Queensland Health Submission

Senate Committee on Finance and Public Administration:

Inquiry into residential and community aged care in Australia

The funding planning, allocation, capital and equity of residential and community aged care in Australia.

Queensland Health commends the decision of the committee to examine both residential and community aged care services as the organisations funded to deliver theses services typically deliver both service types and the delivery of these service are inextricably linked.

Queensland Health would like draw the attention of the committee to three broad points regarding the residential and community aged care sector before addressing each of the individual component of the inquiry's terms of reference:

- The Commonwealth is yet to undertake a review to establish the actual cost of providing residential and community aged care services. Until the actual costs of delivering these services are described any determinations regarding the adequacy of current funding levels will be at best uninformed;
- Current funding levels for the residential aged care sector are not sufficient to encourage service providers to invest capital to build new facilities. An absence of new services has serious implications for the aged care and health sectors in both the short and long term. And;
- Community aged care service subsidies are indexed to increase at a much lower rate than residential aged care subsidies. The declining purchasing power of the community aged care subsidies has already resulted in these packages providing less care to recipients.

a) Whether current funding levels are sufficient to meet the expected quality service provision outcomes

Within Queensland, large non-government organisations provide the bulk of aged and community care services. These service providers typically operate across the entire aged and community care service spectrum, providing not only residential and community aged care services but also providing basic community care services through the Home and Community Care (HACC) program.

Participation of these non-government providers within these sectors is totally dependent on Government subsidy. The continued participation of the non-government sector in providing these very important primary health, residential and community care services is dependent upon adequate levels of government subsidy. Adequate levels of government subsidy are those that cover the true cost of service delivery, including capital expenditure, and that it is adequately indexed to reflect the actual price increases faced by these organisations.

Queensland Health operates a very small number of community aged care packages and therefore comments relating to adequacy of current funding levels are limited to the residential aged care sphere.

According to the Department of Health and Ageing's Annual Report 2007-08, the rate of non-compliance with the expected quality standards in residential aged care homes was 1.4%. However, inadequate funding levels for the residential aged care sector, particularly if the subsidy's purchasing power erodes over time, may not manifest immediately in increased non-compliance within residential aged care facilities.

It is much more likely that reductions in profitability will result in service providers decreasing their involvement in the residential aged care sector. Decreased participation could be manifest in service providers not applying for additional aged care places, handing back bed licences to the Commonwealth, or increasing the level of 'cherry picking' of residents, to ensure that new residents have care needs that can be met with the expected future funding provided.

Clients with care needs not adequately funded under the Aged Care Funding Instrument (ACFI), will have difficulty accessing care within the residential aged care sector. Consequently, within Queensland, these higher care need clients will increasingly continue to require care outside that which can be provided within a non-government facility.

Declining purchasing power of residential aged care subsidies mean that the cost of caring for these higher care need clients will continue to be shifted towards the Queensland Government. In the future, declines in the level of care that can be provided at a non-government facility will increase the number of people receiving care in an acute hospital setting. It will also increase the waiting lists for people seeking care within a Queensland Health residential aged care facility.

Queensland Health believes that the current funding levels for residential aged care are not sufficient to meet the expected quality outcomes outlined in the *Aged Care Act 1997*. The State Government already invests a significant financial contribution in addition to the Commonwealth subsidy in order to ensure quality care is maintained for residents in State run facilities.

The Aged Care Funding Instrument (ACFI) was introduced on 20 March 2008 as the primary Commonwealth residential aged care funding mechanism. It is estimated that the ACFI will decrease Commonwealth subsidy received for Queensland Health residential aged care services from $55 million in 2008-2009 to between $45 and $50 million when the full effects of the new funding mechanism take effect.

Queensland Health believes that this drop in subsidy will limit the capacity of non-government providers to meet the care needs of future residents. Facilities as a result of decreased funding levels will attempt to remain viable through being increasingly selective of the residents they admit. In particular, their capacity will fall in relation to caring for individuals with challenging behaviours, caused by dementia or psychogeriatric illness or with complex care needs. Current funding levels for residential aged care clients are not sufficient to encourage service providers to care for higher or more complex care need clients.

b) How appropriate the current indexation formula is in recognising the actual cost of pricing aged care services to meet the expected level and quality of such services;

Residential aged care, subsidies are indexed using a 75% - 25% weighted average of the Commonwealth Own Purpose Outlay (COPO) and the Consumer Price Index (CPI). The COPO is a Commonwealth derived measure of general wage growth minus productivity growth. The objective of the COPO is to provide subsidy increases to cover only wage growth that is not offset by productivity dividends.

Unfortunately the COPO is a poor indicator of the changes in wage costs that have been experienced in the aged care sector as it makes estimates of productivity dividends that can not apply to service providers. The residential and community aged sectors are labour intensive and focus on providing care for the specific care needs of individuals. The individualised requirements of aged care and the inability to substitute from labour to capital resources means that productivity dividends captured within the economy are unable to be captured by aged care providers.

The 2004 Hogan Review into residential aged care pricing concluded that the indexation arrangements for residential aged care subsidies did not reflect actual price increases faced by service providers. In response to this review the Commonwealth introduced the Conditional Adjustment Payment (CAP). It was designed as an interim measure to offset falls in real funding levels to residential aged care service providers caused by inadequate indexation arrangements. This interim measure was proposed as a stop gap measure pending a full review of the cost of service delivery within the sector.

