Tasmanian Government Submission

Productivity Commission Inquiry – Caring for Older Australians

September 2010

Department of Premier and Cabinet

Tasmania
Explore the possibilities

Executive Summary

- Tasmania has the fastest ageing population of any state or territory and has experienced substantial growth in demand for aged care services.
- There are 112 aged care providers in Tasmania providing 2 426 high care and 2 204 low care beds and 1 284 community care places.
- Current provision of residential aged care places does not meet the demand and providers are not able to invest in and plan sustainable services under the current funding model.
- The availability of packaged community care is also inadequate to meet demand – especially in rural areas.
- Shortfalls in both residential and packaged care are placing increasing pressure on public hospitals – with prolonged hospital stay for older people costing $31.6 million in 2008-2009 and $25.6 million in 2009-2010.
- The Tasmanian Government acknowledges that, as a part of the national health reforms, the Australian Government has agreed to take on full funding and policy responsibility for primary health and aged care.
- Noting this context, reforms are necessary to ensure a sustainable, equitable and quality aged care system in the future, including the following:
  - a complete and thorough review of the strategy for planning, funding and allocation of aged care across the complete care continuum for the older person including residential and community aged care packages, acute and sub-acute rehabilitation and primary health. This should take place in consultation with states and territories;
  - an improved funding formula base, unit pricing and allocation of services which recognises increasing complexity. The funding model would include appropriate indexation, capital investment strategies, weightings and equitable and consistent consumer fees;
  - improved targeting of existing services and reduced gaps and overlaps;
  - continuity of care models that facilitate the transition of clients between services (in accordance with their needs);
  - increased use of case management and service brokerage for clients who have a high or complex level of need;
  - models of care that restore health and prevent ill health;
  - funding that allows flexible service delivery for all areas and especially in rural communities;
  - a streamlined administration and reporting system that reduces the burden on service providers while focusing on the usefulness of data collected; and
  - information technology that eases reporting burden and supports information sharing.
- This submission addresses both the Terms of Reference and the Issues Paper released by the Productivity Commission relating to this Inquiry. The questions posed in the Issues Paper are included in italics in this submission for ease of reference.

1. Tasmania's ageing population

Demographic change is a major issue for Tasmania. Tasmania's population is ageing more rapidly than any other Australian jurisdiction and the median age in Tasmania is the highest in the nation. Over the next 20 years, the proportion of Tasmanians aged 65 years and over is projected to grow by 80 per cent. The number of Tasmanians aged 85 years and over is projected to increase from around 9 700 persons in 2008–09 to 19 300 persons over the next 20 years, and to 41 200 persons by 2050.[1]

In line with these projections, it is anticipated that future demand for aged care services will increase at a significantly faster rate than planned increases in the supply of aged care services. A shortfall is likely to arise as Australian Government aged care funding is currently allocated on the basis of the number of people aged 70 years and over in a population. People aged 80 years and over comprise the most rapidly increasing service group in Tasmania.[2]

An increase in the number of older people living with dementia is also likely to place particular strain on aged care service providers. It is well documented that the incidence of dementia in the community will continue to increase in Tasmania given the demographic profile.

Whilst dementia is not exclusively experienced by older people, the incidence of dementia increases with age. Prevalence is estimated to rise exponentially with age, doubling every 5.1 years of age after the age of 65 years. Among people aged 65 years and over, 6.5 per cent are estimated to have dementia. Of those aged 85 years and over, the estimate increases to 22-24 per cent.

In 2009 there were an estimated 6 300 people with dementia in Tasmania, projected to increase more than four-fold to 26 300 people by 2050. In 2009 there were approximately 1 750 new cases of dementia in Tasmania, projected to increase five-fold to approximately 8 870 people by 2050. Of those people with dementia in Tasmania in 2009, around 57 per cent live outside of Hobart.

Across Australia in 2010, people with dementia are estimated to represent 1.1 per cent of the population in capital cities and 1.2 per cent in regional and rural areas. By 2050, these proportions will rise to 2.9 per cent and 3.8 per cent respectively. That increase is likely to be larger and have greater impact in Tasmania's largely regional and rural population.[3]

The impact of an ageing population is a concern, not only in terms of the increased costs associated with caring for older persons, but because Tasmania's already low labour force participation rate is also likely to be affected, leading to a smaller pool of available workers in the aged care and health sectors.

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[1] Tasmania's population projections are available on the Tasmanian Demographic Advisory Council's website: http://www.dcac.tas.gov.au/

[2] Department of Premier and Cabinet (DPAC), *Tasmanian Government Submission to the Productivity Commission Health Workforce Study for the Council of Australian Governments*, DPAC, Hobart, 2005.

[3] Access Economics, 2009, *Keeping Dementia Front of Mind: Incidence and Prevalence 2009-2050*, Access Economics Report prepared for Alzheimer's Australia, ACT, 2009.

Tasmania has a greater reliance on financial transfers from the Australian Government than most jurisdictions, and so may be more exposed to risks associated with Australian Government policy responses to demographic change.

In response to these issues, the Tasmanian Government established the Demographic Change Advisory Council (DCAC) in June 2006. The DCAC has released a range of papers to assess the demographic change-related issues that Tasmania is likely to face over coming decades and identify possible strategies to address these issues. The issues surrounding the care of older Australians as Tasmania's population ages have been discussed in both the Issues Paper (released 14 October 2007) and the Strategies Paper (released 5 April 2009).[4]

i. Residential Aged Care in Tasmania

There is a mix of 41 residential care providers in Tasmania including both profit and not for profit organisations.

