The
Aged Care Alliance

Submission to the Senate Inquiry
to the Senate Finance and Public Administration Committee Inquiry into
Residential and Community Aged Care in Australia

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Introduction

The funding, planning, allocation, capital and equity of residential and community care in Australia represents the major components of public policy necessary for the effective delivery of care and services to the community.

In 2008, the sustainability of services, their capacity to deliver quality care and accommodation and the expansion of the sector to meet the needs of a rapidly growing, more demanding future customer base, are all affected by the efficacy of current policy.

In 1996, the previous Coalition government commenced its program of aged care reforms. The last major reform of residential aged care policy occurred in 1997. The benefit of those reforms has now been exhausted.[1]

The Coalition Government reforms were examined and crticised in a series of Parliamentary inquiries including two substantial Senate inquiries in 2002 and 2005 and also the House of Representatives which conducted another inquiry.

Policy and funding issues have also been subject to scrutiny outside of the Parliamentary process including the Review of the Pricing Arrangements in Residential Care by Professor Warren Hogan who reported his findings in 2004.

The Productivity Commission produced a further report in September 2008. In October 2008, while the Labor Government conducted a Review of the Conditional Adjustment Payment (CAP) involving central agencies and the Department of Health and Ageing.

In November 2008, the Council of Australia Governments (COAG) considered the wider issue of health reform where residential and community care is part of the publicly funded national healthcare agenda.

[1] Aged Care Policy Blueprint for 2020. Catholic Health Australia. p 5.

There has been considerable review and inquiry into the Australian aged care sector over the last decade; however unfortunately, there has been very little constructive policy reform.

The Senate's examination of the aged care residential and community care sector is welcome as it enables policy makers with the opportunity to conduct a transparent examination of the structure and effects of current policy.

1. Whether current funding levels are sufficient to meet the expected quality service provision outcomes

The extremely low rate of investment return has been noted by several recent independent financial surveys including the Grant Thornton Review[2]. The disparity between salaries paid in the aged care sector and the wider health sector which is significant means that aged care investors, providers and staff have been subsidising the system for some time.

It is the view of the Alliance that the capacity of these groups to continue to do so is now exhausted and unless the funding and regulatory system is substantially overhauled there are two certain effects;

- Existing and new aged care organisations will cease to invest and expand in the sector as there is no financial incentive for them to do so and commercial lending obligations will be insurmountable; and
- Aged care will continue to decline as a positive career choice for skilled and committed workers and the movement to alternative higher paying healthcare providers in the acute sector will accelerate and impact on the quality of care delivered in aged care facilities.

A withdrawal of private provider investment will leave the Government and community with no alternative than to substitute that investment through public provision of aged care infrastructure and much higher outlays for taxpayers.

[2] Grant Thornton. 2008. Aged Care Survey 2008. Summary Findings October 2008

Current funding policy and regulatory practice contains no mechanism either through normal market / pricing practices or regulation to effectively adjust to changes in care costs and capital costs. Current funding policy has failed to anticipate changes in internal and external costs and subsidies have not been adjusted to fully compensate providers for those impacts.

The decision of COAG in November, 2008 to meet rising health costs via an annual indexation mechanism of 7.3% demonstrates that State Governments receive preferential policy attention. The public hospitals deliver health services which have many comparable costs to those in the aged care sector. The federal government's policy of indexation which is applied to the aged care sector results in a substantially lower adjustment.

The principal deficiency in current funding policy and regulatory practice is that it is unable to adequately predict future care costs and also capital investment costs. Current funding policy has failed to anticipate changes in internal and external costs and subsidies have not been adjusted to fully compensate providers for those impacts.

The submission by BlueCare (Queensland) to this Inquiry examines the financial impacts under current policy and that analysis comprehensively details examines the relevant issues. It should be emphasised that the scope and scale of BlueCare's involvement in residential and community care adds weight to the importance of that analysis and the need for substantive policy reform.

The adequacy of funding for care and its relationship to quality of care is a long standing policy issue identified by Labor when in Opposition and was part of its election commitments to the sector in 2001.[3] The policy commitment was to support the development of a benchmark of care.

