Chapter 4

Aged care

Introduction

4.1 In residential aged care, stakeholders raised concerns over planning in relation to the Commonwealth assuming responsibility for the sector, the longer-term viability of the sector, and funding gaps between the cost of providing care and the available government subsidies.

4.2 The need for reform of aged care was acknowledged. The Royal Australian College of General Practitioners (RACGP) noted that the third intergenerational report projects that over the next 40 years the number of Australians 85 years and over will more than quadruple from around 400,000 in 2010 to 1.8 million by 2050. The RACGP went on to comment that this will create an 'unprecedented demand' for the full range of aged care services and emphasised the need to increase funding for the sector.[1]

4.3 Aged and Community Services Australia (ACSA) raised the question of the timing of the health reforms in relation to aged care given that the Productivity Commission's inquiry into aged care and its interface with other social policy areas is currently ongoing. It continued:

> 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.[2]

Zero real interest loans and funding

4.4 Whilst supporting the extension of the Zero Real Interest Loans Scheme (ZRILs), Catholic Health Australia (CHA) raised concerns that it was targeted to selected regions and is 'only a partial response to the inadequacy of the current capital funding arrangements to sustain the expansion and renewal of residential services, especially the high care services that will be needed as the population ages'.[3]

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1 Royal Australian College of General Practitioners, *Submission 15*, pp 1–2.

2 Aged and Community Services Australia, *Submission 17*, p. 1.

3 Catholic Health Australia, *Submission 3*, pp 12–13.

4.5 CHA also raised the problem of access to general practitioner services in aged care facilities. CHA provided the findings of a GP Access Survey concerned with the availability of medical care in residential aged care settings. The survey, conducted across 6,364 residential aged care beds, found that 15 per cent of aged care homes report a shortage of GPs that results in compromised patient care; and 57 per cent of aged care homes reported admitting aged care residents to hospitals because of problems in accessing GPs.[4]

4.6 The ACSA stated that it remained to be seen whether the changes in the terms of the ZRILs will make any material difference to their ability to support the construction of 2,500 new beds.[5] ACSA went on to comment:

> 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.[6]

4.7 The Australian Medical Association (AMA) argued that the interest free loans needed to be supported by proper ongoing funding to ensure that new beds were actually constructed and maintained into the future. It continued:

> The AMA is concerned that without expanded ongoing investment, new aged care beds may not eventuate, and therefore not free up beds in public hospitals.[7]

4.8 Similarly, the ACSA commented that the aged care industry was 'sceptical' about the ability of the zero real interest loans to make more than a marginal difference to the viability of new aged care construction and held that pending the Productivity Commission inquiry's findings, 'the slow down in construction of the new capacity we need to meet the needs of an ageing population will continue'.[8]

4.9 Citing 2009 Access Economics research, CHA noted that revenue streams based on current accommodation payments for residential high care ($26.88 per bed day), construction of a new residential high care home would not proceed even with a construction cost per bed as low as $138,000 as the present value of revenue is less than the estimates of all the costs, making the internal rate of return less than the weighted cost of capital.[9] CHA noted that based on an average construction cost of $187,000 per unit to build an aged care home to contemporary standards, the required

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4 Catholic Health Australia, *Submission 3*, p. 3.

5 The terms of the loans were increased from 12 to 22 years.

6 Aged and Community Services Australia, *Submission 17*, p. 3.

7 Australian Medical Association, *Submission 10*, p. 10.

8 Aged and Community Services Australia, *Submission 17*, p. 3.

9 Catholic Health Australia, *Submission 3*, p. 13.

accommodation payment per day was estimated by Access Economics at $40.32 per bed day. CHA went on to note:

> A consequence of this situation has been under allocation of residential high care places in recent Aged Care Approval Rounds, and the handing back of allocated places (bed licences). Those developments that have proceeded have relied on the cross subsidy of low care and Extra Service bonds, and in some cases entry contributions from retirement village units.
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> As a reflection of this dependency on bonds, the median bond held increased by 29% in 2008-09 to $200,000, and Extra service places grew by 36% in 2008-09.[10]

4.10 CHA held the view that a slow down in building activity will result from the long lead times involved with new service development and renewal. Such a slow down will result in a shortage of supply of suitable residential services in the medium term which will be difficult to reverse quickly.[11]

4.11 CHA also highlighted that extension of the Zero Real Interest Scheme continues the 'complex regime for capital funding, including as it does a mix of accommodation supplements, capital grants and zero real interest loans'. CHA questioned the extent to which fair and equitable treatment of providers is achieved by such complex arrangements and stated:

> In summary, the extension of this highly targeted Scheme for two years does not address the long term sustainability of capital funding arrangements for the sector overall.[12]

Long stay older patients and funding

4.12 CHA raised concerns that the long stay older patient (LSOP) places will be allocated at the 'partial expense' of the expansion of residential and community care places. CHA noted that it was not clear that the number of older people 'inappropriately accommodated in public hospitals will decline while the provision cap of 113 places per 1,000 people aged 70 and over remains in place, unless waiting lists in the community increase'.[13]

