

Our reform directions

- 6.1 We believe that funding should be more directly linked to people rather than places, and to those who are most likely to need care. We propose changing the limit on provision of aged care subsidies from **places** per 1000 people aged **70 or over** to **care recipients** per 1000 people aged **85 or over**.
- 6.2 We suggest that consideration be given to permitting accommodation bonds or alternative approaches as options for payment for accommodation for people entering high care, provided that removing regulated limits on the number of places has resulted in sufficient increased competition in supply and price.
- 6.3 We propose requiring aged care providers to make standardised information on service quality and quality of life publicly available on agedcareaustralia.gov.au to enable older people and their families to compare aged care providers.
- 6.4 We support consolidating aged care under the Commonwealth by making aged care under the Home and Community Care (HACC) program a direct Commonwealth program.
- 6.5 We propose developing and introducing streamlined, consistent assessment for eligibility for care across all aged care programs.
- 6.6 We propose that there be a more flexible range of care subsidies for people receiving community care packages, determined in a way that is compatible with care subsidies for residential care.
- 6.7 We propose that people who can contribute to the costs of their own care should contribute the same for care in the community as they would for residential care (not including accommodation costs)
- 6.8 We propose that people supported to receive care in the community should be given the option to determine how the resources allocated for their care and support are used.
- 6.9 We propose that once assessments, care subsidies and user payments are aligned across community care packages and residential care, older people should be given greater scope to choose for themselves between using their care subsidy for community or for residential care.
- 6.10 We propose that all aged care providers (community and residential) should be required to have staff trained in supporting care recipients to complete advanced care plans for those care recipients who wish to do so.
- 6.11 We propose that funding be provided for use by residential aged care providers to strike arrangements with primary care providers and geriatricians to provide visiting sessional and on-call medical care to residents of aged care homes.
- 6.12 We propose:
- increased use of electronic clinical records in aged care homes, including capacity for electronic prescribing by attending medical practitioners, and providing a financial incentive for electronic transfer of clinical data between services and settings (general practitioners, hospital and aged care), subject to patient consent; and
 - the hospital discharge referral incentive scheme (see Chapter 4) include timely provision of good information on a person's hospital care to the clinical staff of their aged care provider, subject to patient consent.

The distinctive feature of ... aged care ... is that it combines care and treatment, in various ways, with housing and social support services. Residential aged care is where 170,000 older Australians live and involves all three of these services. Community care supports up to a million more to live in their own homes with various combinations of care and support.

In many countries this system is referred to as 'long term care' to distinguish it from the short term or episodic care that more typically characterises the health system. People go to health services to 'get something done' and then leave. By contrast many older people live in, or live supported by, aged care. Their health needs are supported in those settings.¹

In this chapter, we tackle the complex issue of aged care in its own right, as well as the relationship of aged care to the rest of the health system. For many people, 'connecting care' across hospitals, primary health care and aged care is one of the most important, but most difficult, challenges they will experience in their life.

Our terms of reference specifically require us to report on 'a long-term health reform plan to provide sustainable improvements in the performance of the health system addressing the need to ... better integrate acute services and aged care services, and improve the transition between hospital and aged care'.

We argue that aged care needs to be more responsive to the needs of older people, and that this is essential to improving older people's quality of life in aged care, and to improving the productivity and efficiency of delivery of aged care. Central to this is ensuring an increased supply of high quality, efficiently delivered aged care.

6.1 Defining and scoping aged care

Many people will have personal experience of aged care services, either for themselves or family members. One in every three men and one in every two women who live to the age of 70 will subsequently enter residential aged care.² Many more will receive support at home through either the joint Commonwealth-state Home and Community Care (HACC) program or Commonwealth community aged care packages.

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On 30 June 2008, there were about 160,000 people in residential aged care, another 40,000 in Commonwealth community care, and more than half a million older people receiving Home and Community Care (and another 250,000 younger people with disabilities).³

Most aged care services are delivered by the private or non-government sector. For residential aged care:

- Most (60 per cent) is provided by private not-for-profit organisations (primarily church and charitable organisations).
- One-third (33 per cent) is provided by private for-profit organisations.
- The rest is provided through state governments (5 per cent) and local governments (2 per cent).

In contrast, community aged care services are predominantly provided by private not-for-profit or government providers (95 per cent).⁴ In other words, there is very little for-profit provision of community aged care services.

The Commonwealth funds about 70 per cent of the cost of residential aged care, and more than 90 per cent of the cost of community care aged care in its own programs. The balance is met by individuals. The Commonwealth provides about 60 per cent of the funding for HACC, with the balance coming from states and territories (including some from local government).

1 Aged and Community Services Australia (2008), Submission 6 to the National Health and Hospitals Reform Commission.

2 D Cullen (2007), 'The financial impact of entering aged care', *Australasian Journal on Ageing* 26 (3): 145-7.

3 Department of Health and Ageing (2008), Report on the Operation of the Aged Care Act 1997: 1 July 2007 to 30 June 2008 (Commonwealth of Australia: Canberra).

4 Department of Health and Ageing (2008), Report on the Operation of the Aged Care Act 1997: 1 July 2007 to 30 June 2008 (Commonwealth of Australia: Canberra).

6.2 Building on our strengths

Our aged care system has a number of important strengths.

One very important change in recent years has been the shift to funding more aged care services in the community. Targets for aged care provision have been revised over the past two decades to encourage greater community-based service provision (see Figure 6.1). The availability of Commonwealth-funded community aged care has increased from zero in 1990 to more than 46,000 places in mid 2008, including more than 6000 high-level community care packages – Extended Aged Care at Home (EACH) and Extended Aged Care at Home – Dementia (EACHD). This means that people have more choice about whether they receive aged care services through admission to a residential aged care service or through getting these services at home in the community.