The quality service outcomes are defined under the accreditation standards and their comprehensive nature is a major aspect of the compliance

[3] Hansard. House of Representatives. June 15, 2004. Mr Stephen Smith. p30261

obligations of approved providers. The 2005 Senate Inquiry, *Quality and Equity in Aged Care* linked quality of care to resourcing in these terms:

> "The Committee considers that the quality of care could be improved through the development of a benchmark of care which ensures that the level and skills mix of staffing is sufficient to deliver the care required and a review of the Accreditation Standards to define in more precise terms the outcomes in providing care to the elderly."[4]

The persistence by the previous Coalition and now the Labor government with a funding model that is unresponsive to changes in the cost and composition of care sits at the centre of the current policy issues.

In 2005, the National Aged Care Alliance (NACA) made a submission to the House of Representatives Standing Committee on Ageing Inquiry[5] in 2005. The NACA submission was in response to the emerging issues in staffing and wage parity which was prominent factors in the debate over the adequacy of Coalition policy.

In its submission to the House of Representatives, the NACA called for the introduction of a new funding system because of the defects in the indexation mechanism which it stated did not reflect the real costs of service provision and the lack of transparency in the construction of current funding because there was no benchmark. The National Aged Care Alliance proposed a new structure:

> "The benchmark of care must reflect the real costs of providing a quality aged care service in different regions around Australia and allow for flexible delivery of aged care services responsive to the needs of the individual." [6]

[4] Senate Community Affairs Committee, 2005, Quality and equity in aged care, June 23, pg xi
[5] National Aged Care Alliance, 2005, Submission to the House of Representatives Standing Committee on Ageing, page 4.

[6] House of Representatives Standing Committee on Ageing Inquiry into Long Term Strategies to Address the Ageing of the Australian Population over the next 40 years.

The achievement of quality outcomes is dependent not only on funding and its adequacy but also the quality of accommodation. The interdependence of investment, financing decisions, construction costs and demand with the subsidy regime is directly relevant to the sectors' capacity to continue to meet expected quality standards. Residential care subsidies comprise the dominant component of operational revenue for providers. The major components of that funding are, the resident payments and subsidies and supplements paid by the Department of Health and Ageing (DoHA).

Funding policy also provides accommodation subsidies for certain residents which serve to compensate the provider for the notional cost of accommodation. The submission by BlueCare Queensland[7] examines the accommodation supplement and its limited contribution to the necessary capital funding required and the limitations of current policy.

That effect of ACFI demonstrates the implementation of policy without consideration of the effect on the entire system. The introduction of the Aged Care Funding Instrument (ACFI) in 2008 was designed to simplify claims for care subsidies and to reduce the inefficiencies of its predecessor the Resident Classification Scale (RCS).

Despite claims by the Minister for Ageing during 2008 that ACFI represents a major increase in funding, the new care subsidy predominantly shifts funding from low care to high care.

The effect is to further reduce the incentive for retention or development of low care facilities. Many providers who are affected by that policy impact are unable to convert their low-care operations into high-care facilities because an inflexible allocation system of licenses operates in those circumstances. Other providers who hold bed licenses granted before1997 have flexibility to admit high care residents.

All beds prior to 1st October 1997 may be used for either high- or low-care as they were not previously allocated under the current delineation. The

[7] BlueCare Queensland. Submission to Senate Inquiry. November, 2008. Pp17-19.

contradictions of the allocation system are exemplified by the exceptions to those circumstances where in post 1997 existing residents in low-care beds are capable of ageing in place and therefore transitioning to high care, but those facilities can not admit high care residents.

The introduction of ACFI has had an effect on the policy of ageing in place as it now redistributes funding from low- to high-care making it difficult to adequately roster for the combined high/low resident care populations given the significant disparity in acuity, need levels and funding.

The cost of the introduction of ACFI raises the question of the rigor of the regulatory impact statement that should accompany changes of this scale prior to implementation.

It is the Alliance's view that the Regulatory Impact Statement should be distributed prior to legislation being passed so that the assumptions, financial modelling are considered in the context of effective consultation with the sector.

