Chapter 7

The question of inequity in user payments

> Older persons should remain integrated in society, participate actively in the formulation and implementation of policies that directly affect their well-being and share their knowledge and skills with younger generations.
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> *Principle 7 of the United Nations Principles for Older Persons*

Introduction

7.1 This chapter considers user payments between different groups of aged care clients with focus on payments within residential and community aged care respectively as well as in comparison with each other.

7.2 The chapter also explores the views of some providers that greater flexibility is required in the aged care system to accommodate clients with the capacity to pay for services. It also highlights views of providers that greater flexibility in regard to payment and care options is required and explores options including accommodation bonds for residential care and the decoupling of residential accommodation and care. The chapter also considers a concurrent view of many providers that a shift is required in the service and care relationship in aged care from that between government and provider to that of provider and client. In this regard, emphasis was placed on the need for a client-based approach which enables flexibility to respond to the changing needs of such clients and which emphasises continuity of care at the expense of aged care classifications.

Concerns of residential and community aged care providers

7.3 A substantial number of residential and community aged care providers held the view that there are inequalities in user payments in the aged care sector. Anglicare Australia argued that there is an inequality in user payments 'across the whole spectrum of aged care services, from HACC through to high level residential care' and that instead:

> … aged care services should be looked at as a continuum of care (with individuals being able to move flexibly both between levels of services, and in and out of the system, as their needs change). A consistent platform for means tested fee setting, and for the payment of subsidies, should be set across the system. Those with high levels of wealth and income who are able to pay should fully meet the costs of their services and care, while

> those with limited or no capacity to pay should have the cost of their care subsidised at a fair and reasonable level.[1]

7.4 The Aged Care Association Australia (ACAA) held that there is 'considerable inequality' in how a person is treated in the aged care sector depending on where they enter the system, whether community, low care residential or high care residential'.[2] However, of greatest concern to the ACAA and many other residential aged care providers was the fact that unlike low care residents, high care residents are not required to pay accommodation bonds.[3] This issue is addressed later in the chapter.

7.5 In relation to community aged care, Alzheimer's Australia argued that:

> Varying user payments do create difficulties in community care, leading to consumers being uncertain as to how much they are going to have to pay for different services.[4]

Aged Care Funding Instrument

7.6 The Australian Government subsidies the provision of residential aged care to those approved to receive it. Each resident is provided a payment of a basic subsidy plus any supplements that the resident is entitled to.[5] On 20 March 2008, the Aged Care Funding Instrument (ACFI) was introduced as a new system to assess the amount of the basic subsidy. Under the ACFI, all existing permanent residents who entered residential care before 20 March 2008 retain their basic subsidy at the level determined under the former Resident Classification Scale (RCS) but were gradually be assessed under the new ACFI with full replacement of the RCS complete by April 2009. Of the status of existing permanent residents, the Australian Government noted:

> These pre-20 March residents will only move to the new ACFI basic subsidy if the rate determined under the ACFI exceeds their grand-parented rate under the former scale by more than $15 for the regular annual assessment or $30 for an ad hoc 'major change.' The level of basic subsidy for respite residents will continue to be at set rates determined by the ACAT's assessment of the resident as high or low care.[6]

7.7 Whereas the RCS comprised appraisals of aged care residents which were rated on a classification scale of one to eight with associated funding of a 'daily basic subsidy' tied to each classification, the system underpinning the ACFI centres on 12

1 Anglicare Australia, *Submission 67*, p. 4.

2 Aged Care Association Australia, *Submission 92*, p. 23.

3 Aged Care Association Australia, *Submission 92*, p. 23.

4 Alzheimer's Australia, *Submission 87*, p. 6.

5 Australian Government, *Report on the Operation of the Aged Care Act 1997: 1 July 2006 to 30 June 2008*, p. 36.

6 Australian Government, *Report on the Operation of the Aged Care Act 1997: 1 July 2006 to 30 June 2008*, p. 36.

questions that apply to aged care residents, each with four ratings from A to D.[7] According to the Aged Care Industry Council, the ACFI was intended to cater for the 'increasingly high needs of high care residents'.[8]

7.8 Mr Andrew Stuart, First Assistant Secretary of the Department of Health and Ageing (the department) stated in this regard:

> ACFI provides funding on the basis of care level. Taken together the planning arrangements and the funding arrangements try to secure access for a variety of people and then fund appropriately according to their care need.[9]

7.9 Aged and Community Care Victoria (ACCV) held the view that as an assessment tool, the ACFI has the potential over time to:

> …streamline the method of assessing resident care needs when compared to the former RCS system. The strong caution is that the potential for streamlining systems is being compromised due to the continuation of other burdensome compliance obligations, including those under the aged care accreditation system.[10]

7.10 However, the ACCV noted that as a funding tool, there were concerns across the industry about the ACFI in terms of the levels of funding allocated. The ACCV argued that whilst the ACFI was intended to cause a shift in funding from lower to high care, the lack of additional funding and subsequent redistribution of current funding from the current pool will 'inevitably cause gaps and issues'.[11]

7.11 In evidence before the committee, Mr Gerard Mansour of the ACCV continued:

> The ACFI, in effect, only distributed funding from low-care residents to high-care ones. This is the consequence of changing any funding model without allocating significant additional resources. We now have a growing and increasing number of residents with increasingly high care needs. The consequence is clear: an increasing number of Victorians will be denied access to a residential home care place because providers receive zero or minimal funding, despite the fact that they will have ACAT assessment.[12]

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7 Australian Government, *Report on the Operation of the Aged Care Act 1997: 1 July 2006 to 30 June 2008*, p. 39.

8 Aged Care Industry Council, *Review of Conditional Adjustment Payments*, October 2008, p. 3, http://www.health.gov.au/internet/main/publishing.nsf/Content/72F6764DCAD97E9FCA2574E100077804/$File/Submission64.pdf (accessed 15 December 2008).

9 Mr A Stuart, Department of Health and Ageing, *Committee Hansard*, 21.4.09, p. 4.

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

11 Aged and Community Care Victoria, *Submission 89*, p. 4.

12 Mr G Mansour, Aged and Community Care Victoria, *Committee Hansard*, 20.2.09, pp 35–36.

7.12 According to the Royal College of Nursing, Australia (RCNA), the ACFI focus on high care has re-shaped aged care services ensuring that:

> …an access issue is developing for low-care where people with social isolation or anxiety states are not funded in a sustainable way ($0–$6 per day) and are therefore not able to be admitted. As well, the effect of shifting resources from low to high care with no additional funding has overall consequences for staffing, building, equipment and risk management.[13]

7.13 Dr David Cullen, Department of Health and Ageing commented on ACFI assessment for low level care:

> Low-care rates vary from $0 up to…$6 or so. The vast majority of people who enter for low care are at the higher end of that spectrum. It is certainly true that there are some residents who are now assessed under the ACFI and who receive an assessment for $0 or $6, but there were also some residents assessed under the RCS who received $0. There were also some residents who were assessed under the previous hostel care instrument who received $0.
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> It is certainly true that, as a matter of policy, successive governments have sought to encourage community care so that residents who require very low levels of care have received over years—and this goes way back before 1997—lower and lower levels of subsidy so as to encourage them to remain in the community. At the same time, community care was uplifted so that there would be something there for them. But the vast majority of residents who enter at low care are funded towards the upper end of that spectrum of funding.[14]

7.14 UnitingCare Australia maintained that the ACFI has not been developed through the determination of the real costs of delivering care and accommodation to residents.[15] According to the RCNA, the $15 funding hurdle is arbitrary and prevents funding from being matched to resident care needs.[16] The ACCV argued that the $15 funding barrier should be abolished before existing residents can access the new ACFI funding. According to the ACCV, this barrier is a 'clear attempt to artificially 'limit'' funding to match care needs.[17] Grant Thornton Australia also maintained that the subsidy allocations under ACFI (and the previous RCS) are largely arbitrary because research into the cost of delivering care and accommodation has not been conducted.[18]

7.15 The RCNA maintained that the low entry authorised by the Aged Care Assessment Teams (ACAT) if often inconsistent with the ACFI assessment and that

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13 Royal College of Nursing, *Australia*, *Submission 101*, p. 2.

