

Catholic Health Australia

**Supplementary submission in response
to the Productivity Commission's draft
report: *Caring for Older Australians***

April 2011

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About Catholic Health Australia

21 public hospitals, 54 private hospitals, and 550 aged care facilities are operated by different bodies of the Catholic Church within Australia. These health and aged care services are operated in fulfilment of the mission of the Church to provide care and healing to all those who seek it. Catholic Health Australia is the peak member organisation of these health and aged care services. Further detail on Catholic Health Australia can be obtained at www.cha.org.au.

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Introduction

This supplementary submission arises from an invitation by the Productivity Commission, following Catholic Health Australia's (CHA) appearance at public hearings on the draft Report *Caring for Older Australians* on 5 April 2011, for CHA to provide information to the Inquiry on the following issues:

- financial assistance for smaller residential aged care providers to help them adjust to the proposed reforms to aged care;
- the delineation of regional boundaries under the reform proposals; and
- the inclusion of an early intervention, independence and wellness focus in an entitlement based aged care system.

2. Adjustment assistance for smaller residential aged care providers

In CHA's response to the Commission's draft Report, it was noted that:

- the current system for the allocation of rationed residential aged care services (the Aged Care Approvals Round) effectively fostered the current service profile which is characterized by a large number of small approved providers, many of whom were able to enter the market with the assistance of more widely available capital grants; and
- many smaller approved providers are already under pressure from rising standards and regulatory requirements, the increased acuity of residents, higher quality assurance and governance requirements, and the increased availability of community care.

These pressures would be increased by the implementation of a more market based aged care system, with many small residential approved providers reaching a 'tipping point' which will necessitate a reassessment of their future in the sector.

Accordingly, CHA considers that there is a case for the provision of one off adjustment assistance for eligible smaller residential approved providers in order to smooth the adjustment process. As well as assisting smaller providers, a more orderly adjustment process would benefit consumers, regulators and the Government.

We suggest that an adjustment assistance program could operate within the following guidelines.

Objective:

To reduce the risk of service disruption for consumers through a more orderly reform process by targeting adjustment assistance to smaller approved providers of residential aged care whose viability is threatened by increased competitive pressures and greater consumer choice of services.

Method:

One off financial assistance to smaller approved providers of residential aged care to help meet the cost of obtaining the business planning advice needed by owners and managers to assess their future options and prospects in a more flexible entitlement-based aged care system in an uncapped supply environment, including possible changes to their business models, or merger, transition or partnership arrangements, or managed closure.

Eligibility:

The characteristics of approved residential care providers who may come under viability pressure as a result of the reforms are set out below. These could provide the basis for the eligibility criteria.

- EBITDA in the third or fourth quartile
- at least 50% of the building infrastructure is more than 15 years old or the accommodation does not meet the basic standard for supported residents
- less than 100 beds and up to two approved residential services
- evidence of inability to adjust to competitive pressures, such as declining occupancy or an unsustainable business model (eg a hostel configuration which is unsuitable for high care).

Boards of management of approved providers would be able to make submissions for assistance which address the objective of the adjustment assistance and indicators such as the above, with each application judged on its merits.

Quantum: A modest Commonwealth contribution, matched dollar for dollar by the approved provider.

Duration: Could be applied for at any time during the transition period, currently foreshadowed to be about 5 years.

3. Delineation of regional boundaries

The current highly regulated aged care system has a large proportion of its regulatory functions dependent on regional structures, which in turn has necessitated the creation of dedicated Aged Care Planning regions under the *Aged Care Act 1997*. In contrast, the reformed system proposed by the Productivity Commission will have relatively limited dependence on regional structures.

In this regard, CHA understands that the use of regional constructs to support the proposed reforms may relate only to the following functions/activities:

- the regional Hubs of the proposed Seniors Gateway Agency;
- setting regional quotas for supported residents;
- setting prices for the basic standard of accommodation for supported residents based on regional costs of supply; and
- setting the price for scheduled care services in those areas where there are pressures on the cost of service delivery, for example, as a result of remoteness or labour market constraints and pressures.

