national AGED CARE alliance

National Aged Care Alliance

Aged Care Planning, Allocation and Approvals Processes

April 2008

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About the National Aged Care Alliance

The National Aged Care Alliance (the Alliance) is a representative body of 28 peak national organisations in aged care including consumer groups, providers, unions, and health professionals, working together to achieve a more positive future for the aged care sector in Australia.

The Alliance was formed in April 2000, and has developed a united policy agenda to achieve better outcomes for the care of older people in Australia.

Alliance members are concerned about the future sustainability and funding of aged care services, and are seeking the establishment of industry wide benchmarks of care.

The Alliance's vision for aged care in Australia is that:

> *All older people in Australia have access to planned, properly resourced and integrated quality aged care services that are flexible, equitable, that recognise diversity and promote choice and respect for users and workers.*

The Alliance is making its priorities for aged care available to encourage informed discussion on matters of concern in aged care and to articulate our vision for a future of quality aged care services in Australia. Federal election candidates may contact Alliance members to discuss in more detail the issues included in these statements and individual organisation's own policy initiatives.

The following organisations are members of the Alliance:

> *Aged and Community Services Australia; Aged Care Association Australia; Alzheimer's Australia; Anglicare Australia; Australian Association of Gerontology; Australian General Practice Network; Australian Healthcare Association; Australian Medical Association; Australian Nursing Federation; Australian Physiotherapy Association; Australian and New Zealand Society for Geriatric Medicine; Baptist Care Australia; Carers' Australia; Catholic Health Australia; COTA Over 50s (Councils on the Ageing); Diversional Therapy Association of Australia; Geriaction; Health Services Union; Legacy Co-ordinating Council Incorporated; Liquor, Hospitality and Miscellaneous Union; Lutheran Aged Care Australia; OT Australia; Palliative Care Australia; Pharmacy Guild of Australia; Royal Australian College of General Practitioners; Royal College of Nursing Australia; and UnitingCare Australia.*

More information about the Alliance is available on its website: www.naca.asn.au.

The purpose of this National Aged Care Alliance (Alliance) Discussion Paper is to examine the current aged care planning and place allocation processes and canvass some alternative approaches.

Summary

The aged care planning, allocation and approvals processes have been a successful set of Government policies over the past twenty years providing a program structure that has led to Australia's aged care program being recognised as being one of the best in the world.

The Rudd government has committed to reviewing the place allocation process and the planning ratios. The Alliance will be prepared to participate in this review and does pose the question as to whether there is a justification for the continuation of the current arrangements, as they exist, as these do not necessarily enable the supply of places to adequately match the demand for them by consumers.

The Government review of the planning and allocation process will need to examine what is the appropriate number of places required to meet future demand based on the changing demographic profile, changing dependency levels, consumers' care expectations and requirements and how these should be met through the combination of government support and individual contribution.

Introduction to Aged Care Services in Australia

Roughly one in every four older people (i.e. those aged 70 and over) makes some use of aged care. Of those that do, most use community care, that is, care provided while they remain in their own home. At any one time there are about one in ten older people who have left their home to receive care in a residential care facility.

Residential aged care (high and low care) is predominantly financed and regulated by the Australian Government and is mostly provided by the non-government sector (by both religious/charitable and private sector providers). State and local governments, with funding from the Australian Government, also operate a small number of aged care homes.

Around one million older Australians and younger people with disabilities receive community care to allow them to maintain their independence and continue living in their own home. The funding and regulatory responsibility for community care depends on the type of program. The Home and Community Care program (HACC) which provides services to frail older people, younger people with disabilities and carers, is jointly funded by the Australian and State and Territory governments.[i]

Eligible older people can be entitled to receive Australian Government funded community care directly via Community Aged Care Packages (CACPs), Extended Aged Care at Home (EACH) packages and Extended Aged Care at Home Dementia (EACH-D) packages. These community care packages provide low and high care as alternatives to the care provided in residential aged care.