14 Dr D Cullen, Department of Health and Ageing, *Committee Hansard*, 21.4.09, p.33.

15 UnitingCare Australia, *Submission 76*, p. 19.

16 Royal College of Nursing, *Australia*, *Submission 101*, p. 2.

17 Aged and Community Care Victoria, *Submission 89*, p. 5.

18 Grant Thornton Australia Ltd, *Submission 29*, p. 8.

there is some confusion related to the ACAT determined high care/low care category split which has yet to be resolved:

> As a result, bonds levied for low care have to increase. These bonds currently average around $250,000 preventing many from accessing low care when they need it.[19]

7.16 This position was supported by Catholic Health Australia who argued that the ACAT were 'deliberately assessing some people as High care so as they will not have to pay a Bond':

> In one case an ACAT assessed a resident as High care but when assessed under the ACFI, attracted Nil funding for Activities of Daily Living (ADL), Nil funding for the Behaviour Supplement (BEH) and Nil funding for Complex Health Care (CHC).[20]

7.17 The ACCV also voiced concern that the ACFI will result in those with higher care needs being targeted, further accentuating inequalities.[21]

7.18 Catholic Health Australia noted that under the ACFI, of the 64 funding levels, only 12 are low care and of them, 50 per cent generate less care subsidies than was the case under the RCS system. As a consequence, providers are, according to Catholic Health Australia, finding fewer incoming residents assessed as low care with a 'number attracting too little funding to be admitted'.[22]

7.19 Management Consultant and Technology Services and ACCV argued that inequalities in user payments exist with ACAT-assessed residents on RCS categories 6, 7 and 8 unable to obtain subsidies under the ACFI.[23] According to the former, minimum ACFI payment for all clients to assist with bed, board, food, cleaning and laundry costs would bridge the gap between funding and actual costs.[24]

7.20 Grant Thornton Australia noted that under the ACFI, the funding level is now so low for potential residents that 'it is not feasible to admit them unless they can afford to pay a substantial accommodation bond'.[25] The risk therefore is that such people may not have access to community care services to remain at home or live in conditions where the provision of community care services is not possible. Moreover, Grant Thornton Australia argued that whilst the ACFI is expected to provide a greater weighting towards high care needs:

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19 Royal College of Nursing, *Australia*, *Submission 101*, pp 2–3.

20 Catholic Health Australia, *Submission 75*, p. 8.

21 Aged and Community Care Victoria, *Submission 89*, p. 9.

22 Catholic Health Australia, *Submission 75*, p. 8.

23 Management Consultant and Technology Services, *Submission 42*; Aged and Community Care Victoria, *Submission 89*.

24 Management Consultant and Technology Services, *Submission 42*, p. 1.

25 Grant Thornton Australia Ltd, *Submission 29*, p. 8.

> …the overall impact of this initiative is only a redistribution of resources under the same basic framework and the net change in subsidy flow will be negligible after grand parenting provisions expire.[26]

7.21 ECH Inc, Resthaven Inc and Eldercare Inc maintained that the ACFI weighting towards high care residents will cause a reduction in admissions of people assessed as requiring low care and that whilst people requiring low care will not be accepted into residential care, there will be a concomitant reduction in bond revenue.[27]

7.22 The Aged Care Association Australia WA and Aged and Community Services WA maintained that the ACFI had focused funding on high residential care services adversely impacting funding provisions for low care which in turn will have a negative impact on community care services. Of the consequences, the organisations noted:

> The current funding for low care services is becoming a deterrent for future admissions and this will have a very serious impact on the capacity of community care services to continue to deliver care for the growing demand within our wider community.[28]

7.23 Aged and Community Services SA & NT noted that the increasing trend whereby clients were moved straight into high care from the community implicated the revenue raising ability of providers from low care accommodation bonds which implicated the viability of low residential care.[29]

7.24 According to UnitingCare Australia a transparent method of estimating input cost increases which are relevant to the aged and community care sector and capable of being subjected to external review and analysis is required.[30]

Grandparenting

7.25 As part of the transition to the ACFI from the RCS, the RCS 'saved rate' for existing residents will continue to be grandparented until either the person's care needs increase to the extent that an ACFI rate becomes payable or the resident departs care. Therefore, subsidies will continue to be paid at the existing rate (plus indexation) for a resident on an 'RCS-saved rate' until either their care needs increase to the extent that

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26 Grant Thornton Australia Ltd, *Submission 29*, p. 8.

27 ECH Inc, Resthaven Inc and Eldercare Inc, *Submission 85*, p. 9.

28 Aged Care Association Australia WA and Aged & Community Services WA, *Submission 84*, p. 1.

29 Aged and Community Services SA & NT, *Submission 90*, pp 6–7.

30 UnitingCare Australia, *Submission 76*, p. 19.

an ACFI rate becomes payable or the resident is discharged from the aged care home.[31]

7.26 The role of grandparenting in relation to the ACFI was explained by Mr Stuart of the department:

> … it is true that the amount of funding for the most frail residents in aged care is going from $128 to $171 over a period of four years. A part of the reason for that is that, in introducing the ACFI, the government was grandparenting existing residents who are in aged care on the RCS if the provider would be better off as a result of that grandparenting. That grandparenting comes at a very considerable cost because what you are saying on the introduction of ACFI is, 'We will only allow providers to win; we won't allow them to lose.' The impact of that is a considerable net cost to government. As a partially offsetting cost reduction, the government has chosen to phase up the maximum fee for the most frail residents.[32]

7.27 The ACCV voiced concern regarding the financial viability of the aged care industry once the grandparenting impact had worn off and stated that:

> Aged care providers currently receive vitally important short term financial protection from the negative effects of the funding redistribution due to the ACFI grandparenting provisions. This means that residents who would otherwise move to 'lower' ACFI funding rates under the new system will be replaced by new entrants.[33]

7.28 Similarly, UnitingCare Australia noted that without grandparenting, one of its providers would lose $13.94 per resident per day in relation to 1,167 residents or 72 per cent of resident conversions to ACFI.[34]

7.29 The ACFI introduces 64 funding points (compared to the eight funding points under the RCS) which are designed to enable greater flexibility in matching funding to resident care needs. However, the concern of a number of submitters including ACCV is that whilst the ACFI is intended to encourage a shift in funding from those with lower care needs to those with higher care needs, the funding system has been introduced with 'minimal additional funding'. The ACCV argues that the real effect of this 'has been for current funding to be redistributed from the existing pool' which will result in gaps and issues.[35]

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31 Department of Health and Ageing, *Aged Care Funding Index Frequently Asked Questions*, 30 October 2008, p. 31, http://www.health.gov.au/internet/main/publishing.nsf/Content/C78B2B9CA7EECF5FCA2573F600053D1E/$File/FAQs1008.pdf (accessed 15 December 2008).

32 Mr A Stuart, Department of Health and Ageing, *Committee Hansard*, 21.4.09, p. 34.

33 Aged and Community Care Victoria, *Submission 89*, p. 4.

34 UnitingCare Australia, *Submission 76*, p. 6.

35 Aged and Community Care Victoria, *Submission 89*, p. 4.

7.30 Wintringham voiced concern in relation to what it regards as a lack of interconnection between funding and aged care assessment undertaken by the Aged Care Assessment Service (ACAS):

> There is no direct, apparent link, however, between the criteria the ACAS teams use for their assessment, ACFI assessments and the siloed funding linked to each assessment and made available to provide appropriate care. We have repeatedly found that a client's care needs are far more complex and so – far higher and more expensive to provide than their assessed funding level.[36]

7.31 A number of residential aged care providers shared the view that the $10, $20 and $30 cap on the maximum ACFI subsidy for high care residents should be scrapped immediately.[37] The Echuca Benevolent Society stated that the cap should be replaced with 'suitable payment for the care being carried out, that is required for each resident in our facilities'.[38]

7.32 Mr Stuart, Department of Health and Ageing, responded:

> The ACFI is an instrument that is designed to give an overall return to an aged-care home. We do not expect to pay through the ACFI for a particular staff member to stand by a particular bed. Because there is an increased flow of funding to the sector because of the grandparenting cost to government, the government has chosen to put a cap on the growing increase in care funding as well. I am simply explaining government policy to you.[39]

7.33 Despite such concerns regarding the ACFI, Catholic Health Australia reaffirmed that the instrument was still in its infancy. Mr Martin Laverty continued:

> In defence of the ACFI, the ACFI has not been in place for 12 months at the moment. I think when the ACFI is reviewed, which is scheduled to occur by the end of this year I understand, it is appropriate that there is a specific focus on the applicability of the ACFI to address these particular behaviours and we are certainly going to be looking at the review of the ACFI to ensure that it is meeting the specific needs of those who have previously been homeless.[40]

Conclusion

7.34 The committee recognises the ACFI as an instrument that seeks to simplify the system and its administrative burden. Whilst it recognises that there are a range of

36 Wintringham, *Submission 43*, p. 2.

37 See for example, Baptcare, *Submission 59*; Tongala and District Memorial Aged Care Service Inc, *Submission 83*; Aged and Community Care Victoria, *Submission 89*.

38 Echuca Benevolent Society, *Submission 53*, p. 3.

39 Mr A Stuart, Department of Health and Ageing, *Committee Hansard*, 21.3.09, p. 35.

40 Mr M Laverty, Catholic Health Australia, *Committee Hansard*, 13.3.09, p. 12.

views on the ACFI, the committee appreciates that the system requires adequate time to operate before meaningful analysis of its effectiveness can be undertaken. However, the committee recognises that a thorough review of the ACFI is both timely and vital to establish its impact on the sector. For these reasons, the committee encourages the Department of Health and Ageing to consider and address the concerns of aged care providers in the forthcoming ACFI review.

Aged Care Assessment Teams

7.35 The Aged Care Assessment Teams (ACAT) are responsible for assessing and approving older persons for Australian government subsidised aged care including residential aged care, Community Aged Care Packages (CACPs), Extended Aged Care at Home (EACH), and dementia-specific Extended Aged Care at Home-Dementia (EACH-D). The Australian government provides funding to the states and territories to operate and manage the ACAT whilst the states and territories also provide funding to the ACAT.

