Main Points

- Policy influences industry structure and structure is related to quality
- Current trends in the structure of RAC are likely to continue and may impact on potential quality
- There is a lack of clarity around some key aspects of reform
- Wider debate is needed in Australia on the future preferred structure of the aged care industry
Literature review - relationship between structure and quality

• Donabedian (1966, 2005) – Structure/Process/Outcomes (STO) framework
• Remains widely referenced today both health and aged care
• Subsequent researchers, in relation to aged care, have
  ▫ Widened ‘structure’ to include broader inputs (e.g. government regulation)
  ▫ Grouped process and outcomes as ‘quality’
  ▫ Confirmed the relationships – between structure (ownership, location, size of facilities and size of providers) and quality
Literature review – relationship between

Ownership and quality
- Wide international literature on aged care (USA, UK, Canada, Europe etc.)
- Some USA studies based on very large sample sizes (e.g. Unroe 2012 14,000 facilities)
- Most studies find better quality in NFP providers
  - Most facilities irrespective of ownership type meet minimum standards
  - Despite variation findings are consistent across time (past 30 years) and locations
  - Not conclusive but persuasive
  - Consistent with some economic theories

Size of facility and size of provider
- Not as large and persuasive as the literature on ownership
- USA studies find that very large providers, (> 10,000 beds) provide poorer care compared with smaller size providers (Harrington 2011)
- A number of international studies find that smaller facilities provide better quality than larger facilities (e.g. Amirkhayan 2008)
Literature review - relationship between competition and quality

- Sparse literature specific to aged care
- Most recent UK study finds that competition drives down price AND quality to minimum standards (Forder et al 2014)
- USA studies provide inconsistent findings but some support Forder
- No Australian studies
Structure and Size of the RAC sector in 2014

- **Providers**: 52% NFP, 37% FP, 11% Govt.
- Approximately **85 beds per 1000** persons over the age of 70
- 85% residents are **high care**
- 81% of services high care, 2% low care, 17% mixed
- **Occupancy** rates – 93%
- $13 billion held in **Refundable Accommodation Deposits** (residents’ money) by providers

**Size of the RAC Sector**
- Number of providers: 1,016
- Number of services: 2,688
- Number of places: 189,283
- Total revenue: $14.8 B
- Total Expenditure: $14.1 B
- Total net profit before tax: $711 M (5%)
Trends 2003 - 2012: RAC type and location

No. of services by Location and Org Class; 2003 & 2012

- Major city
- Inner Regional
- Outer Regional
- Remote
- Very Remote

Comparison of services between 2003 and 2012 across different locations and organizational classes.
RAC: Trends in service size & No. beds 2003 to 2012

No. of service by service size; 2003-12

No. of beds by Org Type; 2003-12
Pressure for change, commissioned reviews and recommendations

- Numerous reviews in the 1980s and 1990s
- Most recent: Hogan 2004 and Productivity Commission 2011
  - Findings of both based on neo-liberal ideology
  - Neither did a good job at reviewing the international literature
- Drivers of current reform
  - Major assumptions: markets are better at meeting demand than government control
  - Main theme: more choice for consumers
  - Main objective: to make the system financially viable for governments and providers
Residential Aged Care - Reforms in 2014

- Increased consumer co-payment for care
- Providers must **advertise** prices and charges
- Providers can charge for additional services
- Removed the restriction on collecting a Refundable Accommodation Deposit on high care

**Proposed future reforms**
- Removal of allocations of new places to HCP providers in 2017
- Stated aim for removal from RAC in the future
- Introduction of voluntary reporting of quality indicators
Estimated future demand for RAC; 2014 - 2025

ACFA estimate: an additional 82,000 beds will be built between 2014 and 2023 (130 beds per week)
37,000 new beds were built over the past 10 years
Together with the replacement of current stock: total investment of $33b ($217,000 per bed)

Source: ACFA. 2015, Chart 8.6. page 136
Study Methods

- Semi Structured interviews
- 26 elite stakeholders
- Selected through snowballing methodology
- Evenly distributed between, FP providers, NFP providers, Government, Consumers and consultants/advisors
- Either CEO or senior executive with capacity to influence policy
View of participants from recent research interviews on reforms

