Senate Community Affairs References Committee Inquiry into
Planning Options and Services for People Ageing with a Disability
Submission by Dr Kathryn Antioch, Health Economics and Funding Reforms

(1) Introduction

I hereby provide my Submission to the above Inquiry. The Terms of Reference for the *Community Affairs References Committee for Inquiry into Planning Options and Services for People Ageing with a Disability* are to consider access to planning options and services for people with a disability to ensure their continued quality of life as they and their carer's age. Further, the review is to identify any inadequacies in the choice and funding of planning options currently available to people ageing with a disability and their carers. My submission principally builds upon my recent submission to the Senate Finance and Public Administration Committee Inquiry into COAG Reforms Relating to Health and Hospitals[1] which is attached as follows:

- **Attachment 1**: Correspondence to Senate Finance & Public Administration Inquiry into COAG Reforms Relating to Health and Hospitals
- **Attachment 2** Correspondence to Lindsay Tanner & Federal/State Stakeholders re briefing for April 2010 COAG meeting.
- **Attachment 3** COAG April 2010: Update on reforms on Activity Based Funding, Risk Adjustment and EBM Implementation

My submission to the Senate Finance and Public Administration Committee Inquiry relates to reform initiatives that are also relevant to the Senate Community Affairs References Committee Inquiry. This includes recommendations for new *State/Territory Centers of Evidence Based Medicine (EBM), Health Services and Workforce Redesign* and an *International Centre of Evidence Based Medicine and Health Economics*. Further, the risk (severity) adjustment funding reforms can potentially enable funding to match health need for the elderly, including those with a disability and related data could facilitate service planning. The COAG submission at Attachment 3 includes web links to two previous briefs considered by COAG [2] [3] relating to the new National Health Care Agreements in 2009. The Senate Community Affairs References Committee is encouraged to consider all three briefs to COAG as they provide important background to my submission. The relevance to aged care, including those with a disability is outlined more fully below. *System-wide issues* are addressed that could impact on access to planning options and services by the elderly with a disability and their carers. They could also directly impact on the funding and choice of planning options that can become available to these individuals.

(2) Centres of Evidence Based Medicine (State and Federal)

The Proposed new State/Territory Centers of Evidence Based Medicine (EBM), Health Services and Workforce Redesign and an International Centre of Evidence Based Medicine and Health Economics could together assist in streamlining all health sectors including aged care, hospital and community services and improve quality, access and efficiency through implementation of the latest EBM, change management techniques in health services delivery, medicine, surgery, and preventive health across the continuum[1]. EBM and best practice for dementia treatment is a priority area for Health Economics and Funding Reforms. It could also be a priority of the proposed International and State Centres, along with severe arthritis, serious visual and hearing impairments and other disabilities of the elderly population in Australia. There would be a need for the State and International Centres to include effective links to informal carers in the co-ordination of EBM/best practice modalities for the elderly with a disability, and develop 'user

[1] Antioch, KM (2010) *Submission to the Senate Finance & Public Administration Inquiry into COAG Reforms Relating to Health and Hospitals* http://www.aph.gov.au/Senate/committee/fapa_ctte/coag_health_reforms/submissions.htm *(submission 20)*
[2] Antioch KM (2008) Integrating Economic and Clinical Evidence, Guidelines and Equity into National Regulation and Financing: Reforms for the Australian Health Care Agreements (AHCA): 2009 and Beyond. Submitted to *European Journal of Health Economics.* Paper provided to *Council of Australian Government (COAG), other State and Federal stakeholders and NHHRC.*
[3] Antioch KM (2009) Intergovernmental Agreements: Update on Reforms on Risk Adjustment of Health Funding and Evidence Based Medicine (EBM) Implementation. Paper to *Council of Australian Government (COAG) and other State and Federal stakeholders, National Health and Hospitals Reform Commission (NHHRC).*

friendly' communication strategies of such initiatives for both professional and informal carers.[4] The implementation of the new State and International Centres can assist with improving the social, clinical and institutional aspects of aged care and can address access standards, planning mechanisms at the regional level, policy supporting elderly in their homes and business models to meet the needs of the elderly. This would involve key linkages to reforms in other health services to ensure technical and allocative efficiency and ensure smoother service provision across the health care continuum[4]. See Antioch (2008, 2009, and 2010) for further insights on the nature of the State and International Centres and relevance to the COAG reform agenda.