7.36 A number of residential aged care providers raised concerns regarding the complexities involved when a client moves from low to high care including the circumstances where an ACAT re-assessment was required and of the funding gap that results from delays in re-assessment.[41] Mr Ken Baker of Baptistcare elaborated:

> That process is currently complicated, because to go from low care to high care you have to be re-ACATed, and that becomes a real hurdle for us to get through, especially if someone comes in under the current system where they might come in as a low care and we do our initial assessment and find that they are high care. Our funding stream is completely interrupted by the dependence on the ACAT teams to come back and to reassess that person, which they are not always that prompt in doing because, as far as they are concerned, they have done an assessment.[42]

7.37 A gap in funding provision can result as Ms Anne-Marie Archer of the Aged Care Association Australia Western Australia explains:

> With regard to the provision of the aged-care assessment teams, an assessment is made for entry into aged care. Invariably, it is made at the time in a situation that is outside the residential care environment. When someone comes into a care environment, they are assessed then by the provider. The assessment of the care needs in that care environment could be different from those of the ACAT or their care needs may have increased in that time. They do not get funded for the care that they receive in a particular environment up until such time as the ACAT comes back and does a reassessment—for example, if they have gone from low care to high care.

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41 See for example, Mrs Small, Wintringham, *Committee Hansard*, 20.2.09, p. 56 and Wintringham, *Submission 43*, p. 2.

42 Mr K Baker, Baptistcare, *Committee Hansard*, 30.1.09, p. 95.

> There is an enormous differentiation in the amount of money it costs to care for someone in different levels of care. That amount of money is lost in the system up until such time as the ACAT comes out and provides yet another assessment. There is no ability to recoup that, regardless of the fact that they have been providing that care, and that is why one of the positions of the association is to ensure that potentially in the future the ACAT service is to really assess eligibility for care as opposed to simply determining high and low care.[43]

7.38 Anglicare stated before the committee that the delay in ACAT re-assessment had cost them about $100,000. Dr Lynn Arnold of Anglicare Aged Care South Australia explains:

> To the extent that we still have low care and high care, the changes have resulted in our being significantly financially impacted by delays not being retrospectively funded. What that means is that when somebody moves from low care to high care in that assessment, which can take as little as two weeks, it is not a problem when it does, but when it takes two months or more it is a problem. There being no retrospectivity has cost us something like 1,800 days of funding in the last six months, at a cost of about $100,000. That represents quite a significant cost impact for us.[44]

7.39 Mr Wayne Belcher of The Bethanie Group suggested an alternative:

> The assessment issues under ACFI: it seems appropriate to me that ACAT, rather than saying, 'You are high care or low care,' should rather say, 'We have assessed you as being appropriate for residential care, as being appropriate for community care, or either, and we can encourage you by pointing you to appropriate providers who may be able to meet your needs,' and let the existing regulatory framework between providers and clients pick up the necessary service provision.[45]

7.40 Ms Anne-Marie Archer of the Aged Care Association Australia WA also suggested an alternative solution to the committee:

> It would be far more advantageous for the industry if there could be just a simple gatekeeping process as opposed to a stipulation and having to come back out. This is extra resources for the state, but it is a huge impost on providers financially if there is a shift in that person's care needs and they cannot get a staff member out, because they invariably have an understaffing issue themselves.[46]

7.41 Recommendation 10 of a 2007 National Review of the ACATs (the review) addressed the issue of re-assessment:

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43 Ms A-M Archer, Aged Care Association Australia WA, *Committee Hansard*, 30.1.09, p. 40.

44 Dr L Arnold, Anglicare Aged Care South Australia, *Committee Hansard*, 13.3.09, p. 63.

45 Mr W Belcher, The Bethanie Group Inc, *Committee Hansard*, 30.1.09, p. 110.

46 Ms A-M Archer, Aged Care Association Australia WA, *Committee Hansard*, 30.1.09, p. 40.

> That the Australian Government considers revising the legislative requirements for re-assessment of those residents:
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> - moving from low to high care within an aged care complex where the low and high care facilities have separate provider numbers
> - who enter an aged care facility with a low care approval but require high care.[47]

7.42 The consolidated response to the review by Australian, state and territory governments released in February 2008 stated:

> The Department notes this recommendation. In regard to legislative changes this is a matter for the Australian Government to consider in the context of other aged care reforms currently underway.[48]

7.43 Implementation of such a recommendation would address providers concerns raised before the committee. The committee therefore urges the Australian Government to implement the 2007 recommendation with a view to reform of the requirement for reassessment under the two conditions outlined by the national assessment.

Recommendation 22

7.44 The committee recommends that the Australian Government implement the recommendation of the 2007 National Review of Aged Care Assessment Teams and review the legislative requirement for re-assessment of those residents:

- **moving from low to high care within an aged care complex where the low and high care facilities have separate provider numbers;**
- **entering an aged care facility with a low care approval but who require high care.**

7.45 Concerns were also raised during the course of the inquiry about the time it took for the ACAT to conduct assessments. In this regard, Mr Ian Yates of COTA Over 50s Ltd stated:

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47 Communio Pty Ltd, *National Review of Aged Care Assessment Teams*, Final Report, Prepared for the Department of Health and Ageing, November 2007, Recommendation 10, p. 15, http://www.health.gov.au/internet/main/publishing.nsf/Content/135F747EC126FC60CA2574090003E506/$File/National%20ACAT%20Review%20Final%20Report%20Nov%202007.pdf (accessed 3 April 2009).

48 Department of Health and Ageing, *Response to Recommendations of the National Review of ACATs*, 27 February 2008, p. 7, http://www.health.gov.au/internet/main/publishing.nsf/Content/135F747EC126FC60CA2574090003E506/$File/Response%20to%20Nat%20ACAT%20Review%20Final%20270208.pdf (accessed 3 April 2009).

7.46 We would also emphasise that, in terms of inequity and according to the official data, both anecdotally and my understanding of it, access to assessment around the country varies in terms of time and quality. I am sure that departmental staff could talk to you about pursuing that issue between the Commonwealth and the states. For the sake of proposing a benchmark, we have said in here that, if something has arisen and you have a need, you ought to be able to get an ACAT assessment within five working days. Getting the support early that that assessment provides you with is quite critical, because people can escalate in terms of their needs if they are not addressed quickly. In some places you can get ACAT assessments very quickly and in other places waiting lists of weeks and months are not uncommon. I do not think the government of the Australian Commonwealth should accept that. We, as consumer advocates, find that unacceptable.[49]

7.47 Such concerns were also voiced by the 2007 review which noted:

> The key findings that relate to the efficiency of ACATs are:
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> • ACATs demonstrate varying levels of efficiency. Some teams are overwhelmed with demand and are unable to effectively improve processes to improve efficiency. Others are meeting high demand.
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> • Many teams are contributing considerable team time to the development and review of processes, forms, templates, education programs etc. There is little evidence of systematic sharing of resultant improvements. This also appears the case with work being sponsored at the jurisdictional level – advances made in one state or territory are not obviously being shared or extended across others.
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> • The external operating environment that ACATs work in can make their role inefficient. They have to be cognizant of an increasing number of programs, eligibility criteria and service providers.[50]

7.48 In review recommended that Aged Care Assessment Program (ACAP) officials explore and implement strategies to 'increase the efficiency of the ACATs, especially those with long waiting times for assessments' and that a national breakthrough collaborative or extensive use of clinical practice improvement model should be considered in this regard. This recommendation was taken up to the extent that the government committed ACAP officials to explore methods to achieve efficiency improvement.[51]

7.49 In response to concerns relating to both the delays experienced in securing ACAT assessments and concerns regarding re-assessment requirements, Mr Andrew

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49 Mr I Yates, COTA Over 50s Ltd, *Committee Hansard*, 13.3.09, p. 42.

50 Communio Pty Ltd, *National Review of Aged Care Assessment Teams*, Final Report, Prepared for the Department of Health and Ageing, November 2007, p. 12.

51 Department of Health and Ageing, *Response to Recommendations of the National Review of ACATs*, 27 February 2008, p. 4.

Stuart, First Assistant Secretary of the Department of Health and Ageing (the department) stated:

> There are two things being done. One is that the government has already passed legislation late last calendar year to make unnecessary a number of previous kinds of ACAT approvals, a number of which actually go to some of the improved flexibility that people have been asking for at the committee hearing, including today. If you are approved for a high care package at home then you do not have to be separately re-approved and reassessed for a low care package at home, for example, and to reduce the number of times that a person has to go before an aged care assessment team to have it confirmed that they are still eligible for residential care when time passes.
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> We are very significantly reducing the number of aged care assessment teams assessments that are required and are now moving towards negotiating with the states and territories about a new aged care assessment team agreement, which will take effect from 1 July, which will seek to turn that reduced workload into much quicker turnaround on some of the assessments that have been lagging. We are going to be wanting to put in place particular standards and milestones to be met.[52]

7.50 The committee is concerned about this apparent information gap between the experiences of providers and the reforms introduced by the department. The question remains as to whether this disjuncture reflects a reality which, despite such reforms, has changed little for providers. The committee urges the department to launch an information campaign on the ACAT directed at both providers and clients in order that evident deficiencies in information are addressed.

Recommendation 23

7.51 In light of disparities in information regarding the Aged Care Assessment Team (ACAT) assessments and re-assessments between the Department of Health and Ageing and involved providers, the committee recommends that the department launch an information campaign on recent reforms to the ACAT.

