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The Chairperson
Australian Senate Community Affairs Committee
PO Box 6100
Parliament House
CANBERRA ACT 2600

CATHOLIC HEALTH
AUSTRALIA
PO Box 330
DEAKIN WEST ACT 2600
Level 1
Rowland House
10 Thesiger Court
DEAKIN ACT 2600
Telephone
02 6260 5980
Facsimile
02 6260 5486
Email
secretariat@cha.org.au
Web
www.cha.org.au

The Catholic health, aged and community care sector

Catholic Health Australia Incorporated

ABN 30 351 500 103

Dear Chairperson

Inquiry into the *Aged Care Amendment (2008 Measures No. 2) Bill 2008*

Catholic Health Australia (CHA) makes this submission to the Senate Inquiry on behalf of the Catholic aged care sector. CHA is the largest non-government provider grouping of aged care services in Australia. With over 19,000 Commonwealth approved residential aged care beds, the Catholic sector plays a significant role in the provision of aged care services to older Australians.

The terms of reference for this Inquiry are limited in scope. They deal mainly with matters relating to the changing nature of ownership, governance, and management structures that oversee the delivery of aged care services. By way of response to these terms of reference, CHA in Part A provides specific recommendations in relation to the clauses of the *Aged Care Amendment Bill.* The *Bill* in its current form has the broad support of CHA, but in summary CHA does not support proposals as currently drafted to:

1. revoke service provider status;
2. create a new authority to set a maximum bond;
3. impose sanctions on the provision of “future care”;
4. create a new authority to deter future non-compliance.

CHA then in Part B makes broader recommendations in relation to the need for further reform of aged care service provision. These broader recommendations are perhaps beyond the terms of reference of this Inquiry, but are considered crucial to the ability for service providers to meet the care needs of older Australians into the future.

Part A: The *Aged Care Amendment Bill*

1) Revocation of Provider Status: Schedule 1 – Part 1, Clause 24

Clause 24 seeks to repeal the existing Section 10-2 and substitute it with a new provision as follows:

> The approval of a person as a provider of *aged care that is in force lapses if:
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> (a) no allocation of a *place to the provider in respect of any *aged care service through which it provides aged care is in effect; and
>
> (b) no *provisional allocation of a place to the provider in respect of any aged care service through which it provides, or proposes to provide, aged care is in force; and
>
> (c) the transfer day has not occurred for any transfer under Division 16 of a place to the person for the provision of aged care through the aged care service or services through which it provides, or proposes to provide, aged care.

Section 10-2 currently provides that if an approved provider does not deliver an aged care service during a continuous period of 6 months, the approval lapses.

The effect of the proposed amendment would be that as soon as an approved provider with one approved service has all their approved places revoked, their approval as a provider would lapse.

This new clause will also remove the right of an approved provider to seek a waiver from the potential consequence of a lapse, which in turn would eliminate the possibility of having a decision administratively reviewed. Under the current *Act*, service providers are already vulnerable to the loss of approved provider status due to the time it can take for a reviewable decision to be heard by the Administrative Appeals Tribunal, which is generally in excess of six months.

A sudden loss of approved provider status under the current law or the proposed amendment has multiple potential impacts, some of which are not desirable. For example, it may not be desirable to see provider status revoked in circumstances where the provider is the only service within a specific geographic area. Revocation may also lead to the requirement to make immediate refunds of all bond lump sums held regardless of their liquid availability, which would have long term viability impacts on a service that may seek to regain their approved provider status.

The potential and perhaps unintended consequences of this proposed amendment do not appear to outweigh the possible benefit of the amendment. In such circumstances, CHA recommends the amendment as currently drafted not be supported.

2) Setting of maximum bonds: Schedule 1 – Part 1, Clause 96

Clause 96 seeks to repeal subsection 57-14(1) and replace it as follows

> (1) The Secretary may determine, in accordance with the User Rights Principles, that a person:
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> (a) must not be charged an *accommodation bond because payment of an accommodation bond would cause the person financial hardship; or
>
> (b) must not be charged an accommodation bond of more than a specified maximum amount because payment of more than that amount would cause the person financial hardship.

The *Act* currently provides a basis for determining the maximum permissible bond lump sum based on an assets assessment of the resident. This amendment would provide, for the first time, the right of the Secretary to set a maximum bond amount. CHA contends the current asset assessment process as empowered by the *Act* is not ideal but preferable to the proposed amendment which would allow for the first time for a maximum bond to be set.

CHA is concerned that this amendment could be used to legislate specified maximum bond amounts that an approved provider may seek from all bond eligible care recipients. This may result in yet another limitation on the ability of service providers to fund delivery of services by way of reasonable contributions from users with capacity to pay. These same concerns also apply to proposed amendments at:

- Schedule 1 – Part 1, clause 97 Subsection 57-14(4)

  After "*accommodation bond", insert ", or an accommodation bond of more than a specified maximum amount,".

