AGED CARE AMENDMENT (RESIDENTIAL CARE) BILL 2007

SUBMISSION TO THE COMMUNITY AFFAIRS COMMITTEE OF THE AUSTRALIAN SENATE

FROM

AGED AND COMMUNITY SERVICES AUSTRALIA

Aged and Community Services Australia represents over 1,200 church, charitable and community-based organisations providing housing, supported accommodation and community care services to around 750,000 older Australians, people with a disability and their carers.

BACKGROUND:

The need to redevelop the funding system for residential care services funded under the Australian Government's aged care program has been apparent for several years.

Initial discussions between the Department of Health and Ageing and members of its Resident Classification System (RCS) Industry Reference Group occurred in late 2001 and centered on the persistent high volume of changes, mainly downgrades, to the initial classifications conducted by aged care providers and the high level of supporting documentation being prepared to support classification decisions. These discussions were the precursor to the first of a series of reviews of the system.

This first review, conducted by Aged Care Evaluation and Management Advisors (ACEMA) reported in February 2003 and its report was released, together with a Government response, in early March 2003. ACEMA made 20 Recommendations the first of which was that the Department of Health and Ageing should support the development of a new model for residential aged care funding. That is, ACEMA confirmed the need to reform the RCS system root and branch.

Some of the features of the currently proposed Aged Care Funding Instrument (ACFI) that is the subject of this Bill reflect ACEMA's recommendations and some do not. ACEMA argued, inter alia, for consideration of the adoption of the internationally-supported RAI/RUG system and the Australian AN-SNAP system prior to any decision to commence work on redeveloping the RCS but, if any such consideration occurred, it was conducted in house by the Department of Health and Ageing and industry bodies such as ACSA were not involved in any way. Some of ACEMA's recommendations were referred to the Review of Pricing Arrangements in Residential Aged Care Subsidies (the Pricing or Hogan Review) then in its early stages and the Hogan review report became the vehicle for the Government's decision in 2004 to develop a new funding system for residential aged care.

Applied Aged Care Solutions (AACS – Principal, Richard Rosewarne) conducted two projects on the redevelopment of the RCS and it was in this phase that the ACFI title was adopted. AACS first developed a range of options for the new system and then conducted a large trial of the system in the field. Data from this trial underpins much of the modeling of the impact of the ACFI and subsequent budget calculations. Further modeling, on the same field-collected data, but using more recent budget figures and more sophisticated modeling techniques was conducted by Access Economics in late 2006.

Aged and Community Service Australia (ACSA) has been closely involved in this process from its inception and has provided advice, grounded in the experience of our members in the current system and the trial of the ACFI, throughout.

Prior to the trial phase ACSA developed a set of *ACFI Success Criteria* to assist in meeting the challenge of remaining focused on the essential requirements of a new funding system for residential aged care and to support the achievement of the objectives of that system. This was, naturally, done from a provider perspective but has been shared with other stakeholders and discussed by the Department of Health

and Ageing's RCS (now ACFI) Reference group. This set of criteria is used as the framework for the next part of this submission.

THE AGED CARE FUNDING INSTRUMENT

ACSA's ACFI Success Criteria and a summary assessment of the ACFI against them are as follows:

1	**Resource Allocation** The funding system matches resources to resident's needs accurately and effectively

The trial data indicates that the ACFI has the potential to allocate resources to client needs more accurately and consistently than the RCS. In the initial period following the proposed implementation on 20 March 2008 this will be compromised by the fact that the additional funding needed for the two new supplements is to be phased in gradually, in $10 increments, over four years.

The need for additional resourcing for care needs being met but not funded was identified in the original ACEMA review and supported by the later independent work of Hogan and Rosewarne. Phasing in these needed resources, rather than making them available from inception is seen simply as a budget saving measure with no policy or care need justification.

RECOMMENDATION:

Additional resourcing to meet higher care needs should be available from inception.

2	**System Efficiency** The ACFI system reduces the paperwork burden, particularly for care staff.

There are several features of the new ACFI system that are intended to have this effect. However the industry, and many of the other stakeholders are skeptical and are acutely aware that the excessive paperwork burden generated by the RCS was an *unanticipated* consequence of that system, not foreseen in advance. The process of 'validation' of appraisals conducted by providers by staff of the Department of Health and Ageing is agreed to be one of the main sources of this problem under the RCS and, while some aspects of this process have been modified, the new process will involve the interaction of the same people over similar issues.

The power of the Secretary (s88-2) to define the type and form of records that must be kept is, in ACSA's view, designed to *limit* the creation of excessive

paperwork, by making it clear that more information is *not* required. ACSA notes that vigilant post implementation scrutiny will be required on this issue and is willing to continue its long standing support for this reform process by assisting with its continuing development.

RECOMMENDATION:

The issue of system efficiency is kept under active review and be made a key component of a robust Post Implementation Review of the ACFI system after 9-12 months of operation.