Figure 6.1: The target for total aged care places has increased and shifted from residential to community care from 1985 to 2007

Year	Residential high care places	Residential low care places	Total residential places	CACP packages	EACH & EACHD packages	Total community packages	Total aged care places & packages
1985	40	60	100	100
1992	40	55	95	5	..	5	100
1993	40	52.5	92.5	7.5	..	7.5	100
1995	40	50	90	10	..	10	100
2004	40	48	88	20	..	20	108
2007	44	44	88	21	4	25	113

Source: Productivity Commission (2008), Trends in Aged Care, compiled from several published sources.

Note: CACP stands for Community Aged Care Package
 EACH stands for Extended Aged Care at Home packages
 EACHD stands for Extended Aged Care at Home packages for people with dementia

Much of community and residential aged care in Australia is of a high standard, provided by a conscientious, trained workforce. There have also been dramatic improvements in the quality of residential aged care buildings in the last decade with single room accommodation and ensuite bathrooms now the norm for new facilities. Most aged care homes are accredited for three years.

6.3 Identifying the case for change

6.3.1 Meeting future demand

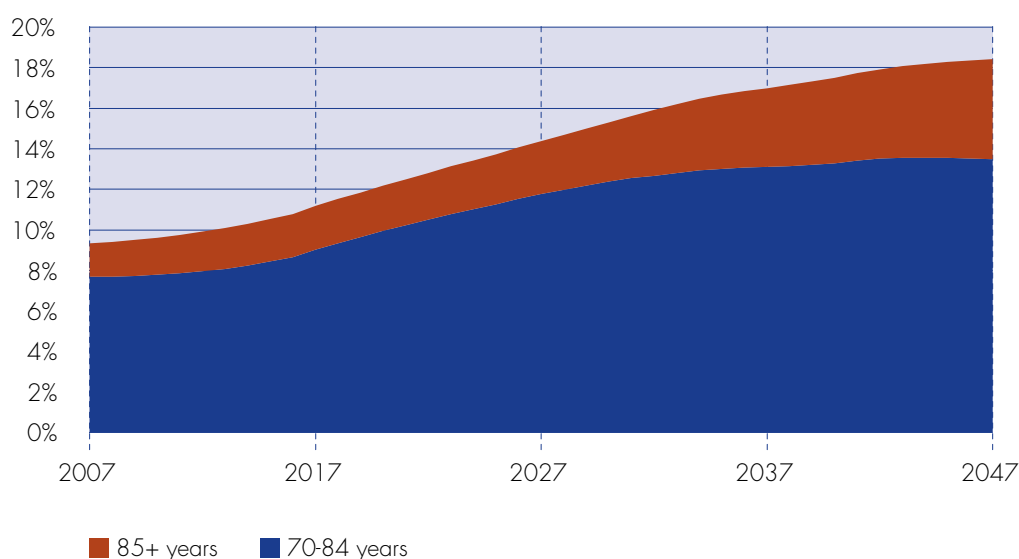
In 40 years, the proportion of people aged 85 or over will triple, and the numbers of people aged 85 or over will quadruple

■ In 40 years, the proportion of the population aged 70 or over will double. In the same time, the proportion of people aged 85 or over will triple (see Figure 6.2). If we express this in terms of the actual numbers of people (not the shares of the population), the numbers of people aged 70 or over will almost triple, and the numbers of people aged 85 or over will quadruple.

The implications of an ageing population for our need to increase aged care services are challenging. The Commonwealth currently aims to provide 113 aged care places (including residential and community care) for every 1000 people aged 70 or more. What this means is that:

- in June 2008 there were 223,107 aged care places across Australia;⁵ but
- by 2020, we will need 337,500 aged care places (an increase of 51 per cent); and
- by 2030, we will need 464,000 aged care places (an increase of 108 per cent over current levels).⁶

Figure 6.2: Older people will be double as a proportion of the population in the next 40 years



Source: Australian Bureau of Statistics (2008), Population Projections Australia

We also need to remember that factors other than population ageing will influence the demand for aged care services. Some of these other factors include:

- If life expectancy continues to increase, more people will live well into their eighties. Dementia is much more common among people in their middle to late eighties. Dementia is a major cause of people seeking entry to aged care, with one estimate being that about half of people in residential care have dementia.⁷
- The trend to smaller families, and the higher incidence of marital breakdown in recent decades, may reduce the availability of 'informal care' for older people in future.
- Continued increases in workforce participation by people of working age may also reduce the availability of informal care.

■ Factors other than population ageing will influence the demand for aged care services

5 Department of Health and Ageing (2008), Report on the Operation of the Aged Care Act 1997: 1 July 2007 to 30 June 2008 (Commonwealth of Australia: Canberra).

6 Calculated by applying the target ratio to the projected population aged 70 or over, using Series C from: Australian Bureau of Statistics (2008), Population Projections Australia (Commonwealth of Australia: Canberra).

7 Australian Institute of Health and Welfare (2007), Dementia in Australia, national data analysis and development (Commonwealth of Australia: Canberra).

The current provision of aged care in the community depends heavily for many people on Commonwealth-funded aged care being supplemented by informal care, usually provided by family members. If access to informal care declines, provision of aged care in the community may be challenged. What does this mean for older people and their families?

An older person receiving a Community Aged Care Package (CACP) receives an average of about seven hours a week in personal care. Many older people receiving aged care under these packages can live independently with no additional help. But 75 per cent of older people who are severely limited in their daily activity and living conditions (more than three severe or profound core activity limitations) rely on the support of an informal carer.⁸

People with more high care needs may receive Extended Aged Care at Home packages (including EACH dementia) which typically provide about 18 to 22 hours of assistance each week.⁹ Even in this situation, many such people will need other support throughout the day. For people with dementia, the presence of a carer is important not only to assist with activities of daily living, but also for their safety depending upon the severity of their condition.

In simple terms, less access to care and support by family or other informal carers means that older people are more likely to need to enter a residential aged care service, rather than living at home.