Access Economics estimates that residential aged care subsidies were indexed to increase at between 3.5% and 3.7% each year since 2004. Since 2004 Access Economics also estimates that wage costs for residential aged care facilities, which account for 75% of ongoing operating costs, increased by between 4% and 6% over the same period. These wage increases have been coupled with CPI increases within Queensland of between 2% and 5% since 2004.

Therefore the current indexation arrangements for residential aged care subsidy can not be confirmed as adequate, as the Hogan Review stated that the indexation arrangements for residential aged care subsidies have been inadequate since at least 1995 and the actual cost of residential aged care service delivery has never been ascertained.

Community aged care subsidies fare much worse from indexation arrangements as they only receive indexation based on the COPO and the CPI. Community care subsidies do not have access to the CAP, or a CAP like payment, that attempts to account for inadequate indexation.

Funding for Community Aged Care Packages (CACPs), Extended Aged Care at Home (EACH) and Extended Aged Care at Home – Dementia is provided at flat rate per client to service providers. The care provided under these packages is not benchmarked like care in residential aged care facilities. In response to decreasing real funding levels for community care packages, service provides have adjusted the level of services they provide under a community aged care package.

The purchasing power for CACPs, because it is indexed using the COPO, has declined over the past five years. As a result of this declining purchasing power service providers are adjusting the

level of services provided to each client under the package. As a result the average number of care hours provided under these packages has fallen. No determination regarding changes in the number of service hours provided under EACH and EACH – D packages can be made as these packages have not been available long enough to assess any change to the extent of services provided.

The development of benchmarks for the services to be delivered under a community aged care package would allow for a determination to be made as to what level of aged care can be efficiently provided within the community. The vast majority of residents, given the choice, would choose to receive aged care services within their own homes and communities.

Determining a maximum level of aged care that can be efficiently delivered within the community would provide a firmer indication of the number of people that can be provided with aged care services within the community, and would allow for a better assessment of the number of individuals that could potentially require residential aged care.

Any benchmarking activities that sought to define the quantum of services provided under CACPs, EACH or EACH – D packages would also require the Department of Health and Ageing to determine the actual cost of delivering these services.

c) Measures that can be taken to address regional variations in the cost of service delivery and the construction of aged care facilities

In order to develop measures to address regional variations in the cost of service delivery, an essential first step would be to identify the actual costs of service delivery.

All current estimates of regional variation in operating costs or construction are extrapolations from other sectors within the economy. Regional variations, particularly in relation to operating costs, need to be verified with residential and community aged care specific data as the measures designed from the generic cost data may not address the underlying causes of residential and community aged care cost variances.

Queensland Health does observe regional variations in the cost of service delivery between its residential aged care homes; however, because of the relatively small number of facilities and the differing size of the 21 facilities it not possible to a identify a single specific cause of these variations.

There are already viability supplements based on service size and regional location available to residential aged care services to account for the additional cost of service delivery within rural and regional locations. However, without a holistic industry wide examination of the cost of delivering both residential and community care services, the adequacy of the current viability supplements will not be able to be determined.

d) Whether there is an inequality in user payments between different groups of aged care consumers and, if so, how the inequity can be addressed;

Structural inequities relating to user payments are enshrined within the *Aged Care 1997*. These inequalities revolve around the different financial incentives provided to service providers between high and low care services based on the assessed care needs of residents on entry. The accommodation payments within the residential aged care sector require eligible low care residents to lodge substantial accommodation bonds whilst high care residents pay an accommodation charge. Queensland Health, as an Approved Provider of residential aged care services, does not charge accommodation bonds to residents in its facilities.

The ability of providers to hold substantial limp sum ammounts through the contribution of accommodation bonds renders the provision of high end low-care services more financially attractive than the provision of high-care services. As a broad principle there should be common arrangements regarding the accommodation payments able to be applied, to clients with sufficient assets, regardless of the level of care a person requires.

e) Whether the current planning ratio between community, high- and low-care places is appropriate;

The current planning ratios for community and residential aged care call for 108 places (44 high care, 44 low care and 20 community places) per 1000 individuals 70 years and over. Queensland is approximately 900 operational residential aged care places short of current service planning benchmarks. Whilst it is difficult to assess the adequacy of planning ratios when they have not been met, there are, on average, over 400 nursing home type patients residing within Queensland's acute hospital facilities because they are unable to access a place in a residential aged care facility. This is a clear indication to Queensland Health that there is significant, latent demand for residential aged care services within the community.

Finally the residential and community aged care planning ratios seem to be based on the premise of 100% occupancy rates in facilities. Targeting 100% occupancy denies individuals a real choice of their residential or community aged care service provider. It contributes to preventing clients being given a real choice in the location of service provider and decreases the competitive pressure within the sector for service providers to increase efficiencies and quality of care.

Planning ratios that allow for spare capacity within facilities would give consumers real choice in selecting an aged or community care provider, whilst being cost neutral to the Commonwealth as the subsidy is only provided to occupied beds. It would allow for individuals that require care, many of whom require care quickly as the result of an unexpected adverse health event, to make real choices about the service they access, instead of the current situation where potential residents feel obliged to accept the first resident aged care places that becomes available.