Twists and turns along the road to aged care reform: Legislated Review

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In brief

Aged care reforms in Australia are directed at achieving over 10 years a market based, consumer driven and sustainable aged care system with equity of access based on assessed need. The *Aged Care (Living Longer Living Better) Act 2013* (Act) provides for certain initial reforms to aged care from August 2013 to July 2014 with a review of the effectiveness of these reforms to be undertaken as soon as practical after 1 August 2013. To this end the Commonwealth undertook a consultation process during the period October to December 2016 (Review).

A large number of submissions were made to the Review. We are particularly interested in home care and have considered a sample of the submissions to the Review representing the experience in relation to home care of care providers, care recipients and peak bodies of both. In this note we have focused on two policy settings in relation to home care: meeting unmet demand for home care and access to home care, and addressed two principal themes we see as emerging from the submissions as follows:

- the unintended and distortionary impacts of some reforms, in particular fee arrangements and means testing;
- challenges to the equitable allocation of scarce resources in the naturally imperfect market for aged care, in particular, the changing profile of care needs, the true costs of care, sustainable funding and access to information sufficient for choice.

Review process

Submissions were sought in relation to the effectiveness of aged care reform by reference to a number of specific matters reflecting the policy settings of the legislation including the meeting of unmet demand, the balance between supply and demand drivers, means testing and alignment of charges, equity of access to care, facilitation of access to care and workforce strategies.

The Review has received 145 written submissions. A report is scheduled to be tabled in Parliament in the middle of August 2017.

In detail

Background to home care

Home care is a key element of consumer choice and aged care system sustainability. For those less familiar with the structure of home care in Australia, we provide the following brief overview.

Home care is supported by the Federal Government in the following ways:

- Commonwealth Home Support Program (CHSP); and
- Home Care Packages Program (HCPP).

Commonwealth Home Support Program

The CHSP is described as "an entry level home help program for older people who need some help with daily tasks to live independently at home". Support services funded under CHSP include assistance with domestic cleaning, laundry and gardening, small repairs such as changing tap washers and light bulbs, shopping, delivering meals to the home, managing medication, physiotherapy and minor home modifications such as the installation of a safety rail. Eligibility for support is determined by a Regional Assessment Service which considers the day to day activities of the aged person rather than their clinical needs.

The CHSP is a grant-funded program and funds are made available to service providers. Clients are expected to contribute to the costs of their support if they can afford to but there is no applicable income or other means testing. The amount contributed is agreed between the client and the provider. In 2015 the Government released the Client Contribution Framework which outlines the principles that providers should adopt in setting and implementing their own client contribution policy. The framework states that client contributions must not exceed the actual cost of service provision and should take account of the client's capacity to pay.

While the principles of the Client Contribution Framework are consistent with those applicable to home care, they are not applied uniformly across CHSP and it appears that services are generally available through CHSP at a lower price point than under HCPP.

Home Care Packages Program

HCPP is part of the Governments continuum of care for older Australians being positioned between residential aged care and the CHSP and helping older Australians with complex care needs to live independently in their own home.

There are four levels of support:

- Home Care Level 1 – basic care needs;
- Home Care Level 2 – low level care needs;
- Home Care Level 3 – intermediate care needs; and
- Home Care Level 4 – high care needs.

Eligibility for a 'Home Care Package' is determined on the basis of an Aged Care Assessment Team (ACAT) assessment including clinical elements.

The Australian Government provides a subsidy to an approved home care provider towards the relevant approved package of care services and case management of a care recipient. The subsidy is different for each level of Home Care Package and the subsidy is reduced for each recipient of a package by an income tested fee payable only if the income of the care recipient is greater than the income of a full pensioner. The income tested fee payable by a care recipient is the same at all package levels. Annual caps apply to the income tested fee (part pensioner as at March 2017 $5,276.08 and self-funded retirees $10,552.18). A lifetime cap of $63,313.28 applies on income tested care fees. Fees are therefore based on income, not care needs.

Each recipient of a Home Care Package may also be asked by the provider to pay a basic daily fee of a maximum of 17.5% of the basic rate for the single aged pension (as at March 2017 $10.10 a day, a maximum of $3,686.50 per annum).

