Mercy Health

Submission to the Productivity Commission Inquiry *Caring for Older Australians*

July 2010

Contents

Executive Summary

Mercy Health welcomes this inquiry *Caring for Older Australians* by the Productivity Commission. The recommendations of our submission include:

- The introduction of a unified care framework and funding instrument that incorporates both residential and community care (3.1).
- Removing the distinction between low and high care (3.1.a).
- Elimination of the different community care packages (3.1.b).
- The provision of care and accommodation should be split (3.1.c).
- The introduction of an equitable contribution to care and accommodation based on capacity to pay (3.1.c and 3.2).
- A call for the Commonwealth Government to develop a sustainable means to enable providers to access capital (3.2).
- Greater emphasis on increased superannuation contributions, both employer and personal contributions (3.2).
- The endorsement of Catholic Health Australia's recommendations to properly fund sustainable aged care services from their initial submission April 2010 (3.2).
- The Commonwealth Government should remain the predominant funder and policy authority for the aged care sector (3.3).
- Regulation of aged related services such as Supported Residential Services should be administered solely by the Commonwealth Government or a common regulatory code be implemented to facilitate consistency at the state and local government levels (3.3).
- A quality improvement framework that promotes continuous quality improvement (3.4).
- The implementation of a regulatory system that encompasses both residential and community care (3.4).
- The Commonwealth Government should move to separate the Complaints Investigation Scheme from the Department of Health and Ageing such that it forms an independent investigative and dispute resolution agency (3.4).
- Further investigation is required if deregulation of bed licences is to be considered (3.5).
- A national focus on promoting aged care as a positive and rewarding career option (3.6).
- Registration of Personal Care Assistants and a nationally consistent scope of practice developed (3.6).
- Investigation as to the role that technology may play to assist in the care of ageing people requires Commonwealth investment in expanding the application of technology and assistive devices in the aged care sector (3.7).
- Mercy Health recommends the establishment of a centre for aged care technology research affiliated with a major University (3.7).

Dr John Ballard
Chief Executive Officer

1. Introduction

This document presents Mercy Health's submission on the reforms necessary to ensure high quality care is provided to all older Australians as we enter an era where the demand for services for the aged will potentially outstrip our capacity to supply.

Mercy Health is a Catholic community provider of care founded and wholly owned by the Melbourne Institute of the Sisters of Mercy. We offer acute and sub acute hospital care, aged care, mental health programs, specialist women's health, early parenting, palliative, home and community care, and health worker training and development. Our aged care services include residential (focusing on high, complex, late stage and dementia care), respite and community care including fee for service and funded packaged care.

In 2004 Mercy Health re-evaluated its strategy, and formed the view that one of the greatest societal pressures emerging, and spanning decades, was the support of the frail elderly. As a Catholic provider, aged care was identified as core mission and ministry and an aged care growth strategy was implemented.

Mercy Health has grown to be a mid size provider of aged care services, with aspirations for future growth to ensure that we are a long term participant in the industry. To date we have grown from 369 residential care licences in June 2004 to 1239 licences as at June 2010.

Recognising the desire of many older people to remain in their own homes for as long as possible, Mercy Health is also seeking to expand its provision of community care. This has seen its growth from only 50 clients in 2007, to today having 2,200 clients, 42 DVA home nursing clients, 110 community packages and delivering over 500,000 home visits per annum.

Mercy Health aims to achieve a long term sustainable position in aged care as a comprehensive provider of care as we provide services both within the community and within residential care settings. Mercy Health's vision is to provide integrated services that address the individual needs of the consumer, based on their wishes and reduce service and administrative duplications through integrated service models that enable the consumer to "age within the organisation".

However such service models require changes in the way aged care is funded, workforce structures and legislation. The following paper addresses some of these issues.

2. Current issues facing the sector

Since the introduction of the *Aged Care Act 1997* there have been numerous reviews undertaken to highlight the issues affecting the aged care sector. The Productivity Commission itself has produced a number of reviews and research papers and clearly identified the challenges in the *Caring for Older Australians* terms of reference.

These issues include:

- An increasing demand for aged care services as the population ages.
- Changes in the type of care required.
- An increase number of people wanting to remain in independent living arrangements.
- A demand for choice in the aged care services accessed.
- Increased prevalence of chronic and neurodegenerative diseases and numbers of people with complex high care needs, resulting in increased care costs.
- A decline in the numbers of informal carers and family support.
- Workforce shortages and competition for labour with other sectors, creating the need to attract, train and retrain a skilled workforce.
- A future decrease in the percentage of the population working and paying tax.
- A sector that has a negative public image.
- Increasing number of people unable to fund their whole retirement.
- Older people inappropriately accommodated in hospitals when no alternative options are available.