6.3.2 Improving responsiveness and choice for people

The aged care system is incredibly complex, with people having to make difficult, life-changing decisions, often at short notice

■ The aged care system is incredibly complex, with people having to make difficult, life-changing decisions, often at short notice. Older people seeking support themselves, and younger people who have had to navigate the aged care system on behalf of a parent or relative know only too well the complexity of the decisions and the immense amount of information that has to be quickly absorbed. Some of the issues and questions that people face include:

- Will we have to sell the family home?
- What are the different levels of charges and how will this impact on pensions and other financial matters?
- How can we get reliable information about the quality of the care provided by a particular aged care service?
- Can we 'try out' a particular aged care home? Can we change to another aged care home if the first one doesn't work out? How long are we likely to have to wait for our preferred aged care home?
- What if mum or dad wants to stay at home? What services are available and will they be accessible at the right times and provide the right mix of services?

Older people and their families often do not know what services are available, and have difficulty finding out how to obtain information on services, let alone the services themselves.

*I cared for my severely incapacitated husband for 12 months, all by myself, until I recently became aware of support services. The services are excellent – but accidentally discovering their existence and availability was the problem. We had no idea of what was available, how to seek them out. I might add it is a 'maze' working out what agency does what and how.*¹⁰

8 Australian Institute of Health and Welfare (2004), Community Aged Care Packages Census 2002 (Australian Institute of Health and Welfare: Canberra).

9 Department of Health and Ageing (2008), Report on the Operation of the Aged Care Act 1997: 1 July 2007 to 30 June 2008 (Commonwealth of Australia: Canberra).

10 Council on the Ageing (2008), Consultations on in-home services for older people final report to Office for the Ageing (OFTA) for 2008–2011 home and community care triennial plan.

This remains true despite a number of initiatives to make access to information easier, both over the phone and on-line:

- Commonwealth Carelink Centres – regional information sources with a single free telephone number nationally – 1800 052 222; and
- <http://agedcareaustralia.gov.au/>, which includes an on-line home finder.

There are no widely available measures of quality of care and quality of life for older people trying to choose an aged care home or provider.

The complexity of the aged care system also means that sometimes it feels like the classic line from Henry Ford – ‘People can have the Model T in any colour – so long as it’s black’. Some examples include:

- People receiving aged care services at home may have no choice in who provides their care. They may also not be able to keep the services of a trusted aged care provider if they are ‘reclassified’ and access higher funding packages. (That is, a person who may be funded for HACC services might have to start again with another aged care provider if they progress to needing more care under a Community Aged Care Package).
- The level of funding support for people receiving aged care services in the community is ‘locked’ into different packages, rather than being based on a scale where need for services might increase incrementally. That is, a Community Aged Care Package (CACP) provided an average of about \$12,684 annually to support care. The next ‘level up’ is an Extended Aged Care at Home (EACH) package that provides over \$42,000 annually. There are no middle tiers of community care for people requiring more than a CACP, but less than an EACH package.
- There is often very little choice when people need to move at short notice from home to a residential aged care service. Nationally, residential aged care services operate on average with a vacancy rate of about six per cent.¹¹ Vacancy rates tend to be lower in metropolitan areas; for people requiring high-level care; and for people seeking a place in an aged care service run by the charitable sector.

For many people, getting access to aged care services that meets their needs at home or in aged care that suits them can be difficult. This applies to both residential and community aged care services.

The rigidity of how the aged care system operates is very different to our expectations about choice in other aspects of our lives. As the baby boomers age, it is likely that people will expect more choice, not less, in how they are able to receive aged care services when they need them. An important emerging concept is that of ‘consumer-directed care’ (see Figure 6.3). Under consumer-directed care, people have more say in deciding what services best meet their needs and which providers they want to receive these services from.

■ For many people, getting access to aged care services that meet their needs at home or in aged care that suits them can be difficult

11 Department of Health and Ageing (2008), Report on the operation of the Aged Care Act 1997: 1 July 2007 to 30 June 2008 (Commonwealth of Australia: Canberra).

Figure 6.3: Under consumer-directed care, people have more say about what care they get from whom

Consumer-directed care is a term used to refer to an approach to obtaining care for frail older people and people with disabilities, under which the person needing care is given direct control over the resources provided for their care. This can take several forms. It can range from simply providing the person requiring care with a sum of money which they can spend as they wish, through providing them with a budget and some management support, but with few restrictions on how the budget may be spent, to providing them with a budget which can only be spent on identified services delivered by approved providers.

Internationally there are programs in place which are examples of all of these different approaches.

- *Austria introduced major policy reforms in both the aged and disability sectors in 1993 and consumer-directed care became available to everyone needing ongoing support. In 2004, 300,400 people used self-directed care: this constituted 4 per cent of the population. Approximately 90 per cent of consumers self-directed their care while living in the community, while the remainder were in residential care. Consumer-directed care was available to all adults regardless of their type of incapacity, and 45 per cent were aged over 80 years. The number of people using consumer-directed care has increased sharply in recent years.*
- *A particular program in the UK provided a man with multiple sclerosis and poor vision with funds to be used as he wished. This attracted some attention when he chose to spend some of the funds on a football season ticket and hiring a companion to take him to the football each week and describe the action on the field and then take him to the pub after the game. He was highly satisfied with the arrangement, as was his wife, who said 'It gives me the only time I get off all week and I don't have to watch football in the wet and the cold'.*

In general the critical design considerations in consumer-directed care seek to balance freedom for the person needing care against protections against the misuse of the funds, and the administrative responsibilities that it can place on the person managing their own care.

Consumer-directed care has been available in Australia for disability care in a variety of specific projects for some time, but is not widespread. There has been discussion of possible use of consumer-directed care in community aged care in Australia but there are no programs currently in place.

Note: This outline of consumer-directed care uses information from a discussion paper: C Laragy and G Naughtin (2008), Discussion Paper on Increasing Consumer Choice in the Aged Care Sector (Research and Policy Centre Brotherhood of St Laurence).