7.52 Other providers emphasised that greater national consistency was required in terms of the assessment process to enable greater efficiency. Catholic Health Australia's Mr Martin Laverty stated in this regard:

> If there were a genuinely national system you would have a consistency as to how assessments were being made. I have to acknowledge that because we are assessing an individual’s characteristic, obviously there is an opportunity for differing subjective opinions as to the capabilities of a person, but when you have one aged care provider saying to us, ‘We know

52 Mr A Stuart, Department of Health and Ageing, *Committee Hansard*, 13.3.09, p. 85.

> that different members of ACAT teams are producing different results', that does not suggest a genuinely national approach.[53]

7.53 In relation to the issue of national consistency, the 2007 review stated that:

> The review team identified variations in interpretation of the true intent of the ACAP. The Guidelines are interpreted in many different ways, often determined by individual values and experiences of staff, based on their work in other parts of the health/aged care continuum.
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> The vast majority of data collected about ACATs is throughput based, with a focus on timeliness and volume. This supports the notion that ACATs are about volume – as the axiom suggests people only manage what they measure. The program needs to be able to articulate what a quality service is and to develop performance measures accordingly. These can then be used to measure team performance, allow for team benchmarking and can be incorporated into funding agreements and accreditation programs.[54]

7.54 The review's recommendation highlighted the need for nationally consistent performance indicators:

> That ACAP Officials seek expert advice to develop a set of validated, specific assessment tools and develop criteria for their use in the ACAT context. This work should build on current models and work undertaken by the Department and other work sponsored by the Australian Health Ministers Advisory Council (AHMAC). The criteria and indicators employed should be consistent with those used in HACC and other community care programs, as appropriate.[55]

7.55 The consolidated response to the review by the Australian, state and territory governments agreed with the recommendation and affirmed that:

> Standardised assessment clinical tools are strongly supported and should lead to greater consistency of ACAT assessments and recommendations. The adoption of a set of standardised assessment tools for ACATs will also improve equitable access to services and overall be an important building block in achieving a stronger relationship between the outcome of assessments and the appropriate level of care.[56]

7.56 The committee acknowledges that standardisation in relation to the ACAT is a 'work in progress' and strongly supports efforts in this regard.

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53 Mr G Laverty, Catholic Health Australia, *Committee Hansard*, 13.3.09, p. 4.

54 Communio Pty Ltd, *National Review of Aged Care Assessment Teams*, Final Report, Prepared for the Department of Health and Ageing, November 2007, p. 157.

55 Communio Pty Ltd, *National Review of Aged Care Assessment Teams*, Final Report, Prepared for the Department of Health and Ageing, November 2007, Recommendation 11, p. 15.

56 Department of Health and Ageing, *Response to Recommendations of the National Review of ACATs*, 27 February 2007, p. 7.

7.57 A number of aged care providers before the committee highlighted that, as a means of ensuring greater national consistency, more was needed to be done for the ACAT to operate as a single nationally consistent program. According to Catholic Health Australia, ideally ACAT would then serve as a genuine single national entry process into aged care. Of the idea, Catholic Health Australia's Mr Martin Laverty stated:

> Quite specifically we think that the ACATs, the aged care assessments teams that the Commonwealth government funds but the states and territories operate, should in fact be a single, nationally consistent program. It does not necessarily have to be operated by the Commonwealth but it should certainly have a greater control by the Commonwealth. We have also said that the entry point should be more visible to the community, just as Centrelink is a visible entry point for those seeking the support of the welfare system. At the moment we do not have a clear understanding as consumers as to how to take advice on how to enter and seek guidance through the aged care system. It is usually a family member who is guiding or making decisions on behalf of someone entering aged care. If that person has not experienced the aged care system before it is the case that they do not really know where to start and they do not know who to trust as they seek their advice. We think the Commonwealth can address that by establishing a single entry point for aged care around Australia.[57]

7.58 Part of the role of ACATs is to assist older people and their carers to establish what sort of care meets their needs when they are no longer able to manage at home without assistance. According to the department, ACATs also provide information on 'suitable care options and can help arrange access or referral to appropriate residential or community care'.[58]

Conclusion

7.59 The committee appreciates that the role of the ACATs should be that of a single national entry point for clients and their families and encourages the department to consider suggestions of this nature with view to simplify the system to the fullest extent possible for aged care clients nationwide. In addition to this, the committee recommends that a parallel education campaign be conducted to inform both new and potential aged care clients of the aged care services available to them and of their rights and entitlements in relation to such services.

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57 Mr M Laverty, Catholic Health Australia, *Committee Hansard*, 13.3.09, p. 3.

58 Department of Health and Ageing, *How Aged Care Assessment Teams (ACATS) Can Help You*, Information Sheet No.1, January 2008, (http://www.health.gov.au/internet/main/publishing.nsf/Content/43EEB445E116CA3ACA256F1900100461/$File/Aged%20Care%20Information%20Sheet%20-%20January%202008.pdf, (accessed 9 April 2009).

Recommendation 24

7.60 The committee recommends that the Department of Health and Ageing review methods directed to affirming the ACAT as a single nationally consistent program which genuinely serves as a single entry point to aged care services. The review should entail dialogue with aged care clients and providers as well as liaison with state and territory health departments.

Recommendation 25

7.61 The committee recommends that the Department of Health and Ageing conduct a national education campaign directed at new and potential aged care clients to raise awareness of the aged care services available to them including the role of ACAT and of their rights and entitlements in relation to such services.

Accommodation bonds for high residential aged care

7.62 A number of submissions held that there is an inequity with regard to the payment of accommodation bonds with many arguing that such bonds should be payable for residential high care and not just low care (hostels) and high care with extra service status.[59] Indeed, Aged and Community Services SA & NT held that low care residents paying an accommodation bond are cross-subsidising high care residents paying an accommodation charge or concessional residents covered by the government.[60]

7.63 A similar view was expressed by Aged and Community Services Australia:

> Increasingly since 1997, low care residents paying an accommodation bond have been cross subsidising high care residents paying an accommodation charge and concessional residents paid for by Government. This is becoming increasingly the case since more new residents are entering as high care and the average value of bonds has increased with the value of residential property in many parts of Australia.
>
> This inequity is compounded by the fact that high care, accommodation charge paying residents are treated differently to bond paying low care residents if they sell their home. For high care entrants any lump sum they hold, and use to pay their accommodation charge, is included for pension assessment purposes whereas the lump sum bond payment made by a low care resident is exempt.[61]

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59 See for example, The Association of Independent Retirees Ltd, *Submission 65*; UnitingCare Australia, *Submission 76*; Echuna Benevolent Society Inc, *Submission 53*; St Mary's Villa, *Submission 2*; Yackandandah Bush Nursing Home, *Submission 35*; Ms Hazel Bridgett, *Submission 100*; Aged Care Association Australia – SA Inc, *Submission 63*; House Group of Companies, *Submission 79;* Aged Care Association Australia WA and Aged and Community Services WA, *Submission 84*; Baptiscare, *Submission 48*.

60 Aged and Community Services SA & NT, *Submission 90*, p. 9.

61 Aged and Community Services Australia, *Submission 72*, p. 6.

7.64 According to Aged and Community Services Australia, the industry's view that the ACFI will result in a re-targeting of residential aged care to clients with higher care needs are being confirmed by early indications and that such a situation will 'further accentuate the inequalities' between low care and high care clients.[62]

7.65 As accommodation bonds are refundable deposits, they entitle the provider to the interest on the bond during the period in which a resident is accommodated. Under the current arrangements, only clients in residential low care and not clients in residential high care can pay accommodation bonds as Grant Thornton Australia explained:

> Unlike low care services, current legislation prevents high care residents from contributing accommodation bonds upon admission to high care facilities. As a result, most new high care facilities must be financed through external borrowings and the financing costs have a major impact on the viability of providers that operate on such tight margins.[63]

7.66 In 2007, Professor Hogan noted the impact of this policy:

> Rejecting of their use in ordinary high care reflects a failure to understand their critical funding role. It denies the role for simple 'user-pays' policies to meet the needs for care of an ageing population in coming decades …[64]

7.67 The Echuca Benevolent Society held that no bonds in high care is unjust because it gives rise to cross-subsidisation between low and high residential care creating with it two tiers of residents.[65] The Productivity Commission expressed the same view in its September 2008 research paper:

> The current pricing arrangements covering accommodation payments give rise to inefficient cross-subsidies between low and high residential care and distort investment decision-making. The problems posed by these anomalies could be addressed in a number of ways. One previously proposed option would be to require all residents who can afford to make a capital contribution to pay either a lump sum bond, or a daily or periodic rental charge (at a level equivalent to the bond).[66]

7.68 The Tongala and District Memorial Aged Care Service Inc expressed the opinion that moving way from the no bonds in high care policy would provide some immediate relief and reduce complexity in the system, provide greater fairness with all

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62 Aged and Community Services Australia, *Submission 72*, p. 6.

63 Grant Thornton Australia Ltd, *Submission 29*, p. 7.

64 Professor Warren Hogan, *The Organisation of Residential Aged Care for an Ageing Population*, The Centre for Independent Studies Policy Monograph 76, 2007, p. 1, http://www.cis.org.au/policy_monographs/pm76.pdf (accessed 8 January 2009).