Background

Prior to the 2nd World War, services for frail and destitute older people without family support were principally the province of charitable organisations with state governments providing some services and some financial assistance.

The Federal Government entered the aged care field in 1954 with the Aged Persons Homes Act which provided capital subsidies to approved charitable organisations to provide essentially self contained and hostel type accommodation.

i HACC assists its target client group avoid premature admission to residential care. HACC services are directly provided either by state, territory and local governments or by not-for-profit, non-government organisations. HACC clients cover the whole range of dependency levels from very high to very low. However, the majority of HACC service users are people with lower levels of care needs than those who receive residential care and community care packages.

The introduction in 1962 of the Commonwealth Nursing Home Benefit payable to both the voluntary and for profit sectors stimulated substantial interest by private investors who viewed nursing homes as low risk, high profit financial ventures, (Kewley 1980)[1].

The consequences were a rapid increase in nursing home beds from 25,500 in 1962 to 51, 300 in 1972 the last year before controls on growth were implemented (McLeay 1982)[2].

In 1972 there were 47.5 nursing home beds per 1,000 people aged 65 and over (Kewley 1980). The introduction of controls in that year resulted in a minor decline to 46.7 per 1,000 people aged 65 and over in 1981 (Nursing Homes and Hostels Review, 1986)[3]. Between 1983 and 1986 new nursing home approvals essentially came to a halt with very limited numbers of new beds being distributed on the advice of the newly created Aged Care Advisory Committees in each state.[4]

The aged care planning, allocation and approvals processes have been in place for over twenty years as a key policy platform with the dual purpose of controlling Commonwealth outlays as well as ensuring places are allocated in geographic areas where the 70 and over aged cohort reside. A fundamental aim of the allocation process when it was established was regional equity. The argument has been that without the allocation of places according to regional planning areas, access would depend on the locational preferences of provider investors.

In 1986 the aged care planning ratio was set at maintaining the then existing national ratio of 100 residential beds per 1,000 persons aged 70 and over once homes with more than fifty per cent young people were excluded with these being transferred to the Commonwealth-State Disability Arrangements in 1987. The 100/1000 formula was made up of 40 Nursing Home and 60 Hostel places, however there were 67 actual nursing home beds per thousand people aged 70 plus. By applying this formula at the regional level, as well as the State/Territory level, a process was put in place to "even up" the then very uneven allocation of places across regions. In the early 1990s when Community Aged Care Packages (CACPs) were introduced, the formula was changed to 50 Hostel, still 40 Nursing Home but 10 CACPs.

In 2004 the formula was again changed to 40 High Care (Nursing Home), 48 Low Care (Hostel) and 20 CACPs thus increasing the overall places to 108 per 1,000 people 70 plus. In 2007 it was changed 44 High Care, 44 Low Care and 25 community care (comprising 21 CACPs and 4 EACH), total 113 places.

The Allocation Process

The process of allocating new places commences with an estimation of the number of new places needed to cater for increases in the target population. Aged Care Planning Advisory Committees in each State and Territory then consider how the new places should be distributed between regions and special needs groups and advises the Secretary of the Department on the most appropriate allocation and distribution by different types of subsidy and proportions of care.[5]

The objectives of the planning process are:

- To provide an open and clear planning process; and
- To identify community needs, particularly in respect of people with special needs; and
- To allocate places in a way that best meets the identified needs of the community (Aged Care Act 1997, Section 12-2).

The Aged Care Act (the Act) (Section 11-3) defines people with special needs as:

- People from Aboriginal and Torres Strait Islander communities;
- People from non-English speaking backgrounds;
- People who live in rural and remote areas;
- People who are financially or socially disadvantaged;
- People who are veterans; and
- People of a kind (if any) specified in the Allocation Principles.

Allocation Rounds are advertised annually by the Department with invitations for applications from approved providers. Applications are assessed against the criteria in the Act and the Allocation Principles 1997. These include whether the applicant has the necessary expertise, experience, suitability and ability to provide the care and whether the premises are suitable for the provision of care.