6.3.3 Connecting care for people between hospitals and aged care

Another major set of issues relates to how services work, or don't work, as older people move between hospitals and aged care services. While our primary concern is always about the impact on people, we also know that poor 'connections' for people as they move through the health and aged care system can result in problems with the effectiveness and efficiency of care.

First, we consider the issues that arise for older people who are in hospital and are assessed as needing an aged care service, either in an aged care home or in the community.

Older people use hospitals more frequently, and have longer stays in hospitals, than the general population

■ On average, older people use hospitals more frequently, and have longer stays in hospitals, than the general population. This is entirely to be expected, given that they have more health problems and generally take longer to heal and recover from treatment than younger people. (However, extended lengths of stay by older people in hospitals are often viewed as one of the factors contributing to over-stretched capacity, with the lack of beds then impacting on whether people can get admitted to a bed from the hospital's emergency department.) A crisis such as changing care needs or the loss of support of a family member (including the death of a spouse who has been the primary carer) can also precipitate the need to receive aged care services.

What often seems to happen in these circumstances is that there is a mismatch between the pressures under which hospitals operate and the difficulty in making decisions and finding access to the right aged care services in a timely fashion.

One response to this challenge has been the establishment of the Transition Care program (see Chapter 5) that provides care for older people leaving hospital who have been assessed as needing aged care services. This operates like a 'bridging' service between hospitals and aged care services, providing access to a low intensity therapy, personal and/or nursing care to help people recover and improve their confidence and independence after a hospital stay.

Another important factor is whether older people have access to the right level and mix of sub-acute services, including rehabilitation and geriatric evaluation and management services. We noted in Chapter 5 that a shortage of these services means that older people run the risk of being prematurely admitted to a residential aged care service. That is, some older people are not given sufficient opportunity to participate in rehabilitation, improve their functioning and so return to living at home.

Even with the addition of Transition Care and better access to sub-acute services, it is likely that the move from hospitals to residential aged care will continue to be a 'bottleneck'. To put this in quantitative terms:

- Hospitals are 'high volume' and 'high turnover' businesses. On average, three and a third million people each year stay at least one night in hospital.¹² This means that on average, on any one day, about 9000 people will be discharged from hospital (excluding those who receive their treatment on a same-day basis). More than a quarter of all hospital episodes are for people aged 70 or over, and about an eighth are for people aged 80 or over.
- Residential aged care services are 'low turnover' businesses. About 60,000 people leave permanent residential aged care in a year (not including respite care). This means that, on any one day, about 160 newly vacant beds become available across Australia. About 70 of these are filled by people entering residential aged care directly from the community. So, on any one day, only about 90 residential aged care places are filled by older people leaving hospital.

A reduction in the number of older people having a prolonged stay in hospital while awaiting a residential care place essentially requires a higher level of vacancies in residential care to improve availability and choice. This, in turn, requires changes to the current restrictions on the supply of aged care places.

A second area for further improvement is in health and hospital care for people already in residential care. Problems here are threefold:

- Some people are sent to hospital for want of care that could, and arguably should, be provided in the residential facility. This includes care that could either be provided by the staff of the aged care home or by visiting primary health care professionals (including general practitioners), if they were better able to be accessed by residents, or hospital outreach services.
- Some people who should be sent for care in a hospital are not transferred when they should be (again, this can be the result of shortcomings in care by the aged care facility but can also be the result of inadequate access to primary health care, resulting in late identification of treatable conditions).
- There is evidence that some older people from residential care suffer significant, avoidable adverse care outcomes as a collateral result of hospital treatment.

■ It is likely that the move from hospitals to residential aged care will continue to be a 'bottleneck'

12 Australian Institute of Health and Welfare (2008), Australian Hospital Statistics 2006–07 (Australian Institute of Health and Welfare: Canberra).

6.3.4 Connecting care – primary health care and end of life care for people receiving aged care

Access to primary health care also needs to be improved for some residents of aged care homes. The trend to increased average frailty among older people is placing pressure on the capacity of aged care services to meet care needs adequately.

There is inadequate access to primary and specialist medical care and nursing care, including palliative care. As advised to us by ACT Health:

ACT Health wishes to draw the attention of the National Health and Hospitals Reform Commission to the urgent need for an organised approach to primary care for people in residential aged care facilities. If a systematic approach can be achieved it will improve safety and quality and enable residents in aged care facilities to access more coordinated care. This would support them in the facility or community and reduce the need for acute care.¹³

Recent increases in payments for general practitioners attending people in residential care may improve access to medical care for aged care residents. However, the problem is not simply a matter of levels of remuneration. Aged care homes often lack facilities, such as a consulting room, to support general practitioners in their work.

We discuss in Chapter 7 issues related to the need to provide better support for people at the end of life. Access to both generalist and specialist palliative care support needs to be improved for people living in residential aged care services. There is also evidence to suggest that too many older people are transferred from their aged care home to hospital for interventions that they would prefer not to have. The National Aged Care Alliance has argued that:

Unnecessary hospitalisation and failure to respect people's care preferences are potentially avoidable through planning for future care that is done in a considered way involving the person, their care team and, optimally, their family, carers and loved ones.

Broader application and implementation of advance care planning will require greater awareness and knowledge among treating practitioners to support the development of advance care plans, greater coordination across and among service providers to support the effective implementation of advance care plans, and enhanced community understanding of advance care plans.¹⁴

6.3.5 Understanding the impact of existing regulatory and funding incentives in aged care

Reform of aged care services for people requires tackling how aged care is regulated and funded

■ While our focus is on people, many of the issues identified in Sections 6.3.1 to 6.3.4 are inextricably linked to the existing regulatory and funding incentives under which the aged care system operates. Reform of aged care services for people requires tackling how aged care is regulated and funded.

Accordingly, we want to briefly describe some of the main features of existing regulation and funding of the aged care sector.

