Chapter 3

The need for reform of the aged care sector

> We do not want a response that bandaids the system financially and ignores the need for reform to deliver better services.
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> *Mr Harold Milham, Carer.*[1]

3.1 From the inquiry's inception, it became overwhelmingly evident that aged care providers and involved stakeholders across the country recognised a need to reform the aged care sector in Australia. Witnesses commented on the 'bandaid' approach that has been taken to problems within the aged care sector and of the fact that they have been calling for reform for many years. It was argued that the significant problems currently facing the sector and the need to meet future demand must be addressed immediately and in a comprehensive and coherent manner. The Aged Care Association Australia highlighted the need for policy to meet expectations in the area of aged care services:

> If Australia is to develop policy solutions that will address these significant demographic, care cost and service volumes, it is fundamental that the current aged care system including the financial basis underpinning the current system is placed on a strong sustainable basis with the real cost of care and capital being realized by Government and community. Further, if Government and community are not prepared to appropriately fund their care and infrastructure expectations then both must be prepared to adjust their expectations accordingly.[2]

3.2 Anglicare Australia argued that a 'systemic shake-up of the way in which aged care services are funded, planned, allocated and provided' is required.[3] Similarly, the Aged Care Association highlighted the need for reform of the sector and dialogue:

> …we strongly believe that there is a real need for long-term structural reform and that that dialogue needs to commence very, very shortly between the Australian community, the Australian aged care industry and the Australian government.[4]

3.3 It is clear that growing demand for aged care services and changing expectations of the sector and indeed changing community engagement with the sector pose key challenges to the provision of quality aged care. As one case in point, growing community demand for single bedroom with ensuite residential care accommodation has serious implications for the financial viability of residential aged

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1 Mr H Milham, Alzheimer's Australia, *Committee Hansard*, 13.3.09, p. 71.

2 Aged Care Association Australia, *Submission 92*, p. 3.

3 Anglicare Australia, *Submission 67*, p. 2.

4 Mr R Young, Aged Care Association Australia, *Committee Hansard*, 13.3.09, p. 46.

care providers. According to Grant Thornton Australia, this expectation is 'the major influence on the design of modern residential facilities in Australia' and yet, the returns for operators of such facilities were 'approximately half of those that were achieved by those with older institutional facilities with shared rooms'.[5] However, current Commonwealth Government certification guidelines require an average across facilities of 1.5 residents per room for new buildings permitting two-thirds of residents to be in double rooms and one-third in single rooms.[6]

3.4 Professor Warren Hogan termed the baby boomer generation the 'most diverse demographic grouping to access residential care services in Australia's history'.[7] The committee considers that there is a need for immediate action supported by ongoing sectoral wide dialogue to identify the needs of this generation and their short- and long-term impact on the aged care sector.

3.5 The committee considers therefore, that all stakeholders including all levels of government, residential and community aged care providers, professional bodies, lobby groups, involved individuals, and clients of aged care services and their families need to be engaged in ongoing dialogue. The committee believes that this is best achieved through the establishment of a national aged care forum. Such a forum would be required to meet on a regular basis to discuss key current and future challenges affecting the sector. It should be supported and coordinated, at least in the first instance, by the Department of Health and Ageing (the department). The committee also recommends that such a forum establish a taskforce (or an equivalent body) representing all such stakeholders to action critical issues identified by the national forum.

Recommendation 1

3.6 The committee recommends the establishment of a national aged care forum, reporting directly to the Minister for Health and Ageing and coordinated by the Department of Health and Ageing, to consider, on an on-going basis, current and future challenges to the aged care sector.

Recommendation 2

3.7 The committee recommends that the national aged care forum establish a taskforce (or equivalent body) representative of all involved aged care stakeholders including clients to action and where possible implement determinations of the national forum.

