Joint initial submission to the Productivity Commission Inquiry

Caring for Older Australians

July 2010

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Introduction

ECH Inc., Eldercare Inc. and Resthaven Inc. are three of South Australia's largest and most experienced providers of residential and community aged care and housing options for older people.

Our combined operations offer a comprehensive range of services and support to frail, older South Australians, including independent living, Home and Community Care (HACC) services, community care packages, Transition Care, health and well-being services, respite and residential aged care. In all, we employ over 3,500 staff and have over 1,000 trained volunteers. Between us we offer nearly 3,000 residential aged care places and several hundred community aged care packages. On a yearly basis that means we provide care and assistance to many thousands of older people.

We have previously made submissions to the:

- Senate inquiry into residential and community aged care in Australia (2009);
- Productivity Commission inquiry into the contribution of the not-for-profit sector (2009);
- the Department of Health and Ageing's (the Department) Reviews of the Conditional Adjustment Payment (2009), the Complaints Investigation Scheme (CIS) and of the residential aged care accreditation process (2010);
- Treasury regarding the 2010 Federal Budget; and
- National Health and Hospitals Reform Commission (NH&HRC) on its Interim Report (2009).

Below are links to the submissions that are available online.

http://www.aph.gov.au/Senate/committee/fapa_ctte/aged_care/submissions/sub85.pdf

http://www.pc.gov.au/__data/assets/pdf_file/0005/89654/sub108.pdf

http://www.health.gov.au/internet/nhhrc/publishing.nsf/Content/073-interim/$FILE/073 - Submission - ECH Resthaven & Eldercare.PDF

Executive Summary

We have argued previously that the aged care sector is at a crossroad and that the wrong decisions now could seriously damage its collective capacity to respond to the many challenges facing both service providers and government alike. Nevertheless, there is a high level of agreement on the major issues, as evidenced by the publicly expressed views of the National Aged Care Alliance and the individual industry peak bodies (including ACSA); by Catholic Health Australia, Uniting Care Australia and other faith based organisations; Alzheimer's Australia;

COTA National; the Henry tax review; the Productivity Commission; and individual providers such as ourselves.

Australia needs a national vision for aged care – a strategic future direction that will guide what is unquestionably one the world's best systems of aged care. The *Caring for Older Australians* inquiry presents the opportunity to offer government such a vision and strategy.

The current aged care system is complex and in need of reform. We agree with the Henry tax review that reform (to supply and pricing for example) will involve significant sequencing and transition issues. The Commission's mandate to address the current and future care needs of older people and the wide-ranging service system required to do so, is large. With this in mind we believe there will need to be a number of incremental changes made to the current system on behalf of the community, to ensure continuity of care is maintained to current recipients. The past 20 or more years has seen significant changes implemented in the aged care system. The last significant major overhaul was in 1997 and changes since then have been largely incremental. The regulatory and policy framework is now out of date and in need of another major reform process. We see this Commission's proposed solution (whatever it may be) likewise needing to be implemented in several critical steps, and propose this occur progressively over five year intervals that incorporate the following principles:

- greater consumer choice of and access to services, including where and how they are delivered;
- independence enhancing and wellness models of care and service;
- flexibility and innovation in service design to deliver individualised care;
- greater connectedness between all parts of the health and aged care systems;
- pricing arrangements that reflect the actual cost of care, rather than the means of recipients (Henry Review 2010);
- assistance for those with limited private means;
- equitable funding and revenue arrangements that will put the aged care sector on a sustainable footing into the future.

In the final section of the submission, under Reform Options and Transitional Arrangements, we have included an indicative approach for the next five years as possibly being:

1. integration of all home and community aged care programs and assessment services;
2. introduction of the various legislative changes needed to reduce the degree or nature of regulatory control over the industry;
3. progressive introduction of an entitlement-based community care system;
4. independent determination of the costs of care and progressive adjustment of all fees, charges and subsidies, with regular reviews;
5. progressive alignment of the residential and community care systems.

RECOMMENDATIONS

1. Progressive movement to a single, comprehensive, entitlement-based system of community aged care with funding based on assessed need;
2. Develop a community care funding system that is linked to an initial independent external assessment, and that is comparable with residential care, to facilitate seamless movement within and across community and residential care settings;
3. Unbundle funding and charging for accommodation, care and services:
    a. determine an adequate level of care and its associated real cost, and fund it, or allow providers to charge for it, accordingly.
    b. people with limited private means to attract government financial assistance so that the provider receives the same income in respect of all residents and clients as it relates to their care and, where required, their accommodation needs;
4. Align the care fees and funding across residential and community care such that they are not linked to accommodation, and that they reflect the actual cost of care required by the resident or client:
    a. Consumers to attract subsidies based on their assessed needs irrespective of where they wish to receive services (in a residential care facility or at home[1]);
    b. The funding to be portable across residential and community care to enable two-way movement between the client's preferred housing location;
5. Include aged care sector representation in the governance arrangements for the primary health care organisations (to be known as Medicare Locals) and Local Hospital Networks announced in the 2010 Federal Budget.
6. Retain the current approach of funding approved service providers rather than individuals pending the results of current CDC trials and further research into client preferences, service quality and viability;
7. Provide older people with information about their options and with indicators of quality care and quality of life to assist them in their discussions with providers;
8. Incorporate the enhancing independence and self-management principles into a redesigned community care system.
9. The government accept the recommendation of the Productivity Commission's report, *Annual Review of Regulatory Burden on Business: Social and Economic Infrastructure Services*, with respect to:
    a. relaxing supply constraints (with, we add, a focus on community service entitlement in the next 5 years);
    b. providing better information to older people and their families; and
    c. removing the regulatory restriction on bonds.