4.13 Highlighting that up to 40 per cent of residents of aged care facilities are malnourished, the Dietitians Association of Australia (DAA) noted that it was not clear whether the funding will only cover the basic costs of care or full services, including dietetic services. The DAA noted that while incentives for GPs will provide greater service to residential aged care, it stated that there is not adequate support for

10 Catholic Health Australia, *Submission 3*, p. 13.

11 Catholic Health Australia, *Submission 3*, p. 13.

12 Catholic Health Australia, *Submission 3*, p. 13.

13 Catholic Health Australia, *Submission 3*, p. 14.

the 'rest of the multidisciplinary team'.[14] The AMA also commented that more could be done to create 'more flexibility in how medical care for aged care residents is provided' and to achieve sustainable access to multidisciplinary medical and other health care and to reduce red tape.[15]

4.14 The ACSA argued that it was inappropriate, uneconomical and may be unsafe for older people to remain in hospital after their treatment had concluded and noted that for them to be appropriately cared for in the community, additional capacity in aged care was required which in turn required solutions to the 'crisis in capital raising'.[16] It noted moreover that:

> 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.
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> In the short term the allocation of places to hospitals may obscure the fact that they are not in demand by aged care providers.[17]

4.15 CHA and other stakeholders expressed the view that access to aged care and subsidies should become an entitlement based on assessed care needs and capacity to pay, providing eligible people and their families a choice of care settings and provider.[18]

Commonwealth responsibility for a national aged care system

4.16 Professor Penington noted that there was 'no explicit plan' in relation to the Commonwealth assuming responsibility for aged care with COAG discussions set for 2011. He continued:

> With an ageing population and the prospect of large numbers of aged people in need of skilled assistance to sustain independent lives for as long as possible, constructive and innovative planning should be underway.[19]

4.17 However, whilst supportive of the Commonwealth's commitment to undertake full responsibility for aged care, the AMA was cautious in its approach to the investment put into aged care under the reform package arguing that, given the level of funding on offer for new places, it is 'unclear whether it will lead to an expansion of

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14 Dietitians Association of Australia, *Submission 5*, p. 2.

15 Australian Medical Association, *Submission 10*, p. 10.

16 Aged and Community Services Australia, *Submission 17*, p. 3.

17 Aged and Community Services Australia, *Submission 17*, p. 4.

18 Catholic Health Australia, *Submission 3*, p. 14.

19 Professor D Penington, *Submission 7*, p. 8.

services in reality, or an improvement in quality'.[20] The RACGP also highlighted that the current funding levels are inadequate and that what was still required included consolidation of Commonwealth community care programs to provide flexible funding for prevention and treatment of chronic and complex disease, greater remuneration for aged care workers (including GPs) to enable greater retention of health professionals in the sector, and increased technology and infrastructure funding to enable health care providers to take advantage of the e-health revolution.[21]

4.18 The ACSA raised concerns about the split in terms of responsibility for Commonwealth-state HACC program clients in which the aged care component will go to the Commonwealth and services for younger people (those below 65 years) becoming the responsibility of the states and territories. Of this it noted that whilst financial responsibility for packaged community care is to be split, the regulation of such services will remain with the Commonwealth.[22] Its position was that whilst on balance it supported the move to full Commonwealth responsibility for aged care:

> 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 unequivocal responsibility.[23]

4.19 The ACSA concluded that the financial measures in the reforms 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' and noted:

> 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.[24]

4.20 The ACSA also commented that there was no representation of the aged care industry in any structures under the reforms.

Conclusion

4.21 The provision of care for Australia's ageing population poses significant challenges. The Government's proposed reforms do not address those challenges and those that were also identified by the Henry Review. They have been formulated before the Productivity Commission has completed its inquiry. The Productivity Commission is not due to report until April 2011.

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20 Australian Medical Association, *Submission 10*, p. 3.

21 Royal Australian College of General Practitioners, *Submission 15*, p. 2.

22 Aged and Community Services Australia, *Submission 17*, p. 4.

23 Aged and Community Services Australia, *Submission 17*, p. 4.

24 Aged and Community Services Australia, *Submission 17*, p. 4.

4.22 The decision by Victoria to retain control of the Home and Community Care (HACC) program will provide additional challenges as the Commonwealth assumes 100 per cent responsibility for aged care policy and funding.

4.23 In the meantime, the aged care sector is still under funded and lacking in certainty about capital funding to ensure that new beds are actually constructed and maintained. The complex funding arrangements remain.

4.24 It is doubtful that the measures to address the issue of long stay older patients will in fact see older people move out of public hospitals. To do so, there needs to be beds for them to go to and more importantly, staff to look after them.

4.25 Given that the Government is to redirect $276.4 million funding over three years from high-care residential aged care beds to the states and territories to provide 'similar levels of care' for LSOP in public hospitals, this seems unlikely any time soon.[25]

4.26 The future of aged care in Australia will continue to be uncertain until and after the Productivity Commission inquiry on aged care in April 2011.

25 Australian Government, *Budget Paper No. 2, 2010–11*, p. 223.