27 May 2010

Christine McDonald
Secretary
Senate Standing Committee on Finance
and Public Administration
Parliament House
CANBERRA ACT 2600

Dear Ms McDonald,

Inquiry into COAG Reforms Relating to Health and Hospitals

Aged and Community Services Australia is pleased to make the attached submission to this Inquiry. Aged and Community Services Australia (ACSA) is the national peak organisation representing around 1,100 church, charitable and community based organisations providing accommodation and care services to more than 700,000 older people, people with a disability and their carers.

ACSA believes that the proposed COAG reforms represent an important opportunity to address longstanding issues in the delivery of aged and community care services. It is important for the well-being of older people and for the delivery of high quality services that meet their needs and preferences, that Australia takes this opportunity and makes the effort required to get the reforms right.

We therefore welcome this Inquiry and would be pleased to discuss our submission further with the Committee should they be so minded. Our comments focus on those Terms of Reference which most directly relate to aged care.

I can be contacted on 03 9686 3460 if there are any questions or if further information is required on any of the points we have raised.

Yours sincerely,

Greg Mundy
Chief Executive Officer
Aged and Community Services Australia

INQUIRY INTO COAG REFORMS RELATING TO HEALTH AND HOSPITALS

Introduction:

There is a pressing case for reforming Australia's health and aged care system. While its components are generally of world class quality, there are issues that need to be addressed. Importantly the linkages between the different parts of the system and the balance between them are not optimal. As a result there are barriers in our current system to genuinely patient or client-centred care and obstacles in the way of efficient and effective service delivery.

The current division of responsibilities between the Commonwealth and the states and territories contributes to these shortcomings and reforming these arrangements will contribute to building a better health and aged care system. We will need a better system to meet the challenges from our ageing population and to continue to improve the health and well-being of all Australians.

Context:

The Government has established an Inquiry by the Productivity Commission into aged care and has given it appropriately broad Terms of Reference. The Issues Paper released by the Commission in May 2010 draws attention to *"the important interfaces between [aged care] and other social policy areas, such as primary health, hospital care, disability services, housing (including social housing) transport and income support"* and notes that *"Service delivery in each of these areas affects the performance of the aged care sector and vice versa"* giving the example of the relationship between the hospital services and demand for community and residential aged care.[1]

The fact that reform of other parts of the overall health and aged care system is proceeding ahead of this specific aged care Inquiry raises the risk that elements of the new health system will be put in place before the necessary linkages with aged care are fully considered. The fact that the aged care industry, aged care professionals and aged care consumers are not represented in any of the government structures and processes set up to progress the health reform agenda compounds this risk. Aged care needs a seat at the health reform table at more than just government level.

Comments on Specific Terms of Reference:

ToR e) Structures, Roles, Operations of New Entities

The COAG reforms refer to three different networks: hospitals, primary care[2] and aged care[3] but the announcements provide little detail about these or how they are to work together – as they must to provide coordinated and efficient person-centred care.

[1] *Caring for Older Australians* Productivity Commission Issues Paper May 2010 p5
[2] Referred to in some documents as 'Medicare Locals'
[3] Referred to in the NHHN report

Firm service delivery protocols between these service networks at the specific local area will be required but we note that management of the hospital networks, through service agreements, is to remain a state responsibility under the new arrangements. System-wide planning for hospitals likewise is to remain a state or territory responsibility. In contrast responsibility for aged care services is to be the responsibility of the Commonwealth under this agreement as it is for primary health care.[4] It is not so clear how seamless service delivery, including to older people with complex and chronic needs is to be planned for and supported in these arrangements. The NHHN Agreement suggests that the Primary Health Care Organisations will 'assist with patients' transitions out of hospital, and where relevant into aged care'[5] How this is to occur or how other linkages between services are to be ensured is not yet clear. It will need to be for the system to work effectively for its clients and efficiently for services and funders.

In ACSA's view there is a key role for e-health to support service delivery across and between different settings but also a need for cross system performance to be managed and assessed. It is not clear to us how it is intended that this be done under the new arrangements though we note that these issues are not systematically or adequately addressed in our current system.

There are some options for the articulation of the new structures with aged care. The new 'Independent Hospital Pricing Authority' is to be empowered to "make binding determinations about cost-shifting and cross-border issues in the health and hospital system"[6] No relationship between this body and aged care services is suggested but, if appropriate price signals are to be sent across the care system, perhaps one should be.