All reports and reviews indicate a clear need for Australia's aged care system to be redesigned to ensure it can meet the challenges facing it in the coming decades.

3. Recommendations

Mercy Health, as a Catholic provider, commends the submissions of Catholic Health Australia (CHA) to the Commission. Mercy Health has chosen to also make a submission in support of reform to the aged care sector and we differ slightly from the CHA submission.

3.1 Developing a more logical care framework

The current framework for care has developed on an ad-hoc basis with multiple changes designed to ameliorate existing deficiencies or "tweak" the system to respond to the changing demographic.

This has produced many improvements but has also left a range of anomalies. It is now time for a more logical framework for the delivery of care that:

- Places residential and community care on an equal footing.
- Provides a seamless path for care recipients as they move through higher levels of care.
- Removes arbitrary administrative boundaries between programs.
- Standardises the obligations of care recipients to contribute to the cost of care subject to appropriate safeguards.
- Enhances choice for care recipients while ensuring minimum standards of care are guaranteed.

Mercy Health believes that the Commonwealth Government should introduce a unified care framework and funding instrument that incorporates both residential and community care.

a) Remove the distinction between low care and high care

The effect of the *1997 Aged Care Act* and the introduction of "ageing-in-place" renders the existing concepts of high care and low care redundant.

The recent introduction of the Aged Care Funding Instrument (ACFI) provides a single tool to assess residents in aged care facilities according to need and acuity. While the ACFI is still relatively new and subject to ongoing review and fine-tuning, it has been met with wide acceptance within the aged care sector.

Accordingly the Commonwealth Government should move to eliminate the concepts of high care and low care and replace them with those "eligible for care".

b) Integrate packaged care and align it with residential care

If the logic of abolishing residential high and low care holds, it follows that it can and should be extended to Packaged Care such that a single funding instrument can be applied, premised on need and acuity, equally to the delivery of residential or community care.

Accordingly, this modified funding instrument should facilitate the elimination of the different community care programs (HACC, CACPs, EACH and EACH (D)) and their assimilation into the unified and consistent care and funding instrument.

This would enhance the choice offered to care recipients and place community and residential care on a level playing field. A single funding instrument that transcends both community and residential care within a common funding matrix could bring about an improved interface between programs, reduce information duplication, but most importantly, reduce the anxiety and stress when consumers have to move between programs or into a residential care facility.

c) Complementary Changes

To maximise the benefits of these changes two additional reforms should be introduced:

1. In the residential setting, the provision of care and accommodation should be split. The Commonwealth Government should maintain mandatory minimum standards of care that will be guaranteed for all consumers, irrespective of means or care setting.

   Accommodation, meaning both the physical built form of the aged care facility and hotel services, should be subject to both a minimum standard plus a resident contribution, premised upon the resident's capacity to pay. This resident contribution should be flexible and both incorporate and subsume the areas traditionally falling under the headings of "Accommodation Bonds" and "Extra Service Places" (ESP). Such an approach allows for much broader consumer choice while concurrently removing anomalies such as the 15% cap on ESP facilities.

2. Given the inevitable tension that exists, and will be exacerbated by the ageing of the population, this principle of "user pays" (or an equitable contribution to care based on capacity to pay) should equally be applied to both residential and community care within the unified framework identified above.

   If the aged care system is to survive the ageing of our population, then a significant increase in the contribution made by those with a capacity to pay is essential. The development of a framework to introduce these changes needs to be carefully considered, subject to broad community and industry consultation and have equity as its central and guiding principle.

   To ensure equitable access for those less well off, any new funding framework should provide a tiered system of incentives to encourage providers to accommodate those who currently fall within the definitions of supported and assisted. Further, minimum levels of supported residents should continue to apply to all providers.

3.2 Paying for Aged Care

The funding of aged care is a fundamental issue for Governmental providers. As discussed above there is a need to change the current funding arrangements to a framework that is more transparent, flexible, rational and systemic.

There are also a range of underlying funding issues that support the long term sustainability of the sector, particularly in residential care.

- The elimination of 'low care' may mean the removal of bonds, which the aged care sector is currently dependent on for capital development. The Commonwealth Government must develop a sustainable means to enable providers to access capital to ensure ongoing access to high care for older people and that the standard of accommodation continues to be high.