A number of aspects of the implementation of ACFI should be reviewed under the guidelines set out by the Office of Best Practice Regulation. The Minister for Finance and Deregulation, Lindsay Tanner has articulated the Government's views on this matter in Parliament in March.[8]

The Productivity Commission in its discussion of the applicability of efficient regulation in aged care and also the recommendations of the Banks Review supported the importance of identifying excessive and unnecessary costs as a consequence of regulation: "Given the high level of community concern and any suggestion of poor treatment of our elderly, the industry is particularly vulnerable to regulatory creep in response to high profile incidents."[9]

Under the previous Coalition Government and the current Government, the sector has been subject to major regulatory change, incremental adjustments,

[8] Hansard. House of Representatives. Minister for Finance and Deregulation. 17th March, 2008, pp 1889 – 1891

[9] Productivity Commission. 2008. Trends in Aged Care Services: Some Implications, Research Paper. P 80.

and in 2008 unlike other sectors of the economy the efficiency of business regulation is yet to be considered. The impact of regulation since 1996 is a significant aspect of the operational realties of Chief Executive Officers who have very limited capacity to absorb the costs of increasing regulation.

Members of the Aged Care Alliance have been placed in the difficult position where the costs of training, documentation and software development represent new costs completely unrecognised by the subsidy regime.

The decline in operational surpluses has reduced the sector's capacity to invest in standard high-care facilities as evident in the analysis provided in the October 2008 Grant Thornton Survey.[10]

The trends in operational financial performance as identified in the Grant Thornton Survey are significant ones and will have other consequential effects such as the ability to service debt to meet obligations such as loan covenants and interest coverage. The capability of the sector to secure finance for capital development has diminished and will continue to erode.

The weakness in current Federal Government funding policy is the presumption that the co-dependency between the government and service delivery by providers is secure. The delivery of residential and community services is built on a policy that supports private organisations under a subsidy based regulatory regime and where providers take operational responsibility for sustaining the delivery of contracted services.

The Grant Thornton Survey and its predecessors indicate that the Government's presumption of a sustainable sector is not soundly based. Recent financial failures by individual providers demonstrate that systemic risk is possible and that corporate failures will extend beyond sporadic and specific events.

The Review of the Conditional Adjustment Payment in 2008 by the Central Agencies of Government received extensive submissions from the sector

[10] Grant Thornton. Aged Care Survey 2008. Summary Findings October, 2008.

concerning current and future viability. The Review and its anticipated report to the Government are to be presented for consideration in the 2009/ 10 budget process[11]. Many submissions stressed the importance of the continuation of that subsidy of 8.75% which originated from the Hogan Report 2004. That subsidy was intended as an interim measure but the effects of external costs, the inadequacy of COPO and workforce issues have created high dependency on its continuation.

2. 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

Providers are constrained by static revenue flows based on subsidies and periodic adjustments by mechanisms such as Commonwealth Other Purpose Outlays (COPO). The effect of existing policy is that providers have limited influence over cost increases whether it is related to labor, statutory costs and goods and services or compliance with legislation and regulation and no capacity to adjust the price of their services.

In the case of providers who have passed on (in full) the annual indexation adjustments provided by the Commonwealth to their staff by enterprise agreements still find the wage disparity is significant.

Professor Hogan[12] in a recent monograph observed that inertia to the review of this policy has continued with the Labor Government noting that:

“The basic COPO structure remains in place and has never been reviewed though a commitment by the previous Government to do that was made soon after the original arrangement was put in place. This has long since lapsed and the objections to this opaque measure have not been met.”

The adequacy of the COPO mechanism was an issue of long-standing contention between providers and the previous Coalition Government.

[11] Cullen, D. Department of Health and Ageing. 2008. Correspondence to the Aged Care Alliance. 25th November, 2008

[12] Hogan. W.T; 2007. The Organisation of Residential Aged Care for an Ageing Population. Policy Monographs, Centre for Independent Studies, Papers in Health and Ageing (1), p 8.

Provider organisations frequently called for a new and more appropriate indexation mechanism that would reflect the cost pressures on the sector. In 2008, that policy of the previous Coalition government remains unchanged.

The Liquor, Hospitality and Miscellaneous Union (LHMU) in their public submission to the Review of the Conditional Adjustment Payment called for rectification of the wage parity gap. The submission succinctly addresses the workforce issues related to a lack of progress on policy dialogue to address the long term effects of Coalition decisions prior to 2007.