The National Health and Hospitals Reform Commission (NHHRC) emphasized that redesign for aged care services should ensure the complex array of services is well co-ordinated and integrated (NHHRC, 2009[5], pg 102). Witnesses for the Senate Standing Committee on Finance and Public Administration Inquiry into Residential and Community Aged Care in Australia commented on the band-aid approach to problems in the aged care sector and reform is needed (SSCFPA, 2009[6]. Pg 15).

In addressing these concerns the State and International Centres would also address the need identified by the Productivity Commission for providing better information to older people and their families so they can make meaningful comparisons in choosing services (Productivity Commission, 2009[7], pg 19; 2010[8]). These EBM reforms would also address the current curtailing of innovation in service design and delivery resulting from the constraints of the current regulatory arrangements as identified by the Hogan Review (2004[9], pg 2). The associated cost savings achieved from EBM implementation would also assist in addressing the increasing fiscal costs for the elderly identified by the Henry Review (2010[10], pg 29), with cost savings estimated of at least $1,367.62m over five years in the hospital sector alone[3] [4].

Linkages between the proposed International and State Centres could be of interest to the Senate Committee given, during 2009 the Health Minister of one of Australia's largest States advised me that the State planned to implement a similar type of State Centre. Further, some other Health Ministers advised that their Departments were considering my proposals in the context of the implementation of the Agreements. Given provisions of the NHHN Agreement (2010) the proposed International Centre and State Centres could facilitate a co-ordination function between the Local Hospital Networks and Medicare Locals. This could be achieved by streamlining the patient journey between sectors (including aged care) in the implementation of Guidelines and evidence by the development, implementation and evaluation of local quality instruments such as *clinical pathways, clinical protocols and management plans*[11]. This holds considerable potential to improve the health care of the elderly, including those with disabilities.

(3) Risk (severity) adjustment of service planning data and health finance to reflect patient complexity

Risk adjustment in Activity Based Funding and other areas in health enable funds to reflect health need[12] and has application across the continuum, including aged care services. Some variables that would be of relevance to aged care would include measures of *functional status/complexity*, such as the Barthel Index or Functional Independence Measure (FIM)[13] [14], with other key issues for consideration such as models of care, care setting, and application of

[4] Antioch KM (2010) *Submission to the Productivity Commission's Inquiry into Caring for Older Australians (Submission 417).*
[5] NHHRC (2009) *A Healthier Future for all Australians, Final Report June.*
[6] Senate Standing Committee on Finance and Public Administration (2009) *Residential and Community Aged Care in Australia April.*
[7] Productivity Commission (2009) *Annual Review of Regulatory Burdens on Business: Social and Economic Infrastructure Services*, Research Report, Canberra.
[8] Productivity Commission (2010) *Caring for Older Australians*, Issues Paper.
[9] Hogan Review. See *Aged Care Price Review Taskforce 2004* (cited in Productivity Commissions Issues paper on Caring for older Australians, 2010).
[10] Henry Review. *See AFTS Secretariat 2010* (cited in Productivity Commissions Issues paper on Caring for older Australians, 2010).
[11] Antioch KM (2010) *Invited submission to the Senate Community Affairs Legislation Committee on the National Health and Hospital Network Bill 2010.* http://www.aph.gov.au/Senate/committee/clac_ctte/Nat_hlth_hospital_network/submissions.htm *Submission 10*
[12] Antioch KM & Ellis RP et al (2007) "Risk adjustment Policy Options for Casemix Funding: International Lessons in Financing Reforms" *European Journal of Health Economics.* September. http://people.bu.edu/ellisrp/EllisPapers/2007_AntiochEllisGillett_EJHE_RiskAdj.pdf
[13] Granger, C et al (2007) "Modifications of the FIM instrument under the inpatient rehabilitation facility prospective payment system" *American Journal of Physical Medicine and Rehabilitation* 86 (11);883-82.Nov