Table 1: Operational bed volumes in Tasmania: aged residential care as at August 2010

Level of care	High care residential	Low care residential
Number of Places	2 426	2 204

ii. Packaged Care in Tasmania

The report *Aged care packages in the community 2007-08, A statistical overview*, stated there were 40 280 operational Community Aged Care Packages (CACPs) offered across Australia at that time, with almost 37 000 individuals receiving assistance at 30 June 2008.[5] Tasmanians comprised 2.7 per cent of all recipients, equating to 996 CACPs, up only 43 from the previous year.

The national distribution of the 3 892 Extended Aged Care at Home (EACH) package recipients at 30 June 2008 was similar. Tasmania received 2.5 per cent of the nationally available packages, which translates to just 94 EACH packages for Tasmania, giving a combined total of 1 090 Australian Government funded aged care packages in the state at 30 June 2008.

The small number of EACH packages means that clients living in rural and remote communities have very limited or no access to an EACH package. This severely limits client options for remaining in their community with appropriate levels of service and significantly increases their risk of entering institutional settings – acute hospitals and residential care.

The report also showed that over the period from 1999–00 to 2007–08, the age of new clients receiving EACH packages has increased, with the proportion of people aged 80 years and over increasing from 57% in 1999–00 to 65% in 2007–08. In Tasmania, 47.3 per cent of

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[4] These papers are available from the DCAC website – http://www.dcac.tas.gov.au/.

[5] Australian Institute of Health and Welfare (AIHW) *Aged care packages in the community 2007-08, A statistical overview*, AIHW, Canberra, 2009.

CACP package recipients were aged 85 years and over, compared to the national figure of 40.6 per cent.

iii. Tasmania's Plan for Positive Ageing

The Tasmanian Government recognises that strategies that support positive ageing and social inclusion may mitigate the impact of an ageing population. The Government's approach to positive ageing aims to enable Tasmanians to remain independent, healthy and socially connected. This approach is outlined in the Tasmanian Government's *Second Five Year Plan for Positive Ageing*, which is available on-line.[6]

2. Findings from previous reviews

Are there findings or recommendations from previous reviews of aged care in Australia that remain relevant? If so, of those that have not been acted on, which are the most important? The commission also invites advice on any international reviews and policy approaches that may be relevant to this inquiry.

The majority of recommendations made in previous aged care inquiries have not been implemented, including the following:

- Reviews of residential aged care funding arrangements by the Productivity Commission in 1999 and Professor Hogan in 2004, both commissioned by the Australian Government;
- Productivity Commission Study into the Economic Impact of an Ageing Population 2004;
- Productivity Commission Health Workforce Study for the Council of Australian Governments, 2005;
- Review of Subsidies and Services in Australian Government Funded Community Aged Care Programs, Department of Health and Ageing, 2006;
- Standing Committee on Finance & Public Administration – Inquiry into residential and community aged care in Australia, 2009;
- Keeping dementia front of mind: incidence and prevalence 2009-2050, Access Economics, Report prepared for Alzheimer's Australia, ACT, 2009.

In formulating its recommendations on this occasion, the Productivity Commission should consider the extent to which recommendations from previous reviews have been implemented and the reasons why implementation may not have occurred.

3. The social, clinical and institutional aspects of aged care

The Commission invites comment and evidence on the main strengths and weaknesses of aged care services — community, residential, flexible and respite care — as they are currently configured.

- Current funding, regulatory and program arrangements underpinning aged care across all settings will not meet the needs of our older population into the future.

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[6] See http://www.dpac.tas.gov.au/divisions/cdd/seniors/tasmanian_plan_for_positive_ageing

- Australia has a rapidly ageing population with shifting demographics. This is a current concern and the effects are becoming sharply apparent, creating increasing pressure on hospitals, mental health services, housing and other services, operated by state and territory governments.
- In the absence of sufficient and accessible aged care services, older people are being prematurely admitted to or spending extended periods in hospitals when residential or community aged care would be safer, cheaper and less stressful.
- The residential aged care service sector is increasingly described as unviable for new or even existing providers due to the lack of economies of scale.[7] Reviews of residential aged care funding arrangements by the Productivity Commission in 1999 and Professor Hogan in 2004, both commissioned by the Australian Government, found that significant structural reform is necessary.
- The aged care workforce is ageing and struggling to be sustainable in an industry perceived as unattractive as a career option and under-funded. To illustrate, as at April 2007, 44 per cent of the Tasmanian Department of Health and Human Services community and aged care nursing workforce were aged 51 years or over, with 77 per cent between 40 and 60 years of age. In a recent review of the Tasmanian Aged Care Assessment Program, the average age of the workforce was 51 years.[8]
- The demand for aged care services is growing and current providers and industry experts claim that choice for consumers is limited by under-funding and unnecessary program boundaries. In the last Commonwealth aged care funding round in Tasmania, there was significant under-subscription for residential places and significant over-subscription for community places. There are long waiting times for residential care in some geographic areas and empty beds in others.
- A significant disparity exists in the viability and availability of aged care services between population centres and country areas, with the Tasmanian Government compelled to subsidise its services in rural and remote areas. For example, the daily subsidy paid by the Australian Government, plus residents' fees, contributed just 29 per cent of the running costs of the aged care beds at a particular State operated facility in rural Tasmania. The comparatively high cost of rural services is of special concern to Tasmania, where 58 per cent of the population lives outside the capital city.
- Managing the ongoing interaction between the demand for aged care and the supply of services in the community sector; the hospital sector; and in aged care residences is a complex task. In addition to the need for the development of a longer term strategic national policy and pricing model for aged care, there is a continuing need to support the types of services made available through the COAG Longer Stay Older Patients Initiative (LSOP) and Transitional Care Program.