• **Elite stakeholders**
  - Recognise the importance of policy and structure but not how they should work together
  - Favour a more market based mechanism for the supply of services
  - Favour competition yet recognise limitations
  - Recognise inconsistency between policy and practice (e.g., *legislation favours not-for-profits but department does not*)
  - Perceptions are not consistent with evidence (e.g. *lack of evidence to support that competition is good for quality, don’t believe there is a difference in quality between FP and NFP*)
Policy Dilemma 1 - support for a market based system

- Stakeholders
  - Recognise market failure outside cities but still believe that a more competitive market will be a better system – a two tiered system
  - Recognise unknown level of competition in the current market for use as a benchmark
  - Some believe FP compete on price and NFP compete on quality
  - Some believe that ‘people know who the good providers are’
Policy Dilemma 2 - different perceptions of ‘choice’

- All stakeholders agree that consumers should have more choice
- Support reforms that promote choice
- Inconsistency on what choice means
  - Choice between home care or residential care
  - Choice between lump sum and weekly payments
  - Choice between providers – but based on what criteria
  - Choice means competition – and competition is good for quality
- Recognise limitations of information on price
- Recognise the limitation of information on quality
Policy Dilemma 3 - role of the not for profit sector

- No consensus on the role of NFPs in aged care
- Some believe NFPs should have a different role to FPs
- Recognise that taxation benefits/no dividends provide a financial advantage but not sure this results in better quality
- Unfamiliar with international literature
- Believe that there is no distinction ACAR based on ownership
- Believe expansion of RAC will favour the FPs
Trends in ownership - comparable countries

• **USA** – FP service increased from 30% to 70% over three decades to 2010
• **Ireland** – FP beds increased from 22% in 1998 to 69% in 2013
• **United Kingdom** – FP beds increased from 18% to 90% between 1980 and 2005
• **New Zealand** – FP services increased from 65% to 76% between 2005 and 2009
• Most of these changes occurred without public debate on the desired mix of service
Summary

- RAC sector will expand by 40% over 10 years by non-government investment
- Future structure will see fewer small providers, more larger providers, larger facilities, numerically and proportionally more FP than NFP providers
- These change in structure (inter alia) are likely to have an impact on quality
- Market based policy may result in a two tiered system – *Major cities and inner regional and the rest*
Conclusions

• Lack of clarity by those influencing policy
  ▫ On what ‘competition’ and ‘choice’ will look like in the future
  ▫ On how competition will drive future distribution of services
  ▫ On the role of the NFP sector

• There is a need for wider community debate on what the future structure of the industry should look like in terms of
  ▫ The role of competition and market forces
  ▫ The mix of FP and NFP services
  ▫ The desirability of a two tiered system based on geography
References

Principal Policy framework for growth - Aged Care Allocation round (ACAR)

- Places per 1000 over the age of 70
  - 1985 - 100
  - 2005 - 108
  - 2007 - 113
  - 2012 - 125 (to be achieved by 2022 by increasing the number of home care places)

*To be achieved by 2021-22*
Background to the RAC in Australia

Residential Aged Care in 2013
- 190,000 residents (75% are high care)
- 2,700 services (facilities)
- Occupancy rates of 92%
- 1,049 providers (mix of for-profit, not-for-profit, govt.)
- $9 billion in annual government expenditure (71%)
- $3.8 billion residents’ payments (29%)
- $13 billion held in accommodation bonds (residents’ money) by providers
- Approximately 85 beds per 1000 persons over the age of 70

Home (aged) care in 2013
- 47,000 Level 1 (16,000 in NSW) – CACP
- 13,000 Level 4 (3,200 in NSW) – EACH
- 5,800 places added in 20132/13
- Occupancy rate Australia 92% (NSW 96%)
- 504 providers and 2,131 services
- $1.16 billion government expenditure (94%)
- $80 (est) recipients contribution (6%)
- Approximately 30 places per 1000 persons over the age of 70
Proportion of aged population receiving RAC & HCP

Less than 1% of those aged 70-74 receive HCP
About 7% of people 65-69 receive CHCP
Use of RAC increases significantly after age 85
About 50% of those aged over 95 are in RAC
About 50% of those over 85 receive CHSP
Only 7% of those aged over 95 receive HCP