A feature of the above is that the functions/activities requiring regional constructs are relatively discrete and distinct, and would therefore not be easily captured by a single set of criteria for determining uniform regional boundaries. For example, the primary criterion for delineating regions for regional quotas would be to include areas whose population exhibits a fairly consistent socio economic profile. The regions used for setting costs of accommodation supply, on the other hand, would embrace areas with characteristics that would influence building construction costs in a consistent manner.

Another important consideration is with whom the function/activity being facilitated through a regional construct interfaces. For example, the setting of regional quotas is a matter between the funder and the provider, with no direct interface with the consumer. On the other hand, the regional Hub has to interface not only with the consumer and service providers, but also relevant health service organisations and Centrelink.

Because the above functions/activities are relatively discrete and independent, it is reasonable to conclude that delineating common regional boundaries which embrace all of the above may not be the most practical approach, or indeed necessary.

On this basis, the following discusses what might be the most appropriate regional delineation for each of the functions/activities.

Regional assessment Hubs of the Seniors Gateway Agency

The activities of the regional Hubs will require an interface with the public, aged care providers, local health service providers and health organisations (such as Medicare Locals and Local Health Networks), and Centrelink.

The interface with Centrelink can be discounted for the purposes of boundary delineation as the relationship will simply be an electronic link with Centrelink to perform a 'back office' administrative function which does not involve ongoing relationships with other parties.

Similarly, boundary considerations would not seem to be very relevant to the Hubs interface with the public. This view assumes that:

- most information about aged care services would be provided over the phone or online, with hard copy information also available in various existing well known public places. This reduces the dependence on a shop front;
- initial comprehensive assessments will involve home or hospital visits by Hub assessors;
- basic assessments will involve a combination of over the phone assessments and assessments by service providers;
- the more important consideration is not the regional boundary itself, but rather the distribution of care assessment staff within a region to facilitate timely assessments;
- the number of shop fronts and their location within any region would be a function of accessibility considerations and expected demand for services, and would not necessarily be limited to one site.

This leaves the interface with aged care service providers and other health service organisations.

In an ideal world, administrative arrangements such as regional boundaries should facilitate better coordination and cooperation with the delivery of the continuum of health and aged care services. In the Australian context, this would best be achieved by ensuring that the regional Hub boundaries coincide with those for Medicare Locals and Local Health Networks. Unfortunately, however, this is not possible at this time in all cases because the boundaries of the latter are not always aligned. Where this is the situation, a choice will need to be made between the two depending on local circumstances.

On balance therefore, the primary determinate for the delineation of regional Hub boundaries should be to achieve maximum congruence with the boundaries of Medicare Locals and Local Health Networks in order to increase the potential for better coordination and integration of health and aged care services.

In all cases, it would be essential for statistical analysis purposes that the boundaries fit with/aggregate to the geographic areas defined by the Australian Bureau of Statistics (ABS) under the Australian Standard Geographical Classification.

Regional quotas

The setting of regional quotas is a discrete regulatory activity between the funder and approved providers. This function is critically dependent on the availability of accurate and timely socio economic data, and the ability to group together populations with consistent socio economic profiles so that the quota is realistic across the region.

On this basis, it would make sense to delineate regional boundaries specific to this function based on aggregations of the Australian Bureau of Statistics' Statistical Divisions and Statistical Sub Divisions which most effectively group populations with similar socio economic profiles.

Regional prices

Under the proposed reforms, an independent pricing authority will set regional prices for the basic standard of accommodation for supported residents which reflect the local cost of supply.

Again, this is a very discrete regulatory activity which sets the level of payment provided by the Government on behalf of supported residents. The factors which will influence local costs of supply will mainly revolve around remoteness and how economic conditions (supply and demand) play out over time in different parts of Australia. As these factors have little bearing on the other regulatory factors discussed above, it would be appropriate for the independent pricing authority to develop regional boundaries specific to this purpose.

Because the analysis behind the setting of prices will, in part, have regard to data collected by the ABS, it would be logical for the independent pricing authority to set regional boundaries having regard to the statistical areas used by the ABS, including the delineation of remoteness contained in the ABS Australian Standard Geographical Classification. It is noteworthy that, in setting its statistical boundaries, the ABS aims to create relatively homogeneous regions characterized by identifiable social and economic links within the region, under the unifying influence of one or more major towns or cities. This homogeneity is likely to be conducive to creating regions with relatively consistent building cost drivers.