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[7] Browne, D "Alarm on Aged Care Services" *The Mercury*, 6 August 2010: http://www.themercury.com.au/article/2010/08/06/164001_tasmania-news.html

[8] Robinson, A and Stirling, C, Leggett, S., Doherty, K., & Churchill, B. (2009). *The Tasmanian Aged Care Assessment Program (ACAP) 2009: A review of the effectiveness and efficiency of the three Tasmanian Aged Care Assessment Teams (ACATs)*. Hobart: University of Tasmania.

- A number of specific weaknesses have been identified that undermine the sustainability of the current model of residential aged care:
  - nursing pay disparities between hospital and residential aged care settings, together with negative perceptions of aged care nursing, discourage Registered Nurses from choosing a career in aged care;
  - shortages of permanent Registered Nurses and increasing use of temporary and agency nurses inhibits the ability of aged care facilities to provide continuity of care, particularly following a resident's return from hospital;
  - funding for and access to allied health care and GP services is insufficient to meet the increasing subacute level therapy needs of a much higher care resident population than in the past;
  - funding is inadequate for the provision of specialised or individualised equipment;
  - residents with dementia require more access appropriate diversional therapy; and
  - those with dementia require earlier diagnosis and co-ordinated care from time of diagnosis through to end-of-life.

Are the aged care services that older Australians require available and accessible? Are there gaps that result in a loss of continuity of care? Is there sufficient emphasis within the current system on maintaining a person's independence and on health promotion and rehabilitation? Should there be greater emphasis on consumer-directed care in the delivery of services, and would this enable more older Australians to exercise their preference to live independently in their own homes for longer with appropriate care and support? How might any inadequacies in the system be addressed?

- The Tasmanian Government acknowledges that the Australian Government has agreed to take on full funding and policy responsibility for aged care as a part of the COAG national health reforms, and makes the following comments in this context.
- Improved flexibility and cooperation is strongly encouraged to manage the care of older persons to ensure a continuum of care truly operates, irrespective of funder or program. Silo funding undermines integration and continuity of care. Prolonged stay in hospital is detrimental to the older person's level and rate of recovery and leads to increased requirement for higher levels of community or residential care.
- Service gaps and overlaps are often noted in the community aged care system, particularly between the Home and Community Care (HACC), CACP, EACH and Veterans Health Care programs. In theory, each program has its own discrete role. The HACC program provides basic level support services to maintain an individual's independence. CACP and EACH packages provide a higher level of community care for individuals who would otherwise require low or high level residential aged care.

- However, in practice, both anecdotal and formal reports show that service gaps and overlaps are common. There is significant variation in the level of services provided under the various program types so that clients in similar circumstances ultimately receive an amount of care that can range from one to 50 hours per week.[9] The gap between funding packages creates problems: the difference in payments between CACP and the EACH package is too large – and often HACC funding is used to fill the gap.

- The current aged care service model is considered unresponsive, overly complex and ultimately unsustainable. Tasmania suggests the Australian Government work in partnership with states and territories, to move towards seamless transitions rather than persist with a model split across high, low or even intermediate care. Service reforms should be aimed at defining service target groups, and facilitating the transition of clients between services in accordance with their needs, rather than by service type.

- The current mix of aged care services needs to be simplified and streamlined with a single access point or pathway to link people with appropriate services. Continuum of care models are suggested as a solution. Case management and service brokerage are also strongly supported by aged care workers. In Tasmania, anecdotal reports from professionals working in the sector argue that case management:

  - enables service providers to respond more quickly to changing levels of need, supporting the most optimal health and social outcomes;

  - has the advantage of allowing easier monitoring and measurement of the outcomes of interventions and services provided;

  - would extend the benefits of integrated portable client records in the future to promote continuity of care between care types and settings;

  - provides clients with easy and immediate access to a key contact to navigate the service system; and

  - is of particular benefit to people with dementia who are living in the community.

- Coordination of service provision and referral is required to discourage 'ownership' of clients and prevent clients being left on waiting lists when alternative services are available.

- While not all people with complex care needs require case management (and some will have carers or significant others who can undertake the role), many require a high level of assistance to organise services, problem solve difficulties and advocate for changes in services.

- Community aged care programs should place a greater emphasis on service models that aim to restore health and prevent acute episodes. Enabling models empower the individual to plan for their own housing and service needs as they age. Such models will be essential to maintain services in the future given the growth in the older population and the longer length of time that they are likely to need support.

- Slow stream rehabilitation and transitional support are important to maximise functional improvement in individuals and facilitate less stressful and more effective movement between hospital and home (including residential care).

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[9] Department of Health and Ageing (DoHA), 2007, *Packaged Care Fact Sheet*, DoHA, Canberra, 2007.

- The commencement of the electronic health care record should allow older people and service providers better access to information to streamline complex care. It should assist in avoiding the duplication of service access and diagnostic tests, decreasing the cost to individuals and service providers.

How well does the aged care system interface with the wider health and social services sectors? To what extent should the aged care system be treated as a separate arm of government policy to other social policies?

- The aged care system does not interface or integrate well with other parts of the system. Even the residential and community aspects of aged care do not integrate or intersect well with each other.
- Better linkages are required between all health and human services. Improvement across all the performance domains of the system could be better achieved if government-funded aged care service programs were integrated and a single access point implemented.
- Aged care policy requires special consideration of the ageing population, increased incidence of chronic disease and a declining workforce.

Is the current system equipped, or can it adapt, to meet future challenges?