3.8 There are widely held concerns regarding what has been seen as a largely piecemeal approach to aged care funding which has not permitted adequate

5 Mr C Ansell, Grant Thornton Australia Ltd, *Committee Hansard,* 30.1.09, p. 2.

6 Mr A Stuart, First Assistant Secretary, Department of Health and Ageing, *Committee Hansard,* 13.3.09, p. 97.

7 Professor W Hogan cited in Grant Thornton Australia Ltd, *Submission 29*, p. 11.

consideration of the sector as a whole, its future challenges and the changing expectations upon it. Witnesses commented that a systematic review of operations under the *Aged Care Act 1997* is required. Baptistcare, as one case in point, argued:

> The *Aged Care Act 1997* is now entering its twelfth year of operation and with the exception of the Hogan review...in 2004, there has been no systematic review into its operations, nor has there been any evidence based data to suggest that the quality of care has improved since its inception...while this inquiry is welcomed, if for no other reason than the lack of any substantial review of the operation of the Act, it does not address some of the features of the Act's operations that need to be addressed if Australia is to meet its aged care challenges over the next 15 to 25 years.[8]

3.9 The Aged Care Alliance (ACA) highlighted that while the 'interdependence of investment, financing decisions, construction, costs and demand with the subsidy regime is directly relevant to the sector's capacity to continue to meet expected quality standards', policy such as the Aged Care Funding Instrument (ACFI) had been implemented without consideration of the effect on the entire system.[9] The ACA continued:

> The policy weakness remains the separate policy decisions made without consideration of the total capacity and mix of service delivery in the medium term where identifiable demographic trends are identified.[10]

3.10 The committee appreciates such concerns and considers that an all-encompassing review of aged care services in Australia needs to be undertaken. The committee also considers that it is timely, after 12 years of operation and in light of emerging challenges for the sector, that a survey of sectoral operations under the *Aged Care Act 1997* be conducted as a major part of the review.

3.11 Moreover, the committee is acutely aware of the need for future planning in light of growing demand on aged care services, It recommends that such a sectoral review consider future projections to enable planning to address challenges that the industry is expected to face in the future.

Recommendation 3

3.12 The committee recommends that the Department of Health and Ageing, in cooperation with the suggested taskforce and in partnership with all involved stakeholders including clients, undertake an all-encompassing review of the *Aged Care Act 1997* and related regulations. The review should:

8 Baptistcare, *Submission 48*, pp 3–4.

9 The Aged Care Alliance, *Submission 40*, p. 8.

10 The Aged Care Alliance, *Submission 40*, p. 17.

- **equally examine the provision of residential and community aged care services in Australia with consideration of both current and future challenges in the provision of aged care services;**
- **provide future projections to enable both short and longer-term sectoral planning.**

Benchmark of care costs for the provision of quality aged care services

3.13 A recurring theme throughout this inquiry was the need to establish benchmark of care costs in order to understand the relationship between subsidy allocation and indexation.[11] Of this, the Australian Nursing Federation stated:

> The recently released Grant Thornton Report argues that margins in high care are as low as 1.1% and up to 40% of providers are unviable and the recent collective decision by some providers to not tender for beds has brought the viability of the sector into the spotlight. The government contends that the sector is viable. It is difficult to ascertain the truth without a true benchmark of care costs, which is analysed against income.[12]

3.14 Catholic Health Australia held that there is no real relationship between the care subsidies and the cost of care and quality outcomes required.[13] It also maintained that a defined and costed benchmark of care is required:

> This benchmark of care must reflect the real costs of providing a quality aged care service in different regions around Australia, and allow for the flexible delivery of aged care services responsive to the needs of the individual.[14]

3.15 However, concerns were raised that, in addition to the need to reconsider current funding levels, future funding levels required to meet expected demand is also critical. Aged and Community Care Victoria (ACCV) stated for example, that in the area of residential aged care, additional income and funding sources were required in order that the sector can 'provide suitable residential facilities that meet the demands which result from our ageing population'.[15] Mt St Vincent Nursing Home and Therapy Centre expressed the view that aged care has never been funded to enable forward planning to implement improved systems that would otherwise alleviate pressures.[16] This view was supported by ACCV which called on the Federal Government to:

