SUMMARY OF KEY ISSUES – National Health & Hospitals Reform Commission

Recommendations	Comment	Issues to be considered
Overall Report: Contains 123 recommendations Recommendations 42 to 53 relate to 'Increasing choice in aged care'. Recommendations 54 57 relate to 'Caring for people at the end of life'.	ACAA endorses the release of the report which can be a major driver of reform in the health and aged care systems in Australia. The Report sets out key reform priorities for both health and aged care. However the narrative and the recommendations are often difficult to marry-up. The Prime Minister has approved a six month consultation process before the Government will commence the task of formally deciding on a Government response to the 123 recommendations.	Does the Report deal satisfactorily with the issues of acute care, primary care and aged care integration?
ISSUE 1: Aged Care Planning and Allocation Process **Recommendation 42** Removal of restrictions on number of aged care places an approved provider can put in the market place with the objective of increasing competition and supply **Recommendation 42** Change the allocation formula from beds per thousand aged over 70 year to beds per thousand aged over 85	**Report proposes abolition of ACAR Round** Remove current restrictions on the number of places an approved provider can offer. The claimed intention is to generate more aged care places, and by association consumer choice and investment by uncapping supply. However, demand and price remain substantially capped which means basic economics is being ignored. The removal of value in the allocated licenses could negatively affect the value of care providers, asset base and therefore impact their borrowing/financing capacity. **ACATs to determine place numbers** Note that the total number of places per region is proposed to be effectively controlled via the ACAT assessment process. That is, presumably the ACAT is allocated a certain number of places per region and this number is the same as would have otherwise been allocated via the ACAR round process.	Concern that 'competition theory' is flawed in regard to the 'ACAR' round and 'competition'. Government retains price control. Government retains funding control. Government retains regulation control. Thus would 'competition' work in practice? Serious concern that there would be an 'over supply' in areas which are 'attractive' to providers eg Eastern Suburbs but limited interest in low income, rural and remote areas. Homeless? Disadvantaged? Fundamental Question – What is the view of ACAA members on this competition proposal? Are there any changes suggested about how this 'competition' proposal could be modified? What would be the impact on your financial status if Government adopted recommendation 42? What is the status of the approved provider? Does DoHA retain control over who can provide aged care services?

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ISSUE 2: Bonds in High Care and Consumer Contributions to cost **Recommendation 43** Accommodation bonds or alternative approaches as payment options for accommodation in high care provided that removing the regulated limits on the number of places has resulted in sufficient increased competition in supply and price.	It is important to note that the NHHRC Report raises the key issue of 'bonds in high care'. It is a positive for our industry that this issue was formally raised in the final report. As there is already a 7% oversupply in the industry today it remains unclear as to when the Commission considered it appropriate for bonds to be introduced into high care. Is it 10% vacancy levels or 15% or higher?	The industry has been calling for a solution to capital income capacity for many years. What are the solutions aged care should be prepared to accept and when if government continues to reject bonds as a solution?
Recommendation 48 That people who can contribute to the costs of their own care should contribute the same for care in the community as they would for residential care (not including accommodation costs).	There is a proposal for more consistency in user payments across aged care. Again it is suggested that this is a sensible step. With the objective being to give consumers greater choice then financial contribution options should be placed on a par with care service options as well as subsidy support options.	There would be broad industry support for more consistency in user payments, but a lack of detail about what is envisaged. Comments and suggestions on how such a scheme might work would be appreciated.
ISSUE 3: Flexible Range of Care Subsidies **Recommendation 47** That there be a more flexible range of care subsidies for people receiving community care packages, determined in a way that is compatible with care subsidies for residential care.	The report notes there are effectively only 3 steps in community care services and subsidies. That is, HACC, then CACP then EACH/EACH D. The report recommends a more flexible range of care subsidies for people needing community care. The 'Implementation Plan' at the rear of the Report (Appendix H) proposes five new funding points between the current CACP and EACH levels. The proposal for five additional funding points	Are there any impediments to a seamless funding stream that reflected the clients needs? ACAT re-assessment should not be necessary when moving from one level to another. Will this proposal enhance consumer