Aged care is highly regulated. The Commonwealth Government regulates the supply of aged care places, specifying a target for the number of aged care places per thousand people aged 70 or over. It also regulates or controls the 'demand' for aged care services through the use of Aged Care Assessment Teams (ACATs). ACATs act as the gatekeeper for aged care services, with people requiring an assessment in order to be rated as eligible for aged care services. This regulatory framework is designed to ensure that public expenditure on aged care services is limited to those genuinely needing care.

13 ACT Health (2008), Submission 5 to the National Health and Hospitals Reform Commission.

14 National Aged Care Alliance (2008), Submission 453 to the National Health and Hospitals Reform Commission.

Restrictions on the number of aged care places limit choices for older people. They result in an aged care sector with high occupancy: there is little real opportunity for people to move between aged care services; and people often feel they must take the first available place, rather than wait for their preferred facility, especially if they are waiting for aged care in a hospital. There is little incentive for aged care providers to be entrepreneurial and responsive to older people and their families – essentially, they have a ‘captive market’ – and no matter how well they provide care, they cannot increase their market share simply by attracting a larger number of older people, as they cannot simply expand existing facilities or open new ones due to restrictions on places.

Aged care funding is also complex and highly regulated.¹⁵ Because supply is constrained, most charges are also regulated so that providers cannot take advantage of scarcity to charge higher prices. In residential aged care, there are essentially two kinds of payments: those related to care and those relating to living and accommodation expenses. In community care there are only payments for care.

In residential care, payments for care are determined, using the Aged Care Funding Instrument (ACFI), in three parts according to need for support for activities of daily living (such as bathing, dressing eating and so on), a behavioural supplement and a supplement for complex health care. This results in 64 different levels of payment up to a maximum of \$171.43 per day.

People in residential aged care can be asked to contribute up to a maximum of \$58.15 per day to their care fees on a sliding scale depending on their income. A person’s government-funded care subsidy is reduced in proportion to their capacity to pay. Full pensioners pay nothing towards their care fees.

In addition to any care payment, the maximum charge (basic daily fee) for living expenses for all residents is set at 85 per cent of the single basic aged pension or \$32.95 per day.

The type of accommodation charge a person may be asked to pay depends on whether they enter for low-level residential aged care (formerly hostel care) or high-level care (formerly nursing home care). People entering for low-level care can be asked to pay a lump sum bond, while people entering for high-level care cannot – they can only be asked for a daily fee.¹⁶ Apart from small bonds, most of a person’s bond is refunded when they leave care.

Under the regulations the limit on accommodation bonds is the level of the person’s assessable assets less an amount equal to 2.5 times the annual single basic rate of pension (this equates to \$35,500 at time of writing).

The average new bond agreed with new residents by those homes taking bonds rose from an estimated \$58,400 in the period 1997–99 to an estimated \$188,798 in 2007–08.^{17 18} This represents an average, annual increase of more than 12 per cent in nominal dollars.

The maximum daily charge for accommodation for people entering high care is currently \$21.39 per day for pensioners and \$26.88 per day for non pensioners. People entering residential aged care generally undergo an assets test, which determines their level of assessable assets. For those with few assets (less than \$91,410.40 at time of writing) the Commonwealth Government pays an accommodation subsidy on sliding scale up to \$26.88 per day.

15 Aged care fees and charges change through the year, based upon indexation and changes to the aged pension. Information on aged care payments fees and charges in the following paragraphs is taken from the Department of Health and Ageing’s website at www.health.gov.au and was current as at 15 December 2008.

16 There is an exception to this: people entering ‘extra service’ high care can be asked to pay a bond, and virtually all of them do. Extra service places must offer a higher level of amenity, and the number of places that can be offered as extra service is limited to 5 per cent of all residential places.

17 Department of Health and Aged Care (1999), Report on the Operation of the Aged Care Act 1997: 1 October 1997 to 20 June 1999 (Commonwealth of Australia: Canberra).

18 Department of Health and Ageing (2008), Report on the Operation of the Aged Care Act 1997: 1 July 2007 to 30 June 2008 (Commonwealth of Australia: Canberra).

For Commonwealth community aged care packages there are no set fees or payments for living expenses or accommodation as these remain the responsibility of the person being cared for.¹⁹ There are essentially only three levels of care payment in Commonwealth community care:

- \$34.75 per day for a Community Aged Care Package;
- \$116.16 per day for an Extended Aged Care at Home package; and
- \$128.11 per day for an Extended Aged Care at Home – Dementia package

People can also be charged for community aged care packages. Older people on the maximum basic rate of pension can be charged up to 17.5 per cent of that pension – \$6.78 per day at time of writing. People on higher incomes may be asked to pay additional fees up to 50% of any income they have above the maximum pension rate. The revenue from these charges goes to the provider, with no offsetting reduction in government subsidy.

6.4 Creating a better future

6.4.1 Funding people, not places

We have noted above that the Commonwealth currently limits the number of aged care places and also requires people to be assessed for eligibility to receive subsidised care. This can be likened to restricting the number of seats on buses (the number of aged care places), while also restricting the issuing of bus tickets (ACAT assessments of people's eligibility for Commonwealth-subsidised aged care).

We suggest that the number of aged care places should no longer be restricted

■ We suggest that the number of aged care places should no longer be restricted. This is not complete deregulation: providers of aged care would still need to meet existing criteria in order for the care they provide to be eligible for government support, including being an approved provider under the Aged Care Act and their facilities being accredited. However, if they meet these criteria, approved providers could offer as many places as they wished.

This would increase the chances that a person assessed by an Aged Care Assessment Team in hospital as eligible for aged care would be able to obtain a place in the home of their choice in a reasonable period.

However, in order to contain government spending on aged care, we are proposing that the number of people at any one time receiving subsidised aged care should be limited to the target ratio for provision. This would be done by Aged Care Assessment Teams having a maximum number of approvals for care that could be in effect at any one time for people living within an aged care planning region.

The maximum number of approvals would be calculated on the basis of a target ratio per 1000 older people in the same way as the current planning ratio for aged care places. Where the number of people assessed exceeds the approvals available, the assessments could provide a basis for assigning priority for the next available approval according to assessed need.