> …undertake, in collaboration with the industry, a review to set in place a defined and properly costed funding benchmark for residential and

11 Grant Thornton Australia Ltd, *Submission 29*, p. 10.

12 Australian Nursing Federation, *Submission 94*, p. 9.

13 Catholic Health Australia, *Submission 75*, p. 6.

14 Catholic Health Australia, *Submission 75*, p. 6.

15 Aged and Community Care Victoria, *Submission 89*, p. 3.

16 Mt St Vincent Nursing Home and Therapy Centre, *Submission 1*, p. 1.

> community care which reflects the real costs of providing quality services. This benchmark should exhibit the real costs of staffing and operating quality care for our elderly, including those who are frail and have complex care needs.[17]

3.16 According to Mr Cam Ansell of Grant Thornton Australia, there is a 'mismatch' between recognition of the need for care and the subsidy levels resulting from the fact that:

> …we have never actually done the amount of research to work out what it does cost to look after a resident, not just in terms of their care and their clinical cost but what does it cost to accommodate them? What are their costs in terms of their support with their personal needs? If we are able to do that, we would be able to build a subsidy system that better reflects actual need…
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> So if you understand what it costs to deliver the care and the accommodation, you can come up with suitable strategies for your subsidies, you can work out what is appropriate in terms of what the user should pay for and what the taxpayer should pay for, and it also gives you the opportunity to consider how those things change over time so we can then apply an indication that meets that cost.[18]

3.17 The Aged Care Association Australia (ACAA) held that a study of the benchmark costs of care should take place as part of a 'longer review of industry structure and quality deliverables'. Mr Rod Young of the ACAA noted that:

> Until this exercise is undertaken, it will be difficult to know what providers are expected to provide, what the community expects us to provide and what government expects us to deliver. In considering what the index for the industry should be, ACAA is persuaded that it should be done using the index that applies to age pensions, which is made up of either 25 per cent of average male weekly earnings or the CPI, whichever is the greater.[19]

3.18 Mr Young continued:

> What is it actually costing? If we expect the industry to provide this level of service at this level of quality, what should we be paying for that to be achieved? All we have ever done in any of our reviews is look at what the current subsidy is and accept that. When you look at what Hogan did, there were over 700 providers participating in a financial survey. Then what was accepted was: These are our average costs across the various parts of the accounts of those providers and we accept that as being a reasonable assessment. This is the subsidy being paid by government and the income

17 Aged and Community Care Victoria, *Submission 89*, p. 3.

18 Mr C Ansell, Grant Thornton Australia Ltd, *Committee Hansard*, 30.1.09, p. 11.

19 Mr R Young, Aged Care Association Australia, *Committee Hansard*, 13.3.09, p. 47.

> being paid by residents, and we accept that as being a reasonable payment for those care services. We never really analysed it.[20]

3.19 Care Connect suggested that establishing benchmark of care costs for CACP, Extended Care at Home (EACH) and Extended Care at Home Dementia (EACH-D) should consider non-direct care costs such as the initial time spent assessing clients before they are 'activated' on a package of care and case management time.[21]

3.20 Mr Greg Mundy of Aged and Community Services Australia stated that establishing benchmark of care costs is long overdue in Australia:

> The Productivity Commission recommended that in their 1999 report on residential aged groups 10 years ago…I think coming up with a firmer definition of what we expect to be done, what that is likely to cost and relating our subsidies to that would be well supported by many of the stakeholders rather than, as we have been doing, just simply doing what we can get away with in terms of market forces. It would put an end to lots of arguments. It might cause a headache principally for the funders, but I think the other stakeholders would all support getting some data on the table, saying: 'This is what we should be doing. This is a reasonable cost for it. That is where we should start from.'[22]