The Labor Government has yet to apply the 2007 ALP National Platform policy on workforce issues and wage parity into caucus policy as a new Government. The Labor Party Platform[13] in commenting on a range of major workforce issues identified the differences of wages between residential care and the acute sector. The party has signalled its intentions "to develop strategies to improve the recruitment and retention of nurses and direct care staff with a focus on: addressing the wage disparity."

Stakeholders including providers and unions have been affected through the long term impacts of the use of COPO on the workforce. The major effect has been to compound the disparity in wages between the residential care sector and the acute sector.

The NACA in its policy position paper prior to the 2007 federal election called for a better policy that would establish comparable wages and working conditions with the acute health care sector.

The submission by the Australian Medical Association to this Inquiry raises concerns about the deterioration in staffing and support for General Practitioners in the sector and calls for specific funding for providers.[14]

The contradiction exists where the Queensland and Victorian Governments as operators of nursing homes under the same Federal policy and the same

[13] The Australian Labor Party Platform 2007. Chapter 8. Section 208.
[14] Sullivan, F. 2008. AMA Submission to the Senate Inquiry to the Finance and Public Administration Committee. 18th November, 2008.
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funding regime have maintained public sector parity in those states for their employees at additional cost to the taxpayers of those states. Those state governments are direct providers of services in both residential and community settings and have a distinct competitive advantage in recruitment and retention over private providers.

The previous government maintained it had no direct responsibility for wage levels and the use of subsidies by providers to address workforce. The Australian Labor Party adopted an alternative view on wage parity in its 2007 National Policy Platform. The implicit retention of COPO in 2008 by Labor will compromise its policy agenda for health and hospital reform while the wage parity issue remains unresolved.

The release by the Australian Nursing Federation (Victorian Branch) of a study by Melbourne University[15] report titled "Working in Aged Care: Medication Practices, Workplace Aggression, and Employee and Resident Outcomes" of 1,000 registered nurses emphasises the effect of deficient funding policy and the deleterious effect on the workforce. The study found that policy had placed pressure on nursing home providers to cut costs contributing to increased workloads highlighting the urgent need for improvement in working conditions in the aged care sector.

The experience of members of the Alliance is the impact of the long standing deficiencies of COPO limits their scope in the negotiation of enterprise agreements with unions and staff. The current indexation mechanism and its deficiencies have had an accumulative effect since 1996 on sector capability.

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

The organisational pressures in regional areas are different to and often involve greater costs than apply in major centres and capitals. The current policy does not recognise those differences.

[15] Melbourne University. Sergeant. L; 2008. Working in Aged Care: Medication Practices, Workplace Aggression, and Employee and Resident Outcomes.

In most instances the local aged care service is the major employer in many regional and remote locations. In other circumstances the aged care service compete directly with the Government acute care services, meaning that the ability of the aged care service to access suitably qualified personnel is negatively impacted.

A viability supplement is made available to remote services, however the level of supplement is modest at best, and very restricted in its application and availability, and bears no relationship to the realities and cost profiles in such areas. Federal government policy does not provide the financial incentives to private providers that would encourage the investment that is required in regional areas.

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

Long standing policy under Labor and the Coalition has required an appropriate financial contribution from residents upon admission to residential care and in the use of community care. This policy of co-contribution for accommodation was expanded by the previous Coalition Government in 1997 after the reversal of its policy to introduce bonds for high care in nursing homes.

The principal forms of co-contribution are income tested fees based on the private wealth of residents and the accommodation charge or its alternative bonds in extra service facilities. The structure and purpose of that policy remains substantially unchanged as residents are required to supplement federal contributions where their assets and income indicate a capacity to do so.

In high care residential facilities entry is based solely on care needs and a similar standard of accommodation generally applies in that type of facility and this is stipulated by the federal certification standards. It is a major segment of the sector and it is possible to find accommodation which includes residents in four and eight bed rooms. The recent closure of Rosden nursing home in

Victoria included media commentary on the existence of residents in an eight bed room.

The existence of such variations in nursing home accommodation reflects the fact of design and construction in the 1960's and 1970's. The second type of available accommodation is low-care facilities previously constructed as hostels under Labor's policy of ageing in place prior to 1996 and actively supported with capital grants. In those low care facilities the capacity to require an entry contribution or accommodation was introduced under Labor policy to support providers invest in the capital development of accommodation which gave residents a higher level of accommodation that applied in nursing homes.