This change is equivalent to funding the 'people' needing access to an aged care service, rather than aged care services. Aged care providers would then have an incentive to compete for people assessed as needing aged care.

19 Some kinds of community support that replace living expenses, such as meals on wheels, often do involve some charge to the recipient.

We also note that the existing regulation involves an allocation of places on a geographic basis to promote equitable access to aged care services. Under our proposal to remove the regulation on the number of funded places, there may still be a need for regulatory or financial incentives to ensure there is not a flight of provision from the country to the city. Regulatory incentives might consist of a requirement to provide places in the country as well as the city in order to maintain approved provider status. Financial incentives might consist of little more than the existing viability supplements paid to rural and remote aged care providers. However, these may have to be adjusted to reflect the true additional cost of providing in rural and remote areas.

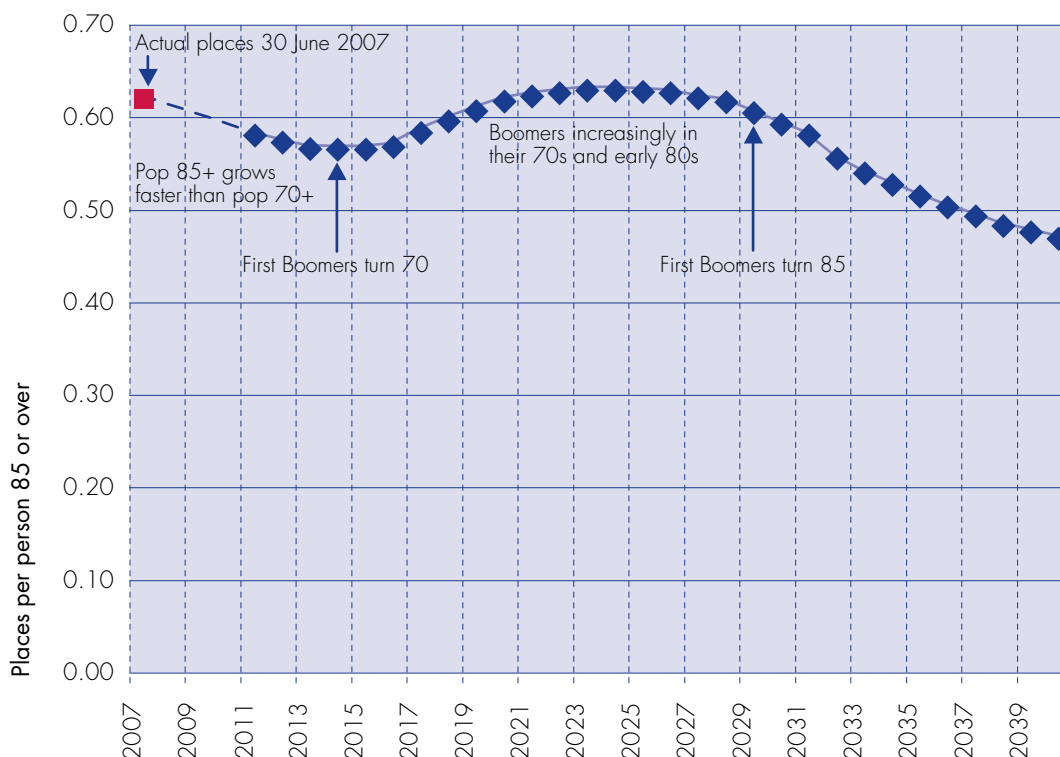
There is a second element of the existing regulation of aged care places that we believe is in need of review. The current benchmark for Commonwealth aged care provision is based upon the population aged 70 or over. The use of this population dates back some decades, when people had shorter life expectancies and entered residential care at earlier ages.

We are suggesting that the population aged 85 or over would be more appropriate, as it reflects the age of those who actually use Commonwealth aged care. If the aged care places available in mid-2007 were expressed as a ratio to the population of people aged 85 or over, it would be equivalent to 620 places per 1000 people.²⁰

Population projections from the Australian Bureau of Statistics indicate that, over much of the next decade, the population of people aged 85 or more will grow faster than the population of people aged 70 or more. If we continue to use a benchmarking planning ratio for aged care places based upon the population aged 70 or more, we will see a shortfall in the actual places that we need (see Figure 6.4).

²⁰ The precise figure may need to be adjusted to reflect levels of occupancy. Further consideration is also required as to how best to allow for the younger ages at which Aboriginal and Torres Strait Islander people make use of aged care. At a minimum, the existing use of a ratio of 113 per 1000 Aboriginal and Torres Strait Islander people aged 50 or over should continue for this population.

Figure 6.4: Using the current planning ratio there will be fluctuations followed by a long-term decline in aged care places per person aged 85 or over.



Source: Australian Bureau of Statistics (2008), Population Projections Australia, series c and places ratio of 113 per 1000 people aged 70 or over

Reform direction 6.1

We believe that funding should be more directly linked to people rather than places, and to those who are most likely to need care. We propose changing the limit on provision of aged care subsidies from **places per 1000 people aged 70 or over** to **care recipients per 1000 people aged 85 or over**.

As noted earlier, the current restriction on the number of aged care places means charges must also be regulated to ensure that providers don't use their control over a scarce service to charge increased prices. Removing restrictions on the number of aged care places in line with reform direction 6.1 above should result in increased competition in the provision of aged care, which may extend to price competition. This may enable some cautious relaxation of current constraints on charges for residential care accommodation. There may need to be continued regulation of charges in areas (for example, rural areas) where there are too few providers for there to be a competitive market for provision.

Once again, we are not proposing complete deregulation. To ensure that people reliant on government subsidies are not disadvantaged in their access to care, existing requirements for aged care homes to have more than 40 per cent of all residents qualifying for a government accommodation payment (supported residents) should continue. In addition, consideration should be given to linking the level of government assistance for residential accommodation charges to, say, 80 per cent of the market average of the deregulated charge, so that homes catering disproportionately to the less well off do not lag too far behind in terms of the level of amenity they can provide.