Developing computerized procedures for the ACFI and more streamlined methods of checking or verifying claims should remain a high priority.

3	**Stability** ACFI provides a more stable funding basis without the continual changes to funding that characterise the RCS.

Professor Hogan's recommendation for fewer levels in the funding system was focused on reducing the volatility of the RCS in which 30-50% of original appraisals are subsequently changed by the validators. Hogan argued that fewer, broader levels would mean fewer changes. The ACFI while having fewer questions than the RCS and fewer primary levels (3 rather than 8) in fact has more, finer levels or funding points.

ACSA is cautiously supportive of this more finely gradated funding but the real test of stability will come when the system is in operation. As with Criterion 2 this issue must be kept under active review and volatility levels reduced. A target of single digits percentage changes is suggested as a maximum with the ideal being zero.

RECOMMENDATION:

The issue of funding stability is kept under active review and be made a key component of a robust Post Implementation Review of the ACFI system after 9-12 months of operation.

A target of zero changes is suggested.

4	**Incentive Structure** The ACFI provides incentives which reward appropriate provider behaviour and positive outcomes for residents.

The incentive structure built into the current RCS system could be characterised as one which encourages dependency since providers are paid more the more they do for people and the less independent they become. This feature of the RCS was identified as a negative in all of the reviews of the system.

The ACFI takes a step towards addressing this principally by removing the requirement for automatic annual reviews (Division 27). If aged care services can make people 'better' that is, more independent, they will no longer lose funding as a result of doing so.

This change for the positive has been limited in the Bill in that it doesn't apply to residents admitted from hospital or to residents whose classification has been significantly changed in the previous 6 months.

The need for these limitations on eliminating reappraisals, whose principal function is to limit financial risk to the Commonwealth rather than to ensure optimal care for residents, should be reviewed to ensure that the incentive structure in the funding system is optimized for residents.

In fact, as the Second Reading speech makes clear, 60,000 of the current mandatory annual reappraisals result in no change to the amount of funding. This implies that the impact of removing the mandatory annual appraisals may be more on reducing meaningless paperwork than it on creating a better incentive structure.

RECOMMENDATION:

The limits placed by ss27-2 (1) on positive incentives for rehabilitation through 'enduring' classifications be reviewed after 9-12 months operation.

5	**Assessments** The ACFI has an appropriate assessment process in place and eliminates resident reassessment issues.

The Bill proposes one key improvement in this area in that a resident can take an existing assessment with them when transferring to another facility provided that the receiving facility is satisfied that it is accurate. This should remove one set of unnecessary assessments.

During the development phase of the ACFI the possibility of using external assessors (such as ACATs) to appraise residents was considered but a decision was taken not to proceed with this option, at least on inception. This issue could be re-visited in the future. Links between assessments for residential care and community care could also usefully be explored, noting the significant differences in the context and dynamics of these two modes of service.

The assessment instruments have been newly designed, tested and refined and in-principle agreement to the establishment of a technical reference group to ensure that they are kept up-to-date with current practice has been reached. Issues such as the substitution of the Psychogeriatric Assessment Scale for the more familiar 'mini mental' (MMSE) need to be carefully evaluated by skilled and knowledgeable practitioners balancing technical merit, familiarity and other considerations.

The requirements to review certain classes of assessments after six months. referred to above, will result in additional assessments of residents at additional cost and at additional potential inconvenience to residents. ACSA understands that these provisions are designed to control the financial risk to the Commonwealth but observes that this protection comes at a cost.

RECOMMENDATION

That a time limit of 24 months (ie a 'sunset' provision) be imposed on the restriction of the validity of certain classification decisions to six months (s27-1) and that this restriction be lifted after this period unless there is compelling evidence to support its continuation for a further period of 12 months.

6	**Implementation Impact** Changes in funding for specific facilities are minimized and managed. Implementation is adequately resourced.

Funding for existing residents is 'grandparented' under the ACFI proposals although at the price of reduced funding for higher care needs in the first four years of operation and a substantial threshold before new levels of funding are provided. That is, residents remain on their RCS funding until their ACFI funding is $15 higher. This is another cost saving measure which takes resources away from the provision of care. It also gives rise to additional complication in the system by creating a class of residents who are to be subsidised at an 'RCS saved rate'. This measure adds complexity to the system while reducing funding.

Such thresholds also apply where a resident is reassessed and found to have to higher care needs. They are equally arbitrary in this context and should be removed.

Until the indicative 'prices' for the ACFI are available it will not be possible to fully assess the full financial impact of the ACFI on individual services or organizations and hence this criterion.

The recently announced delay in implementation until March 2008 is very welcome and will be much better in terms of system development, software development, information and training than the previously proposed 1st July 2007 date.

RECOMMENDATIONS:

Additional resourcing to meet higher care needs should be available from inception and not phased in to offset the cost of 'grandparenting'.

Arbitrary thresholds limiting the payment of higher subsidies should be abolished.