Whilst zero interest loans may be a solution, particularly in areas of social disadvantage they serve to mask the real cost of the provision of care. In more affluent areas, where people are financially able to contribute to accommodation costs, means tested co-payments must be considered a viable option.

- A greater emphasis should be placed on increased superannuation contributions, both employer and personal contributions to better position people to support themselves and their health needs in their latter years. Even with greater superannuation contributions, there will be a significant percentage of people who will be unable to pay for the services that they require. Mercy Health strongly advocates that the inability to pay should not mean a lesser standard of care.

- Mercy Health does support the introduction of a community rated insurance scheme to pay for care for the aged. We strongly oppose risk rated schemes that would discriminate against those with disabilities.

- The increase in the cost of providing aged care services, particularly in salaries, recruitment expenses, insurance premiums, increased specialised nursing products, in residential care, and to a lesser extent community settings, needs to be recognised in any change to the funding for services.

Mercy Health endorses CHA's recommendations that the following arrangements be implemented;

1. Special Purpose Financial Reports or equivalent be developed which would allow the collection of comprehensive and audited national comparative financial data and independent analysis of the financial performance of the aged care sector.

2. The Productivity Commission undertake an initial independent review of the cost of aged care and support (including the cost of caring for people with special needs such as people living with dementia, people with psycho geriatric and challenging behaviours and people needing palliative care) to ensure that current care prices are based on contemporary care practices and standards, having regard to benchmarks of care.

3. Independent periodic reviews of the cost of aged care and support be undertaken to inform the periodic rebasing of the basic care subsidy. This role would be analogous to the activity based costing to be undertaken by the proposed Independent Hospital Pricing Authority for the National Health and Hospitals Network.

4. The high care accommodation supplement and accommodation charge be increased to a level which would allow high care service development to generate at least a breakeven net present value (NPV) or an internal rate of return (IRR) greater than the weighted cost of capital (WACC).

3.3 The Role of Government

The Commonwealth Government should remain the predominant funder and policy authority for the aged care sector. While a culture of continuous improvement in regards to standards of care is needed, the government should continue to stipulate the minimum standards required, to protect consumers.

The multiple discontinuities in regulation effecting service provision require attention. For example, Supported Residential Services are governed by a diverse range of both state and local government legislation. These regulations are often inconsistent, both between and within states. This discontinuity results in significant diseconomies for providers and produces differential outcomes for consumers. Regulation of these services should be administered solely by the Commonwealth Government, or a common regulatory code be implemented to facilitate consistency at the state and local government levels.

3.4 Regulation of the Sector

There are significant differences between the accreditation process in the acute health setting and that used in the aged care setting, administered by the Aged Care Standards and Accreditation Agency.

The aged care standards operate on a bipolar basis of “pass/fail” and seem to result in a punitive approach to quality and safety. The 44 outcomes are not qualitatively assessed as there are no qualitative outcomes or key performance indicators attached to each standard. This approach results in assessors applying their own subjective views to each outcome. There are examples of organisations applying the same approach to various sites, however, one site may pass yet another may fail, the only apparent difference being the assessors.

Aged care staff often report that accreditation visits are stressful and assessors take a ‘policing’ approach to quality. This could be due to a blurring of the Agency with complaints and compliance monitoring requirements. The unannounced visits send the message that residential aged care facilities need to be ‘caught out’, that the situation that greeted the assessor during the announced visit was ‘staged’, and that staff cannot be trusted to provide quality care to their residents.

The fact that accreditation is so closely linked to funding, places a large amount of pressure on management to guarantee they pass accreditation. The establishment of a non punitive culture rewards incident reporting, which is essential if we are to address incidents that put resident’s health and well being at jeopardy.

The present aged care standards are focused more on the achievement of minimum standards than on the idea of continuous quality improvement. In contrast to the EQuIP program in Hospitals, aged care standards compliance is enforced via a range of sanctions available to the Commonwealth Government under the Aged Care Act. Best practice accreditation systems focus on quality improvement to find the underlying causes of errors or system failures so that their future incidence can be reduced.

The Aged Care Standards and the delivery method utilised by the Agency has improved residential care. However the industry is now ready to move towards a quality improvement framework that promotes continuous quality improvement that is measurable, non punitive, of best practice and improves the outcomes for residents and staff. Community care whilst not highly regulated, does fall under a number of different regulations and standards, including the *Aged Care Act 1997*, the *Commonwealth Home and Community Care Act 1985*, Department of Veteran Affairs and Traffic Accident Commission standards. This array of regulation and associated discontinuities should be addressed with a move to a common framework that is in line with best practice.