65 Echuca Benevolent Society Inc, *Submission 53*, p.3.

66 Productivity Commission, *Trends in Aged Care Services: some implications*, September 2008, p. xxi.

eligible residents paying the same type of accommodation payment and remove the existing two tiers of residents.[67] Of the policy, Baptist Community Services of NSW and ACT stated:

> If the 'no bonds in high care' stance of various Australian Governments over the years is maintained, it is critical that the current accommodation charge for high care be reviewed. Data from the Stewart Brown Aged Care Report 2008 shows that providers are supplementing the day-to-day operational costs with income from capital. The result of this is high care facilities operating at a net trading loss per day of $7 and low care also showing a net trading loss per day of $4.[68]

7.69 A number of witnesses argued that accommodation bonds are vital in meeting the costs of capital funding which is not currently adequate under funding arrangement. Indeed, in his 1997 report, Professor Warren Hogan noted that, for this reason, accommodation bonds have provided an important source of funding for the expansion of aged care facilities:

> Accommodation bonds have been the sole means of bringing flexibility to an otherwise rigid pricing and funding system arising out of central planning. Bonds have allowed access to funds for meeting the servicing costs of capital funding not otherwise effectively provided through government subsidies and payments, or approved charges on residents. Access to accommodation bonds in low care and extra-service high care has also helped support provision of facilities in high care, especially in those facilities where a mix of care between low and high is offered.[69]

7.70 The Western Australian Government highlighted that the unavailability of accommodation bonds to high care providers has hindered new construction and the upgrade of existing facilities in Western Australia. In addition:

> This situation has been further exacerbated by the 2008 Aged Care Act Accreditation requirements where all providers irrespective of the level of care, are required to undertake substantial capital investment to meet new privacy standards.[70]

7.71 ACCV held the same view, arguing that the ongoing reduction as the proportion of residents entering low care has ensured that the level of accommodation bond will continue to increase, which in turn, providing further fuel to the argument that low care residents effectively cross-subsidise the facility capital realising costs across the industry.[71] Similarly, Japara Holdings stated that accommodation bonds

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67 Tongala and District Memorial Aged Care Service Inc, *Submission 83*, p. 4.

68 Baptist Community Services of NSW and ACT, *Submission 21*, p. 3.

69 Professor Warren Hogan, *The Organisation of Residential Aged Care for an Ageing Population*, The Centre for Independent Studies Policy Monograph 76, 2007, p. 3,

70 Western Australian Government, *Submission 111*, p. 2.

71 Aged and Community Care Victoria, *Submission 89*, p. 7

should be introduced into high care enabling provides to receive the capital required to build new facilities and complete renovations on older-style facilities to bring them up to best practice standard.[72] Catholic Health Australia further noted:

> The regulations surrounding accommodation bonds have had the effect of reducing available capital investment within the sector….The current disparity between who is charged an accommodation bond and who is not creates perverse incentives.[73]

7.72 The ACAA highlighted the consequences for high care residents of their ineligibility to pay an accommodation bond:

> …a person who enters high care and who is not exempt from making a capital contribution will be required to pay a daily accommodation charge of $26.88 per day plus a basic daily care fee and if appropriate, an income tested fee.
>
> If, as is often the case, a resident needs to liquidate their home to pay these contributions, then any funds held on the sale of the home will be considered when assessing income and assets for pension entitlement.
>
> Whereas the same person entering residential low care and paying a bond will have the bond exempt from any assessment for pension entitlement.[74]

7.73 In instances where self-funded retiree couples have non-home assets and one of the couple needs to enter residential care, half the assets of the couple are assessed for the person entering care and brought to account. If the person is entering low care, they will be required to pay a bond. However, if the couple's non-home assets are held in superannuation, part of their funds will have to be released to pay the bond. According to the ACAA, this can 'on occasions leave the person not requiring care in a seriously depleted financial state'.[75]

7.74 In the case of high care residents, any lump sum held by them which they may use to pay their accommodation charge is included for pension assessment purposes whereas accommodation bonds in low care are exempt.[76] Professor Hogan noted in 2007 that bonds for high care was attractive to management compared to charges because:

> …of their contribution to the capital needs of the aged care entity; whereas accommodation charges simply meet the costs of servicing the capital

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72 Japara Holdings Pty Ltd, *Submission 74*, p. 4.

73 Catholic Health Australia, *Submission 75*, p. 8.

74 Aged Care Association Australia, *Submission 92*, p. 23.

75 Aged Care Association Australia, *Submission 92*, p. 23.

76 Aged and Community Services SA & NT, *Submission 90*, p. 9.

> which still must be raised and, most importantly with debt, repaid. Accommodation bonds offer a self-replenishing means of funding.[77]

7.75 Mr Cam Ansell from Grant Thornton Australia noted that whilst the introduction of bonds would by itself 'create some impetus and the opportunity for stimulating the sector into developing':

> It would also create a much greater interest in the for-profits outside of the existing group. As a short-term solution, I certainly think that that would have a very positive effect. It does not take aside the fact that there are many other aspects of the industry that are heavily overregulated. While that might be a good short-term fix, I think there is a strong argument to go back and look at the broader system to see what we can do to encourage investment and sustainability in the longer term.[78]

7.76 Whilst a substantial proportion of residential aged care providers supported accommodation bonds for residential high care, others expressed caution with the option. Aged and Community Services Australia, was one case in point as Mr Greg Mundy explained:

> What we have argued for in our submission is to take a step back and say, 'The concept we should think about here is rent'—that anyone who occupies any space, whether it is an office, a hospital or their home, has to pay something that covers the replacement value of the accommodation that they are in. That is the underlying concept. If you are living in a high-cost city like Perth or Sydney then the rent is going to be higher than in a low-cost place such as Dubbo or Wagga or somewhere like that. It would much more sensible to link those two things in the same property market so that you allow people to realise the value of assets that have appreciated in that place and pay a price that matches the value of those assets.
>
> Once we have established that concept that people should pay a fair rent for their accommodation—and the government should pay for those that cannot afford it—how they pay is a second-order question. If people want to pay it upfront in a lump sum, we should discount what they pay, because that is a value to us. If we allow people to pay from their estate, we would need a reasonably tight contract around that, but we should charge more because the interest cost applies to us.
>
> But if everyone paid on an equal basis for what they are getting, with protection for the majority of our clients who are going to be income poor, then I think we could offer people choices in terms of how they pay. Bonds might well suit lots of people. The pension system treats bonds very kindly and, unless the government was going to change that, most older people would be better off capitalising their rent and paying it once. But, as for the

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77 Professor Warren Hogan, *The Organisation of Residential Aged Care for an Ageing Population*, The Centre for Independent Studies Policy Monograph 76, 2007, p. 1.

78 Mr C Ansell, Grant Thornton Australia Ltd, *Committee Hansard*, 30.1.09, p. 9.

> concept that people should pay the replacement costs of the accommodation they are in, I find it hard to find convincing arguments against that.
>
> One of the old, traditional objections to the bond system is that, for people going into high care, where the average length of the stay might be six or seven months, you are adding one more stress factor in what is already a very difficult period in their lives. Let people pay a monthly rental while they see how things pan out. And long-stay high-care residents—essentially those with dementia—could go down the capitalisation route. They are going to have to sell the house anyway. It would be convenient for people. For those who genuinely are in a form of palliative care, we would charge on a fortnightly or monthly basis like any other form of accommodation. So bonds could be part of the solution, but I think there is room to open up that concept a little bit and make sure that it is fair and equitable.[79]

7.77 Moreover, it was noted that the introduction of bonds in high care would not necessarily impact on providers who focus on meeting the needs the financially vulnerable. The Brotherhood of St Laurence is one such provider which operates a concessional rate at approximately 85 to 90 per cent for residential care. Of the issue of bonds for high care, Mr Alan Gruner of the brotherhood noted:

> As I mentioned, we only have about 10 per cent of our residents actually pay bonds anyway, so it is not an area we particularly target. My own personal opinion is that there is a need within the industry for something to happen in aged care, in terms of funding, because the growing need is in the provision of high care. But without adequate revenue, it is becoming more and more difficult to provide those sorts of services. So whether it is through a bond or another means I think there needs to be an allocation of funding within the high-care area to assist service providers to provide their services, particularly building costs, as well as service provision.[80]

7.78 The Australian Nursing Federation, which does not support bonds in high care, recognised the need for an alternative to bonds which have traditionally funded capital costs particularly in light of the fact that 70 per cent of aged care residents are entering high care.[81]

7.79 Mr Stuart of the Department of Health and Ageing raised three issues for consideration in relation to bonds for high care. First, people going through a rapid health related transition would, have at the same time, to make immediate decisions about their financial affairs. Mr Stuart noted two other matters:

> My second comment is in relation to equity. The discussion we have just been having applies equally to bond charging, because bonds are an uncapped financial contribution. In low care, particular residents are worth more to the provider than others because an uncapped bond can be charged

79 Mr G Mundy, Aged and Community Services Australia, *Committee Hansard*, 20.2.09, pp 3–4.

80 Mr A Gruner, Brotherhood of St Laurence, *Committee Hansard*, 20.2.09, p. 21.

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

> for some and not for others. Currently, in high care, that is not the case. In high care, we have people whose needs are more urgent and less discretionary than those in low care. So you would have to think very hard about what increased regulation you would need to put in place to ensure access for people with low assets into high care if you were going to allow an uncapped bond to be charged.
>
> The third area is in relation to prudential requirements. The bond is by its nature essentially an unsecured loan from the resident to the aged-care provider. The aged-care provider is not a financial institution. The government has managed this risk—and you would appreciate the kind of risk we are talking about, particularly since we have been experiencing a global financial crisis—by making the industry as a whole responsible if a particular provider defaults on the bond amounts…
>
> What I am raising is the issue that the size of bond holdings would then potentially be more than double and there would be a large number of providers who would never have held bonds before. Under those circumstances, the department would be thinking very hard about prudential arrangements…[82]

Conclusion

7.80 The committee appreciates that accommodation bonds for high care are widely supported by residential aged care providers. It also notes that many providers believe that the high / low care separation is artificial and based on a classification of the ACFI with no relation to the support needs of the resident population.[83] The committee believes that the full ramifications of the implementation of bonds in high care are yet to be analysed and should be included in the recommended holistic review of flexible funding options for the sector.