Packages are awarded to clients through a national prioritization process based on the length time the client has waited and their degree of risk.

Integration

It is proposed that there be a single integrated home care program from July 2018.

Meeting unmet demand for home care

Although consumers have a greater opportunity to access care while living at home, the profile of Home Care Packages available does not align with the profile of the take up of Home Care Packages. Means testing and fee arrangements and the relationship between CHSP and HCPP appear to be having the unintended outcome of discouraging a choice of level 1 and 2 Home Care Packages. As a consequence there is an oversupply at levels 1 and 2, an undersupply at levels 3 and 4 and distortion of the home care market generally as consumers prefer the CHSP (where they are able to) including by supplementing their care informally.

Misalignment

A number of key concerns were raised in the review in relation to unmet demand for home care:

- there is a low take up of level 1 and 2 places (the average national occupancy rate for level 1 places in 2013-14 was 48.4% and level 4 places 90%);
- there are insufficient level 3 and 4 places;
- the demand for level 3 and 4 places is increased because people have not taken up lower levels of care and had the benefit of early intervention;
- surpluses of level 1 and 2 packages and insufficient level 3 and 4 packages mean longer waiting periods for the correct level of care or take-up of an inappropriate level of care;
- people without the correct level of care tend to need to move prematurely into residential care;
- further data is required to understand the extent of unmet demand for subsidised services, in particular, an understanding of the private market for care and more insight into consumer preferences gained by monitoring of the waiting list through the MyAgedCare prioritisation process.

Factors relevant to the misalignment were considered to include the following.

Income testing

The prerequisite for a Home Care package is income testing. Testing is not only complex but the cost of it at the lower end of contributions may not be justified. The provision of care may also be significantly delayed by delays in the receiving the results of income testing.

Fee arrangements confusion

Fee arrangements in relation to Home Care Packages have been found to be confusing.

Prior to the reforms to HCPP in 2014 the full value of the package was paid through subsidies and supplements to the provider. The provider had a discretion to charge home care clients a fee that could include a basic amount of up the 17.5 per cent of the basic rate of the single aged pension plus an amount up to the equivalent of 50% of the person's income above the basic pension. Thus there was no reduction in the subsidy and in addition to the subsidy there was one fee payable to the provider by the client.

The current system distinguishes the income tested care fee and the basic daily fee and causes confusion. There are not two distinct purposes for the two fees. Because the basic fee is not uniformly charged by care providers it is not able to be characterized as a basic contribution by all consumers for accessing the home care system. Both fees are allocated to and accounted for in the consumer's budgeted care. However, only one fee is income tested, reduces the subsidy and is counted towards annual and lifetime fee caps. Further, additional elective services may be provided subject to payment of additional fees for those services.

Fee arrangements poor value

Fee arrangements in relation to Home Care Packages have been found to provide comparatively poor value at levels 1 and 2.

There are significant similarities between services provided at levels 1 and 2 of HCPP and those available under CHSP. However, as noted above, there are different access and eligibility arrangement for CHSP and different funding and fee structures. The same or similar services may be obtained under CHSP

without an ACAT assessment or means testing or access through the national prioritisation process. Many consumers are choosing to remain on the more generous and flexible CHSP.

HCPP income tested care fees are based only on income, not the level of care provided. Consumers can also be asked to pay the full basic daily fee, regardless of their assessed care needs. The submissions indicate that the total maximum consumer contributions for lower level packages, particularly level 1 packages are too high as a proportion of the package value compared with consumer contributions to higher level packages. It is considered that this relativity may be influencing consumer decisions not to take up level 1 packages.

The Aged Care Financing Authority (ACFA) in its report prepared to inform the Review and dated April 2017 noted that the maximum part pensioner contribution of $8,962.58 (including the full basic daily fee) was 76% of a level 1 package, 49% of a level 2 package, 25% of a level 3 package and 17% of a level 4 package.