Source: ACFA 2015, Chart 6.11 p. 111
Changes in language/labels

Residential care

- WAS: Bond
- NOW: Refundable Accommodation Deposit (RAD)
- WAS: Periodic Payment
- NOW: Daily Accommodation Payment (DAP)
- WAS: Accommodation Charge (for partially supported residents)
- NOW: Refundable Accommodation Charge (RAC)
- WAS: Accommodation Charge (for partially supported residents)
- NOW: Daily Accommodation Charge (DAC)

Home Care/HACC

- Consumer – preferred term by consumer orgs
- Care recipient – used in legislation
- Client and customer – not preferred or defined

30 Sept 2015
Short historical overview

- 1800s – Aged care policy commenced with Governor Macquarie’s and the Benevolent Society – (govt. funding – non-govt. provision)
- 1850 and 1960s – State government provide aged care for limited numbers between
- 1960s – Aust. Government commences capital and recurrent subsidies RAC and some home nursing services
- 1980s – HACC program commenced which combined and increased community based care

- 1990s
  - Funding Home Care Packages (HCP) (not-HACC) commenced
  - States (other than Victoria) progressively withdrew from aged care other than in R&R – now increasing
- 2015 – HACC ends and Commonwealth Home Support Program (CHSP) commences on 1 August

In summary
  - Aust. government now has major responsibility for all aged care
  - Multiple incremental policy changes over the past 50 years
Productivity Commission Review 2011

Findings

Information is not easily available or reliable. Assessment processes are often repetitive and inconsistent, difficult to access and understand and do not support informed decision making. High demand for more choice, lack of independence and transparency in governance.

Recommendations

- Remove supply-side limits on places
- Higher user contributions through a ‘comprehensive aged care means test’.
- Providers should publish up-to-date information on price and quality.
- ‘In the Commission’s view, competition would be a powerful incentive for providers to improve quality and efficiency, and to offer care solutions that better address the needs of individuals’ (Productivity commission 2011 pxxx111)
Government announced reforms 2011

RAC

- Greater access to information for consumers – myagedcare.com.au
- Allows choice between an **Refundable Accommodation Deposits** (RAD) and a **Daily Accommodation Payment** (DAP)
- Providers can charge for **additional services**
- Removes the distinction between **High** and **Low Care** and Extra Services
- Increases **consumer payments** for care – means tested

HCP and HACC

- Changed levels of services
- Expands home care
- Introduced consumer directed care (CDC)
- Increased consumer charges
- HACC to change become an Australian Government responsibility
## Aged Care in Australia 2013-14

<table>
<thead>
<tr>
<th>Metric</th>
<th>HACC</th>
<th>HCP</th>
<th>RAC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of providers</td>
<td>1,676</td>
<td>504</td>
<td>1,016</td>
</tr>
<tr>
<td>Number of services</td>
<td>n/a</td>
<td>2,212</td>
<td>2,688</td>
</tr>
<tr>
<td>Number of consumers/places</td>
<td>775,959</td>
<td>66,149</td>
<td>189,283</td>
</tr>
<tr>
<td>Total revenue</td>
<td>$1.8 B</td>
<td>$1.3 B</td>
<td>$14.8 B</td>
</tr>
<tr>
<td>Commonwealth contribution to total revenue</td>
<td>95%</td>
<td>92%</td>
<td>65%</td>
</tr>
<tr>
<td>Consumer contribution to total revenue</td>
<td>5%</td>
<td>7%</td>
<td>27%</td>
</tr>
<tr>
<td>Other contribution to total revenue $^4$</td>
<td>-</td>
<td>1%</td>
<td>8%</td>
</tr>
<tr>
<td>Total Expenditure</td>
<td>n/a</td>
<td>$1.1 B</td>
<td>$14.1 B</td>
</tr>
<tr>
<td>Total net profit before tax</td>
<td>n/a $^5$</td>
<td>$120 M</td>
<td>$711 M</td>
</tr>
</tbody>
</table>

Source: ACFA 2014 Table i

NB: HACC is now Commonwealth Home Support Program; HCP is Home Care Packages; RAC is Residential Aged Care

30 Sept 2015
Proportion of aged population receiving aged care

CHSP is the most used program
For 70-74 year olds
- Less than 1% receive HCP
- Over 20% receive CHSP
Use of RAC increases significantly after age 85 years
About 50% over 95 are in RAC
About 50% over 85 receive CHSP
Only 7% of those aged over 95 receive HCP

NB: Expansion of the HCP may not significantly influence demand RAC; CHSP estimates only
Source: ACFA, 2015, Figures 4.3, 5.5, 6.11,
Consumers and government funding, 2013/14