3.21 The committee acknowledges the need for benchmark of care costs with a view to establishment of an aged care index. In this regard, the committee recalls recommendations of the Productivity Commission and Senate Community Affairs Committee respectively. Recommendation 2 of the Productivity Commission's 1999 inquiry report on *Nursing Home Subsidies* stated:

> The Government should specify its intended outcomes in terms of a standard of care benchmark. The purchase price of care outputs from providers by way of subsidy funding, in combination with funding from residents, should be adequate to meet the cost of providing that benchmark standard of care.[23]

3.22 Recommendation 13 of the Senate Community Affairs Committee's 2005 *Quality and equity in aged care* inquiry report in relation to the Aged Care Standards and Accreditation Agency noted:

> That the Agency, in consultation with the aged care sector and consumers, develop a benchmark of care which ensures that the level and skills mix of staffing at each residential aged care facility is sufficient to deliver the care required considering the needs of residents. The benchmark of care that is

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20 Mr R Young, Aged Care Association Australia, *Committee Hansard*, 13.3.09, p. 51.

21 Care Connect Ltd, *Submission 71*, p. 1.

22 Mr G Mundy, Aged and Community Services Australia, *Committee Hansard*, 20.2.09, p. 8.

23 Productivity Commission, *Nursing Home Subsidies*, Inquiry Report, 1999, p. 86.

> developed needs to be flexible so as to accommodate the changing needs of residents.[24]

3.23 The committee reaffirms the work of the Productivity Commission and Senate Community Affairs Committee in this regard and recommends a national survey of benchmark costs of residential and community aged care. Such a survey will establish benchmark of care costs which can then be applied to funding and operational issues.

Recommendation 4

3.24 The committee recommends that the Department of Health and Ageing in association with the suggested taskforce and in consultation with all aged care stakeholders including clients undertake analysis to establish benchmark of care costs.

Audited General Purpose Financial Reports

3.25 Aged care providers are required to submit Audited General Purpose Financial Reports to maintain the Conditional Adjustment Payment (CAP) funding. Concerns were raised in relation to the relevance of information required in the reports and that the Department of Health and Ageing no longer releases the data contained in the reports. Of the first concern, Mr Cam Ansell of Grant Thornton Australia stated:

> General purpose financial reports... are highly summarised information that apply all Australian accounting standards. Unfortunately, in terms of giving an indication of performance, it is very limited. It only provides a very small assessment of what performance is in residential aged care.[25]

3.26 According to Mr Ansell, initial recommendations that general purpose financial reports 'allow providers to understand how they are performing and for decision makers to be able to understand what aspects of their business were causing them to perform the way they were performing' were not taken up.[26]

3.27 ACAA also noted that the department has not released the data from 2005–06 onwards which makes:

> …this important piece of industry financial benchmarking data unavailable to aged care providers for site specific benchmarking and to the industry more broadly.[27]

3.28 The department responded that the data had not been made available in the last few years 'because we had some concerns about the methodological soundness of it'.[28] Dr David Cullen, Department of Health and Ageing, commented further:

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24 Senate Community Affairs Committee, *Quality and equity in aged care*, June 2005, p. 50.

25 Mr C Ansell, Grant Thornton Australia Ltd, *Committee Hansard*, 30.1.09, p. 5.

26 Mr C Ansell, Grant Thornton Australia Ltd, *Committee Hansard*, 30.1.09, p. 6.

27 Aged Care Association Australia, *Submission 92*, p. 5.

> The CAP reporting requirements developed over time. In the first few years providers were permitted to opt out of certain accounting standards and also not to report at the residential care segment. They reported at the whole entity level rather than at their residential care operations level. We provided that data for the first two years because we had agreed to do so, but we were very unhappy with the accuracy or the ability to draw conclusions from that data because there was noncompliance with accounting standards. We then went through a process of tightening those…
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> Providers were transitioning towards compliance with the accounting standards. We chose to pause for a few years with releasing the data because we had concerns about whether adequate conclusions could be drawn from it. We are now satisfied that we have all providers reporting according to the accounting standards and reporting on their residential care segment. So this data set is one that we are confident about and on which some analysis has been done.[29]

