentives for innovation. Moreover, as discussed in chapter 6, addressing impediments to competition would provide scope for improving productivity and enhancing efficiency.

Indeed, there are other opportunities to improve efficiency in the sector as outlined by the Business Council of Australia:

> The limited consolidation within the sector, which has been driven by the poor investment returns, has meant that the 'cottage industry' nature of the sector has remained unchanged. As a result, there is, at the broadest level, a striking underinvestment in information and communication technologies and other infrastructure that might improve efficiency and productivity. (sub. 274, p. 6)

Other participants identified inefficiencies at the interface between the aged care system and the health care system. Health Care Consumers' Association of the ACT noted:

> There are numerous facilities which are not visited by a medical practitioner, meaning that aged care residents are often transported to hospital … for medical care which they could have received at their residential facility had there been a suitably trained practitioner (nurse or doctor) available to treat the individual. This situation is ridiculous, costly, traumatic and inefficient. (sub. 326, p. 6)

Measures aimed at getting the different parts of the aged care system and the health care system to work together are discussed in chapters 9 and 10 .

Where to from here?

The Commission believes that to better meet the objectives of the aged care system, and ensure its sustainability, a fundamental redesign of the aged care system is required. A number of recent reviews and inquiries into the aged care system have also consistently identified a need for fundamental reform to address the weaknesses associated with the current system and to allow the sector to respond to the challenges outlined in this report (box **Error! Not a valid link.**).

Box 5.3 A consistent message from recent reviews is the need for significant reform

Australia's future tax system: Report to the Treasurer (Henry Review):

> Limiting the number of subsidised aged care places and associated price controls impedes competition between providers, undermining both their capacity to respond to the needs of older people and their incentive and ability to plan for future growth in an industry driven by an increasingly ageing population. Responsive and sustainable aged care services are particularly important because many people requiring the services are vulnerable, and the fiscal costs to the economy are increasing. (2010, p. 629)

NHHRC's *A Healthier Future for All Australians: Final Report*:

> The underlying premise of our recommendations … is that we need to redesign health services around people, making sure that people can access the right care in the right setting. This must include a 'full service menu' of health and aged care services necessary to meet the needs of an ageing population and the rise of chronic disease. Redesign also involves ensuring that this complex array of services is well coordinated and integrated. (2009, p. 102)

Senate Standing Committee on Finance and Public Administration's (SSFPA) *Inquiry into Residential and Community Aged Care in Australia*:

> … it became overwhelmingly evident that aged care providers and involved stakeholders across the country recognised a need to reform the aged care sector in Australia. Witnesses commented on the 'bandaid' approach that has been taken to problems within the aged care sector and of the fact that they have been calling for reform for many years. It was argued that the significant problems currently facing the sector and the need to meet future demand must be addressed immediately and in a comprehensive and coherent manner. (2009, p. 15)

Productivity Commission's *Annual Review of Regulatory Burdens on Business: Social and Economic Infrastructure Services*:

> The aged care industry is characterised by centralised planning processes which result in a heavy regulatory burden on aged care providers in order to maintain the quality of care. Without tackling the underlying policy framework that constrains supply it is unlikely that the regulatory burden can be substantially reduced … the government should explore options for:
>
> – relaxing supply constraints in the provision of aged care services
>
> – providing better information to older people and their families so they can make more meaningful comparisons in choosing an aged care service
>
> – removing the regulatory restriction on bonds as a source of funding. (2009, p. 19)

Review of Pricing Arrangements in Residential Aged Care (Hogan review):

> … regulatory arrangements stem, at least in part, from fears about the vulnerability of residents to exploitation and unsafe practices. Nevertheless, these constraints affect a wide range of economic outcomes. First, they diminish the extent of competition between providers and, in particular, make it more difficult for prospective providers to enter the market. Second, they restrict consumer choice and reduce the consumer's ability to bargain over entry conditions. Third, they curtail innovation in service design and delivery. Finally, they adversely restrict enterprise mix and investment in the sector. (2004b, p. 2)

These views are echoed by a vast number of submissions from a variety of stakeholders including consumers and consumer groups, providers and industry bodies, and governments. For example, the Aged Care Association of Australia contended:

> The time for continuing to apply band-aid solutions has passed. Together, we have the opportunity to construct a new aged care system which will allow a smooth transition to a new model which will effectively provide the care needed in 10–20 years time … The Australian aged care system needs to migrate from its current inflexible structure to a new, more flexible and viable model which will provide greater choice within a quality system. (sub. 291, pp. 4–5)

And, according to the Australian Nursing Federation (Victorian Branch):

> The aged care system is at the crossroads. The Australian Government has commissioned ample reports and inquiries to consider how the overall quality of aged care services can be improved. There is no shortage of knowledge on the factors contributing to its decline or about the measures required to steer it onto a path of sustainability.
>
> What appears to have been lacking to date is a willingness to take firm action, and a commitment to implement the concerted, brave and bold reform that is required if the system is to be equipped to competently meet rising demand … (sub. 341, pp. 8–9)

While it must be recognised that the system has generally performed well, the problems can no longer be fixed by small adjustments. As COTA argued:

> On an internationally comparative basis Australia's current aged care system has served many of its users and their families well over recent decades. It has gone through a number of major improvements since the 1980s. These have focused primarily on improving service quality and user rights within the current service paradigm. There are now marginal returns at best in further 'tweaking' the current system. (sub. 337, p. 11)

The Commission agrees that the time is right to consider broad changes that will build on the strengths of the current system to set the industry on a sustainable path to meet the challenges outlined in earlier chapters. The following chapters outline proposed reforms which the Commission considers are required to enable government, industry, carers and volunteers to better meet the objectives of caring for older Australians.