- The future demand for aged care services in Australia is expected to grow alongside the ageing of the population. The growing frail aged population will require a corresponding increase in available services. The current system and funding formulas do not meet current demand and will not meet future demand.
- Restructuring and streamlining the current system will go some way toward meeting the needs of people requiring support. It will not, however, address the issue of insufficient funding to meet demand.
- Although residential aged care will continue to play a vital role in meeting the needs of ageing Australians, it is expected that community aged care services will have an increasingly central part to play. The increasing need for more community aged care services is highlighted by the cost benefits of community based health services and the associated prevention of early admission to acute and residential care. It is reinforced by the preference of most people who require support to live at home in the community for as long as possible.
- It is anticipated that in the future there will need to be an overall increase in all current community aged care services. Feedback from Aged Care Assessment Teams (ACATs) suggests that service expansion in programs that provide assistance with personal and instrumental activities of daily living will be the most effective response. Key service areas that impact on admission to residential care, such as continence, mobility and cognition, will need to be given the greatest priority.[10]
- Carers should be provided with greater support in their role, with their needs recognised and met through the provision of counselling, respite (in home and day centre attendance) and education in how to care for the person they are caring for, as well as self-care.

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[10] Patterson, C *Independence: Support for the elderly in their communities: HACC Consumer Consultation Report 2009* Tasmanian Council of Social Services, 2010.

- The introduction of EACH Dementia packages has been welcomed by Tasmanian service providers but feedback indicates that the small number currently available goes nowhere near meeting demand.
- Residential facilities will need to provide a broader nursing and allied health model of care to accommodate an increase in chronic disease in the population.
- Workforce structures will need to be reviewed to ensure their capacity and capability or appropriateness into the future.

Comments are also invited on the current system (and possible alternative arrangements) for providing services to people with special needs, including those living in rural and remote locations, those with culturally and linguistically diverse backgrounds, Indigenous Australians, veterans, the older homeless, older people with a mental illness, those with a disability, and other special needs groups, such as gays and lesbians.

- Unlike most mainland states and territories, where populations tend to be concentrated in capital cities, Tasmania's population is spread across the State. Tasmania has the highest percentage of people living outside its capital city of any state in Australia, with 59 per cent of the population living outside of Hobart.[11]
- This dispersed population has a number of implications for access to health and aged care services. Outside the major centres of Hobart and Launceston, the provision of many health services is more costly. Rural and remote clients often have to travel to access services or wait for health professionals to provide outreach services.
- Tasmania has special needs that arise from its regional status and the geographical spread of its population. Clients living in rural areas simply do not have access to the same extent of basic care services or specialist services, such as Parkinson's Disease nurses, as their metropolitan counterparts.
- Some particular barriers reported by aged care workers in rural Tasmania are listed as follows:
  - Older people and their carers often have very limited choice in the services available to them. There is a clear lack of CACPs and EACH packages in rural areas, which often results in admission to an aged care facility being the only care option available. Access to allied health professionals is also very limited.
  - Transport is a significant issue that impacts upon all community health services provided in rural areas. The need for non urgent medical transport is growing right across the State with existing service providers struggling to meet demand. In the case of CACPs and EACH packages, it has been suggested that providers may be more willing to take on rural clients if there was additional funding built into the package to allow for provider travel costs.

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[11] Resource Planning Development Commission (RPDC), *State of the Environment Tasmania*, www.rpdc.tas.gov.au/soer/recommendation/120/index.php, RPDC, Hobart, 2003.

- Rural clients often do not have an easy point of contact that they can go to for information and assistance about available programs. Program outposts in rural areas, or service brokers who reside locally, would give clients a physical presence in the community, be able to work more closely with local providers and could reduce the cost of travel. The co-location of these workers with existing services would be an ideal solution.
- Residential respite needs to be more available and more flexible in rural areas. This is a particular problem in the North West region of the State.

- To address these types of concerns, it is suggested that future service planning and funding for community aged care services in rural and remote areas needs to be provided in a flexible manner. In some instances, services need to be designed and implemented locally to meet the specific needs of local communities. Planning at the local level should be based on the whole range of resources available in a given community, and give particular recognition to the high cost of travel between clients in isolated areas. Aged Care Approvals rounds, and other planning, should be more closely aligned with the HACC planning and growth management process. Silos of funding should not prevent effective cost efficient care – this is true in the metropolitan areas but particularly in the rural areas.
- Tasmania's small, dispersed population offers little scope to gain economies of scale in service provision. There are other areas around Australia facing similar challenges.
- In residential aged care, small size creates problems of financial viability. Distance adds to those challenges. Unless adequate weightings compensating for size and distance are built into the residential aged care funding model, aged care facilities in regional, rural and remote areas are facing an uphill battle just to stay open.
- There is a concern that small residential aged care services and, in particular rural services, are already not viable.[12] This raises concerns regarding the adequacy of care being provided and the future of such services as well as limiting the potential for clients to remain in a location close to their community.
- Unlike larger states, Tasmania's residential aged care sector is dominated by private not-for profit operators, comprising 87 per cent of all places. Private for profit operators have just 10 percent of the places with the Tasmanian Government needing to provide the remaining 3 per cent of places in very rural or remote areas of the State where both the private for–profit and not-for profit providers are unwilling to operate.
- Regional and rural aged care facilities are often strongly supported by their local communities through fund-raising, donations and bequests. They might even, from time-to-time, attract some one-off funding through a regional community grants initiative. The obligation that they accept, on behalf of their communities, to provide valuable yet under-funded services creates uncertainty and anxiety about their future.
- Recruitment and retention of qualified staff is another growing issue and represents a major risk to the ongoing sustainability of rural services and the level and quality of care that can be provided.

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[12] Vowles, G "Tasmania's Aged Care Crisis" *The Mercury* 18 April 2010.

