

**(1) Introduction**

I hereby provide my submission to the Productivity Commission on "Caring for Older Australians". My submission principally builds upon my recent submission to the Senate Finance & Public Administration Committee Inquiry into COAG Reforms Relating to Health and Hospitals<sup>1</sup> which is attached as follows:

- **Attachment 1:** Correspondence to the Senate Finance & Public Administration Inquiry into COAG Reforms Relating to Health and Hospitals
- **Attachment 2** Correspondence to Lindsay Tanner and other Federal/State Stakeholders re the briefing for the April 2010 COAG meeting.
- **Attachment 3** COAG April 2010: Update on reforms on Activity Based Funding, Risk Adjustment and Evidence Based Medicine Implementation

My submission to the above Senate Committee Inquiry relates to reform initiatives that are relevant to the Productivity Commission's Inquiry. This includes recommendations for new *State/Territory Centers of Evidence Based Medicine (EBM)*, *Health Services and Workforce Redesign* and an *International Centre of Evidence Based Medicine and Health Economics*. Further, the risk (severity) adjustment funding reforms enable funding to match health need. The COAG submission at Attachment 3 includes web links to two previous briefs considered by COAG<sup>23</sup> relating to the new National Health Care Agreements in 2009. The Productivity Commission is encouraged to consider all three briefs to COAG as they provide important background to my submission. The relevance to aged care is outlined more fully below.

**(2) Centres of Evidence Based Medicine (State and Federal)**

The Proposed new *State/Territory Centers of Evidence Based Medicine (EBM)*, *Health Services and Workforce Redesign* and an *International Centre of Evidence Based Medicine and Health Economics* could together assist in streamlining all health sectors including aged care, hospital and community services and improve quality, access and efficiency through implementation of the latest EBM, change management techniques in health services delivery, medicine, surgery, and preventive health across the continuum. EBM and best practice for dementia treatment is a priority area for Health Economics and Funding Reforms. It could also be a priority of the proposed International and State Centres, along with severe arthritis and serious visual and hearing impairments. There would be a need for the State and International Centres to include effective links to informal carers in the co-ordination of EBM/best practice modalities and develop 'user friendly' communication strategies of such initiatives for both professional and informal carers.

The implementation of the new State and International Centres can assist with improving the social, clinical and institutional aspects of aged care and can address access standards, planning mechanisms at the regional level, policy supporting elderly in their homes and business models to meet the needs of the elderly. This would involve key linkages to reforms in other health services to ensure technical and allocative efficiency and ensure smoother service provision across the health care continuum. See Antioch (2008, 2009, and 2010) for further insights on the nature of the State and International Centres and relevance to the COAG reform agenda. The National Health and Hospitals Reform Commission (NHHRC) emphasized that redesign for aged care services should ensure the complex array of services is well co-ordinated and integrated (NHHRC, 2009<sup>4</sup>, pg 102). Witnesses for the Senate Standing Committee on Finance and Public Administration Inquiry into Residential and Community Aged Care in Australia commented on the band-aid approach to problems in the aged care sector and reform is needed (SSCFPA, 2009<sup>5</sup>. Pg 15).

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<sup>1</sup> Antioch, KM (2010) *Submission to the Senate Finance & Public Administration Inquiry into COAG Reforms Relating to Health and Hospitals*

<sup>2</sup> Antioch KM (2008) Integrating Economic and Clinical Evidence, Guidelines and Equity into National Regulation and Financing: Reforms for the Australian Health Care Agreements (AHCA): 2009 and Beyond. Submitted to *European Journal of Health Economics*. Paper provided to *Council of Australian Government (COAG), other State and Federal stakeholders and NHHRC*.

<sup>3</sup> Antioch KM (2009) Intergovernmental Agreements: Update on Reforms on Risk Adjustment of Health Funding and Evidence Based Medicine (EBM) Implementation. Paper to *Council of Australian Government (COAG) and other State and Federal stakeholders, National Health and Hospitals Reform Commission (NHHRC)*.

<sup>4</sup> NHHRC (2009) *A Healthier Future for all Australians, Final Report June*.

<sup>5</sup> Senate Standing Committee on Finance and Public Administration (2009) *Residential and Community Aged Care in Australia April*.

In addressing these concerns the State and International Centres would also address the need identified by the Productivity Commission for providing better information to older people and their families so they can make meaningful comparisons in choosing services (Productivity Commission, 2009<sup>6</sup>, pg 19).

These EBM reforms would also address the current curtailing of innovation in service design and delivery resulting from the constraints of the current regulatory arrangements as identified by the Hogan Review (2004<sup>7</sup>, pg 2). The associated cost savings achieved from EBM implementation would also assist in addressing the increasing fiscal costs for the elderly identified by the Henry Review (2010<sup>8</sup>, pg 29), with cost savings estimated of at least \$1,367.62m over five years in the hospital sector alone<sup>3</sup>.