The independent pricing authority will also have a role in setting prices which reflect the additional cost of service delivery in rural and remote areas. It would seem logical that, for this purpose, the authority would have regard to the delineation of remoteness contained in the ABS Australian Standard Geographical Classification.

4. Early intervention, independence and wellness in an entitlement based system

As we indicated in our response to the Commission's draft Report, we consider that the Commission is correct to highlight that the aged care system of the future should include a focus on early intervention and promoting independence and wellness in order to enhance personal wellbeing and to reduce the need for expensive ongoing services.

When considering independence and wellness approaches, it may be useful to distinguish between episodic short term early intervention and restorative care measures and the incorporation of wellness and independence philosophies within the ongoing provision of care and support. While not denying the importance of the latter, available research suggests that there is particular benefit to be gained through short term and timely intervention, education and assistive technologies.^{1 2 3} The

¹ Ryburn B, Wells Y and Forman P *Enabling Independence: Restorative Approaches to Home Care Provision for Frail Older People* (Australian Institute for Primary Care 2009)

references by CHA in earlier submissions to ‘enablement teams’ were focussed on short term interventions, recognising however that, depending on each individual’s ageing journey, an individual may be referred for short term restorative care more than once.

In our submissions to the Commission, we also identified that a major barrier to greater use of early intervention and independence approaches, both short term interventions and as part of a philosophy of ongoing care delivery, is the fragmented nature of the current provision of basic care and support through the Home and Community Care Program (HACC).

Under current funding arrangements, each of the approximately 3,300 organisations providing HACC services is limited to providing contracted quantities of specified services within a capped budget which constrains their flexibility to tailor services to the needs of each care recipient and carer, including applying appropriate early intervention and independence strategies. Understandably, such arrangements tend to encourage a service delivery culture which is focussed on managing inputs and outputs, and is less conducive to innovation in service delivery aimed at maximising independence and wellness.

This culture is further reinforced by the relative absence of assessments tools which drive an early intervention and restorative approach, and the relative absence of reporting and accountability requirements which focus on client outcomes (as opposed to quantities of services delivered).

This suggests that a key requirement for achieving wider use of early intervention and wellness and independence approaches is to foster the emergence of a number of larger basic care and support providers with the flexibility to tailor services to each individual’s needs.

The following canvasses some other considerations which are relevant to pursuing short term early intervention and restorative care strategies within an entitlement based system.

The primacy of consumer choice

An important issue is the extent to which consumer choice of services should have primacy, or whether there is a role for assessors to provide information and guidance to ensure that service selection is consistent with independence objectives.

CHA’s view is that consumer preferences should be tempered by guidance through information sharing and consultation to ensure that effective early intervention and restorative care measures are taken up. A proactive preventative approach is not only beneficial to the individual, but also important to the sustainability of the overall aged care system and to give confidence to the community that the new arrangements will reduce long term costs and make the reforms more affordable.

The provision and acceptance of guidance, and the avoidance of ongoing service costs, would be helped if the short term early intervention and restorative measures were exempt from co contribution requirements.

Assessment arrangements and tools

The inculcation of an early intervention and an independence and wellness culture will require the inclusion of appropriately trained staff in assessment teams, irrespective of where they are located, and the development of assessment tools which identify, as a matter of course, opportunities for early intervention and restorative care and support.

² Windle K et al *National Evaluation of Partnerships for Older People Projects Final Report* (The Personal Social Services Research Unit December 2009)

³ Lewin G and Vandermeulen S *A non-randomised controlled trial of the Home Independence Program: An Australian Restorative Programme for Older Home Care Clients* (Health and Social Care in the Community 2010)

Funding classification system

Another consideration is how an early intervention and independence approach is accommodated within an entitlement based funding classification system for an integrated system of care provision.

There appear to be three funding options:

- Introduce funding bands or packages for basic care and support, similar to that which currently applies in residential and community care for the frailer aged.
- Allow providers full flexibility to tailor services to each individual based on assessed needs, including early intervention services aimed at greater independence, within a fixed or uncapped budget.
- Separately block fund short term early intervention and restorative care.