- The Tasmanian Government operates a number of residential aged care services in rural and remote areas. It has been required to provide substantial additional funding to these services because of the shortfall in Australian Government funding. Support includes a Rural and Remote Allowance, District Allowance, Island Airfare Agreement, Training and Clinical Support, Medical / Clinical Support, Rural Medical Management and Agency Nurse Support.
- The additional costs, predominantly incurred to ensure safe staffing levels and to ensure appropriate quality and safety support, add an additional cost equivalent of 12.8 per cent to nurse salaries over a similar service in a metropolitan area.
- The number of people from a culturally and linguistically diverse (CALD) background assessed by the ACATs in Tasmania has grown steadily over the past ten years from 4.8 per cent of total assessments in 1998-2000 to 6.8 percent in 2008-09. While that figure does not reflect the 14.3 per cent CALD representation in the Tasmanian population of persons over 70 years, the 58.3 per cent growth rate in assessments for aged care is indicative of increasing demand as that cohort ages.

4. Options for reforming the funding and regulatory arrangements across residential and community aged care (including the HACC programme)

i. Objectives of the Aged Care System

How effective has the aged care system been in addressing the objectives outlined on page 15 of the Issues Paper? What changes, if any, should be made to the objectives? What are the implications of such objectives for any redesign of the current system?

Should the objectives have equal weighting or should some have higher weighting, and if so why? Where conflicts might arise, which objectives should be given priority?

Should Australia have an 'aged care system' as currently conceived, or could a broader conception of care and disability policy be more appropriate, with the needs of the aged being one part of this continuum?

- The Australian aged care system was very effective in realising the listed objectives in the past but has had a declining ability to meet those objectives for well over ten years. Reviews of residential aged care funding arrangements by the Productivity Commission in 1999 and Professor Hogan in 2004, both commissioned by the Australian Government, found that significant structural reform was necessary.
- The objectives reflect general principles and should not be weighted. All are equally important as underpinning values for the system.
- In Tasmania, units within the Department of Health and Human Services work together to make sure that home and community care services and disability services are provided appropriately to the people who have the greatest priority. Disability Services, HACC and the ACATs are three separate units that work together to provide a cooperative approach to support independent living, where it is possible and practicable.

- Implementation of the new disability/aged care policy split under the national health reforms will need to consider existing cooperative arrangements like those noted above to ensure that the new responsibility split does not detrimentally affect service provision. Potential impacts to existing non-government organisations that provide integrated services will need to be similarly considered.

ii. Funding Options

Who should pay for aged care services? Are the current government subsidies and user charges for aged care appropriate? Are there components of aged care costs — accommodation, living expenses, personal and health care — that warrant government subsidies and/or should they be the personal responsibility of older Australians? To what extent should means testing be applied?

Under the current system, have differences in user charges for aged care services led to problems or distortions in the demand for services? How appropriate are the current accommodation user charges in residential care (including the regulatory restrictions on accommodation bonds for high care residents)? Do accommodation bonds act as a disincentive to access appropriate care? What has been the effect of allowing payment for extra service? What changes, if any, should be made to user contributions to the cost of accommodation for residential care?

How might the public and private exposure to the financial risks associated with aged care costs be best managed? Should it be a mixed model with a dominant taxpayer funded component (as currently applies), or a system that relies more heavily on consumer contributions underpinned by a financial safety net? This could involve additional or alternative mechanisms such as greater reliance on private savings (including reverse mortgages) or the introduction of private long-term care insurance or a social insurance scheme. If an additional funding mechanism is considered appropriate, should it be for all aged care costs or for particular components of aged care costs?

- Australian Government subsidy levels are insufficient and there are some key risks associated with that under-funding.
- With respect to community care, insufficient funding to meet the assessed needs of the population is often translated into what is usually described as 'unmet need'. Given that there is no mandatory obligation on the part of community care providers to supply any or all of the services that an applicant or client may desire or need, providers will only offer what they can.
- Generally, community care providers maximise provision of services at the expected quality within the funding allocated.
- Due to the non-intrusive and fragmented nature of community care, it is difficult to source reliable data concerning current need for services. Some providers maintain waiting lists for services but these are not a reliable indicator as the applicants on them have often not been assessed for eligibility.
- However, it can be reasonably assumed that unmet need exists through evidence of community care providers with 'closed books' reporting that they routinely turn away, or refer on, eligible older people due to insufficient capacity.
- In relation to residential care, the question of whether funding levels are sufficient to meet the expected quality service provision outcomes is often expressed in terms of business viability or residents' safety and care.

- The residential aged care industry has expressed significant and increasing concern over recent years about the inadequacy of the funding model.
- As the Department of Health and Ageing stressed to the Senate Estimates Hansard: Standing Committee on Community Affairs in 2009, many larger residential aged care providers operate as viable businesses. They manage to reinvest surpluses in improving outcomes for residents, growing their facilities or returning a dividend to their shareholders.
- Industry advice, however, indicates that an absolute minimum of 60 beds are required for business viability. In Tasmania over 40 per cent (16 out of a total of 38) of residential aged care providers Statewide operate 60 beds or less. Between them they have 662, or about 15 per cent, of the beds available across the Tasmanian community.
- Against the widely accepted 60 bed benchmark, the 662 beds located at those facilities must be, at best, marginal and could be regarded as at some considerable risk. Of particular concern is that many of those beds are outside population centres, further limiting local client choice should they be forced to close.
- It is noted that those numbers exclude the 144 beds operated by the Tasmanian Government in communities where historically, there has been low or no interest from non-government providers.
- The Tasmanian Government provides the capital needed, together with substantial subsidies, towards the recurrent cost of making those beds available in communities where the level of Australian Government funding would otherwise make it impossible. The Tasmanian Government supplements Australian Government funded beds by up to 70 per cent in some areas.
- Reforms to user contributions need to ensure that contributions are fair and equitable based on the client needs and ability to pay. Clients and carers should contribute to care costs, but not be denied access to both community and residential care if they are unable to do so.
- An important point to note is that aids and equipment are often funded directly by clients or through packages, which can effectively reduce the value of the package for purchasing direct care services. Supportive equipment and consumables are an important element within any community health service that aims to prevent admission into acute or residential care and should be recognised as such and funded appropriately.
- There also needs to be ongoing assessment of clients' ability to pay fees. Anecdotal reports suggest that in Tasmania there are variations in the criteria used by HACC service providers in their assessment of clients' ability to pay fees. Some HACC service providers review their clients' HACC fee waiver status every six to 12 months. Others may grant clients an indefinite HACC fee waiver status. Consideration needs to be given to a framework for managing waivers and fee reductions (for both the HACC program and packaged care).