ACFA notes that of the consumers of level 1 packages in 2015-16, only 15% were part pensioners or self-funded retirees but that this group constituted 27% of level 4 packages. ACFA suggests that current fee levels are sending price signals resulting in older Australians who are not on the full pension seeking services through CHSP, the private market, care up to the subsidised amount plus informal care or no care at all.

A number of submissions to the Review called for client contributions to be amended to provide for a tiered contribution linked to the quantum of services received, plus a means tested amount with means testing linked to pension/seniors health card assessments to avoid duplication.

One submission stated that until the proposed integration of home care programs (scheduled for July 2018) has been implemented and the impact on the market evaluated, new reforms for home care should not be considered.

Access to home care

Subsidised aged care places are controlled under the national provision ratio which in 2015-16 provided for 113.2 places for every 1,000 persons aged 70 years or over. This ratio is set to grow to 125 by 2021-22 with home care places increasing from 27 to 45, residential places reducing from 86 to 78 and the addition of two restorative care places.

A number of submissions considered, consistent with the ultimate objective of the Aged Care Roadmap, that the market should determine the number and mix of places subject to ensuring financial sustainability and the protection of special needs groups, rural, remote and other areas of thin markets.

Key concerns of the submissions in relation to access to care include that:

- a capped supply system is not consistent with a consumer driven, market based system;
- it may be doubted that the current planning ratios will be able to meet the dynamic demand for home care;
- while a capped supply system remains in place allocating scarce resources requires that the prioritisation methodology not only be consistent, equitable, evidenced based and transparent but also remove current systemic obstacles to streamlined access caused by wait times, particularly those arising from assessment and means testing requirements;
- the true components and costs of care must be recognised and their impact taken into account in financial and demand modelling particularly in relation to providing:
    - adequate levels of care;
    - service quality;
    - a sufficient return on capital for providers;
    - stable and predictable baseline funding to enable provider investment and innovation; and
    - appropriate funding models including consumer contribution models such as insurance and home equity release;

- older people and their carers must be adequately informed to enable them to perform their consumer role, electronic platforms must be supplemented with other support including face to face and documentary information.

Allocation of scarce resources

Priority to take up the limited supply of Home Care Packages is determined by reference to assessed need and the time spent waiting, with income means testing a prerequisite to the allocation of a subsidised package. Submissions highlighted the systemic delays, particularly arising from the complexity of income testing, which not infrequently result in a change in the nature of the consumer's care requirements and the need for reassessment. Statistics provided by COTA Australia, a national peak body for older Australians, show that 1 in 5 consumers who have an aged care approval (ACAT assessment) wait more than 9 months to enter into the aged care system.

The market for care is uneven and littered with special needs circumstances where there really is no contestable market. These special needs circumstances are not static. The submissions indicate that the list of special needs groups identified in the legislation should be reconsidered and expanded. In particular, the list does not take account of a range of emerging vulnerable client profiles such as cohorts requiring palliative care, people presenting with chronic and complex health care conditions or severe behavioral symptoms of dementia. Special needs cohorts can also be identified other than by reference to health and location such as those experiencing elder abuse, those with disabilities or in the justice system or accessing services across multiple systems.

Care services, once considered to be 'niche' services are in fact now core services for care providers (for example, dementia care) and there needs to be continuing consideration of changing core care profiles.

The Commonwealth's financial and demand modelling must be dynamic.

The true components and costs of care

Protecting equity of access to care includes preserving care at the appropriate level against erosion by ancillary outgoings. This requires that the true components and costs of care must be identified and their impact taken into account such as:

- service quality;
- administration;
- diversity in rural areas;
- the significant differential between metropolitan areas and rural areas;
- interpretation services;
- culturally appropriate care; and
- consumers crossing a range of categories such as veterans of the Australian Defense Forces identifying as part of the culturally and linguistically divers (CALD) population.

As an example of the impact of the true costs of care, one submission referred to the care component of a $14,000.00 per year home care package being reduced by $3,000 in the first year to pay for the translation of a care contract into the consumer's own language. Under current Department of Health policy, translation services are available to service providers for their operational matters such as negotiating a care agreement, co-designing a care plan and arranging a care budget. This translation was outside the service provider's operational requirements.