Prior to 1 October 1997, places were allocated as either nursing home, hostel or CACPs and these services could only admit care recipients approved by the Aged care Assessment Teams as eligible for that level of care.

Since that date places have been allocated as either High or Low care, CACP or in latter years EACH or EACH Dementia. These places are restricted also as to the care recipients that they can admit, but the pre 1 October 1997 places can admit either High or Low care.

Prior to the Act, a small number of nursing homes were designated as Exempt Nursing Homes. These homes offered a superior standard of accommodation and hotel services and could charge a higher fee to residents but in return the Commonwealth reduced the care subsidy payable under the Resident Classification Assessment Instrument (RCAI).

With the advent of the Act, these homes were called Extra Service and the Act extended to Low care the opportunity for allocated places to be classed as Extra Service. These places must be either all of the places in the approved service or in a distinct part of the facility providing it is physically identifiable as separate from the rest of the service. There must be at least five places in the distinct part and it must include sufficient living space, including dining and lounge areas, for the exclusive use of the residents living in it.[6]

As with the Exempt Nursing Home, Extra Service places can charge a higher daily fee in return for receiving a lower care subsidy. The major difference is that, in addition, Extra Service operators may also charge an Accommodation Bond regardless of their level of care. These Extra Service places will generally not need to meet the concessional ratio requirements.

With the Act, the number of Extra Service places could not exceed twelve per cent of places allocated, but this was subsequently increased to fifteen per cent. Despite this target, only around six per cent of all places are so designated.

Aged Care Planning and Approvals Process

Professor Warren Hogan in his major report on residential aged care recommended to government (2004)[7] that the aged care approvals round process have a price signal attached to it. Hogan suggested that the aged care industry, rather than having aged care approvals round places allocated as a free asset transfer to the Industry, should have the places auctioned with the result that in attractive areas approved providers would pay government for the allocation whilst in unattractive areas the Government may need to pay approved providers to build and operate aged care places.

If adopted, Hogan's suggestion would have the immediate impact of sending a price signal to government about the attractiveness of building aged care places. The Government for some time has argued that while approved providers are applying for aged care places at a rate of four to one of the places available then government will not take the industry claims of inadequate capital for High Care seriously.

Since the publication of his report, Professor Hogan has modified his view. In an article in the Australian Financial Review (2007)[8], Hogan said:

"Existing arrangements reinforce a centrally-planned system limiting the say of both providers of aged care facilities and users of those facilities. The political and administrative leadership determines the number of beds allocated each year. Boards and management of aged care facilities are dependent on these allocations before any

investment decision can be taken. Users of services and their families have few choices, if any, in seeking a place in a residential facility.

The choice for the government is simple: maintain the current rigidity, which has done nothing to foster efficiency and quality in aged care, or implement a new regime offering flexibility to providers of aged care services and choice to users.

The boards and managers of aged care facilities should be permitted to make their own investment decisions based on their perceptions of need and their ability to compete effectively to attract residents. Centralised government quotas have no place in such a system. Official bed allocations should be abandoned.

Under a freer system, users of services would enjoy real choice. Their need for aged care support would still require approval by Aged Care Assessment Teams. Given access to aged care subsidies, it would be for them and their families to negotiate with providers and choose the facility which best suits their needs."

In a later publication,[9] Professor Hogan stated, "the underlying purpose is for enhanced competition and stimulus to quality, the two going hand in hand."