- At present, fee structures vary between the different community care programs. This can be a disincentive for people to move to more appropriate support options, especially if the new service charges higher fees. For example, it is often reported that clients will opt to remain with a HACC service even when their care needs would be better met by an Australian Government care package because of increased service costs. Similarly, there is considerable variance across packaged care providers with regard to user contributions, resulting in inequity for clients.

- A balance needs to be reached to ensure equity between areas, client groups and incomes. It would be useful to align user contributions across all programs in terms of clients' level of need (ie. basic, complex). A consistent system across community care, similar to the Centrelink assessment approach used in residential care, is a possible solution. Any system would need to be strictly enforced to ensure industry compliance.

- Under the current arrangements the residential aged care sector receives an accommodation bond for low care residents, but not for high care residents. There is no fixed bond, but the amount of a bond cannot leave the applicant with less than $38,500 in assets (excluding the family home). As bonds are not payable for high care residents it has been argued by some in the industry that this arrangement discriminates against people accessing low care places, and that bonds should be payable for both high and low care.[13]

- For CACP and EACH packages the client may be charged up to 17.5 per cent of their pension. This is significantly higher then the usual fee regimes in the HACC program, which in Tasmania are generally capped at $10.00 per week. As some services, such as community nursing, are not available through CACPs clients may be required to pay for those in addition to their program fee.

- The current user pays system restricts access to early intervention services to those who can afford them, or those who are willing to pay. It also provides perverse incentives to seek sub-optimal care until need becomes acute. Those unable or unwilling to pay for higher levels of support that will prevent residential placement or hospital admission, remain with levels of service that are not optimum for their needs. The consequent deterioration in health and well being is costly - both for the person's welfare and for health services, with avoidable health decline resulting in acute admissions or premature residential home placement.

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[13] S McKeith "Call for capital to head off care crisis" *Australian Financial Review*, Monday 20 September 2010, p.4

How important is the provision of choice for older people requiring care? Are there components of aged care which older people value choice more highly than others? Is there any evidence which suggests that the provision of greater choice may have resource implications? Should subsidies that 'follow' approved clients be paid to providers directly or should care consumers be given the choice of receiving such payments first to promote a greater capacity to exercise choice?

- Regardless of whether adequate services are available to meet demand, service brokerage models are strongly supported for their ability to provide greater choice for consumers and monitoring of outcomes. While it is important to provide choice and 'competition' from a consumer perspective, it should be noted that brokerage models can be more costly.

What are the critical funding implications and concerns arising at the interface of the aged care system with the disability and hospitals systems?

- The pressure on public hospitals to accommodate people waiting for residential placement is anticipated to increase under the current aged care planning and funding arrangements. In 2008-2009 over 500 older people across Tasmania's four main hospitals waited 28 326 (bed) days until they were able to gain access to residential aged care. Using a Productivity Commission hospital acute bed day cost of $1 117[14] the 'notional' cost of that avoidable care to the State's public hospital system was close to $32 million in 2008-2009 and $25.6 million in 2009-2010. The jointly funded Transitional Care Packages and COAG LSOP programs have proved very useful and successful in containing some of the forecast growth in this area.

Are current subsidies sufficient to provide adequate levels of care? What are the minimum benchmark levels of care in each of the service areas and how should they be adjusted over time to meet changing expectations?

What are the most appropriate methods for adjusting public funding, or insurance arrangements, to keep pace with cost increases and changes in any care benchmark, while providing incentives to increase efficiency and productivity?

- The principle that all residential aged care facilities should meet quality service provision outcomes is supported. The Tasmanian Government recognises the excellent standards and accreditation record over many years across Tasmania's facilities.
- However, if the funding for providers from all sources (primarily Government and residents) is insufficient for business viability it is also likely that safety and quality standards will also be at risk of failing.
- The multiplicity of programs, funding bodies and service providers leads to significant confusion not only for consumers but also within the sector. Rationalisation and integration of programs and funding arrangements is critical to simplify access and ensure maximum utilisation of programs.

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[14] Department of Health and Ageing, *Report on the Operation of the Aged Care Act, 1997*, 1 July 2006 to 30 June 2007, p.39.

- A shortage of affordable capital available to providers limits the development of aged care facilities. Difficulty in accessing capital impacts on quality and bed availability, as providers are unable to improve existing facilities, expand to meet increasing demand or enable growth for sustainability.
- Concern is regularly expressed at the inadequacy of both core funding and annual indexation. In 2008-09, the Australian Government's indexation model for residential aged care resulted in the Department of Health and Human Services receiving a base funding increase of close to two per cent while it has needed to deal with a Consumer Price index at over three per cent, health inflation at over 7 per cent and wage increases closer to 10 per cent.
- The subsidy increase is based on the combination of the Consumer Price Index and the Safety Net adjustment. This does not reflect the increase in cost to the industry, whose business costs are strongly weighted towards wages, and will not be able to gain the level of efficiencies in production costs to which some other industries have access.
- The true costs of service delivery need to be established to support the development of a more responsive pricing model across both the residential and community care sectors. This should be undertaken with a standardisation of client payments taking into account equity and transparency factors.

iii. Regulatory options

Is the current level and scope of regulation and its enforcement appropriate?