OTHER ISSUES RAISED BY THE BILL

Definition of High and Low Care

The policy intent behind the changes to the definition of high and low care is that there should be no change 'on the ground. The moving of the definitions from the primary Act to the Classification principles is supported because it may need to be adjusted to ensure the achievement of the policy intent. The proposed definition of high care in ACFI terms has been established on the basis of the data gathered in the

ACFI trial conducted by Applied Aged Care Solutions and many of the trial participants are apprehensive that in real operations a bias in favour of high care may emerge (That is the same incoming resident may be more likely to be classified as 'high care' than under the RCS. While on its own this may not be so much of a problem, it could have significant negative effects on the capacity of the industry to raise capital for new or refurbished buildings given that the policy on user charging for accommodation between high and low care remains significantly inconsistent, despite recent changes.

The definition of high and low care is also invoked in a number of professional, regulatory and industrial demarcation issues centering on the question of which tasks must be performed by which type of staff in high and low care settings respectively ie if its high care, it must be nursing.

High Dependency Care Leave

The Bill proposes the abolition of High Dependency Care Leave which currently allows two aged care facilities to receive a subsidy at the same time for the same resident where a temporary period of high care is required by a normally low care resident. The Department of Health and Ageing has advised ACSA that the use of this provision is rare, has been misapplied in some instances and is not required in facilities that are able to provide for 'ageing in place'. The fact that the usage of this current provision is rare can be used to support its retention just as much as its abolition. In areas where ageing in place is not available within a facility, is it necessary or desirable to remove a potential source of flexibility from the system? There are cases where this provision has been used, correctly, and it doesn't cost much.

Penalties for Late Submission

The ACFI system incorporates penalties for the late submission of applications for classification. A $25 reduction in the daily rate of subsidy is applied for the period between when an application was due and when it is received. In ACSA's view there is a sufficient penalty imposed by the late payment of a subsidy for a late claim without the additional imposition of what is effectively a fine. The industry sees this as an arbitrary exercise of administrative power. Care is being provided throughout the period of the penalty rate and the imposition of what is effectively a substantial 'fine' is simply punishment for non compliance with bureaucratic timelines. If there were any genuinely increased costs to the Commonwealth, a one off administrative charge could be considered but in fact late applications save the commonwealth money!

RECOMMENDATION

That the arbitrary penalty for late submission of applications for classification be abolished.

New Measures for Addressing Poor Compliance

Section 25-4 introduces new measures for dealing with situations where the Department of Health and Ageing is not satisfied with the capacity or performance of an aged care provider in making classification decisions. The provisions of this section, to suspend or *stay the suspension* of an approved provider from making classification decisions and to impose conditions on the reinstatement of such powers, contain new elements (the powers to stay and to impose conditions) and will need to be carefully monitored in practice. The power to impose an adviser on classification appraisals will need to be exercised in such a way as to not simply generate work for consultants at the expense of providers, there is a potential for corruption in such transactions which will need to be carefully scrutinised. For this and other reasons the operation of this section should also be in scope for the post-implementation review recommended above.

RECOMMENDATION

That the operation and use of the power to suspend approved providers from making classification decisions be included in a formal Post Implementation Review of the introduction of the ACFI.

Power of the Secretary to Change a Classification

As noted above, this is an existing power and the high volume of changes that resulted from its exercise was one of the reasons for entering into the long process of reviewing the RCS and developing the ACFI. The Bill seeks to clarify the Secretary's power to change a classification if they are satisfied it is incorrect for *any* reason.

ACSA notes that a classification appraisal can only be correct at a point in time (the time of assessment) and that the Secretary's power to change a classification retrospectively must be limited by this fact. The key here is that the power must be to change a classification that *was* incorrect, *at the time it was made* and not to change a classification that now happens to be incorrect due, for example to a resident's condition improving as a result of good care. ACSA understands that this was the policy intent and wishes to ensure that this is given effect in the Bill, as implied in the Explanatory Memorandum.

CONCLUSION

Changing something as complex as the funding system for a $5 billion industry is a significant undertaking and ACSA commends the Government for undertaking this reform. Because the system is complex, because it is about the interaction between different parties (such as providers, residents and funders) and because it is subject to very detailed specification and control by the Department of Health and Ageing through the Aged Care Act, it is not really possible to make an overall assessment of the impact of changes to it at a single point in time.

ACSA has identified in this submission the principal issues that we believe will need to be kept under scrutiny if the funding system is to optimally realize its goal of supporting the best possible residential care for older people. We support the sentiment, expressed in the Second Reading speech, that it will be necessary for the Government to continue to work closely with the aged care industry to ensure that unnecessary 'red tape' is eliminated and that the system directs funding to residents according to their needs efficiently.

It will also be necessary for all interested parties to review the changes to the Principles made under the Aged Care Act that will be necessary to give full effect to the new ACFI funding system. ACSA seeks the Committee's support in requesting that adequate time be allowed for scrutiny of these Principles and consideration of their likely effect.