We support the view that accommodation bonds in high care should be restricted in the existing circumstances of supply and regulation of aged care. However, if the current restrictions on the supply of aged care places are removed, as proposed in reform direction 6.1, and if the quest for residents demonstrably leads to sufficient competitive pressure on accommodation charges to bring growth in these into line with growth in general construction costs (not aged care specific construction costs), then it would seem reasonable to give new residents the option to pay an accommodation bond rather than an accommodation charge, if they wish.

Reform direction 6.2

We suggest that consideration be given to permitting accommodation bonds or alternative approaches as options for payment for accommodation for people entering high care, provided that removing regulated limits on the number of places has resulted in sufficient increased competition in supply and price.

6.4.2 Informing choice

We note that it is difficult for older people and their families to find good information on the relative performance of aged care providers, upon which to base their choice of provider. To remedy this, we believe that the Commonwealth should require all aged care providers to publish standard measures of the quality of care and quality of life of the people for whom they provide care.

Such measures should include information such as the number and kinds of direct care staff, measured in terms of average minutes per care recipient per day; measures of adverse events; care recipient satisfaction measures; and participation in recreational activities; to allow older people to make informed choices.

We note that a range of potentially useful indicators is set out in *Developing resident-centred quality indicators in residential aged care*, one of a number of reports developed in 2006 as part of 'an evaluation of the impact of accreditation on the delivery of quality of care and quality of life to residents in Australian Government subsidised residential aged care homes'.²¹

■ It is difficult for older people and their families to find good information on the relative performance of aged care providers

Reform direction 6.3

We propose requiring aged care providers to make standardised information on service quality and quality of life publicly available on agedcareaustralia.gov.au to enable older people and their families to compare aged care providers.

6.4.3 Integrating aged care and enabling older people to have more control over their care

Many people found the information pathways, forms, and assessment processes for home care difficult to understand and confusing. People not yet getting services were uncertain how to find and get assistance.²²

We mentioned earlier some of the problems in ensuring continuity of care for older people moving from one kind of aged care service to another. If we look across the Home and Community Care (HACC) program, community aged care places (including Community Aged Care Packages and Extended Aged Care at Home Packages) and residential aged care services, there are a raft of different program rules that make the system complex for people and their families.

21 Developing resident-centred quality indicators in residential aged care, at: <http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-iar-dev-residential-aged-care.htm>

22 Council on the Ageing (2008), Consultations on in-home services for older people final report to Office for the Ageing (OFTA) for 2008–2011 home and community care triennial plan.

We believe that making HACC aged care a solely Commonwealth program would provide an opportunity to align the design and administration of HACC services for older people with Commonwealth community aged care.

This should include simplified assessment of eligibility for care, so that people can go through a single assessment process and be found eligible for HACC services, or for a Community Aged Care Package, or for Extended Aged Care at Home, and/or for residential aged care. This is not suggesting that someone who requires low-level assistance at home through HACC should be subject to a full ACAT assessment – rather, that there be a single graduated approach to assessment that takes the assessment only as far as is needed to identify the person’s needs for care. For example, HACC providers might continue to assess people for HACC services, but using a common approach, and might refer people for ACAT assessment where it is apparent that higher levels of care are required.

Importantly for people, information obtained from one assessment would be passed on, with the client’s consent, to any subsequent assessment to minimise the need to re-capture the same information again. Work towards this has been under way for some time. However, making HACC aged care a direct Commonwealth responsibility might enable it to be done more quickly.

Reform direction 6.4

We support consolidating aged care under the Commonwealth by making aged care under the Home and Community Care (HACC) program a direct Commonwealth program.

Reform direction 6.5

We propose developing and introducing streamlined, consistent assessment for eligibility for care across all aged care programs.

Funding for community aged care is not closely related to an assessment of a person’s need for care

■ We noted earlier that funding for community aged care is not closely related to an assessment of a person’s need for care. This concern was reinforced in the submission from the National Aged Care Alliance who observed that:

*The current unit cost base funding model in community care promotes task centred care which has been demonstrated to promote dependency rather than independence. With the increased acceptance that we need to change the current service model within community care to one that more actively involves the client and promotes independence and well being, it becomes increasingly essential that the funding model be changed to one that is consistent with capacity building and independence promotion. Package funding allows for flexibility and matching the support to an individual’s needs. Two package levels are, however, insufficient to cover the range of needs. A casemix funding model which has sufficient classes to describe the whole spectrum of needs across both community and residential care is required.*²³

These views were echoed by Alzheimer’s Australia:

*Reform of the aged care system ... should ... restructure and reform community care so that care is available to respond to a range of needs, without inflexible program boundaries.*²⁴

Currently, the Aged Care Funding Instrument (ACFI) is used to determine the level of government care subsidy for people entering residential aged care.

23 National Aged Care Alliance (2008), Submission 453 to the National Health and Hospitals Reform Commission.

24 Alzheimer’s Australia (2008), Submission 215 to the National Health and Hospitals Reform Commission.

We suggest that the ACFI should be further developed for use to determine the level of subsidy that should apply to a person receiving a community care package. This would ensure subsidies are provided in line with a more objective measure of need, and would also allow the care subsidies received by people in community care to be aligned with those in residential aged care.

Reform direction 6.6

We propose that there be a more flexible range of care subsidies for people receiving community care packages, determined in a way that is compatible with care subsidies for residential care.

Existing funding and charging arrangements across aged care can create perverse incentives, so that people do not necessarily get the right care. The National Ex-Service Round Table on Aged Care argued that:

We have noted, for example, that some providers are 'packaging up' HACC and other services into forms of community care packages because clients are reluctant to pay the extra fee in moving to higher levels of care, which runs the danger of denying simple care services, because availability is monopolised. Our plea is for a seamless service which progresses through HACC (and DVA's Veterans Home Care scheme) to more complex care through CACPs, EACH and EACH-D, with a few going on to residential care.²⁵

A further distortion between current programs of aged care is the quite different user charging regimes that apply. As noted earlier, currently, providers of community care can charge full pensioners up to 17.5 per cent of their pensions, and people with higher incomes up to 50 per cent of any income they have above the maximum rate of pension. All charges go to the provider, and the government subsidy is undiminished.