Decoupling of residential aged care and accommodation costs

7.81 In light of ongoing concerns in relation to the adequacy of aged care funding as well as the disparities between high and low residential care funding, decoupling costs of residential care from accommodation costs was suggested. Mr Geoff Taylor of the Aged Care Association Australia WA stated of his organisation's support for such an initiative:

> The problem we have with paying wages and the care side of it is purely to do with the poor indexation of our funding system and, if it were indexed properly, the care side of it would cover the wages…The families should have the choice of the accommodation, based on what they can afford and what is provided, and the government should subsidise properly for the

82 Mr A Stuart, Department of Health and Ageing, *Committee Hansard*, 21.4.09, pp 29–30.

83 See for example, Catholic Health Australia, *Submission 75*, p. 7.

concessional residents who have no assets, who cannot afford to pay anything.[84]

7.82 Mrs Susan Parr of Aged and Community Services Tasmania (ACST) held a similar view:

> It is the belief of our members that a separation needs to occur between care and accommodation. A range of options for accommodation could well be developed, and care is the area where we should be striving for excellence. Accommodation should be linked, we believe, to market forces. That would free up enough of the sector for it to be able to operate as a business while care services remain as highly regulated as they need to be and funded accordingly.[85]

7.83 Whilst in support of such an initiative, Mr Greg Burgess of the Freemasons' Homes of Southern Tasmania highlighted the need for a safety net:

> ACST suggested—and our organisation has in its submission—that the separation of care and accommodation should be considered. The deregulation or the market forces would then look at the accommodation issues. Certainly there would need to be a safety net built into any process to cater for supported residents, as there is now with rental assistance, for example, for low-income pensioners with rental payments. Allowing market forces to determine and for the industry to provide options as to the quality and size of accommodation may well be a very reasonable option to be pursued across all areas of resident classification—high and low. But I stress there would need to be a safety net for supported residents.[86]

7.84 Mr Ian Yates of COTA Over 50s argued along similar lines:

> You should have a classification instrument for care, and paying for accommodation should be a separate issue. You should work out what your user contributions are and then users and their families should be able to pay them flexibly in a way that suits them—and what will suit one may not suit another.[87]

7.85 Mr Andrew Stuart, First Assistant Secretary of the Department of Health and Ageing also raised concerns of a context emerging whereby:

> …aged-care housing costs were completely open slather and to be borne by the resident because that would lead to the exclusion of less well-off people from care. Because residential care housing and residential care in the end come as a package people have to gain access to both the housing and the care to get residential care. So if housing costs became open slather

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84 Mr G Taylor, Aged Care Association Australia WA, *Committee Hansard*, 30.1.09, p. 47.

85 Mrs S Parr, Aged and Community Services Tasmania, *Committee Hansard*, 27.3.09, p. 5.

86 Mr G Burgess, Freemasons' Homes of Southern Tasmania Inc, *Committee Hansard*, 27.3.09, p. 28.

87 Mr Ian Yates, COTA Over 50s Ltd, *Committee Hansard*, 13.3.09, p. 43.

> depending on what people could afford, then you would really have to worry about access.[88]

7.86 Mr Stuart noted, moreover, that if the industry were allowed to 'charge open slather on housing costs', it opened up the question of how the government should respond for concessional residents who currently make up approximately 50 per cent of the current population:

> Does it pay open slather for them too? I do not think so. I do not think that would be efficient for the taxpayer. There would have to be some thought about ramping up the regulatory requirements on access if you were to uncap accommodation costs.[89]

7.87 At the same time, a number of witnesses held the view that decoupling or unbundling residential aged care services had considerable potential. As one case in point, Grant Thornton Australia stated:

> Whilst the principles would need to be developed with reference to the government's broader health and welfare policy framework, the unbundling of residential aged care services would provide the foundation for a system that enhances consumer choice and facilitates sustainability for both providers of care and the Australian taxpayer.[90]

7.88 In its 2008 research paper, the Productivity Commission noted that clients of community care receive subsidised personal and health care, they generally have to meet their own accommodation costs and living expenses from private means or from income support payments. However, at the same time residential care clients may receive a subsidy for accommodation and everyday living expenses as well as subsidised personal and health care. Of this, the Productivity Commission noted:

> These inequities arise because the public financing principles generally applying in the health system have been applied to all components of residential care, even though some components are more akin to services that are typically provided through the welfare system.[91]

7.89 According to the Productivity Commission, unbundling care and accommodation may address this discrepancy:

> 'Unbundling' the service components that make up aged care provides a way of ensuring that appropriate and consistent public financing principles are applied to each of these components across different types of care. It is also a way of ensuring consistency between aged care services and

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88 Mr A Stuart, Department of Health and Ageing, *Committee Hansard*, 21.4.09, p. 27.

89 Mr A Stuart, Department of Health and Ageing, *Committee Hansard*, 21.4.09, pp 27– 28.

90 Grant Thornton Australia Ltd, Answer to question on notice, 30.1.2009 (received 6.3.09).

91 Productivity Commission, *Trends in Aged Care Services: some implications*, Research paper, September 2008, pp 70-71.

> equivalent services provided through the broader health and welfare systems.[92]

7.90 The Productivity Commission listed a number of challenges involved in unbundling the costs of aged care services. At the same time, however, it held the opinion that arguments in favour of unbundling in order to 'achieve equity across different types of care, better targeting of the public subsidy, are fundamentally sound and warrant detailed analysis.'[93]

7.91 Whilst raising caution in relation to concessional residents, Mr Andrew Stuart of the Department of Health and Ageing also recognised the validity of decoupling:

> On the plus side: it recognises that people have housing costs in their own homes, so why shouldn't they have housing costs when they are in residential care? That seems like a reasonable statement to me.[94]

7.92 However, Dr David Cullen, Assistant Secretary of the Department of Health and Ageing held the view that as of March 2008 the government had 'essentially split care and accommodation funding':

> In residential care now the accommodation is paid for by the resident, essentially through their basic daily fee and through their accommodation payment. Where they cannot afford to pay for it, it is paid by the government through the accommodation supplement. That takes care of the accommodation side. On the care side there are the care subsidies and the resident makes a contribution through their income tested fee. So there already is a clear split between payments for accommodation and care.
>
> One of the key structural features of the 2008 changes was that we did ensure that all residents from an accommodation point of view in high care were worth exactly the same amount to the provider. The government pays all of the accommodation supplement for the poorest residents; the richest residents pay all of the accommodation charge themselves; and in between those the government's payment is reduced at the same rate as the resident's payment is increased so that everyone is worth exactly the same. That mechanism means that you have no access equity issue. Providers have no reason to choose one client over another, so you can have a relatively loose regulatory burden as far as access is concerned.[95]

7.93 The committee recognises that the government has taken steps towards what is effectively the decoupling or unbundling of residential care and accommodation. However, it also recognises that additional measures can be taken which would enable

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92 Productivity Commission, *Trends in Aged Care Services: some implications*, Research paper, September 2008, p. 71.

93 Productivity Commission, *Trends in Aged Care Services: some implications*, Research paper, September 2008, p. 74.

94 Mr A Stuart, Department of Health and Ageing, *Committee Hansard*, 21.4.09, p. 27.

95 Dr D Cullen, Department of Health and Ageing, *Committee Hansard*, 21.4.09, p. 28.

greater flexibility for both residential care clients and providers. However, it considers that further analysis is required to establish the ramifications of such measures on aged care funding and service provision. For this reason, the committee recommends that the Department of Health and Ageing conduct a review into decoupling of residential care and accommodation.

Recommendation 26

7.94 The committee recommends that the Department of Health and Ageing analyse decoupling of residential care and accommodation. Such a review should consider and assess the views, concerns and recommendations of involved stakeholders including the Productivity Commission.

Community aged care

7.95 Concerns regarding residential aged care funding regarding the distinction between high and low care in terms of funding are also felt in relation to funding across community aged care. Indeed, a substantial number of witnesses maintained that inequalities exist between the elderly receiving Home and Community Care (HACC) services and those on Community Aged Care Packages (CACP) and Extended Aged Care at Home (EACH) packages.