If the funding model for aged care is to change to one covering both residential and community care, then it would be appropriate to implement a regulatory system that encompasses both areas.

The Commonwealth Government should also move to separate the Complaints Investigation Scheme from the Department of Health and Ageing such that it forms an independent investigative and dispute resolution agency.

3.5 Deregulation of Bed Licences

While there is a need to provide people with greater choice and options in their selection of services, Mercy Health does not support the deregulation of bed licences, unless there is a mechanism to encourage service development in areas of social need.

The deregulation of bed licences, and the removal of the socio-demographic allocation model, is likely to lead to an increase in the number of beds provided in areas of relative affluence, to the detriment of lower-socio-economics areas.

We are unaware of evidence that demonstrates deregulation of bed licences would have a positive impact on the care outcomes of older people.

3.6 Workforce

A number of studies have shown that over the next 40 years there will be difficulties in securing an adequate number of people with the necessary skills to support the delivery of aged care services.

The aged care workforce represents the oldest workforce segment of the Australian economy. This makes it the most vulnerable to the retirement of the baby boomer generation.

We acknowledge that nurses working in residential aged care are paid less than their counterparts in acute care and, although more money would be welcomed, it is not the sole solution to the workforce issues. Nursing personnel, Division 1 only represent 15% of the workforce and Division 2 a further 10%. There are other matters of work value as yet unaddressed in the wages debate.

Mercy Health has had some success in attracting and retaining workforce. We recognise the value of developing our people to meet the organisation's growth and development, and secure a future workforce.

Attraction and retention requires a wider focus than remuneration. Other factors include the provision of opportunities for flexible employment options to accommodate people's changing needs over time, continuing education and career progression. The development of flexible models of care that reduce task orientated work programs and are holistic further engage staff.

In acknowledgement of the success of Mercy Health's programs and initiatives to attract and retain personnel, Mercy Health has received a number of awards, including: Diversity @ Work awards, HR Leadership awards, Equal Employment of Women in the Workplace Agency (EOWA) Business Achievement Awards, Australian Human Resource Institute Awards and the Victoria Government's Working Families Council Fair and Flexible Employer Award.

As an EOWA Employer of Choice, we now have a 98% retention rate across our organisation, and a return to work rate from parental leave of 97%. In a climate of limited resources, our innovative programs continue to deliver real benefits to the organisation and better position us to attract, engage and retain talented people.

Working in aged care needs to be promoted with a national focus as a viable career option for younger people. This requires investment by both the Commonwealth Government and peak bodies.

Promotion of a career in aged care needs to begin as early as year 10 work experience programs, to gain familiarity with the needs of the frail aged and demonstrate that there are career and educational options for the future.

Mercy Health welcomes the 2010/11 Federal budget announcement of an investment in the aged care workforce of $310 million over four years. The funding of the Aged Care Nurse Practitioner Program will promote access to aged care nurse practitioners as well as explore appropriate models of care.

The majority of employees in aged care are Personal Care Assistants (PCA) with much compassion but relatively limited skill sets. We recommend a move to registration of PCAs to establish a base line skill set nationally and to enhance the professionalism of this segment of the workforce.

Registration of PCAs would enhance the attractiveness of the role and provide increased assurance to families that their loved ones are cared for by registered professionals.

Concurrently, and recognising the chronic shortage of Registered Nurses, a nationally consistent approach to scope of practice for registered Personal Care Workers should be developed. This regulatory instrument should also serve to remove ambiguities with other legislation such as the Victorian Drugs and Poisons Act and those regulating the practice of Registered Nurses Division 1 and 2.

This approach would lead to the development of new workforce models that are less reliant on Registered Div 1 and 2's. Registered Nurses could move towards more senior roles that oversee both business and clinical management, roles that Universities have prepared them for. Registered Personal Care Workers would deliver care at the coal face which is less task orientated, less medicalised but more resident focused.

3.7 Technology

Aged Care is a labour intensive area of work. Investigation as to the role that technology may play to assist in the care of people requires national investment.

Technology should not be limited to administrative support but must encompass clinical functions and assistive devices. An example of a tangible benefit is the reduction of medication errors when electronic health records are used to share health and prescribing information between health professions.

Mercy Health is embracing the use of assistive technology in aged care, and has implemented PeoplePoint, a software system that supports the provision of integrated care management, across all facilities.

Encouraging innovation in the area of technology for provision of care to the elderly has positive outcomes for people provided care, the workforce, and also the public image of the sector.

Mercy Health recommends the establishment of a centre for aged care technology research affiliated with a major University.