These charges are steeper than the income-tested care fees that can be levied in residential care. Yet, full pensioners can ill afford to lose any part of their pension in care fees, while still having to meet their living expenses.

We believe that there is merit in aligning income-tested care fees for community aged care packages with those for residential care. The objective we want to achieve is to ensure that choices about different types of aged care are based more on need, rather than the costs or different charging arrangements.

■ There is merit in aligning income-tested care fees for community aged care packages with those for residential care

To illustrate this concept, this might mean that for people receiving community aged care packages the following would apply:

- no fees for full pensioners;
- a more moderate escalation of fees for people with higher incomes;
- limits to the maximum fee that could be charged; and
- a dollar for dollar reduction in the government subsidy, removing the current incentive for providers to maximise their charges as they retain 100 per cent, and yielding some savings to government.

We also know that there are quite different charging regimes for HACC services. HACC provides low levels of support to more than half a million older people. It would not be appropriate to institute the kinds of means assessment that currently apply to residential aged care to HACC recipients. However, a simpler approach, which would at least see full pensioners protected from charges for care services²⁶, could be considered.

25 National Ex-Service Round Table on Aged Care (2008), Submission 120 to the National Health and Hospitals Reform Commission.

26 In this context, care services does not include services which meet ordinary costs of living, such as meals on wheels, for which a small out-of-pocket cost may still be appropriate.

Reform direction 6.7

We propose that people who can contribute to the costs of their own care should contribute the same for care in the community as they would for residential care (not including accommodation costs).

Existing funding arrangements for community aged care are not set up to support 'consumer-directed care', where people might choose the level and type of services they want to receive. Instead, funding is locked into 'packages' such as Community Aged Care Packages and EACH packages. The funding packages reflect 'average' levels of need, rather than actual levels of assessed need for the people receiving community aged care.

There would be more opportunity to move down the path of consumer-directed care

■ We have proposed in reform direction 6.6 that there be a more flexible range of care subsidies for people receiving community aged care. If this occurred, there would be more opportunity to move down the path of consumer-directed care. The level of resources available to people would be more closely related to an assessment of their need for care.

In addition, having an approach to assessment for care subsidy that is similar across community and residential care would provide a better basis for people to opt for community care rather than residential care. This might also enable a wider range of accommodation choices for people needing care, including, for example, through combining a budget allocation for consumer-directed community care with retirement village accommodation.

Reform direction 6.8

We propose that people supported to receive care in the community should be given the option to determine how the resources allocated for their care and support are used.

Reform direction 6.9

We propose that once assessments, care subsidies and user payments are aligned across community care packages and residential care, older people should be given greater scope to choose for themselves between using their care subsidy for community or for residential care.

We noted earlier (and we discuss at more length in Chapter 7) issues related to the need to improve end of life care. It is apparent that many older people would prefer to have more say in the level of care they may receive, which is aimed at prolonging their life.

Reform direction 6.10

We propose that all aged care providers (community and residential) should be required to have staff trained in supporting care recipients to complete advanced care plans for those care recipients who wish to do so.

6.4.4 Improving access to medical care in aged care

Some residents in aged care facilities do not currently get adequate access to primary health care, including primary medical care.

We propose that funding be made available for aged care providers to strike arrangements with primary care providers (including general practitioners) and geriatricians to provide visiting sessional and on-call medical care to residents of aged care homes. Under such arrangements, residents would retain the right to be attended by, or to visit, their usual general practitioner, but would also have the option to see a visiting doctor during, say, a weekly 3.5 hour session on-site at the aged care home. These arrangements should also include establishment of an on-call roster between homes and general practitioners and geriatricians within a region. It seems more likely that general practitioners and geriatricians would make themselves available to be on-call if this were distributed among a larger number of practitioners, with fewer on-call periods per practitioner.

These arrangements might be struck between aged care homes and the proposed Comprehensive Primary Health Care Centres proposed in Chapter 2.

- Some residents in aged care facilities do not currently get adequate access to primary health care

Reform direction 6.11

We propose that funding be provided for use by residential aged care providers to strike arrangements with primary care providers and geriatricians to provide visiting sessional and on-call medical care to residents of aged care homes.

6.4.5 Information to support care

An important part of 'connecting care' as people move between aged care, hospitals and primary health care is good information. In their submission, the National Ex-Service Round Table on Aged Care stressed the link between good information and quality of care for aged care residents:

Improvements in the quality of care could be made if a ready electronic communication system existed between hospitals and residential care, if patients had personal records that travelled with them, if there was some form of 'pay for results', i.e. hospitals were penalised for poor transfers, and/or if there was a discharge nurse who was responsible for managing this.²⁷

We believe that general practitioners attending residents of aged care homes would welcome an improved capacity to maintain common clinical records, electronically, in the aged care home and at their usual practice.

In Chapter 4 we have proposed that there be financial incentives for timely provision of discharge information by hospitals to a patient's nominated primary health care service. We believe the same incentives should apply to people living in residential aged care services, with timely provision of information by the hospital back to the aged care service.

27 National Ex-service Round Table on Aged Care (2008), Submission 120 to the National Health and Hospitals Reform Commission.

Reform direction 6.12

We propose:

- increased use of electronic clinical records in aged care homes, including capacity for electronic prescribing by attending medical practitioners, and providing a financial incentive for electronic transfer of clinical data between services and settings (general practitioners, hospital and aged care), subject to patient consent; and
- the hospital discharge referral incentive scheme (see Chapter 4) include timely provision of good information on a person's hospital care to the clinical staff of their aged care provider, subject to patient consent.