Models of funding

If the provision of aged care is to be sustainable, ensuring adequate funding for investment, innovation and the appropriate level and quality of care, different models of funding must be considered from the Commonwealth and from consumers themselves, such as:

- extension of homeless hardship supplements;
- a form of block funding for special needs;
- automatic application of the financial hardship assistance for the basic daily care fee once key criteria are met;

- home equity release schemes;
- public and private insurance such as is available for health care generally.

Some submissions noted concern in relation to financial inequities as between consumers, including asset and income redistribution by the aged person to their families to optimise their subsidy entitlement. ACFA also noted that some providers were not collecting the maximum amount for fees under the HCPP. While in such case the Commonwealth subsidy is still reduced by the value of the income tested care fee, it appears that some consumers are paying the full income tested and basic daily fee and others in similar circumstances (same financial and care needs) are paying less but still receiving the full package of services. ACFA queries whether it should not be compulsory for care providers to collect the full basic daily fee.

The information deficit

While submissions acknowledged the desirability of an electronic gateway implementing a nationally consistent aged care assessment solution and providing greater consumer choice and control, many submissions considered that access to care through the MyAgedCare system of a call centre and website (MAC) had significant shortcomings. Concerns included the following:

- MAC provides only limited financial information and much information is out of date, overly general and inaccurate and so is insufficient to enable consumers to make informed decisions;
- systems required to underlie the MAC services do not talk to each other so that information necessary for providers to commence services may be missing or unable to be provided in a timely manner;
- the system is not reliable so there are extended wait times and some providers have failed to receive referrals through MAC;
- the website needs greater functionality including an appropriate search function;
- assessment interactions are process driven, intrusive and cumbersome;
- more clinically skilled personnel are necessary to understand clients' needs;
- people generally find the system difficult to navigate, both potential clients and providers 'drop out';
- CALD clients are particularly disadvantaged;
- most elderly potential consumers are hesitant to use technology and require support to become more familiar and comfortable with the system;
- there should be more printed material and face to face information: many elderly people will not speak to a call centre;
- more information is required to be provided to non-aged care workers who may be key contact points for older people including paramedics, meals on wheels volunteers, taxi drivers who provide services to the aged, pharmacists, newsagents, hairdressers, postal outlets, GPs and GP practice managers, local community centres, Seniors Clubs, Men's Sheds, CWA and University of the Third Age; and
- it has been reported that implementation of MAC with its focus on and communication with the care recipient has had a negative effect on carers, in particular:
    - leading to a significant reduction in the data collected in relation to carers; and
    - the shift to allocate respite to carers based only on the needs of the care recipient.

Submissions from the National Aged Care Alliance and COTA support the implementation of 'outreach' and 'system navigation' to ensure access of vulnerable populations as follows:

- Outreach: the activity of actively seeking out and engaging with clients/communities/groups in their own environment to link them into or back into the system rather than waiting for the a request for a service or for a referral from another agency; and
- System navigator: a person to "walk beside" the person as they navigate aged care, providing one-on-one support to formulate and achieve goals and identify suitable providers: achievable by targeted funding to vulnerable population outreach and advocacy services, or as an optional service through the home care package.

The takeaway

The objectives of individualism and marketisation in aged care in Australia reflect international trends. Consumer directed care is expected to lead to competition, improved service quality and cost reductions. Conditions for consumer purchasing power, however, usually include access to full information, real choices, low switching costs and competition between suppliers. Submissions to the Review have:

- highlighted features of aged care reform which create market distortions; and
- identified market distortions challenging the effectiveness of reform.

We have considered some of these distortions in relation to the meeting of unmet demand for home care and access to home care, in particular:

- means testing and fee arrangements;
- the dynamic landscape of care needs;
- the true components and costs of care; and
- the consumer information deficit.

The Review is just one element of continuing assessment by the Federal Government of the outcomes of reform measures against the key objectives for aged care reform of equity, choice, flexibility and sustainability.

We look forward to providing further perspectives following the publication of the report.

Let's talk

For a deeper discussion of how these issues might affect your business, please contact:

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