### (3) Risk (severity) adjustment of health finance to reflect patient complexity

**Risk adjustment** in Activity Based Funding and other areas in health enable funds to reflect health need<sup>9</sup> and has application across the continuum, including aged care services. Some variables that would be of relevance to aged care would include measures of *functional status/complexity*, such as the Barthel Index or Functional Independence Measure (FIM)<sup>10,11</sup>, with other key issues for consideration such as models of care, care setting, and application of clinical pathways, management plans or protocols<sup>12</sup>. Some classification systems include, inter alia, the Sub acute Ambulatory Classification (SACS), Casemix Rehabilitation Admitted Funding Tree (CRAFT)<sup>13</sup> Australian National Sub acute and Non acute patient (AN-SNAP)<sup>14</sup> and the Diagnostic Cost Group Hierarchical Condition Category (DCG-HCC)<sup>15</sup>. The development of adequate risk adjustment could enable transparent financing to enable high quality standards and would be important in addressing information and market asymmetries through developing more accurate price signals.

### (4) Equity Issues in Financing Arrangements

Demographic change is increasing demand for aged care and reducing the supply of informal carers (eg family members). These caregivers co-ordinate formal community care services for the aged in their homes. A shortfall in caregivers may undermine sustainability of community care and increase demand for residential care with additional budget costs for governments. Taxpayers may need to pay more although they will insist on more exacting standards of equity and efficiency. Different treatment for funding accommodation, personal care and health care components of residential aged care may be required given the former are not exclusively associated with disability and frailty. Baby boomer households are worth approximately 1.3 times that of the average Australian household. Reverse mortgages have made it easier for the aged to finance a greater proportion of their residential aged care costs. Other options to consider are voluntary and compulsory insurance<sup>16</sup>. These initiatives, highlighted by Mitchell (2010)<sup>16</sup> are worthy of detailed consideration.

### (5) Conclusion

The foregoing contribute to forging a path for transitioning from the current regulatory arrangements to a new system that ensure continuity of care and allows the sector adequate adjustment time and within the government's medium

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<sup>6</sup> Productivity Commission (2009) *Annual Review of Regulatory Burdens on Business: Social and Economic Infrastructure Services*, Research Report, Canberra.

<sup>7</sup> Hogan Review. See *Aged Care Price Review Taskforce 2004* (cited in Productivity Commissions Issues paper on Caring for older Australians, 2010).

<sup>8</sup> Henry Review. See *AFTS Secretariat 2010* (cited in Productivity Commissions Issues paper on Caring for older Australians, 2010).

<sup>9</sup> Antioch KM & Ellis RP et al (2007) "Risk adjustment Policy Options for Casemix Funding: International Lessons in Financing Reforms" *European Journal of Health Economics*. September.  
[http://people.bu.edu/ellisrp/EllisPapers/2007\\_AntiochEllisGillett\\_EJHE\\_RiskAdj.pdf](http://people.bu.edu/ellisrp/EllisPapers/2007_AntiochEllisGillett_EJHE_RiskAdj.pdf)

<sup>10</sup> Granger, C et al (2007) "Modifications of the FIM instrument under the inpatient rehabilitation facility prospective payment system" *American Journal of Physical Medicine and Rehabilitation* 86 (11):883-82.Nov

<sup>11</sup> Mackintosh S (2009) "Functional Independence Measure" *Australian Journal of Physiotherapy* Vol 55 pg 65.

<sup>12</sup> Antioch KM, Jennings, G & Botti M et al (2002) "Integrating cost-effectiveness evidence into clinical practice guidelines in Australia for Acute Myocardial Infarction" *European Journal of Health Economics* 3:26-39

<sup>13</sup> Brook K et al (2007) "The effect of the introduction of a casemix based funding model of rehabilitation for severe stroke: an Australian experience. *Archives of Physical Medicine and Rehabilitation* 96(7):827-32, July

<sup>14</sup> Gordon R, Eager K and Currow D et al (2009) "Current funding and financing issues in the Australian hospice and palliative care sector" *Journal of Pain and Symptom Management* 38 (1): 66-74 July

<sup>15</sup> Pope G et al (2004) "Risk Adjustment of Medicare Capitation Payments using the CMS-HCC". *Health Care Financing Review* 25(4): 119-141.

<sup>16</sup> Mitchel, A (2010) "Aged Care doesn't add up" *Australian Financial Review* pg 62. 4 August.

term fiscal strategy. There would be considerable economies of scale and efficiencies associated with the State and international centres, along with an appropriate focus on dementia as a key priority area for aged care. Risk adjustment will enable funds to be allocated at a level to meet health need.

***Dr Antioch is Principal Management Consultant Health Economics and Funding Reforms. She held two Ministerial appointments, as the health economics member, to the Principal Committees of the National Health and Medical Research Council (NHMRC) for six years to 2009. These were the Health Advisory Committee and National Health Committee which approved Clinical Practice Guidelines and translated evidence into clinical practice. Dr Antioch worked as part of Senior Management of Bayside Health (now Alfred Health) in Melbourne until 2005 where she led the translation of evidence into clinical practice across three tertiary, community and rehabilitation hospitals, involving inter alia, aged care. She led similar work across Western Health Network until 2007. She presented the model of EBM translation across Australia in 2007, sponsored by the Australian Health Care and Hospitals Association, in the context of the renegotiations of the Australian Health Care Agreements and briefed COAG and other Federal/State stakeholders on the recommendations arising from the national consultations. She also led the risk adjustment reform of Activity Based Funding (ABF) in Victoria for the Victorian Government. 5 August 2010***