3.29 The committee acknowledges the concerns expressed by the department in relation to the soundness of the data. In the circumstances of the current claim and counter claim about viability, the committee finds it very difficult to understand the delay in fixing such a vital tool. However, if the department is satisfied that the reports are now in accordance with accounting standards, publication of the data should recommence as soon as practicable.

Recommendation 5

3.30 The committee recommends that the Department of Health and Ageing recommence publication of Audited General Purpose Financial Reports as soon practicable and continue to publish such reports annually as a matter of course.

Recommendation 6

3.31 The committee recommends that the Department of Health and Ageing review the Audited General Purpose Financial Reports with an aim to identifying any necessary reporting changes to ensure that the information available provides a clear and comparative understanding of provider performance.

Nationally consistent aged care data

3.32 During the inquiry, concerns were also raised about the lack of nationally consistent aged care data. Ms Derryn Wilson of the Municipal Association of Victoria stressed the importance of addressing the issue from the perspective of local councils:

> In terms of a national aged-care planning framework, there needs to be a coordinated development and use of supply, demand and utilisation datasets. That fundamental need for data has been there for quite some time,

28 Mr A Stuart, Department of Health and Ageing, *Committee Hansard*, 21.4.09, p.26.

29 Dr D Cullen, Department of Health and Ageing, *Committee Hansard*, 21.4.09, p.26.

> and it is an absolute necessity. There is opportunity to build on the local area data and to incorporate a range of related program areas with agreed processes with the three tiers of government and the involvement of providers and consumers.
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> The lack of publicly available supply and utilisation data to the local area level from the Commonwealth aged-care programs has long been a source of irritation for councils. That need for data has been around. It really needs to be addressed. We also believe that it is fundamental to good service system planning, and it requires that opportunity to be able to evaluate and consider what is really a quality product.[30]

3.33 Whilst there are a number of bodies who conduct surveys on performance in the aged care sector, much of the research is conducted by private companies which offer their analysis for a fee. Therefore, their data may not be publicly available, and rather, has to be purchased as part of a commercial-in-confidence arrangement between the body in question and the purchaser. The committee is also concerned that different methodological approaches which utilise different indicators and employ different definitions do not lend themselves easily to comparative analysis. Moreover, where such data is not publicly available, public scrutiny and discussion across the sector is all but impossible.

3.34 The committee recommends that a common assessment approach be considered by the sector in cooperation with all levels of government in order that a nationally accepted standard be instituted and published with a view to establishing the financial status of aged care in Australia. Such an approach should be transparent and enable disaggregation of information.

3.35 The committee appreciates that a number of bodies, including the Australian Institute of Health and Welfare, produce important information on the aged care sector and that in many instances, what is required is greater coordination to enable data sharing rather than simply the creation of new data sets. In this regard, Ms Derryn Wilson of the Municipal Association of Victoria noted:

> I think there is certainly existing data that could and should be shared, but I think…that, as we move forward, with an older Australia, there are lots of issues that do need to be built into the data collection, and that includes relationships with other programs. For instance, there is quite a lot of data on HACC utilisation that is shared between the state and LGAs. And you cannot really look at CACPs without looking at who and how many are using the HACC services.[31]

3.36 Similarly, Ms Janet Carty of the Tasmanian Department of Health and Human Services emphasised the need for streamlining reporting across the sector:

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30 Ms D Wilson, Municipal Association of Victoria, *Committee Hansard*, 20.2.09, p. 14.