Catholic Healthcare (2006)[10] argues the current capped supply environment where demand exceeds the supply of places dilutes incentives for service providers to give proper attention to the quality of their services, the efficiency of their delivery, their responsiveness to client needs and to innovate

They state, *"In order to give older people and their families real choice, there is a case for removing or relaxing the current overall cap on the provision of subsidised places and the caps applying to residential and community care places. Real choice would be further assisted by 'unbundling' the subsidies for care and accommodation so that the basic care subsidy could be received in the location of choice.*

As well as giving users choice, the removal of the cap on aged care places and the 'unbundling' of care and accommodation subsidies would:

- *increase competition for service provision in most areas of Australia, which would encourage greater attention to the quality of aged care services, increase efficiency and help control costs of service delivery and prices (the objectives of national competition policy);*
- *encourage innovation in service design and delivery;*
- *reduce regulatory costs for taxpayers and service providers; and*
- *encourage the development of housing more suited to 'ageing in place' and the development of 'intermittent' type care services which would support people in need pending being able to return to their home.*

For example, an expanded Day Therapy Centres program could be enhanced to include short term overnight stay where it would help an individual to intersperse their care at home with more intensive therapy and preventative care, support and advice that would allow that person to return to, and live longer, in their own home. The current day respite component of the HACC and NRCP programs could also be incorporated to create a more streamlined and comprehensive service."

Gray (1999)[11] forecast that eventually the government would move to the next wave of change embracing a more competitive model of aged care as the effectiveness of accreditation, building quality and approved provider requirements laid the foundation for providing consumers the right to choose where their care should be delivered, either at home or in residential care.

"This wave, driven by competition policy, will involve further deregulation by the abandonment of the planning ratios, the uncapping of user pays and changing the ACAT approval process.[ii]"

He stated that this would likely commence between 2008 and 2010.

In a presentation at the Catholic Health Australia 2008 National Conference[12], the CEO of a major Catholic aged care provider, Mr Barry Wiggins, argued for a voucher scheme whereby all ACAT approved care recipients would be entitled immediately to a level of community care service, based on assessment of need, from any approved aged care provider. Consumers could then move between providers as they wish and also between residential and community care. These changes would enable a quick response for people in crisis thus avoiding many residential care placements. It is argued that this would create spare capacity in residential care and more competition.

Providers would have an option to grow their business by attracting community care clients with financial viability linked to their ability to adapt and deliver services that work for consumers. Wiggins argued that the balance between consumers and providers would shift in favour of consumers and this would in turn pressure providers into focusing on quality and innovation rather than having to continually respond to regulation of supply of aged care.

Being freed from a significant amount of regulation regarding the allocation of aged care places would enable providers to operate as businesses, but in a more dynamic environment. This would entail more business risk but greater opportunities.

"We could stop blaming the government and move towards running our operations in ways that continually respond to our customers' needs", Mr Wiggins concluded.

ii Aged Care Assessment Teams (ACATs) act as gatekeepers determining eligibility to access Commonwealth Government funded residential and community care. The ACAT program is jointly funded by the Commonwealth and State/Territories but administered by the latter.

However, Hogan (2004) has noted that the relationship between the consumer and provider is asymmetrical. Consumer choice is complex and is dependent on the availability of different services, the level of user friendly information and a range of other factors. Deregulation of supply could potentially limit the availability of services that are less profitable, for example those in regional and remote areas or catering to special needs. Therefore though uncapping supply may provide more choice for consumers, sufficient regulation would be needed to ensure that supply meets demand for a range of services to a group of consumers with diverse needs in different geographical locations.

Alternative Place Allocation Processes

The following approaches are put forward by the Alliance to stimulate discussion on possible reforms to the current system.

Competitive Tender

Rather than the Government going through the existing processes of determining state-wide and regional place allocations and then attempting to determine the best allocation distribution amongst the successful applicants in each of the 70 planning regions, the Government could go through a formal competitive tender process across broad geographic areas thus allowing tenderers to submit bids based upon multiple regions.

Providers could then put forward a whole of organisation business plan and forward projections that indicate why providers are looking for additional places and how these will be utilised across the broader organisational structure and to clearly indicate the integration of allocations across the organisation's geographic spread.

Choice, competition and integrated care are what consumers want. Care providers want to be able to integrate resources across different program areas and offer consumers a continuum of care.