The third type of residential accommodation gained clearer policy separation after 1997 when following the Coalition's retreat from its policy intent to introduce bonds into nursing homes extra service allocations became a limited alternative. The allocation of extra service places was restricted to a maximum cap in the overall allocation of residential care. Significant differences in the standard of accommodation apply between the two types of facility.

An attempt by the Coalition to extend bonds to high care, a policy objective in 1996 was abandoned and the substitute of accommodation charges (with no relativity to accommodation bond income levels) was introduced in 1997.

Yearly retention drawdown's from accommodation bonds were initially set at an amount equivalent to 10% of the average bond amount, the relativity of 10% was not maintained as the average bond increased by more than 500%. Accommodation charges to a linked to those amounts which relate to costs 11 years ago.

Had that financial arrangement been preserved, the industry would now have substantially greater capital funding.

In a unitary system of residential care where regulation, standards and compliance is equally applicable to both low-and high-care facilities that separation of the existing policy of resident co-contribution for accommodation is an artificial one.

The experience of Chief Executive Officers under contradictory policy is that the capacity to require bonds in low care but not high care is the impediment to capital investment. Company officers and directors carry responsibility for ensuring that debt can be serviced and bank loan covenants may also include minimum ebitda/ interest coverage are met.

The organisational response to the risks of the construction of stand alone nursing homes, has been to integrate such facilities where possible with adjoining low care facilities so that bonds cross subsidise high care. The funding policy has resulted in one group subsidising high care residents and inequitable treatment is the result.

5. Whether the current planning ratio between community, high- and low-care places is appropriate

The residential and community care system is shaped by the annual cycle of allocations (ACAR) released for applications by providers and the subsequent assessment by the Department and the allocation of places to successful applicants.

The allocation system assumes that providers have the capacity to invest in new service delivery, infrastructure and training and that they can and will always participate in making applications for new license allocations. ACAR operates in isolation from the policy effects of current funding policy, capital investment criteria that influence expansion decisions by providers and the state of workforce issues.

The Probity Review and Report by the external consultants to DoHA examined the process of allocation of residential and community care places to individual providers. The Review sought the view of providers on competitive application selection process used by the Department. It has been

argued that the principal effect of existing selection processes has been that no reliance could be placed on the rigour of the selection process.

6. The impact of current and future residential places allocation and funding on the number and provision of community care places

The allocation of residential and community care places is long standing policy and practice and it's principal purposes are to control the Federal Governments growth in funding commitments for the delivery of aged care services. The allocation system operates in tandem with the aged care assessment teams (ACAT) who determine eligibility for low- and high-care eligibility and the appropriate type of subsidy. In 2008, the effect of the allocation system is to reduce choice for the community, restrict access to care, and to limit sector efficiency.

Catholic Health Australia which is the largest non-Government provider grouping of aged care and community care services in Australia made the following observation of current aged care policy in its Aged Care Policy Blueprint for 2020 that "Current residential aged care policy is restraining the ability of Church and other aged care services to meet consumer need. Quality standards, service funding, access to capital, and consumer charges are tightly controlled by Commonwealth law "[16]

The policy weakness remains the separate policy decisions made without consideration to the total capacity and mix of service delivery in the medium term where identifiable demographic trends are identified. The absence under the Coalition and Labor of a clear structural framework for the sector and a dialogue on how future needs can be planned and addressed remains incomplete. Policy composition remains incremental or reactive with the main emphasis in 2008 on compliance and the priority to resource regulatory oversight in depth.

[16] Catholic Health Australia. Aged Care Policy Blueprint for 2020. November. 2008

The basis for deciding the structure and mix of places between residential and community care should recognise the dynamics of demographic change. The Productivity Commission (2008)[17] identified the ageing of Australia's population as "challenges posed by the increasing diversity of older people in terms of their care needs, preferences and affluence."

A significant number of organisations operate across the spectrum of service provisions as this optimises the use of organisational staff resources and enables providers to respond to community need. The policy deficiency is that a centralised allocation system seeks to predict demand for service when providers have a greater ability to do so.

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[17] Productivity Commission Research Paper. Trends in Aged Care Services: Some Implications. September 2008.