KinCare

5 May 2011

Mr M.C. Woods
Presiding Commissioner
Productivity Commission

Via email

In-Home Care Specialists

Dear Mike,

Thank you for the opportunity to meet with you in Brisbane on Friday 25 March 2011, and share our perspectives on the future of Aged Care Services in Australia. As discussed at that time and in our written response to the draft report we are broadly supportive of the directions proposed. Please find following the additional information I promised to provide after our meeting.

1. Integration with Health Services – Section 2 Overall response

The vision we have for integration with health services is that many services currently provided in a hospital environment could in fact more efficiently be provided in the community. In our discussion I used continence as an example and you suggested that as far as possible it should be managed in the community but then be escalated to a hospital for specialist support when required. This is often possible subject to sufficient funds being available in the client's package, which can depend on the number and complexity of other services they require.

What we are seeking over time though goes beyond this. We are exploring ways that more specialised levels of support can also be provided in the community. There will need to be further research on the feasibility and efficiency of doing this condition-by-condition, but overseas research is promising. It is not important to define what all of these health conditions may be at this stage, but is important to begin developing a suitable funding environment.

Separating health services from some of the other services being provided in a client's care as proposed in the draft report would be a useful step. A variety of health services could be explicitly funded in the community. This could start with services already provided in packaged care and gradually extend to more complex services presently only provided in hospital environments. This could ultimately include things like the management of heart disease and cancers in the community. Community care services with specialist nursing and allied health staff would deliver complex services in the client's home using telemedicine infrastructure and working closely with the client's GP and medical specialists. There should be an expectation that an increasing range of health services will be provided in the community and appropriate funding mechanisms to achieve this. Aged care services should become an alternative to services presently only funded in hospitals. Community care can become an alternative to hospital infrastructure in some circumstances in the same way it has become a strong alternative to residential aged care for many clients.

T 1300 733 510
F 1300 733 520
www.kincare.com.au

PO BOX 218
DEAKIN WEST
ACT 2600

PO BOX 7607
BAULKHAM HILLS BC
NSW 2153

PO BOX 257
MULGRAVE
VIC 3170

PO BOX 237
APPLECROSS
WA 6953

2. Consumer Co-Contributions – Section 6 of report

Our preference is a system in which co-contributions are not regulated to the extent proposed. We accept that a client can choose to have additional services outside of those approved for government funding. However the Aged Care Act and regulations provide protections for consumers that go beyond normal consumer protections for other types of service. We see this as valuable for clients in a context in which very vulnerable people are receiving services into their own homes. If consumers cannot elect to stay within the regulated system when receiving services of this kind it would be beneficial to consider adding some consumer protections in other ways for vulnerable older people receiving services in their homes.

There are government funded services in other sectors that follow a model of having a base government-subsidised fee that attaches to a client for a particular service, but that allows each service provider to tailor services to their market and to set their fee based on the features of the service they provide. This is common in the medical field. For example, GPs, psychologists and certain allied health services can claim a fixed fee for services from Medicare but are not restricted in the co-contribution they can charge. This gives them flexibility to tailor services to their market above a regulated minimum standard. Many GPs for example choose to bulk bill and meet the minimum standard with no client co-contribution. Others offer additional features such as more personal and longer consultations and charge above the Medicare rebate for the value they provide. Similarly in private education, government funding attaches to each student attending a school, but this does not restrict the school from choosing their market positioning, the features they will offer to students and parents and the price they need to charge to deliver that service. Over-regulation of pricing can inadvertently limit innovation and additional features and offerings

3. Funding of Supplements – Section 8 of report

During our discussion you asked me to provide the specific reference from the report that created our concern with the funding of supplements. Please refer to page 236 of the report in Box 8.2. The second dot point indicates that, "the funding that would be allocated will only be directed at the 'marginal' cost in these areas over and above what is already taken into account in the base layer payment". In our discussion you indicated payment levels for services would be transparently and independently set on a full cost-recovery basis that included consideration of the cost of capital and a reasonable return on investment. However, this dot-point may indicate otherwise. Our concern is that we believe an increasing array of health services should be funded in the community. These logically align well with the 'supplements' proposed. However, as these could become a greater and greater percentage of the total funding for a given client as community care providers pick up services previously provided in hospitals, funding them at marginal cost could make services unviable and stifle investment and innovation over time. The supplements need to be funded on a full-cost recovery basis including cost of capital and a reasonable return on investment in the same way as base services.

A simplified illustration of this is provided in the table below. This illustrates what occurs as a supplement funded only at the direct marginal cost of the supplement increases as a percentage of the overall service. The numbers in the model are arbitrary for the purpose of the illustration and for the purpose of simplicity assume the overhead is the same for managing a supplement as for managing a base service (this is a reasonable assumption as while the supplements add volume, they tend to be more administratively complex, requiring more highly skilled staff, systems, governance, etc.). All base services and supplements need to be funded at the full cost of providing those services.

Base Fee	$	15,000.00	$	15,000.00	$	15,000.00
Supplements	$-		$	1,000.00	$	25,000.00
TOTAL	$	15,000.00	$	16,000.00	$	40,000.00
Gross Margin on Base		30%		30%		30%
Gross Margin on Supplement		0%		0%		0%
Gross Margin $	$	4,500.00	$	4,500.00	$	4,500.00
Operating Overhead		20%		20%		20%
Operating Overhead	$	3,000.00	$	3,200.00	$	8,000.00
Net Margin/Loss$	$	1,500.00	$	1,300.00	-$	3,500.00
Net Margin/Loss %		10.00%		8.13%		-8.75%

You will see in this example that even with a $1,000 supplement funded only at its marginal cost an organisation's margin in this scenario would drop from 10% to 8%. If the supplement becomes a very significant proportion of the service as in the third scenario, the organisation's overhead would not be covered and the organisation would be in a loss-making position. The more complex an individual client or complexity across an increasing number of clients or services could lead to organisations becoming unviable. Bear in mind that this scenario uses arbitrary figures and that in reality the position is probably worse as most aged care and community care providers actually currently operate on much smaller margins and already experience viability issues in some services.

Given our discussion in the meeting it is possible we are misunderstanding what this statement in the document intends. However, given we strongly advocate an increasing number of supplements and complexity of services being managed in the community this is an important issue to be clarified to ensure services remain viable.

Thank you for the work of your team in preparing such a well considered proposal for the future of the industry. We look forward to working with you and the government to explore ways to implement these changes over coming years.

Wishing you all the best with the enquiry and final report and we await the release.

Yours sincerely,

Therese Adami
General Manager