7.96 COTA Over 50s held the view that inequalities in user payments existed between fees for Community Aged Care Packages and comparable sets of services delivered through the HACC program.[96]

7.97 The ACCV highlighted the repercussions of different payments between HACC and CACP:

> HACC clients pay less for an equivalent range and amount of services than those on the other packages. Lower fees for HACC services have seen some clients refused CACP, because it costs more.[97]

7.98 The Tasmanian Government Department of Health and Human Services also held such concerns. Ms Janet Carty of the department elaborated:

> It is not only the disconnect between HACC and packages; it is the disconnect also within the packages, because there are gaps and overlaps – so we agree with all of that. We are working with the Australian government to try to improve that. There are also different funding regimes, different reporting regimes and different quality regimes.[98]

7.99 Alzheimer's Australia held the same position but from a different viewpoint:

96 COTA Over 50s, *Submission 93*, p. 3.

97 Aged and Community Care Victoria, *Submission 89*, p. 10.

98 Ms J Carty, Department of Health and Human Services, *Committee Hansard*, 27.3.09, p. 87.

> Because of the difficulties associated with means testing most providers charge only the minimum amount for CACPs and EACH.
>
> In regard to HACC, there exists a national fees policy which, among other things, ensures that a person will not miss out on a HACC service because of inability to pay, and sets limits on the total level of fees for people receiving multiple services, but the policy allows each State and Territory to set its own fees. This has led to considerable variation across States.[99]

7.100 Aged and Community Services SA & NT detailed the allocation differences and consequences:

> The allocation differentials between HACC (a few thousand dollars up to $75,000 +) and CACP ($12,000), EACH ($42,000) and Each D ($46,000) result in difficulties for providers trying to care for clients' changing needs. It is not uncommon for a provider who may have a CACP client to not be able to offer an EACH package because they have none available. Individuals have by necessity had to seek another provider.[100]

7.101 One of the primary concerns raised in relation to HACC was articulated by Care Connect:

> HACC clients are able to access far more hours of service on a low fee as opposed to a lower number of hours per week they can access on a Commonwealth package of care; as such we see a trend of clients seeking to remain on HACC to high care levels and not transition onto a packaged care program.[101]

7.102 According to the National Ex-Service Round Table on Aged Care (NERTAC), the 'failure of the HACC Program to implement a consistent fees policy has created inequity and introduction of co-payments in other programs has created difficulties for consumers and providers'.[102] Similarly, Catholic Health Australia maintained that:

> HACC service user fee arrangements vary between jurisdictions and when compared with the regulated variable fee arrangements under Commonwealth funded community care packages, act to discourage consumers from moving from HACC to the packages despite their increased support needs.[103]

7.103 COTA Over 50s and Alzheimer's Australia held the view that the current gap between CACPs and the various EACH packages is too great.[104] As Alzheimer's

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99 Alzheimer's Australia, *Submission 87*, p. 6.

100 Aged and Community Services SA & NT, *Submission 90*, p. 2.

101 Care Connect, *Submission 71*, p. 3.

102 NERTAC, *Submission 8*, p. 7.

103 Catholic Health Australia, *Submission 75*, p. 11.

104 COTA Over 50s, *Submission 93*; Alzheimer's Australia, *Submission 87*.

Australia noted, the CACP subsidy is currently $34.75 per person a day whilst the EACH subsidy is $116.16 per person per day, and the EACH-D subsidy $128.11 per person per day.[105] In addition, COTA Over 50s held that the differential in some contexts between fees for CACPs and comparable services provided through the HACC program created inequalities.[106]

7.104 According to Catholic Health Australia, part of the problem rests with the fact that no benchmark of care costs have been undertaken in relation to community aged care. The body highlighted that CACPs, EACH packages and EACH-D packages have 'only one funding level each regardless of the hours of care each individual package recipient requires'. For this reason, according to Catholic Health Australia, the service provider is required to 'pool the total package income received and fund the varying hours of care accordingly'.[107]

7.105 The Aged and Community Services Association of NSW and ACT held that funding is unable to meet assessed needs:

> In community care the set rate for care provision of CACP, EACH and EACH-D clients only provides 3 levels of subsidy. This results in declines in the level of services offered to clients as package funding is unable to meet assessed needs. A New Strategy for Community Care – The Way Forward includes the review of fees in community care however this process needs to be driven forward quickly if older Australians are to be able to receive appropriate quality care.[108]

7.106 The Council of Social Services of New South Wales maintained that CACPs provide a 'very low amount of service' as a result of the levels to which they are funded compared to EACH:

> What is CACPs' role, given it can no longer provide a hostel level of care service at the existing levels of funding, as originally intended. Many CACPs try to top up their support using HACC services, even though it's not allowed, as the amount of hours isn't sufficient for many clients to support them appropriately. The difference between support levels of CACP and EACH is significant with no package support level in between.[109]

7.107 Ms Derryn Wilson of the Municipal Association of Victoria argued that rigidity within community care was a central concern:

> I think the rigidity is more between the home and community care services and the CACPs and EACH packages. It is about the community care. I

105 Alzheimer's Australia, *Submission 87*, p. 8.

106 COTA Over 50s, *Submission 93*, p. 3.

107 Catholic Health Australia, *Submission 75*, p. 8.

108 Aged and Community Services Association of NSW and ACT Inc, *Submission 61*, p. 3.

109 Council of Social Services of New South Wales, *Submission 52*, p. 6.

> think what everybody finds is that people's needs change over time, and they can go up and down. You have a system that says, 'If you are around this level of care, you get your services from that, and if you are at this level of care, or you need some additional things that are not available here, you have to tip over into that. There are different providers in the two systems, so people have to swap into another set of arrangements with different fees and different personnel. But often a lot of their core needs remain the same. They will still need help with housework. They might still need help with showering. They might still need a bit of home maintenance. Particularly for people who have already been getting those services in HACC, it is quite a jump to have to go into a care package, primarily sometimes to get case management because case management is not available in HACC. So I think what we are saying about the rigidity is it is this problem of silo programs and not allowing people to have a range of needs met over time and up and down through the one provider, the one system of local care.[110]

7.108 The ACCV argued that there funding distinctions between CACP and EACH implicated the ability of providers to cater for individual client needs:

> From a client or user perspective, the enormous gap in funding between the current CACP and EACH packages means providers are simply unable to cater for individual client needs as they become more frail. Unlike the new ACFI system which has 64 funding points, there are only three points in relation to commonwealth funding community aged care packages: CACP, EACH and EACH Dementia. To compound and limit the flexibility of providers to match care to client needs, individual elderly clients must receive a further ACAS assessment before they can move from the CACP level to the EACH level.
>
> The consequence is clear. Those receiving CACP packages will have substantial increases in their level of frailty or complex care needs and yet be ineligible for additional funding support until they are assessed by the ACAS as needing an EACH package. This substantially limits the capacity for providers to meet care needs.[111]

7.109 A number of providers took the view that community care packages should be streamlined into a single system. Alzheimer's Australia argued that all HACC funding for aged people should be managed by the Commonwealth to enable an 'integrated approach to packaged care across CACPs, EACH and HACC'.[112] ECH Inc, Resthaven Inc and Elder Care Inc held the same view and argued for a 'single, seamless system of home and community aged care'.[113] Baptist Community Services of NSW and ACT maintained that it was difficult for people to move easily between CACPs and EACH

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110 Ms D Wilson, Municipal Association of Victoria, *Committee Hansard*, 20.2.09, p. 15.

111 Aged and Community Care Victoria, *Submission 89*, p. 5.

112 Alzheimer's Australia, *Submission 87*, p. 3.

113 ECH Inc, Resthaven Inc and Elder Care Inc, *Submission 85*, p. 4.

because of availability issues and that such arrangements needed to be streamlined if the system 'is to be able to support people efficiently and effectively'.[114]

7.110 Similarly, Anglicare Australia held that barriers between community-based aged care services as well as the barriers between community and residential care should be eliminated to enable people to move 'flexibly between modes of care as their needs change.' It held that:

> For many people, the pathways to community-based and residential aged care services are complex and daunting. This is amplified by many people entering the system as a result of a crisis event. Now is an opportune time to work together to make the service system more streamlined, easier to navigate and more efficient.[115]

Conclusion

7.111 The committee appreciates the concerns of community aged care providers in relation to funding and its implications on the provision of quality services to Australia's elderly population. For this reason, the committee reaffirms its recommendation to establish benchmark of care costs for aged care. Notwithstanding the establishment of benchmark of care costs, the committee acknowledges that the funding and services for community aged care need to be expanded in light of the demand for such services which is only set to increase.

Recommendation 27

7.112 The committee recommends that the Australian Government expand community aged care funding and services to meet growing demand and expected quality service provision outcomes.

7.113 The committee also acknowledges the views of many providers in relation to dissolving the demarcations between and within community and residential aged care and streamlining services for the purposes of continuity of care and to emphasise care needs over service categories. However, the committee takes the view that such an initiative can only be considered during the course of an overarching review of the aged care sector as a whole.