- Schedule 1 – Part 1, clause 98 Subsection 57-14(4)(b)

  After "accommodation bond", insert ", or a larger accommodation bond,".

- Schedule 1 – Part 1, clause 99 Subsection 57-14(7)

  Repeal the subsection, substitute:

  > (7) If the Secretary makes a determination, the notice must:
  >
  > (a) set out any period at the end of which, or any event on the occurrence of which, the determination will cease to be in force; and
  >
  > (b) if the determination is that a person must not be charged an *accommodation bond of more than a specified maximum amount—specify the maximum amount of the accommodation bond.

The potential benefit of these proposed amendments do not outweigh their potential detriments. In such circumstances, CHA recommends the amendment as currently drafted not be supported.

3) Impact of non-compliance on future care: Schedule 1 – Part 1, clause 116

Clause 116 seeks to add after paragraph 65-2(c) the following:

> "(ca) whether the non-compliance would threaten the health, welfare or interests of future care recipients;"

This amendment would give to the Secretary a new authority to impose sanctions on a service provider for non-compliance with standards in relation to "future care recipients." The amendment proposes this new authority without prescribing how the Secretary's decision would be made in relation to "future care," that is, the Secretary will be authorised to make a decision about an event that has not yet in fact occurred. In the absence of further detail as to how and on what basis this authority might be exercised, the amendment appears vague and open to uncertain interpretation.

Current practice enables the Secretary to impose a requirement that an approved service not be paid a care subsidy for new approved care recipients for a period of up to six months whilst sanctions remain in place. This current practice has the effect of preventing a service operating under sanction from taking on new clients until such stage as standards have been complied with.

Given the ability of the Secretary to prohibit payment of new care subsidies to a service provider under sanction, and given the uncertain working of the proposed amendment, CHA recommends the amendment as currently drafted not be supported.

4) Determent of future non-compliance: Schedule 1 – Part 1, clause 117

Clause 117 seeks to add after paragraph 65-2(d) the following:

> "(da) the desirability of deterring future non-compliance;"

This amendment seeks to introduce a new concept into the *Act*. How this new approach would be actually applied is uncertain. At the very least, its application would be open to subjective interpretation. In the absence of specific directions on its operation, it may result in operator uncertainty and could have the effect of resulting in punitive action being taken against operators who may otherwise be unaware of their new obligations.

CHA believes it is desirable to prevent non-compliance with standards, but believes effort should be placed into *"enabling and incentivising"* service

providers to meet standards compliance rather than creating a new potentially punitive mechanism to *"impose"* compliance.

CHA recommends that the amendment not be supported in its current uncertain form, but does recommend the Inquiry consider methods of *"enabling and incentivising"* standards compliance.

Part B: The need for further reform in aged care

The last major reform of residential aged care policy occurred in 1997. The benefit of those reforms has now been exhausted. The first major reforms of aged care policy occurred under the Hawke Keating Government. CHA considers that it is time for the next major reforms to be implemented and that it would be appropriate for these to occur under a Rudd Government.

CHA has three key goals for aged care reform:

1. Older Australians receive the care they need in the accommodation of their choice, whether in their own home, in the community or in a residential facility;
2. Demographic based funding will be oriented to ensure the delivery of excellence in person centred, compassionate care
3. The funding framework will ensure that the care of older Australians is delivered by an appropriately skilled and qualified workforce.

In seeking to achieve this vision CHA has produced a Blueprint for policy change in aged care, which it offers to this Inquiry and Government as a plan for how improvements in aged care services can be achieved.

Residential aged care is currently regulated and funded by the Commonwealth. Commonwealth regulation limits the allocation of residential aged care beds and the user fees that can be charged for their provision. Commonwealth operational funding is insufficient in that it does not relate to the actual cost of service provision. Subsequently, in October 2008 the failure of this regulatory and funding mix was highlighted again with overall average earnings for aged care providers having dropped away by 10% in just one year and the estimated average return on investment for new, single room facilities as now 1.1% and falling. (1)

The challenges being faced in Australia are no different to those being faced internationally. The United Kingdom and Sweden, who have principally funded aged care services from the tax system, are encountering problems relating to the scarcity of revenue. These countries are moving away from solely tax payer funded arrangements. In Australia, aged care funding is not solely tax payer funded, yet the ability to fund it from user charges in unreasonably limited.

To the extent that the Commonwealth does fund aged care services, its funding is insufficient. From March 2008, a new funding instrument (the Aged Care Funding Instrument) appears to be compounding the problem as high care admissions (that are not able to charge bonds) replace low care admission (where a bond can be charged) and many older people with social and psychological needs (who do not attract sufficient funding under the new instrument) may go without residential aged care due to their lack of financial means or lack of available appropriate residential aged accommodation.