[1] 'home' being regarded as the older person's preferred housing situation other than residential care, be it in a traditional family home, a single unit or some form of retirement living.

10. Retain the planning and allocation system for residential care places but allow providers to offer additional beds for a variety of health and aged care uses, including the provision of community care funded services, respite, subacute and transition care.
11. Increase the maximum accommodation charge and accommodation supplement towards what is reasonably identified as the cost of building or accommodation provision within a market context.
12. The government act on the PC Review of Regulatory Burden Report's other 14 recommendations, all of which have significant merit and reflect a serious attempt to identify the ineffectiveness of current regulation within the system and where inefficient duplication exists. Among the areas considered in the PC report are duplication of requirements for certification and compliance with the BCA; monitoring of fire systems and the overlap between the Department and the Agency.
13. Simplifying the access point assessments to only require an older person to undergo one external assessment for their entry to the care system, after which the level of care should be determined by the relevant funding tool, whether that be in a residential or community care context.
14. The government to accept all the recommendations of Associate Professor Merrilyn Walton's *Review of the Aged Care Complaints Investigation Scheme (October 2009)*;
15. The government to commission an independent review of the Accreditation and Quality of Care Standards and of the development of Quality of Life indicators, which is open to public submissions.
16. The government to establish a panel of independent accreditation authorities for the administration of the Standards.
17. In considering competition and market forces in an aged care context, regard must be had for the limitations on the market and its users.
18. Regulation of the retirement village and retirement living sector remain the province of State and Territory Governments and separate from Federal aged care regulation.
19. COAG agree to institute nationally consistent State level regulatory protections of older individuals within various accommodation settings that they may own, or rent and/or occupy.
20. An independent financial cost analysis be undertaken to determine the true cost of aged care services, followed by regular reviews to ensure that funding levels are adjusted accordingly;
21. Alignment of fees and funding across residential and community care for people with similar care needs;
22. The development of an indexation factor or factors that reflect movements in the actual cost of care over time.
23. The PC further review the potential negative effect that the licensing and regulation of aged care workers may have on the supply of such workers in the future, if employment is based on a minium qualification entry point.

The Service Delivery Framework

Much has been said about the rapidly increasing older population and the challenges it presents. The ageing of the population is at times portrayed as a burden, accompanied by rather apocalyptic predictions about soaring costs. For example, the Intergenerational Report 2010 contains projections of a significant increase in government spending on health and aged care, mainly driven by population growth and ageing. Residential aged care is said to be the main contributor to the predicted increase in aged care costs. This has the danger of creating a negative image of older people.

Yet leading aged care academic, Professor Hal Kendig from the University of Sydney, is reported to have said that the cost increases will actually be due to better utilisation and quality of health for us all. He attributes only 20% of the projected increase to population ageing.[2]

Furthermore, based on a longitudinal study of 1,000 older Australians he has said, "We've shown empirically through our research findings that most people in (the over 65) age group live in the community until very, very near – often to the last month – before their death. Those who do enter residential care do so partly for their disabilities or medical conditions, but also for a range of social factors, such as a lack of family support or for reasons related to the insecurity and unaffordability of their accommodation." [3]

In 2008-09, residential care accounted for only 20% of all people who received a funded aged care service. The real issue is that residential care accounted for around two-thirds of the total funding – almost $7 billion (DoHA 2009). It therefore makes sense to focus some attention on reducing the demand for residential care and not just increasing supply or reducing the total cost to government.

As shown by Kendig, several factors (besides disability or medical conditions) can lead an older person to be admitted to residential care (and we'd add hospital). Often these factors, including the degree of urgency, could be ameliorated, if not obviated altogether, for example by:

- better information earlier on;
- timely assessments and interventions to improve health and well-being;
- relatively low level forms of care and support;
- reducing social isolation;
- improved housing;
- age friendly neighbourhoods; and
- greater support for carers[4].