Client-based aged care system

7.114 A number of aged care providers expressed the view that the aged care system is extremely complex, rigid and inflexible and argued that the funding inequalities within the system were in part, a consequence of an aged care model which is neither client-centred nor client-focused. Suggestions to ensure greater flexibility particularly in relation to funding arrangements focused on the need for a client-based system presupposing a shift from a relationship which is government/provider focused to that

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114 Baptist Community Services of NSW and ACT, *Submission 21*, p. 6.

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

with a client/provider focus. Mr Cam Ansell of Grant Thornton Australia stated in this regard:

> I think an ideal situation is that, rather than this being a constant negotiation or relationship between the government and the provider, in the future it is necessary for the relationship to be one between the aged-care provider and the resident in the discussions about how they provide financial support in terms of their accommodation; whether it be in the form of an up-front payment—call it accommodation bond if you will—or they may prefer not to do that. They may prefer to hold on to the money or the assets and pay an ongoing fee or rental, like we do in most other areas of our society. I would like to see perhaps a little bit of a view of: what does the consumer want? What are their preferences?[116]

7.115 Mr Ian Yates from COTA Over 50s argued for an entire focus shift:

> We believe that the whole system needs to move to a more consumer directed care model, with much greater involvement of consumers and their carers. All of that is based around a paradigm of our needing to see older people as not having a 'best by' date. We need to see them as being able to make contributions and being supported, with their strengths built upon, encouraged and challenged. That is how we ought to recast the system that we have at the moment.[117]

7.116 Ms Robyn Batten from UnitingCare Australia expressed the view that what is required is planning based on assessed need rather than available supply.[118] Ms Batten continued:

> Effective consumer directed care will not be achieved by just cashing out service funding. It requires consumer involvement in overall system and service design and it is really important at the design phase. Access to independent advice about care options, life planning support and the opportunity to choose when and how to access informal and professional services, sometimes concurrently, and training and technical support to service providers will be required to ensure individual budgets are implemented in a way that provides a high level of satisfaction to consumers.[119]

7.117 Wintringham also stated its concern of the current model:

> Aged care funding is provided in distinct silos. Funds are limited to specific amounts dependent on care recipients meeting certain, established funding criteria.[120]

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116 Mr C Ansell, Grant Thornton Australia Ltd, *Committee Hansard*, 30.1.09, p. 9.

117 Mr I Yates, COTA Over 50s Ltd, *Committee Hansard*, 13.3.09, p. 40.

118 Ms R Batten, UnitingCare Australia, *Committee Hansard*, 13.3.09, p. 25.

119 Ms R Batten, UnitingCare Australia, *Committee Hansard*, 13.3.09, p. 25.

120 Wintringham, *Submission 43*, p. 2.

7.118 The need for system flexibility to enable continuity of care was also highlighted by witnesses before the committee. One such example is that of situations where clients seek to move from one facility to another and a new operator is required to either accept an existing accommodation bond or refuse admittance. The ACAA highlighted concerns in this regard:

> Family members often indicate a wish to relocate a loved one and are often able and willing to pay the additional contribution required by the new facility.
>
> However, providers must accept the existing bond agreement and even if a relative wishes to pay a lump sum contribution on behalf of the resident, the Aged Care Act 1997 requires the provider to return these funds to the care recipient or their estate not to the person paying the bond on behalf of the resident.[121]

7.119 Similar concerns were raised from other providers about community care including Mr Nick Mersaides of Catholic Health Australia who stated:

> The fact is that on the community care side it has evolved as a type of service well behind residential care. Residential came first. As other witnesses have put to you, the current arrangements around community care are quite restrictive and rigid in terms of being able to, as your care needs increase, transition to a higher level of subsidy in the same way as you would in residential care. We need to have the same calibration of subsidy levels in the community care sector as we have in residential. Indeed if you want to have a real choice there has to be a signatory between the level of subsidies available on the care side; putting aside accommodation which does not apply, there needs to be some symmetry and consistency of policy in those levels of subsidies between residential and community.[122]

7.120 Mr Ian Yates from COTA Over 50s held the view that HACC needed to be more client focused:

> With HACC, in some cases, you are providing what is essentially community-development infrastructure and services, but we would like to see it being much more client focused than it is at the moment. We think the principal distortion for HACC is that it gets used to create packages because the packages or care system in the community is insufficient. The really big thing that our consultation has told us for over a decade is that consumers want more and more robust community care and community care with much more flexibility in it. They want it to be available at the time they need it and so that it meets their needs. There are too many people in, firstly, the healthcare system and, secondly, residential care because they cannot get access to community care.[123]

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121 Aged Care Association Australia, *Submission 92*, p. 23.

122 Mr N Mersaides, Catholic Health Australia, *Committee Hansard*, 13.3.09, p. 6.

123 Mr Yates, COTA Over 50s Ltd, *Committee Hansard*, 13.3.09, p. 44.

7.121 The committee appreciates the concerns of providers in relation to the aged care system and recognises that the emerging future challenges for the sector require considerable planning in close association with both current and future aged care clients themselves. For this reason, it suggests that its recommended all-encompassing review of the aged care sector take a client-based approach in order that its findings are client focused. Current practices and future challenges should be considered through the lens of aged care clients.

Recommendation 28

7.122 The committee recommends that the all-encompassing review of the residential and community aged care sector take a client-based approach in order to ensure that its findings are client focused.

7.123 As part of calls for greater client-based care, the need for more flexibility to enable a user-pays system for clients who have the ability to finance their care services was raised during the course of the inquiry. This debate centred around a lack of flexibility on the part of the system which ensures that choices of services are limited as are the payment options available to clients as Mr Stephen Teulan of UnitingCare Australia explained:

> Because of their various personal financial situations, some people would prefer to pay up front for a refundable amount. Some would prefer to say, 'I don't want to pay at all now. I would like it charged to my estate.' There is everything in between in terms of daily charges, annuity purchases and everything else. At the moment you cannot do those sorts of things, because the system is completely and utterly inflexible. Both consumers lose out because ultimately they will have lack of choice and they will have fewer services and providers lose out because they cannot provide the services into the future. There will not be the capital to do that. We say the government should pay the actual cost for those people who cannot afford to pay themselves. Those people who can afford to pay should have choice based on various types of services. It should be means tested so they should never be in financial hardship, but there should also be flexibility in the payment arrangements so they can work out their own circumstances. We would be happy with that.[124]

7.124 The Productivity Commission highlighted that one of the key challenges to the sector is the growing and increasingly diverse range of elderly Australians who are expected to demand higher quality aged care services and greater choice in the services they are offered:

> The nature and composition of aged care in the future is being inexorably shaped by two emerging trends: the growing diversity of the aged population and their expectations of greater choice in the availability of

124 Mr S Teulan, UnitingCare Australia, *Committee Hansard*, 13.3.09, p. 33.

services; and a growing capacity for some older people to self-fund a greater part of their retirement needs (including for aged care).[125]

7.125 A number of providers maintained that given the increasing demand and expectations on care services, greater flexibility is required to enable those who have the means to pay to do so. Catholic Health Australia was one such proponent of this view as Mr Martin Laverty explained:

> …we note the need for a change in the approach to care fees. Our position is that those who have the ability to contribute to their own care should. Those who do not have that ability must be protected by a rigorous safety net, and that is the role of the Commonwealth government to ensure that the concessions that are available for consumers without financial means are legitimately equal to the cost of the provision of their care; at the moment we suggest there is a substantial gap between the actual concession provided by the Commonwealth and the actual cost of delivering care.[126]

7.126 Mr Cam Ansell of Grant Thornton Australia expressed the view that the role of government needs to be that of ensuring access to aged care for those who cannot afford it rather than 'limiting the options available for people who can'.[127]

7.127 A number of witnesses identified decoupling residential aged care and accommodation as the means of ensuring greater flexibility to enable clients a choice and ability to finance their own care services where able.[128] Baptistcare is one such provider as Mr Robert Bunney explained:

> As we have said, you need to separate the accommodation element from the other elements, and then people can have a choice. Yes, there will be people who cannot afford the most basic level of accommodation and that is where government comes in and says, 'All right. We will fund this level,' and the government might decide it will fund shared bathroom facilities.[129]

7.128 Whilst the committee recognises that there have been initiatives undertaken by the Australian, state and territory governments to rebalance public and private financing of aged care services, it believes that there may be scope for greater flexibility in this regard. However, it notes that this issue is entwined with that of the decoupling of residential aged care and accommodation debate and is grounded on common consensus that greater flexibility on the part of the aged care funding system is required. For this reason, the committee encourages its suggested holistic review of the aged care sector to encompass options including decoupling of care and

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125 Productivity Commission, *Trends in Aged Care Services: some implications*, Research paper, September 2008, p. 104.

126 Mr M Laverty, Catholic Health Australia, *Committee Hansard*, 13.3.09, p. 3.

127 Mr C Ansell, Grant Thornton Australia Ltd, *Committee Hansard*, 30.1.09, p. 8.

128 See the above section on decoupling residential aged care and accommodation.

129 Mr R Bunney, Baptiscare, *Committee Hansard*, 30.1.09, p. 104.

accommodation, greater flexibility to enable payment and service options for clients, and a system designed to meet aged care client needs.

Recommendation 29

7.129 The committee recommends that the all-encompassing review of the aged care sector consider options to enable greater flexibility in relation to payments and services directed at providing a client-centred aged care system for Australia.