Zero Place Allocations

In the less regulated approach suggested by Catholic Healthcare and forecast by Gray, the Australian Government withdraws from allocating aged care places and leaves that provision to approved providers and market forces. The rationale behind this argument is that there is no cost to the Government until a place is occupied by an approved care recipient. It is only then that a care subsidy entitlement becomes payable. Vacant capacity cost falls to the approved provider and then mainly with residential places.

The threat to the Industry of such an arrangement would be the possibility of financial institutions heavily discounting the value of the licences held by industry providers from a relatively expensive secondary market value today of approximately $40,000 on average to a substantially lower value if there were to be no controls on the supply side.

The benefit of a less regulated scheme would be that providers could build when and where required, look to other alternative incomes outside the Commonwealth domain more readily and be more responsive to market forces than is currently possible given the controls on allocation, sale and relocation of licences within the existing scheme.

The current approved provider, building quality and accreditation processes would still be in place to ensure that only those providers approved to receive a care subsidy would be able to benefit. Also building quality and care standards would continue to be maintained.

Instead of controlling outlays through planning and allocation, the Government would be faced with tightening the eligibility for an entitlement to a care subsidy. The other challenge would be ensuring that places for special needs groups would still continue to be provided and expanded. This could be achieved through increased Government care subsidies specifically targeted accordingly.

From the Government's point of view, there would be two major problems with deregulation. Firstly is the problem of fiscal risk when control would be on demand not on supply, with demand being regulated by ACATs. ACATs are not currently tasked with controlling demand, but with matching people's needs with available services. To take over this responsibility, ACATs would need to become an Australian Government managed program.

Secondly is the problem of regional equity. A purely market based approach would result in little investment in rural areas, or in areas where the prospect of reasonable size bonds is remote. Whilst ever equity of access by geography is a goal of the aged care system, then some degree of regulation of supply would be considered politically necessary.

Rather than zero place allocations, place approvals could still be in place but not be specified for residential or community thus allowing providers to choose the type of place offered and be able to swap a vacant place allocation at any time in order to meet consumer demand. However, where it is more profitable to provide one type of care as compared to another, availability to consumers of the less profitable type of care could be an outcome.

Government Contracts

An alternative to the options above is that the Government specifically contracts with approved aged care providers to build and operate an agreed number of places within a geographic region with the Government including within their contracts an agreed number of funded places the Government requires to be operated. The approved provider would be at liberty to utilise the balance of their service to provide care support to other self funded or insurable aged care recipients or other clients that the provider may be able to attract, eg step down or post acute rehabilitation.

As with the Medicaid system in the United States, this approach would create two types of clients, Government and other, thus moving the aged care system in Australia away from being a universal system.

The potential concerns with respect to "regional equity" (referred to previously) and creating two types of clients could be addressed through higher subsidies for clients in these categories.

Status Quo

If none of these alternatives are attractive then the Industry needs to accept that the preferred way forward is to maintain the status quo and improve the existing allocation process to ensure the most efficient and effective use of resources both by government and the industry.

Improving the Aged Care Allocation Round Process (ACAR)

The existing scheme needs to be changed to provide a better planning framework for approved providers with a higher level of certainty than the current scheme. The current scheme has tended to be a lottery with providers almost being forced to submit annual applications in the hope that they may be successful whether or not their strategic plan really calls for additional capacity. One commentator has dubbed the process as "bed lotto."

Disclosure and Management of Planning Data

The whole process should be based on accurate population and usage data for each local government area, regularly updated according to census outcomes and projections and publicly disclosed.

If aged care providers were able to know three years in advance that they had been allocated approvals in principle and that they needed to achieve certain milestones within agreed time frames during the three years in principle approval, such as local government approval, financing, land purchase, architectural plans and building contracts and that the particular places were to be brought online within a given forward period then there would be a lot more certainty attached to the current planning scheme and providers would be able to operate with certainty.

During 2005-0613 the estimated total building work completed or in progress in new, replacement and upgrading work was $2.25 billion and with the projected doubling of the demand for care services over the next 25 years there is no indication that current capital needs are going to decline.