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[2] http://www.australianageingagenda.com.au/2010/06/21/article/The-times-they-are-a-changing/WFKOUYGDUD.html

[3] Making A World Of Difference To Australia's Ageing Population - FHS - The University Of Sydney

[4] see also http://www.sapo.org.au/binary/binary2721/Changing.pdf p.9

One of the weaknesses of current arrangements in achieving better outcomes for older people is the rigidly defined division of services and funding and the inconsistencies in policy and administration. For example:

- HACC, day therapy and respite services are funded on fixed budgets through grant programs whereas community aged care packages and residential care are funded on the basis of fixed subsidies per approved care recipient;
- average government funding jumps from around $2,200 a year for a HACC client to approximately $13,000 for a CACP client, $44,000 for an EACH client and perhaps $50,000 for residential high care;
- fees vary from zero to over 50% of the cost of care;
- individual older people might be forced to change service providers as much as four times as they progressively require more and different care and support.
- the pathway is most often one-way rather than allowing services and funding to vary according a person's changing needs; and
- access to aged care services/funding is explicitly rationed for residential and community packaged care services and there are varying eligibility (rationing and prioritisation) approaches for all types of HACC, respite and other grant funded community programs.

In this submission we are recommending a new framework for the way in which services should be provided and funded. We have not attempted to address every question raised the Commission's Issues Paper.

Interface with wider health and social services sectors

Based on the abovementioned research and our own experience, increasing the availability of and access to a variety of community and in-home assistance has the potential to have a marked impact on future demand for residential aged care services. Simply increasing the supply of existing community care services in itself is not the answer though. As noted in the NH&HRC report, there needs to be greater 'connectedness' between the health and aged care systems. However, we would argue, unlike the government's response to the NH&HRC Final Report, that greater emphasis should be placed on non-hospital based approaches (in addition to General Practice) as a means of improving interactions between the aged care, primary health, sub-acute and acute care systems. The planned increase in the number of GPs and incentives for GPs to provide more support for aged care residents are welcome, as is the proposed increase in funding for sub-acute care, but these initiatives are rather limited in scope.

As indicated above, there are a range of community-based allied health and non-clinical approaches that can be highly effective in avoiding or delaying a person's entry into residential care or hospital. A great deal could be achieved through a more flexible and adaptable home and community care system and, for example, more creative housing, therapy and activity programs, as well as strategies that address social isolation and loneliness.

The cost of expanding and re-designing the community care system would be more than offset by the potential reductions in future government outlays on residential care and the hospitalisation of older people through such an approach.

RECOMMENDATIONS

1. **Progressive movement to a single, comprehensive, entitlement-based system of community aged care with funding based on assessed need;**
2. **Develop a community care funding system that is linked to an initial independent external assessment, and that is comparable with residential care, to facilitate seamless movement within and across community and residential care settings;**
3. **Unbundle funding and charging for accommodation, care and services:**
    a. **determine an adequate level of care and its associated real cost, and fund it, or allow providers to charge for it, accordingly.**
    b. **people with limited private means to attract government financial assistance so that the provider receives the same income in respect of all residents and clients as it relates to their care and, where required, their accommodation needs;**
4. **Align the care fees and funding across residential and community care such that they are not linked to accommodation, and that they reflect the actual cost of care required by the resident or client:**
    a. **consumers to attract subsidies based on their assessed needs irrespective of where they wish to receive services (in a residential care facility or at home[5]);**
    b. **the funding to be portable across residential and community care to enable two-way movement between the client's preferred housing location.**
5. **Include aged care sector representation in the governance arrangements for the primary health care organisations (to be known as Medicare Locals) and Local Hospital Networks announced in the 2010 Federal Budget.**

We wish to be clear here that we are not advocating for a model of fund holding by Medical Locals. Indeed, we would be opposed to having intermediaries controlling aged care funding (for reasons such as the State Government imposts that have been added to HACC funding arrangements). We would also oppose the potential erosion or rationing of aged care funding by another level of bureaucracy that might choose to redirect funding to medical/clinical components of support and away from non-clinical community supports. We are also not wanting to open the door to a separation of case management and care planning

[5] 'home' being regarded as the older person's preferred housing situation other than residential care, be it in a traditional family home, a single unit or some form of retirement living.

from direct care service delivery (as is the case with some international models, and disability care models currently operating in Australia).

Consumer-directed care (CDC) and Enhancing Independence

CDC can best be described as a service concept rather than a service delivery model. Examples of CDC internationally range from fully cashed-out voucher systems and paid family carers, through to agency-managed 'person-centred care'. The essence of the various approaches is the high degree of client control or influence over decisions that affect their care. The degree to which they actually manage the funding and other resourcing varies considerably.

We wouldn't expect very many older people or their families to want full responsibility for managing their care and services but some certainly would. Rather, like most of us, older people want to be involved in the decision-making process but not necessarily have the worry of hiring staff and managing the finances.