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[1] Grant Thornton Aged care survey 2008, summary findings October 2008

In looking to bring about reform, the CHA Blueprint for policy reform makes a number of key recommendations. CHA argues reform should not be piecemeal. Rather it should include revision of how consumers plan for their entry into aged care, how they are assessed for entry, how aged care services are licensed for operation, how services are funded, and how staff are trained and rewarded for their role as care givers. The importance of this final focus on staff identification, training, and retention cannot be under estimated. If action is not taken to build the caregiver workforce of the future, there will be inadequate numbers of caregivers to look after those Baby Boomers who are soon to enter care.

With the Baby Boom bulge expected to peak around 2030, Australia needs to be ready for an increase in demand for residential aged care. At present, some aged care operators are refusing to develop new residential services because the risk of doing so outweighs the incentive. Action must be taken to reverse this trend.

To be ready for the residential aged care needs of the Baby Boom bulge, CHA in this Blueprint has provided an assessment of current policy settings, a summary of international comparison, and a policy plan for achievement of aged care reform. Most importantly, CHA's plan for reform does not expect Government to fund all service provision – it expects Government to contribute financially in a manner that reflects actual cost of service provision, but it also expects Government to free up current constraints so that consumers can better contribute to their own care where they are financially able to do so.

Within the CHA Blueprint for Policy Reform, some of the key recommendations for reform include:

- **A new consolidated single funding program linked to actual cost of service provision.** Funding of aged care is currently provided by a multitude of Commonwealth and Commonwealth/ State/Territory funded programs. A single, simplified and consistently applied national aged care program would better enable older Australians to receive the right care, in the right place, at the right time.

- **Aged Care Assessment Team program to be fully funded and managed by the Australian Government.** This service would ensure consistency of eligibility is applied, and there is no conflict of interest when undertaking assessments.

- **Consumer Directed Care**. Consumer Directed Care provides choice and control. Consumers are able to choose which services they receive and who will deliver these services and when. CHA believe that aged care service consumers in Australia would benefit through increasing consumer choice by way of vouchers or managed purchasing of aged care as a possible alternative to direct funding of services.

- **Localised population based funding**. A population approach would facilitate equitable access to aged care services. By establishing indicators of need across regions, Government would be able to ensure greater flexibility and responsiveness in service delivery.

- **Removal of limitations on consumer fees**. Commonwealth regulation currently prohibits an aged care service from determining the cost of its service that is purchased by the consumer. Re-regulation would allow the user fee to reflect the cost of the service, and give consumers choice in the type of service they seek. Safety nets, such as those already provided by Catholic aged care services in the form of subsidised concessional beds would be required for those unable to meet service costs themselves.

- **Abolition of the distinction between low and high care.** With changes in the needs of those entering care, the technical distinction between low and high care is becoming increasingly irrelevant. The merger of low and high care would also require the review of the regulatory requirements for each category, allowing bonds to be levied for all residential aged care where the consumer and provider agree to do so.

- **An innovation fund.** Creation of an innovation fund that promotes a leading edge approach to person centered aged care, and ensures the dissemination of this research.

- A **National Health Workforce Commission** that consolidates all current initiatives aimed at the health workforce planning and development, with a specific mandate to provide skilled workers for community and residential aged care services.

- **Increasing Superannuation to 15%.** The ability of future retirees to fund their aged care service needs is likely to be directed by the availability of funds at their disposal. Superannuation should be increased to its originally proposed 15%, with consideration to be given to the quarantining of a portion of superannuation payouts to be available specifically for purchase of aged care services.

- **Creating insurance products to contribute to aged care.** More than 40% of Australian's are used to the concept of self insuring for their health care. Australia's health system depends on a strong pool of consumers with private health insurance. Private health funds and other insurers should be given incentives to develop products to fund future aged care.

In developing this Blueprint for policy reform, CHA is seeking to contribute to Government planning for the future of aged care. Few if any of the proposals for reform described here and in CHA's Blueprint are new. Rather

their failure to be acted on by previous Governments speaks to the urgency for action.

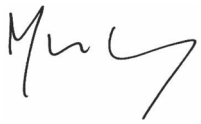
Conclusion

CHA would welcome the opportunity to appear before the Inquiry to address the specific terms of reference in relation to the *Aged Care Amendment Bill.*

CHA would also welcome the opportunity to provide to the Inquiry its more detailed Blueprint for policy reform. CHA is aware that the Finance and Public Administration Committee is currently conducting an Inquiry into residential and community care in Australia, and CHA will outline the detail of its Blueprint for policy reform of aged care to that Inquiry in due course.

Thank you for the opportunity to provide this submission.

Yours sincerely



Martin Laverty
Chief Executive Officer