The current ACAR process does not provide certainty as the outcomes appear on many occasions to be opaque and incomprehensible. The process is certainly not transparent resulting in many providers choosing to submit an application in the off chance that they may be successful.

Transparency could be enhanced by the publication of both the successful and unsuccessful applicants for places. This would then impose greater rigour on Department decision making as to which applicants should be successful.

The Alliance welcomed the partial reform of the existing allocation process announced by the Government in 2004 providing for three year projections of allocations at state and regional level however this fails to go far enough to provide the level of certainty aged care providers and the financial institutions need.

As already stated, aged care providers should know three years in advance that they have received an allocation so that they can then plan for the development and construction of required capacity and not be required to construct a new residential facility from scratch within the impossibly short timeframe of two years. The two year coming on stream period should begin from the end of the three year approval in principle period.

The Alliance believes that all the data available to the Department in making planning decisions should be in the public domain so that existing and future providers can proceed with future business planning and place applications in the fullest understanding of the requirements of certain geographic areas.

In addition, feedback from the Department informing unsuccessful aged care providers of the reasons for their failure to be allocated a place needs to be more substantial and transparent within the bounds of maintaining commercial in confidence information of other applicants.

Aged Care Planning Ratios

The original decision to plan aged care approvals on the basis of 100 places per 1,000 persons aged 70 years and over was arrived at by reference to the then number of nursing home and hostel places and the age and dependency levels of the residents.

Whilst dependency may be a better measure for place demand, the current ratios of 88 residential places and 25 community care places are still a relevant proxy. They will only cease to be a relevant proxy once the baby boomer demographic bulge moves out of the 70 to 80 age range. What is now out of step is the way the 88 residential places are split equally into 44 High and 44 Low Care. As 69 per cent of all new residents are assessed as High Care, the continuation of the High/Low Care split is irrelevant.

The Government contends that it is increasing the overall ratio to meet the growing demand for home care and thus providing greater choice to consumers. Some commentators have suggested the increase in the community care planning ratio and the consequent potential for higher levels of vacancies to occur within the industry has the risk of reducing the number of operators in the field and may, in the end, have the consequence of actually reducing the choices available to consumers. In addition, government takes no risk when aged care places are vacant as government pays no price for a place that is not occupied in either an operating context or a capital context. The full risk of having a place vacant in the current scheme is totally borne by aged care providers.

Aged care providers should not have to carry the full risk of vacant places whilst the Government continues to apply the very strict controls on the income available to providers. If supply is to be in excess of demand, then the cap on price will need to be loosened in order for aged care businesses to survive.

Occupancy rates around the country are variable with a number of capital cities experiencing long term substantial vacancy levels and many new facilities taking far longer than previously to reach 75 per cent occupancy or higher. At the same time there are numerous examples of facilities with long term waiting lists in parts of the country. It is debatable why these significantly different outcomes are occurring though it is likely that the existing planning undertaken by the Department in its forward projections for bed allocations is proving deficient in some respects otherwise one would expect far better distribution and more even outcomes in respect of occupancy levels.

At the same time the Department's own figures clearly indicate that occupancy is declining. Since June 2000 occupancy has steadily declined from 96.3 per cent to 95.0 per cent14 as at June 2006. It is expected that the average occupancy rate across the country will have fallen to 94 per cent by 30 June 2007 and on current trends will continue its downward slide. With an average occupancy of 94 per cent many facilities must be running at an occupancy level of 90 per cent or lower. The financial viability of these facilities is questionable.

Respite

The current system of allocating respite days in the ACAR round needs examining. Residential respite continues to be a problem, with consumers complaining they can't get it, and providers not using the full allocations government provides.

Providers prefer to have their approved residential places filled with permanent care recipients than deal with the administrative, regulatory and care issues that are part and parcel of continual resident turnover with respite.

Changes to the place planning and allocation processes are an essential starting point in improving the provision of respite places.

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