Community aged care services do need to focus on ways of enhancing independence. By this we mean the client sets their own goals (based on a comprehensive, holistic assessment of their needs) and defines the support that they themselves say they need (with assistance from skilled staff) to continue living an independent life. This is achieved through listening to what is important to them, and with them, supporting/facilitating the client-designed care plans that allow them to achieve their goals. It means developing creative, flexible interventions that enable older people and their carers to achieve their goals and optimise their quality of life and well-being, while not creating undue dependence on the service provider. Many of the interventions can be time-limited.

In applying this approach more broadly, it would be important to remove barriers and disincentives to such choice and flexibility within both the community and residential care service delivery and funding structures. Current program structures can make older people captives of a particular service(s) system and can be quite dependency-creating – as can notions of assessment that extend beyond a broad, high level assessment of eligibility for particular levels of care.

In community care this means establishing an open entitlement to services with approved service providers system, as against the current system which is based on entitlement overlayed by a limited supply of places.

In residential care it would be a system similar to that which exists currently but with the elimination of:

- barriers that prevent individuals choosing to move between providers;
- the restrictions on accommodation bonds and charges; and
- the financial risk for both providers associated with the validation of an ACFI assessment when a person moves from one residential care provider to another.

In considering CDC approaches, we believe it is important not to settle on a single approach by assuming that all older people would want to manage their own funding, for example. Rather, we advocate the retention of funding being provided to service providers as the principal approach (at least over the next few years) but with the option for providers and clients to negotiate the details of the arrangement. In this way, some providers might decide to only offer a fully managed arrangement, while others might offer a choice of self-management or a mix of both agency-managed and self-managed service delivery.

An entitlement system would allow clients to choose the arrangement that best suits them (including who provides what services and where) and to change providers if they so wished.

A wholesale change to direct funding of individuals would not be in everyone's best interests, including prospective clients, if it led to making the service experience more stressful, or to market failures. We do not support changes on a scale that might further damage the viability of reputable, individual service providers or the sector more broadly. For the time being, we recommend a balanced approach.

RECOMMENDATION

6. **Retain the current approach of funding approved service providers rather than individuals pending the results of current CDC trials and further research into client preferences, service quality and viability;**
7. **Provide older people with information about their options and with indicators of quality care and quality of life to assist them in their discussions with providers;**
8. **Incorporate the enhancing independence and self-management principles into a redesigned community care system.**

Funding and Regulatory Arrangements

As Box 1 in the Issues Paper acknowledges, a great deal has been said and written about the need to reform the aged care sector. Our various submissions (see references and links on page 1) addressed several issues that we and others believe require attention and we would draw your attention in particular to the following:

- the case for more consumer choice through greater flexibility in what providers can offer;
- the need to ensure that pricing and funding reflect the actual costs of care;
- the tension between the existing fixed, capped or limited arrangements and the expectations of the accreditation and compliance regimes;

- the inconsistencies and inflexibilities in residential and community aged care that militate against independence-enhancing, rehabilitative and restorative approaches;
- the high level of regulation and zero-risk approach adopted by government despite very high, sustained levels of service quality and compliance; and
- inadequate funding indexation.

Regulation

We are not arguing for deregulation of the aged care system. Rather, we are putting the case for simpler but smarter regulation in terms of the necessary level of provider accountability, without stifling the sector's capacity for growth and service innovation. The need, at times, for providers to take limited resources away from service support, to respond to unnecessary administrative burdens, must be minimised in any new service system.

Quality and compliance

The Aged Care Standards and Accreditation Agency (the Agency) currently has a monopoly on the application of the Accreditation Principles, which only apply to residential care services. Community care (other than HACC services) are governed by the Quality Standards set out in the Quality of Care Principles under the *Aged Care Act 1997* (the Act) and are administered by the Department of Health and Ageing. HACC also has its own quality framework.

We believe there is a case for a more efficient and responsive arrangement whereby a selected number of independent accrediting bodies could be approved on a panel basis to administer both the Accreditation and Quality of Care Principles to cover both residential and community care. A further efficiency would be to not place a time-limit on accreditation. In other words, once accredited, a service would remain accredited indefinitely unless that accreditation was revoked. This would remove the arbitrary three-year cycle that imposes unnecessary deadlines on the accrediting authority. It would pave the way for a rolling program of inspections and audits

Our submission to the Department's *Review of the Accreditation Process* also argued that the current regulatory regime, including the Accreditation process, and the cost and funding of aged care, come at a cost to the people they are designed to serve. That cost manifests itself in a number of ways including an increasingly restricted ability on the part of providers to offer the type of care services and life-style options to residents that they desire and deserve.

There would have been some logic in the Department first reviewing the Accreditation Standards and developing the proposed Quality of Life (QoL) indicators before embarking on a review of the process. A key consideration will

be the development of QoL indicators in respect of an environment wherein many residents have significant dementia and other frailties, and in which they neither choose to nor aspire to live and die. Additionally, any processes associated with such indicators should be offset against any revised accreditation processes so as not to add to the regulatory effort.