What impact does the regulation and its enforcement have on older people, their carers (including access to, and quality of, care) and providers (including their business models and size of their operations)?

Are the rights of aged care consumers adequately protected and understood? Are complaints and redress mechanisms accessible, sufficient and appropriate for all parties?

Do current regulatory arrangements act as a disincentive to older Australians wishing to move to more suitable accommodation (such as eligibility for the age pension and the imposition of stamp duty on the sale of property)?

What specific regulatory reforms could address the concerns listed above? How would the reforms improve outcomes for users and providers of aged care services while maintaining appropriate control of quality and safety?

Where multiple regulatory instruments are seen as requiring joint reform, which reforms should take priority? What scope is there to reduce duplicative regulations (for example, the dual gatekeeping mechanisms imposed by the ACAT assessment and the allocation/planning system)?

Comments are sought on the lessons that can be learnt from aged care reforms and systems internationally and the extent to which that experience is relevant to Australia.

- In the recent Australian Institute of Health and Welfare report, *Cutting the Red Tape*, a National Community Services Data Committee examined the problem of multiple reporting by providers of community services.[15] The findings in this report demonstrate that community service providers are experiencing an increased data collection and reporting workload due to:
  - the requirement of program-centred reporting for service providers to use separate, program provided data collection forms and/or software resulting in the service provider recording and reporting on the same client on multiple occasions; and
  - the lack of electronic data capture, storage and reporting systems in the community services sector which would give providers the capacity to record data once, from which multiple reporting could then occur.
- In Tasmania, community aged care service providers commonly report these kinds of difficulties. Peak bodies in the aged and community care sector argue that the various community care programs have created separate reporting requirements and different eligibility rules for each.[16] Often the same organisations provide a mix of community care programs and must complete multiple sets of very similar information in order to satisfy the reporting requirements of their various funding bodies. These requirements duplicate administrative costs, taking funding away from direct service provision, which in turn threatens the provision of quality services.
- A possible solution to these problems will be the introduction of a common reporting framework for community care. Aged care workers argue that a framework in line with the HACC Standards might be useful. This would assist those providers who have accountability for a mix of Australian Government and HACC funded programs. The HACC quality model more clearly identifies expectations and benchmarks than does the quality reporting process for packaged care. Standardisation of quality approaches across all aged care programs would be welcomed by providers.
- Another possible means of reducing the reporting burden would be standardised or compatible information software across aged care programs to reduce the number of times the same data is provided, entered and reported by service providers.
- Integration of data systems across the aged care sector: residential, community; primary health, sub acute and acute services would assist to reduce duplicated effort and the administrative burden as well as increase the opportunity for service continuity. In Tasmania, the Department of Health and Human Services has recognised the need to invest in this area. Improved IT infrastructure would not only ease the reporting burden in HACC but also facilitate better communication between services providers (both internal and external) through the sharing of information. Improved data collection would also enable a more strategic approach to planning for the future delivery of services. It is believed that other aged care programs would benefit from improved IT resources in a similar way.

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[15] Australian Institute of Health and Welfare (AIHW), *Cutting the Red Tape: Preliminary Paper Detailing the Problem of Multiple Entry and Reporting by Service Providers*, AIHW, Canberra, 2006.

[16] Department of Health and Human Services (DHHS), Caring for Ageing Tasmanian's: Project Background Paper, unpublished, 2006.

iv. Roles of the different levels of government

Will the announced changes in government roles and responsibilities benefit aged care users and improve the administration of the aged care system? Will the changes facilitate greater integration in the delivery of support and care services? In particular, what will be the implications for the administration and delivery of HACC and community care packages? Should common system entry points and assessment be developed, and if so, what are the opportunities and risks?

What issues remain to be addressed? Should there be further reforms to the way in which the system is administered? What are the net benefits that such reforms might deliver?

What are the possible medium and long-term fiscal impacts of such administrative reforms?

Examples and evidence are sought of administrative reforms that have delivered improvements to related areas such as health and disability services in Australia or internationally. Views on the extent to which such reforms may be transferable to the aged care system are welcome.

Comment is sought on issues and potential solutions at the interface of the aged care system with other regulated services systems, including the hospital and disability care systems.

- Further clarification of the national health reforms will be required to understand the impact on service providers, consumers and their families.
- The changes in government responsibility for aged care provide an opportunity for administration of the system to be streamlined. There is concern that the recommendations resulting from the 'Review of Subsidies and Services in Australian Government Funded Community Aged Care Programs, Department of Health and Ageing, 2006' were not implemented.
- The impact on the administration and delivery of HACC and community care packages cannot be assessed until further information is provided detailing the Australian Government's direction in the operational management of these programs.
- Opportunities clearly exist to further integrate HACC into the broader community care system but this must be carefully managed to avoid disintegration at the local level.
- Single access point and assessment are required to simplify entry into aged care services. Tasmania has already expanded to a statewide single entry point for HACC services. This single access point is providing significant benefits for clients and referral agents as well as improving information about how clients move around and within systems.
- While common entry and assessment processes are supported, it is critical that these act as enablers to accessing services and not become access blockers. The problems seen in gaining entry to Australian Government programs through the ACAT gateway must not be repeated or continued under the new national system.
- Case management and Advanced Care Planning are required to co-ordinate care across aged care and other health sectors.
- Central to the Tasmanian Government's management of long stay older patients has been the development of multidisciplinary Residential Aged Care Liaison Teams within each area of Tasmania, consisting of medical, nursing and allied health professionals. These teams, funded partially through the COAG LSOP initiative, have been valuable in

working closely with providers of residential and community aged care in facilitating discharge from hospital or avoiding unnecessary admissions.