Similarly the new 'National Performance Authority', to be established to monitor hospital performance, raises the question of how overall system performance is to be assessed. Similar comments apply to the now permanent 'Australian Commission on Safety and Quality'.

We are not suggesting that aged care services should necessarily be part of the remit of these bodies - aged care is about more than just health care – but the inter-relationships between health and aged care (and other parts of the care system) in terms of performance, noted by the Productivity Commission (see above), nonetheless need to be addressed. Consideration of how these new bodies might relate to the aged care system is warranted.

In the Australian Government's media release on aged care, issued the day after the COAG Communiqué, the report of the recent review of the aged care Complaints Investigation Service was released. This suggested the establishment of a new more independent body for handling complaints about aged care services. Greater independence (and the other recommended improvements) is certainly supported but this too raises a question about whether a *separate* body for aged care complaints is the right direction in the overall reform context.

[4] COAG *National Health and Hospitals Agreement* pp 5-6
[5] NH&HN Agreement p 21
[6] COAG 19-20 April Meeting *Communiqué* p5

ToR i) Aged Care

i) Zero Real Interest Loans

Zero real interest loans (ZRILS) were introduced in 2008 to support the construction of new aged care facilities. They do not change the planning ratios for residential aged care services – the ratio of 88 beds per 1,000 people aged over 70 remains – but they are intended to increase the likelihood that allocated bed licences will become operational and to increase the attractiveness of such licences in the face of declining demand for them by providers.[7] The term of these loans was increased from 12 to 22 years in the Australian Government's recent announcements, removing one of the obstacles to their uptake – the fact that these loans typically fell due before any traditional bank financing - which made some banks reluctant to lend in combination with ZRILs.

It remains to be seen whether this change in the term of the ZRILs will make any material difference to their ability to support the construction of 2,500 new beds in aged care facilities as foreshadowed in the COAG announcements. The ZRILs are capped at $120,000, well below the cost of construction of new aged care homes ($180,000 upwards) meaning that other financing is likely to still be required. The ZRILS, and other loans, also do need to be repaid which means that a return on the capital investment is still required which is not possible under the current arrangements for funding accommodation in high level residential care.[8]

The aged care industry is sceptical about the ability of the ZRILs to make more than a marginal difference to the viability of new aged care construction projects and looks forward to more complete and lasting solutions to our capital raising crisis from the recommendations of the Productivity Commission Inquiry referred to above. Pending this, it is anticipated that the slow down in construction of the new capacity we need to meet the needs of an ageing population will continue.

ii) Beds for Longer stay Older Patients

The Australian Government has allocated $280 million over four years to support 2,000 aged care places (i.e. $35,000 per place) for longer stay patients in public hospitals. These are referred to as time-limited places and this should be a time-limited measure. It is not only uneconomical for older people to remain in hospital after their treatment has concluded, it is also inappropriate and may even be unsafe[9]. In order for older people to be more appropriately cared for in the community including in residential aged care homes, additional capacity will be required. This in turn requires solutions to the crisis in capital raising referred to

[7] Not only were the bed licences offered in the last Aged Care Approvals Round not fully subscribed (over 1900 were converted to community care places) but nearly 800 licences were also returned to the Department of Health and Ageing.

[8] Access Economics in their *Economic Evaluation of Capital Financing of Aged Care* 2009 argued, conservatively, that the Accommodation Charge of approximately $28 per day would need to be raised to over $42 per day just to reach a break even point.

[9] Due, for example, to the risk of infection.

above together with revisions to the aged care planning system and funding levels[10].

iii) Funding

It has been suggested that the use of aged care funds to pay for longer stays in hospital by older people is inappropriate and that it does not set the right incentive to more appropriately look after older people in the community. ACSA has not looked at this initiative in this way, seeing it rather as lining up previously unaligned incentives. Under the new arrangements the Australian Government is paying 60% of hospital costs (rather than 0%) and, under this measure, is only offsetting the cost of the 2,000 beds by the amount of the aged care subsidy (average $96 per day on the figures above) leaving it with an incentive to find a more appropriate and cheaper placement in the community. It is imperative however that this subsidy is not looked on as a long term solution.

In the short term the allocation of places to hospitals may obscure the fact that they are not in demand by aged care providers.