Quality of Life indicators, by their very nature, are highly subjective. According to Gilhooly, 'if QoL is individualised, it cannot be meaningful to assess it in the same way for everyone.' ... 'Because health, wealth and social relations have all been found to be prime determinants of subjective QoL.'[6]

If consensus could be reached as to what constitutes QoL for an aged care resident or client, whatever model evolved should be developmental: educative and instructive, not punitive or based on compliance with predetermined standards.

Our views with respect to the accreditation process and approach are somewhat similar, while accepting there needs to be a compliance aspect as well as a focus on process improvement. It is the absence of a degree of tolerance in the accreditation system and the lack of a risk management approach that concerns us. We believe the application of the Standards and their attendant Expected Outcomes are sometimes at odds with the reality of what is in the interests of the resident and client, and with what's possible under the current funding and industrial arrangements. For example, a resident's right to take risks can be at odds with perceptions of required resident safety; and a provider can be found in breach of the Act because of the actions of an individual employee who consciously ignored strict employer policy.

Accommodation payments

On the question of accommodation payments, the government has offered no justification for its refusal to allow accommodation bonds to be charged for all residential care. By contrast, virtually every other review and inquiry into aged care in recent years has supported the lifting of regulatory restrictions in this area.

Other measures could include an increase in the maximum accommodation charge and the accommodation supplement to help encourage new capital developments.

It is very concerning that successive governments and the Department have dismissed submissions and evidence about the significant understatement of the base cost of capital development. The result has been that limits on accommodation charges and accommodation subsidies have been set at unrealistic levels. This was emphasised in an Access Economics report, *Economic evaluation of*

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[6] Gilhooly, M. Technology and quality of life: Ethical and conceptual challenges in exploring the role of ICT and AT in successful Ageing. In: Gerontechnology 2010;9(2):84-85

capital financing of high care (March 2009)[7] commissioned by a coalition of key church groups.

Planning and allocation of places

We are suggesting a balanced approach to the planning and allocation of new aged care places. On the one hand we recommend that community care be changed to an entitlement system, with access to it based on an independent external assessment of a person's care needs at the time of assessment. Community services would therefore not require an allocation of places. In this way, approval to receive services would be linked to the individual, not a pre-determined number of places.

In relation to residential care however, there are certain advantages in maintaining a degree of supply control, both for consumers and providers. Putting aside the question of the planning ratio for the moment, we support a system whereby a specific number of residential places are allocated on a priority basis, as a means of ensuring future provision of services to special needs groups and an equitable regional spread. The fact that Australia has had a system of allocating residential places for over 20 years has, we believe, resulted in a highly equitable distribution and greatly improved access to care for all eligible persons. We do not support introducing uncertainty to future provision through a completely free market approach at this stage.

However, we are suggesting that in addition to the planned (controlled) approach, providers be permitted to add residential places according to their own program and business strategies. The proportion of additional places could be limited to perhaps 10% of any new development for the first few years while the effect of such a change is evaluated.

If community care subsidies were commensurate with residential care for people with similar needs, and were a portable entitlement, providers could offer community care clients the option to use their subsidies for periods of residential care as and when needed. This option could add real value in pursuing independence-enhancing approaches. In combination with other reforms, including those recommended by the NH&HRC, it has the potential to greatly increase the provision of overnight and longer term respite for carers; sub-acute care services; palliative care; and various forms of transition.

Competition and deregulation

We acknowledge that the PC's and other reports with an economist perspective recommend greater competition, freeing up of supply and more price-based market conditions as a means of achieving better outcomes for older people, for supply and for efficiency. Competition is promoted as being inherently good. Such

[7] http://www.cha.org.au/site.php?id=92

views are often offered from a theoretical perspective not reflective of some realities of the aged care 'market'. Clearly, the devil is in the detail when these views are applied to the aged care sector, which the NH&HRC has recognised, like health, as being a 'quasi-market', with fundamental differences from normal markets.

For our part, we see older people as having a right to services as is the case with essential health care. We also believe that frail older people are deserving of the community's recognition, having special regard in the development of any new service system. We do not see any evidence that very frail, older people or carers have the propensity to actively participate in a so-called 'market' environment in the way some commentators imply with respect to competition and decision-making.
Issues of frailty and the urgency of care need, combined with limited financial resources, are characteristics of many older people. They will always affect the notions of how the 'market' might and should work with respect to decision making, choice and transferability. The next 10 or 20 years will continue to reflect a client group of older people with very limited finances, as has been their historical profile, with high proportions of full and part pensioners. This will have a significant effect on the market is like from our perspective, in an environment where there will continue to be minimal standards for all services that continue to be regulated.

The test therefore is how we consider the needs of this group in what we are told is a world class system, relative to alternative models available. From a service provider perspective and with the client group's characteristics in mind, we assume all future governments will retain a level of regulation which will further affect notions of market, as they have in the past. Hence our view is that regulation (of supply, quality, pricing etc.) should be simplified (compared to the current imposts), not that the 'market' be deregulated.