A packaged care approach to short term interventions is not favoured because the range of short term activities and services that could be in scope would not lend themselves to inclusion in a range of defined funding packages.

On balance, CHA would favour a block funded approach as it allows for greater flexibility while lending itself to greater accountability through electronic care records, and the use of co contribution policies which would encourage participation in early intervention activities.

Role of the regional Gateway Hubs

One option is to give the regional Hubs primary responsibility for assessing for, planning and coordinating the delivery of short term early intervention services. Upon completion of the short term intervention, individuals would be referred to the provider of their choice to receive any ongoing care and support.

This option has the advantage of locating responsibility for a significant portion of the enablement function within a single accountable entity, separate from the service provider function. A possible downside of this approach, however, is that it may lead to service backlogs due to capacity constraints, noting the wide scope of functions envisaged for the regional Hubs, and some overlap in responsibilities.

An alternative approach is for the regional Hubs to refer individuals assessed by the Hub as having the potential to benefit from short term early intervention to selected agencies who would in turn use their enablement/case management teams to plan and arrange the delivery of the appropriate services. Their role would include coordinating the provision of home modifications and aids and supports for carers. The Leading Agency concept canvassed in Appendix B of the Commission's draft Report provides a good model for the use of selected agencies.

A concern with this approach could be that there would be insufficient separation between assessment and service provision. An implication may be that the Leading Agency is then well placed to be the provider of any ongoing services that may be required, and may lead to client capture concerns. On the other hand, clients will be free to choose their provider of ongoing services.

To ensure accountability, performance audits of electronically held data would be necessary to monitor outcomes.

Overall, the latter approach would appear to be the more efficient approach.

Sub acute care and Day Therapy Centres

The delivery of early intervention and restorative care strategies aimed at improving independence requires a depth and spread of skill sets which could more effectively be achieved if they were deployed within selected larger agencies, such as Leading Agencies, rather than being thinly distributed.

One option for achieving greater depth in skill sets and economies of scale would be to reconsider the role and distribution of the current Commonwealth-funded Day Therapy Centres. The skill sets and resources in these Centres could become an integral part of assessment/enablement teams in Leading Agencies.

In earlier submissions, CHA also referred to the advantages of allowing aged care providers to compete for the delivery of case mix funded sub acute services. The collocation of such services with Day Therapy Centres (and Transition Care services) would produce a depth of appropriately skilled teams to drive short term early intervention and restorative care services, which could cater for both post acute referrals and referrals direct from the community via the regional Hubs.

The identification of Leading Agencies

A model for delivering basic care and support based on Leading Agencies faces the issue of how such agencies are identified or emerge, noting the fragmented nature of current service delivery arrangements in most areas.

Under an entitlement approach with consumer choice of provider, such agencies may emerge as consumers exercise their right to choose their provider of care services.

Under CHA's preferred model of block funded short term intervention services, one option would be for the funder to identify services which could best perform this role eg through a tender arrangement. This could include re-tendering for Day Therapy Centres at the same time, and increasing overall funding for Day Therapy services.

As noted earlier, there would have to be robust accountability requirements to ensure that restorative care is being effectively pursued.

Research

It is worth noting the current debate as to whether all older people would benefit from an enablement approach, or whether the benefits are greater for selected clients. Further research in this area needs to be encouraged.

Summary

CHA considers that a short term early intervention and restorative care approach within an entitlement based system could take the following form:

- Block funded to allow greater flexibility and the application of co contribution policies which would encourage consumer participation in short term intervention strategies, supported by performance monitoring through auditing of de-identified electronic care records.
- Delivery through Leading Agencies on referral from regional Hubs of the Seniors Gateway Agency.
- Incorporation of the current Day Therapy Centre program funding, expanded as necessary, into the restorative care function of the Leading Agencies.

- Allow Leading Agencies to compete for sub acute and transition care services funded on a case mix basis.

This approach should be complemented by the adoption of wellness and independence philosophies within the day to day administration of ongoing care and support services.

There is also a need for further research to identify populations with the potential to benefit from early intervention approaches, and to assess the relative effectiveness of different early intervention and restorative care measures and models.

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