The financial measures in the COAG package also do nothing to address the immediate issues facing the delivery of aged care services the declining value of care subsidies relative to costs and the lack of adequate access to capital. This means that the decline in the amount of community care available will continue as will the inability of aged care providers to pay higher wages to staff and compete with hospitals in the same labour market.

iv) Transfer of Funding, Management and Delivery Responsibility for a National Aged Care System

There is much to be done to equip Australia's aged and community care system to meet the challenges posed by an ageing population. Prominent among these is the need to strengthen and resource our system of community care which cares for up to one million older people, people with a disability and their carers each year[11]. Most of these are clients of the Commonwealth-State HACC program which is now to be split with the aged care component going to the Commonwealth and services for younger people (<65) becoming the responsibility of the states and territories. Financial responsibility for packaged community care services is to be split, however the regulation of such services is to stay with the Commonwealth.[12]

ACSA believes that the reforms and improvements needed in community care are made easier, though not guaranteed, by having a single level of government with

[10] Increasing the responsiveness of the aged care system so that it can admit older people on the day they are discharged from hospital will require additional capacity, more vacancies and a higher level of subsidy to cover the cost of vacant places.

[11] The Allen Consulting Group *The Future of Community Care;* Report to the Community Care Coalition 1997

[12] Reasons for this are not given in the NHHN Agreement bit it should be noted that packaged care is also funded under the HACC program as Community Options (Linkages in Victoria) There are not many younger people in Commonwealth-funded packaged care due to eligibility rules. This area looks messy.

unequivocal responsibility. Similarly the Aged Care Assessment Teams[13] can be re-vamped more easily with one funder and policy maker rather than with two. On balance we support the move to full Commonwealth responsibility for aged care.

Such a move is not without downsides and risks however. Introducing an arbitrary age criterion into community care services will need to be managed with care if it is not to give rise to a whole new set of boundary and border problems for clients. Given that the number of people ageing with a disability is increasing and that some of the typical conditions of old age can strike some people at an earlier age, the population grouped around this border is growing, not shrinking.

Ensuring that there is no disruption to services for clients and maintaining business continuity for providers are essential. A new potential for cost and blame shifting is created by the aged-based division of responsibility. Details of how this will be managed need to be developed in consultation with affected stakeholders.

ToR k) Any Other Related Matter

The announcements following the COAG reforms also include the development of a system of 'one-stop shops', information, assessment and referral services to help older people gain access to the services they need in a timely fashion. This is suggested as a way of dealing with the labyrinthine complexity of Australia's community care system.

It is certainly true that providing accurate, informed and timely information to older people and their families to support their decision-making on matters of care is currently under-resourced.[14] However it is also true that the complication and inconsistency in Australia's community care system is the product of Government funding rules and policies and that a considerable degree of simplification of these is not only possible but desperately needed. That is, the complexity of the system should be dealt with by consolidating all of the nearly three dozen Commonwealth and state funding programs into a single broad-banded community care program and not be 'papered over' by creating a coordination mechanism 'over the top'.

This would mitigate the risk of the one-stop shops becoming bottlenecks in the way of timely access to services by concentrating their role of decision support, where it is needed, in matters of care. Acknowledgment that some people's service needs are simple and do not require extensive assessment must also be built into such a system if we are not to run the risks of a) spending more on assessment than service delivery and b) taking away rather than enhancing older people's self determination.

It is important to note too that some people's care needs are relatively volatile, creating a frequent need for re-assessment or adjustment in the services being provided. This capacity for responding flexibly to changing needs must not be located in an external body but be built into service delivery organisations in aged care, as it is in hospitals and other care services. As funding sources are consolidated and service

[13] Called 'Aged Care Assessment Services' in Victoria
[14] As opposed to the provision of pamphlets and the like.

provider organisations also aggregate, the argument for an external assessment layer – the one stop shop idea – becomes progressively weaker. Regardless of this the concept of 'no wrong door' needs to be combined with that of the 'one stop shop' from the outset or client access will be impeded rather than assisted in many cases.

The reform package also expresses support for a greater degree of direction by consumers of the care that they receive. ACSA supports this broad direction but would observe that there is much to be learned from the experience of services that have trialed such approaches, in Australia and overseas and cautions against the uncritical adoption of Consumer Directed Care. ACSA has developed some Principles to guide the development of Consumer Directed care and a copy of these is attached.

Giving consumers more say means giving administrators and politicians less detailed control and this is a good thing.