The service system within residential care has been characterised for 30 to 40 years with a significant government system of control of supply. In the 1970s and 80s this involved deficit funding models. Since the mid-1980s we have had the current system of planning and allocation of places, with some major changes along the way, a number of incremental improvements and, unfortunately, significant extra red tape.

Sustainability of the aged care sector has been an ongoing matter in all these models. It is also clear that certainty within the system has been important, as reflected in the importance of high occupancy rates to maintain viability. Creating a deregulated environment where underlying sustainability associated with occupancy levels becomes significantly uncertain represents an extraordinary risk for service providers and older people not seen in other essential services. Entitlement to community care services itself is a key change to introduce with respect to 'market' behaviour. We do not see any evidence that frail older people or their carers 'shop around' once a service has been secured.

We therefore strongly caution against assumptions about market forces, supply and price competition being a panacea in this context, given the characteristics of the users of the market, particularly at the high frailty end.

We agree with the Productivity Commission's view of the NH&HRC's recommendations in this respect, that they do not make any advance on the current system and potentially cause other issues of risk within the service system.

These views influence how we consider moving forward and how we adopt principles of market choice in different parts of the service system. We see emerging an initial focus whereby the residential system and community system are considered within different allocation frameworks:

- residential care supply having similar characteristics to the current system of allocation but with some flexibility for additional growth;
- an increase in residential low care being a minimal but important component; and
- moving community aged care to a less regulated method of provision based on entitlement with the retention of an 'approved provider' system.

Despite the greater emphasis on high care, a need remains for residential low care. For some older people, residential low care is a preferred form of accommodation and service. An entitlement system in community care, with funding portablility, would allow such people the choice of remaining at home or moving to a congregate-living environment, either for the short or long term.

Security of tenure also needs to be considered if the intent is to create greater flexibility. We ask the Commission to further reflect on the role of security of tenure as the practical application of the User Rights Principles in relation to tenure is sometimes unworkable. Examples include people who refuse care and treatment, violent clients, and unsafe conditions for staff in a person's home.

If greater market conditions were to apply we believe the rights of providers should also be considered.

RECOMMENDATIONS

9. The government accept the recommendation of the Productivity Commission's report, *Annual Review of Regulatory Burden on Business: Social and Economic Infrastructure Services*, with respect to:
   a. relaxing supply constraints (with, we add, a focus on community service entitlement in the next 5 years);
   b. providing better information to older people and their families; and
   c. removing the regulatory restriction on bonds.

10 Retain the planning and allocation system for residential care places but allow providers to offer additional beds for a variety of health and aged care uses, including the provision of community care funded services, respite, subacute and transition care.

11. Increase the maximum accommodation charge and accommodation supplement towards what is reasonably identified as the cost of building or accommodation provision within a market context.

12. The government act on the PC Regulatory Burden Report's other 14 recommendations, all of which have significant merit and reflect a serious attempt to identify the ineffectiveness of current regulation within the system and where inefficient duplication exists . Among the areas considered in the PC report are duplication of requirements for certification and compliance with the BCA; monitoring of fire systems and the overlap between the Department and the Agency.

13. Simplifying the access point assessments to only require an older person to undergo one external assessment for their entry to the care system, after which the level of care should be determined by the relevant funding tool, whether that be in a residential or community care context.

14. The government to accept all the recommendations of Associate Professor Merrilyn Walton's *Review of the Aged Care Complaints Investigation Scheme (October 2009)*;

15. The government to commission an independent review of the Accreditation and Quality of Care Standards and of the development of Quality of Life indicators, which is open to public submissions.

16. The government to establish a panel of independent accreditation authorities for the administration of the Standards.

17. In considering competition and market forces in an aged care context, regard must be had for the limitations on the market and its users.

Retirement Villages

We see the regulatory control of retirement housing as being outside the Federal aged care system and remaining at State level. Retirement villages are but one housing option for older people: others being the family home, units, flats and even caravan parks. Housing is a State Government responsibility and should not be confused with the responsibility for aged care services that might be provided to the occupant.

In each of these types of housing/accommodation, some form of home and community care might be a chosen support option, supplemented by whatever other user-pays support they choose and can afford. However, a great many older people receive no formal home care. Hence we see the relevant monitoring of services as being via the regulatory framework applying to the government funded approved service provider of community services, not the housing/accommodation provider.

We do not agree with the Commission's comment that 'the distinction between retirement villages and residential aged care facilities is, in some respects, becoming less marked' (Issues Paper, p.14). The corollary would be that a person's own home is similar to a residential care facility simply because the person receives a community care package.

We believe that COAG should confirm that there are already in place at State level, appropriate regulatory protections of older individuals within the various accommodation settings they may own or rent and occupy.