HACC sees the most consumers
RAC costs the most
Home care smallest sector

Source: ACFA 2015 Fig1

Australian government funding
Number of consumers
Home Care Packages

- **ACAT** assessment required for access to home care

- **New Program** (HCPP) commenced 1 July 2013 replacing CACPs, EACH & EACH-D
  - Home Care Level 1 - basic care needs 2%
  - Home Care Level 2 - low care needs (previously CACPs) 76%
  - Home Care Level 3 - intermediate care needs 1%
  - Home Care Level 4 - high care needs (previously EACH). 21%

- Met demand (unmet demand not reported) based on ACAT Assessment
  - 30 June 2014 88%
  - 30 June 2013 92%

- In 2013-14 providers made a **10% profit/surplus**

- Planned number of packages per 1000 persons over the age of 70
  - In 2014, 25 packages
  - **By 2023, 45 places**
  - **60% increase** or 60,000 additional package – 34,000 of these by end of 2017
    - Av. of 150 new places a week across Australia
Growth of FP sector in HCP market: to 30 June 2014

<table>
<thead>
<tr>
<th>Level</th>
<th>Not-for-profit</th>
<th>For-profit</th>
<th>Government</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>878</td>
<td>350</td>
<td>75</td>
<td>1,303</td>
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<tr>
<td>Level 2</td>
<td>40,917</td>
<td>4,143</td>
<td>5,097</td>
<td>50,157</td>
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<tr>
<td>Level 3</td>
<td>686</td>
<td>241</td>
<td>83</td>
<td>1,010</td>
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<tr>
<td>Level 4</td>
<td>11,528</td>
<td>1,629</td>
<td>522</td>
<td>13,679</td>
</tr>
<tr>
<td>Total</td>
<td>54,009</td>
<td>6,363</td>
<td>5,777</td>
<td>66,149</td>
</tr>
</tbody>
</table>

- New levels commenced in 2013
- FP providers had 7% of market in 2012 and 10% in 2013
- FP providers have higher growth with new levels - 30% verses 10% of previous levels
- This pattern likely to increase after 2017
Consumer directed care

- CDC theoretically allows consumers **more choice** of services, power over decision making and greater transparency
- **Budgets** prepared with monthly reports
- All home care places are CDC from 1 August 2015
- Can be used for additional ‘nursing, allied health or other clinical services’ BUT there is some lack of clarity around dental services
- Early days in relation to CDC
  - Some authors report wide variations in practice
  - Challenges for case managers making the change
  - Challenges for providers in financial management
  - Loss of cross subsidisation – between consumers and services
Australian Aged Care Quality Agency

**RAC**
- Must maintain accreditation to keep funding
- Accreditation survey every 3 years
- 44 Standards – standard 2.15 Oral and dental care:
  - Care recipients’ oral and dental health is maintained
- Assessors made a determination based on a review of policies and procedures, interviews and records
- No formal performance criteria

**Home care**
- Three standards and three principles
- 18 outcomes – five relate to access and service delivery
- No single way for providers to demonstrate that they meet the standards
- No specified indicators or data collection
- No specific outcomes related to oral health or dental care
Trial of quality indicators

• Quality indicators for RAC widely used overseas
• **Victorian Government** mandates 5 quality indicators related to – pressure ulcers, falls, restraint, poly-pharmacy and weight loss/gain
• **Australian Government** during 2015 trialling 3 indicators – ulcers, restraint and weight loss/gain plus a ‘quality of life’ indicator
• System is likely to be voluntary use of myagedcare website
• No suggestion that dental health would be included as a quality indicator
Policy framework that shape the structure of the aged care industry

- **ACAR**
  - Enables government to control supply of the number of aged care places
  - Allocations made to specific providers in specific locations
  - Based on unweighted regional population >70 years old
  - Allocation to specific providers to be removed for home care by 2017
  - Planned to be removed for RAC in the future

- No articulated preference for FP, Govt. or NFP providers
- Mix of consumer co-payments and government subsidies
  - balance has changed
Trends over the past 10 years - measurement of quality in aged care in Australia

- Overreliance on accreditation
- No distinguishing reporting to guide decisions on quality
- Inadequate development of benchmarks and indicators
- Victorian experience with quality indicators
- Current quality indicator project