Conclusion:

Reforming Australia's health and aged care system will require sustained effort by many people over a number of years. Many aspects of the reform program, not least those required in aged care, have still to be developed and some of those that have been announced, need to be fine tuned. It would be ACSA's hope that this Inquiry will contribute to this development and fine tuning. It is our view that, just as the development of the reform program was informed by an extensive program of consultation with the hospital and health care sector, not just governments, its implementation needs to be similarly guided. While a specific Inquiry into aged care has commenced it is important to ensure that no aspect of the broader reform agenda is locked in without due consideration of the links with and implications for aged care.

The report of the National Health and Hospitals Reform Commission referred to health and aged care as being 'two giant interconnecting cogs'. We need to ensure that the teeth mesh, that they do not grate and that the cogs continue to turn.

Attachment: *Guiding Principles for Consumer Directed Care*

ATTACHMENT

Aged & Community
Services • Australia

GUIDI NG PRINCIPLES FOR CONSUMER DIRECTED CARE

ACSA POSITION PAPER

April 2010

Consumer Directed Care (CDC) is both a philosophy and an orientation to a service delivery option where consumers control and choose the services they get, including what, when, how, where and who provides those services. Individuals will vary in the level of choice and control they want, and the circumstances and capacity of people will also affect the level of control they exercise.

There is not yet an agreed definition of CDC, with interpretations including consumers receiving direct cash payments, individualised service budgets and consumer participation and direction of their service planning. Likewise the scope of CDC is not settled with possibilities ranging from within program services (eg packaged care or respite) to consideration of the wide range of services and supports available to older people to manage their lives (eg Transition Care, continence support, aged and community care, respite etc).

This Position Paper should be considered in conjunction with the ACSA CDC Discussion Paper released in September 2008.

Aged & Community Services Australia (ACSA) supports the following as Guiding Principles for CDC in aged and community care:

1. **Access and choice is a right** of all consumers and CDC is an important **option** for older people and their families.

2. CDC model development must take into account the importance of a **viable and sustainable** aged and community care service system which provides easy access for all frail older people.

3. The emphasis of CDC is on the **choice and control** consumers have over the services and the Government funding for which they are eligible.

4. CDC can be managed and administered in a variety of ways. ACSA recognises the **different approaches** and supports its members (in partnership with consumers) to explore the range of options.

5. Consumers should be supported in their decision making through the provision of **capacity building programs** (including information and education) and the presence of appropriate **safeguards**.

6. A person's funding should be based on an **objective assessment of their support needs,** with capacity for individual self-assessment to be a part of the process.

7. The services of an **advisor/manager/support broker** should be available to the consumer if required.

8. Government, industry and consumer **partnership** is required to lead the ongoing development of CDC.

9. Government involvement is essential to determine **resource allocation models, the parameters of choice** and an **entitlement based system.**

10. CDC must not be seen as a **cost saving measure** for the government.

11. Appropriate **staged and transparent transition arrangements and support** will need to be established to enable aged and community care providers to prepare for the extension of CDC as a service option for older people.

12. Ongoing **research and testing** of CDC in aged and community care in Australia will be important in defining and scoping CDC, and to develop approaches which suit consumer preference, meet government accountability requirements and which enable service providers to deliver viable services.

Role of ACSA in the development of CDC as a service delivery option

a. ACSA will work in collaboration with key consumer peaks to facilitate the evolution of CDC as a viable service delivery option for aged and community care. ACSA will ensure the interests of its membership to provide quality aged care to older people are represented in this process.

b. The initial focus for ACSA will be community care, while still keeping the CDC debate broad to encompass all aged and community care.

c. ACSA will work with members and consumer groups to identify government barriers to CDC.

d. ACSA will take a leadership role to skill the workforce to facilitate maximum consumer choice and delivery of the most flexible, effective system possible.

e. ACSA will advocate for necessary changes to government policies, guidelines and legislation to enable CDC to be a genuine option for consumers and to support the capacity of providers to change, while remaining viable, to meet consumers' evolving needs and preferences.

f. ACSA will keep the membership informed of best practice examples of CDC and enable providers and consumers to share their experiences.

g. ACSA will promote and articulate the processes and practices that demonstrate industry's responsiveness to CDC.

h. ACSA will provide members with information to enable them to position their business to support increasing consumer choice in aged care.

Development of Consumer Directed Care as a concept for aged care is an evolving process and ACSA will review this position paper regularly to ensure its relevance to current wisdom.