The current South Australian legislation for example defines retirement villages on the basis of the 'scheme' under which residences are occupied (e.g. a lease, licence or purchase). This legislation already provides, inter alia, for the registration of schemes, rights of residents and access to an independent tribunal.

RECOMMENDATION

18. **Regulation of the retirement village and retirement living sector remain the province of State and Territory Governments and separate from Federal aged care regulation.**
19. **COAG agree to institute nationally consistent State level regulatory protections of older individuals within various accommodation settings that they may own, or rent and/or occupy**

Funding

The actual cost of residential and community care and their respective operating results are being increasingly analysed and reported on by firms such as Stewart Brown Business Solutions and Bentley.

Stewart Brown's most recent industry survey provided data on average operating results grouped by bands of operating income per occupied bed day. **No group achieved an operating profit**. The results showed that residential care facilities may be reaching their limits in terms of staff hours and productivity savings. The ratio of 'other nursing staff' to registered nurses has increased and the average number of hours worked per resident per day for the reputed highest financially performing facilities (the Top 25%) has dropped even further. The limited notions of efficiency and productivity applied to the sector have no benchmark or real substance but have been used politically to imply that the whole sector is inefficient. Such notions ignore the reality of deteriorating financial circumstances in the service system which have had a negative impact on service levels for older people.

The Stewart Brown survey also shows that the community care sector has continued to produce positive financial results although profitability has been in

gradual and sustained decline for some time. Notably, care wage costs have been increasing such that average client care staff hours have had to be reduced and are now below five hours per client package per week. This trend is increasing the risk of premature entry to a residential care service due to the real reduction in the service levels brought about in community care by the 'flawed' indexation system and the lack of a graduated subsidy system for individuals of differing needs (as applies in residential care).

Fully costed pricing levels for both residential and community care need to be established and form the basis of future fee structures and funding levels. As mentioned previously, accommodation and living expenses should be unbundled from care and support. Fees and funding should then be based on the actual costs of care and accommodation and not on an individual's means and/or the artificial limits imposed by government via the regulatory system that currently applies.

Each funding stream should be relatively simple, with a high degree of compatibility in terms of people with similar needs, whether they reside in the community or in residential care. One approach might be an activity-based funding system similar to that being proposed for the hospital sector, with prices being set by an independent authority.

The aged care sector has long argued for an indexation formula that reflects the real costs of providing services. The issues facing residential care were detailed in submissions to the Department's *Review of the Conditional Adjustment Payment* (CAP). Notably, the ANZ Bank's Chief Economist, Saul Eslake, commented at the 2008 Aged and Community Services Australia national conference that the historic aged care indexation formula (based on the Commonwealth Own Purpose Outlays (COPO) index), even in combination with the CAP, did not reflect the reality of rising costs.

The *Review of the Conditional Adjustment Payment* (2009) has never been released and the CAP is now fixed at 8.75%. The COPO formula is based on a discounted proportion of minimum wage movements and a heavily discounted CPI and, as a result, has fallen well short of actual cost increases each year for the last 10+ years.

The Department has also revealed in evidence to past Senate Committee hearings and inquiries that in determining the annual indexation factor, it assumes a level of annual productivity gain. As the Commission has stated, 'The COPO is premised on the view that virtually all wage increases are productivity based. Hence, it only makes provision for safety net increases in wages and for economy-wide movements in non-wage costs. Thus, if productivity gains within the aged care sector do not keep pace with other sectors, the subsidy, as indexed, will be increasingly inadequate.'8

[8] Productivity Commission, *Trends in Aged Care Services: some implications*, Research Paper, September 2008, p.99

Being a highly labour intensive industry, aged care has much less scope for productivity gains than other industries. It should also be remembered that the majority of providers are small to medium sized organisations and are often stand-alone services - possibly the only service in town. Furthermore, around 65% of residential care facilities have fewer than 60 beds, while only 10% have more than 100 beds[9]. The assumptions about productivity should therefore be treated with some scepticism.

Recent government initiatives have only added to the cost increases facing the sector. The new industrial relations system (Fair Work Australia) with its National Employment Standards and Modern Award system, has introduced significant prospective cost increases over the five year transition period; together with less flexibility; and, we expect, less choice in service delivery. Risks of cost blow-outs have further increased with the more recent government proposal to raise employer superannuation from 9% to 12 %; and the government encouraged fair remuneration claims in both community and residential care. For older people, the significant risk is a further reduction in services and health outcomes if these increases are not matched by government subsidy increases and/or reduced regulation.

RECOMMENDATION

20. An independent financial cost analysis be undertaken to determine the actual cost of aged care services, followed by regular reviews to ensure that funding levels are adjusted accordingly;
21. Alignment of fees and funding across residential and community care for people with similar care needs;
22. The development of an indexation factor or factors that reflect movements in the actual cost of care over time.

Government Roles and Responsibilities

We support the COAG decision that the Australian Government will assume full responsibility for aged care. We see no advantages in a reallocation of any responsibilities across Commonwealth and states and territories.