31 Ms D Wilson, Municipal Association of Victoria, *Committee Hansard*, 20.2.09, p. 18.

> What we are talking about here is – and I think it was what the providers were talking about in the previous section – that there is a huge reporting burden. That is a major amount of work, and we would like to see some of that streamlined. We have done a lot of that work through the community care reform initiatives. We are aware that you can get synergies across the system in planning and in quality reporting. It is of concern that there are major disparities across each different program type, and different requirements under each program type. We would suggest that you could possibly develop a system—or even that a system may have been developed, through submissions—that might be less onerous for providers to report on.[32]

3.37 In light of the evidence before it, the committee recommends the establishment of a national roundtable of key bodies engaged in research, aged care surveys and data gathering which is representative of stakeholders across the sector including all levels of government. The objective of the roundtable would be to discuss and publicise methodology, approach and findings to enable streamlining of data and provide for comparative analysis and ongoing information sharing.

3.38 Comprehensive nationally agreed data sets and application across the sector have the potential to provide a clear picture of the financial health of aged care providers, their efficiency in meeting client needs, to inform ongoing debates in the sector, and the policy decisions emanating from them.

Recommendation 7

3.39 The committee recommends the establishment of a nationally consistent methodological approach to data gathering and research on the financial status of the residential and community aged care sector. Towards this goal, the committee recommends the establishment of a roundtable of key stakeholders engaged in such research and facilitated by the Department of Health and Ageing to discuss and agree upon common indicators and definitions to enable comparative analysis.

Deficiencies in information on aged care needs and services

3.40 The Australian Institute of Health and Welfare noted a number of information gaps which limit service planning including:

- the absence of a currently accepted approach to measurement of potential or action demand for formal aged care services;
- the lack of national level information about the care preferences of potential and current aged care program consumers and their carers and families;

32 Ms J Carty, Department of Health and Human Services, *Committee Hansard*, 27.3.09, p. 82.

- the lack of on-going information about the care needs of people who receive CACPs, EACH or EACH-D packages and the amount and type of assistance provided through these programs; and
- the absence of cross-program information which could be used, among other things, to develop more robust estimates about the numbers of people using all aged care services and to build better evidence about utilisation patterns and pathways through the system of aged care services as a whole.[33]

3.41 Witnesses before the committee including Mr Greg Mundy of ACAA emphasised that such information is vital for planning and to establish greater accuracy in regard to the current ratio of high and low care:

> The current ratio does not recognise the actual demand that presents at the door, which is more like 60 per cent high care rather than 50 per cent, so we ought to take account of that. But rather, than just come up with a number, I think it would repay a quick three-month study of more detailed characteristics of older people and their needs so that we have got just a little bit more science behind those numbers.[34]

3.42 Concerns were also raised about the lack of information provided on the Commonwealth planning process. Ms Derryn Wilson from the Municipal Association of Victoria elaborated:

> The Australian Institute of Health and Welfare reports have the data at the state and national level, but data on either the Commonwealth planning process or for utilisation in parts of the other planning processes for community care is not made available at the state level. So there is a big gap there in everybody being on the same page with the same knowledge that helps, then, look at the quantitative situation and allows that qualitative discussion about why are we different from this place. What is different about our community that we are not using as many of this sort of thing? It does make the process much less rich and informed.[35]

3.43 The committee acknowledges such deficiencies in information and the need to address them and suggests that the recommended taskforce (or equivalent body) under the auspices of the national aged care forum consider means of address.

Recommendation 8

3.44 The committee recommends that the Department of Health and Ageing in association with the suggested taskforce (or equivalent body) and in collaboration with the Australian Institute of Health and Welfare review and address deficiencies in information in the aged care sector.

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33 Australian Institute of Health and Welfare, *Submission 113*, p. 4.

34 Mr G Mundy, Aged and Community Services Australia, *Committee Hansard*, 20.2.09, p. 6.

35 Ms D Wilson, Municipal Association of Victoria, *Committee Hansard*, 20.2.09, p. 14.