clinical pathways, management plans or protocols[15] [4.] Some classification systems include, inter alia, the Sub acute Ambulatory Classification (SACS), Casemix Rehabilitation Admitted Funding Tree (CRAFT)[16] Australian National Sub acute and Non acute patient (AN-SNAP)[17] and the Diagnostic Cost Group Hierarchical Condition Category (DCG-HCC)[18] [4.] The *Frailty Adjuster for Program* of All-inclusive Care for the Elderly (PACE) for CMS-HCC would be of considerable interest. Some scales and indexes that could be useful to consider for the service needs, planning and also funding for the elderly with a disability could include the Charlson Index (Romano Adaptation), Charlson and Elixhauser co-morbidities, SF 36V Physical Component Score, SF 36V Mental Component Score, Diabetes Severity Index (DSI), Burden of Illness Score for Elderly Persons (BISEP) and the High Risk Diagnoses for Elderly Scale. The development of adequate risk adjustment could enable transparent financing to enable high quality standards and would be important in addressing information and market asymmetries through developing more accurate price signals. It would also assist in service planning.

(4) Equity Issues in Financing Arrangements

Demographic change is increasing demand for aged care and reducing the supply of informal carers. These caregivers co-ordinate formal community care services for the aged in their homes. A shortfall in caregivers may undermine sustainability of community care and increase demand for residential care with additional budget costs for governments. Taxpayers may need to pay more although they will insist on more exacting standards of equity and efficiency. Different treatment for funding accommodation, personal care and health care components of residential aged care may be required given the former are not exclusively associated with disability and frailty. Baby boomer households are worth approximately 1.3 times that of the average Australian household. Reverse mortgages have made it easier for the aged to finance a greater proportion of their residential aged care costs. Other options to consider are voluntary and compulsory insurance[19]. These initiatives, highlighted by Mitchell (2010) [19] are worthy of detailed consideration [4].

(5) Conclusion

The foregoing contribute to forging a path for transitioning from the current regulatory arrangements to a new system that ensure continuity of care and allows the sector adequate adjustment time and within the government's medium term fiscal strategy. There would be considerable economies of scale and efficiencies associated with the State and international centres[4], along with an appropriate focus on dementia and other significant disabilities as a key priority area for aged care. Risk adjustment will enable improved service planning for the elderly with a disability and could also enable funds to be allocated at a level to meet health need.

Dr Antioch is Principal Management Consultant Health Economics and Funding Reforms. *She held two Ministerial appointments, as the health economics member, to the Principal Committees of the National Health and Medical Research Council (NHMRC) for six years to 2009. These were the Health Advisory Committee and National Health Committee which approved Clinical Practice Guidelines and translated evidence into clinical practice. Dr Antioch worked as part of Senior Management of Bayside Health (now Alfred Health) in Melbourne until 2005 where she led the translation of evidence into clinical practice across three tertiary, community and rehabilitation hospitals, involving inter alia, aged care. She led similar work across Western Health Network until 2007. She presented the model of EBM translation across Australia in 2007, sponsored by the Australian Health Care and Hospitals Association, in the context of the renegotiations of the Australian Health Care Agreements and briefed COAG and other Federal/State stakeholders on the recommendations arising from the national consultations. She also led the risk adjustment reform of Activity Based Funding (ABF) in Victoria for the Victorian Government*[12]. 25 August 2010

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[14] Mackintosh S (2009) "Functional Independence Measure" *Australian Journal of Physiotherapy* Vol 55 pg 65.

[15] Antioch KM, Jennings, G & Botti M et al (2002) "Integrating cost-effectiveness evidence into clinical practice guidelines in Australia for Acute Myocardial Infarction" *European Journal of Health Economics* 3:26-39

[16] Brook K et al (2007) "The effect of the introduction of a casemix based funding model of rehabilitation for severe stroke: an Australian experience. *Archives of Physical Medicine and Rehabilitation* 96(7):827-32, July

[17] Gordon R, Eager K and Currow D et al (2009) "Current funding and financing issues in the Australian hospice and palliative care sector" *Journal of Pain and Symptom Management* 38 (1): 66-74 July

[18] Pope G et al (2004) "Risk Adjustment of Medicare Capitation Payments using the CMS-HCC". *Health Care Financing Review* 25(4): 119-141.

[19] Mitchel, A (2010) "Aged Care doesn't add up" *Australian Financial Review* pg 62. 4 August.