- The COAG LSOP funded hospital aged care liaison teams have improved movement through the system through the provision of case management, referral and discharge planning to enable clients to access appropriate pathways in a timely way when leaving hospital.

5. Future workforce requirements of the aged care sector

What are the key issues concerning the current formal aged care workforce, including remuneration and retention, and the attractiveness of the aged care environment relative to the broader health and community care sector?

Views are sought on reform options to secure a larger, appropriately trained and more flexible formal aged care workforce into the future. In particular, views are sought on the need for and nature of reforms to models of care, scopes of practice, occupational mix, service delivery, remuneration, education, training, workforce planning and regulation.

Are reforms required to more appropriately support informal carers and volunteers?

Are there unexploited productivity and efficiency gains in the aged care sector? Where such unexploited gains are seen to exist, what policy changes are needed to support their realisation? How might technology be used to enhance the care of older Australians? Are there any impediments to technological developments that could ease workforce demand or enable higher levels of support?

- Industry leaders regularly note that aged care has a relatively unattractive image among nursing graduates and is perceived as an undesirable work environment. Aged care is perceived to be an unappealing career choice.
- On the other hand, advocacy bodies and unions regularly call for improvements in working environments in aged care facilities, particularly the reintroduction of adequately staffed shifts, appropriate ratios of Registered Nurses to residents, better access to GPs and allied health professionals and increased availability of activities for residents.
- While the increasing proportion of frailer, high care residents indicates a need for more highly trained Registered Nurses and a nursing model of care in preference to home style model of care, the industry maintains that aged care facilities are not sufficiently funded to provide that level of care.
- A significant shortage of Geriatricians exists nationally, particularly outside the major population centres.
- Pay disparities between hospital and residential facilities are an aged care workforce disincentive.
- The Aged Care Assessment Program workforce experiences difficulty recruiting staff due the complex regulatory requirements of the program. Consideration needs to be given to transferring the knowledge and experience of the ageing workforce to the next generation of employees.
- The need for specialised and individualised equipment and assistive technology has increased in residential facilities.

6. Transition from the current funding and regulatory arrangements to a new system

What lessons should the Commission draw from previous reforms of aged care systems (in Australia and overseas) to minimise adjustment costs faced by older Australian and their carers, providers, aged care workers and governments of moving to a new system?

Views are sought on desirable timing and sequencing of transitional arrangements, including any changes to existing regulatory and funding settings, and on alternative or additional mechanisms that may be required to facilitate a smooth adoption of a new aged care system.

- The extensive residential aged care reforms in Australia during the 1980's were largely successful due to comprehensive consultation across the sector in relation to each component of the reforms together with well planned and industry supported education and training over a reasonable timeframe.
- The details concerning timing and transitional arrangements should depend on the extent and complexity of the changes. A conservative rather than ambitious timeframe is recommended as a general principle. Needlessly rushed reforms are often opposed by industry stakeholders and aged care users and communities. Even apparently positive changes, such as some proposed in the late 1990's can fail in this way.
- The timeframe for the Australian Government to assume responsibility for the HACC program is ambitious. It is recommended that consultation with the states and territories should commence as soon as possible if the timeframe is to be met.

7. Retirement specific living options

The Commission seeks comment on the regulatory and financial issues facing retirement villages. How do retirement specific living options interact within the broader aged care system and what changes are expected in both the number and structure of villages over coming years?

Should the regulation of retirement specific living options be aligned more closely with the rest of the aged care system?

Are there any factors that act as a barrier to older Australians entering retirement specific living options (such as opportunities to age in place and departure fees)?

And, more generally, is the way the retirement village sector operates compatible with an ageing population, including in regards to quality, clients' expectations and as a platform in which to receive aged care services?

Are there particular models of retirement specific accommodation that are suited to the provision of social housing to meet the needs of low income or disadvantaged older Australians?

- The *Retirement Villages Act* 2004 (Tas) does not apply to any building or part of any building in a retirement village that is used for the provision of residential care within the meaning of the *Aged Care Act* 1997 (Cth) by an approved provider.
- This provision allows for a clear line of distinction between the formal provision of aged care and retirement villages and is intended to ensure that there is no conflict between the relevant Commonwealth legislation and the Tasmanian *Retirement Villages Act* 2004.

- Nevertheless, the interaction between retirement villages and the provision of services to aged persons is complex and this separation may be largely artificial. There are a number of retirement villages in Tasmania which exist in various forms. While the *Retirement Villages Act* deals largely with the formation of, and the procedures around the performance of a residence contract, it is common that a number of other services are provided either by the retirement village operators or within the framework of these contractual arrangements.

- There is certainly a need for a formal analysis to determine whether there are provisions within the *Retirement Villages Act* that impede the provision of aged care services or whether the Act could be strengthened to support such services.

- There has been an historical issue with ingoing contributions to retirement villages. While there are rules in the act that provide for refunds in certain circumstances, there are problems with delays when persons transfer from a retirement village to a nursing home or hospital environment. The key objective of the regulation in this area is to ensure fairness and transparency. However, the purpose and the relationship of an ingoing contribution to weekly rental is often unclear. Occupants of retirement villages should be able to compare their payment arrangement (including the return value of a contribution) with the current commercial value of the property. There is scope, notwithstanding the provisions of the existing Act, for greater transparency and better rules of disclosure.

- A key issue that underpins the retirement villages market is commercial viability. A number of retirement villages are managed by community organisations and run on limited budgets for the benefits of the residents and the community generally. However, other are managed as commercial operations and are responsible to boards to return a profit. There have been a number of collapses in recent times, the most notable recently being Village Life. There are concerns about the recovery of ingoing contribution in the event of collapse and about the security of tenure of residents. This is an issue that other jurisdictions have explored. However, it is difficult to ensure profitability in any market and security of tenure remains a concern for residents of retirement villages.