Having a single funder and policy maker has clear benefits. However, we do recommend that responsibility for the administration of certain aspects of aged care be independent of the Department, namely:

- accreditation and quality standards;
- complaints;
- building and accommodation standards; and
- price setting.

[9] ibid, p.17

State Governments will be retaining responsibility for occupational health and safety, food standards, fire safety etc., and there seems to be no reason to change this.

Other questions raised in the Issues Paper in respect of the role of government are largely addressed elsewhere in this submission.

Workforce Requirements

An inseparable consideration in the prevailing financial circumstances is the effect on the sector's ability to offer market competitive rates of pay to all categories of care staff, be they nurses, care workers or allied health professionals. In this context it is worth noting that, on average, more than 70% of operating income in residential high care relates to labour. Without a comprehensive response by government to the evidence of the deteriorating state of the aged care sector's financial position, the workforce issues will only grow in significance.

The attractiveness of the aged care environment as an employment sector is negatively affected by current rates of remuneration. It should be recognised that restrictions on models of care and scope of practice, coupled with over-regulation, also have a major effect on attracting, and in particular retaining, employees.

The aged care workforce of the future will need to be more flexible and adaptable, with greater scope for mixed or changeable roles, including between residential and community care, and health and aged care. In this respect, Health Workforce Australia will play an important role in working with the aged care sector on the *Workforce Innovation – Caring for Older People Program.*

The Federal Government's May 2010 Budget has allocated funds to explore the regulation of direct care workers. We urge caution in this area of regulation. Some stakeholders who have argued for such regulation (e.g. the ANF) have also argued that up to 35% of the workforce does not have a minimum Certificate 3 qualification10. No stakeholder has yet guaranteed that a regulatory or licensing system would not eliminate this 35% of the current workforce pool in aged care. In a service environment where support for such significant growth in demand is predicated on a growing and more flexible workforce, introducing entry barriers as the means of qualify control is not the answer. We ask the Commission to further review the complex consequences or risk of licensing aged care workers.

RECOMMENDATION

23. The PC further review the potential negative effect that the licensing and regulation of aged care workers may have on the supply of such workers in the future, if employment is based on a minium qualification entry point.

[10] Ged Kearney, "Because we care", Address to National Press Club, 16 September 2009

It is worth noting that the Royal College of Nursing has not expressed support for licensing of workers. Rather, it is advocating for a framework that makes clear the scope of practice of unqualified and Certificate 3 qualified workers to aid workers in understanding boundaries and aid their employers and work supervisors in appropriate scope of practice[11].

Related to this is the existing accreditation system and CIS that also review such matters within the current regulatory system. Adding yet another level of regulation seems to only offer increased red tape and would be an administrative burden in addition to the potential to exclude a pool of workers in a limited workforce environment.

Reform Options and Transitional Arrangements

We recognise that several of the recommendations in this submission would involve radical changes in government policy and legislation. They might also pose significant shorter–term challenges for some providers (many of which are small to medium-sized organisations with few facilities or services) as well as their residents and clients.
As stated at the outset, we are suggesting an incremental approach be taken in this regard.

Reform on the scale we are advocating would obviously involve significant changes to legislation and government policy, as well as to the way in which aged care providers need to plan and operate. There would be a major broadening of the products and services on offer which would require public information campaigns and time for the market to adjust and respond.

We see long term benefits for older people and their families, for providers and for government. Importantly, government outlays would not necessarily increase disproportionately in relation to the growth in the older population. There are potential savings to be realised through a relative decrease in reliance on residential care; investment in early intervention, health promotion and a range of rehabilitative and restorative approaches; efficiency gains from the integration of all community care programs and the establishment of single access assessment services. The greater connectedness between the health and aged care systems sought by the NH&HRC has the potential to significantly improve outcomes for older people and lead to a greater degree of independence and self-management.

An indicative approach over the next five years might be as follows in terms of priorities:

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11 http://www.rcna.org.au/_literature_66559/23_April_2010_Productivity_Commission_must_consider_unlicensed_workers

1. integration of all home and community aged care programs and assessment services;
2. introduction of the various legislative changes needed to reduce the degree or nature of regulatory control over the industry;
3. progressive introduction of an entitlement-based community care system;
4. independent determination of the costs of care and progressive adjustment of all fees, charges and subsidies, with regular reviews;
5. progressive alignment of the residential and community care systems.

Reform on this scale simply must be managed with the full cooperation of the major stakeholders. Engagement with consumers, providers, unions and the health sector is critical if a change program is to succeed. Rather than the usual government advisory bodies however, we recommend the direct involvement of stakeholders in the governance arrangements that would need to be established to guide the reform process.

We would be more than happy to meet with the Commissioners in person to discuss the above matters in more detail, either in Adelaide, or elsewhere at the Commissioners' convenience. If there are to be public or closed hearings, we are also quite prepared to travel interstate to attend.

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