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	between CACP and EACH would have significant benefit provided 'consumers' could seamlessly move from one level to another as their needs changed.	choice? Are aged care providers supportive of the concept?
ISSUE 4: Greater Consumer Choice **Recommendation 49** That people supported to receive care in the community should be given the option to determine how the resources allocated for their care and support are used.	This recommendation creates the first step in a series of recommendations that enhance consumer choice. Individuals get an opportunity to receive direct funding via some form of 'personal budgets' which they control or more transparently negotiate with a service provider.	Are aged care providers supportive of this recommendation to enhance consumer choice?
Recommendation 50 That once assessment processes, care subsidies and user payments are aligned across community care packages and residential care, older people should be given greater scope to choose for themselves between using their care subsidy for community or for residential care.	Individuals get greater choice between community and residential aged care	Are providers of residential care concerned that this recommendation is likely to impact demand in residential care? Or are frailty and dependency levels now such that this recommendation is unlikely to impact residential care demand?
Notwithstanding this, we note that, given the increase in frailty and complexity of care needs, for many elderly people residential care will remain the best and only viable option for meeting their care needs.	This recognizes the limitation of enhanced community care where inadequate voluntary carer support is available and residential care is the only option.	Do aged care providers agree with this assessment?
The level of care subsidies should be periodically reviewed to ensure they are adequate to meet the care needs of the most, frail in residential settings.	ACAA has argued for many years that a regular , at least five yearly, benchmark cost of care, independent analysis of the actual cost of care is required, if Government and industry are to understand what it is that providers are expected to provide, at what quality and in what volume?	Is a benchmark cost of care supported by the industry? If adopted is a five year review process sufficiently frequent?

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In the lead up to freeing up choice of care setting, there should be a phased plan over five years to enable aged care providers to convert existing low care residential places to community places.	In relating this recommendation back to recommendation 42 & 43 there is a clear need for Government to understand that if the capital stream created in low care due to lump sum contributions disappears because providers move the places into the community and inadequate provision is made for capital raising from other sources then infrastructure spending will become frozen.	Will this option be attractive to aged care providers? Is it likely to impact industry capital raising capacity? Are there other alternatives that should be considered?
Recommendation 44 Information to support effective decision making - availability of standardised information about aged care providers to support effective decision making	Additional information about 'provider performance' posted on a website for consumers to exercise greater choice.	Will this recommendation achieve the objective? What information should be displayed? Where should the information be displayed?
ISSUE 5: HACC and ACAT to the Commonwealth **Recommendation 45** Consolidating aged care under the Commonwealth Government by making aged care under the Home and Community Care (HACC) program a direct Commonwealth program.	This issue has been on the COAG agenda for at least two years. When previously considered by the aged care industry it has received general support. It would mean transferring approximately 540,000 HACC clients from state responsibility to Federal Responsibility.	Are there reasons why ACAA would not support this recommendation?
Recommendation 46 Development and introduction of streamlined, consistent assessment for eligibility for care across all aged care programs. This should include: • transferring the Aged Care Assessment Teams to Commonwealth Government responsibility; • developing new assessment tools for assessing people's care needs; and integrating assessment for Home and Community Care Services with more rigorous assessment for higher levels of community and residential care.	Transferring of HACC aged care clients to Federal responsibility would almost automatically drive systems change for common assessment tools across the whole aged care program. Under the current structure if ACATs are to continue in the role of gatekeeper then it would appear essential that their role, function and accountability move from state/territory control to federal government	Creation of industry wide consistent tools would make sense. Are there any alternate views? Is there any objection to Federal Government takeover of ACATs? Is there any reason why ACATs should not be responsible for gatekeeper assessment functions?

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ISSUE 6: Better and innovative use of technology and communication **Recommendation 53**		
• The safety, efficiency and effectiveness of care for older people in residential and community settings can be assisted by better and innovative use of technology and communication such as:	The Report proposes a substantial increase in the use of technology in both residential and community care settings.	Is there broad industry support for greater use of technology?.
• supporting older people, and their carers, with the person's consent, to activate and access their own person-controlled electronic health record;	There is little doubt that people are interested in having greater control over their health information. Access to personal data will enhance this control and personal responsibility	How will consumers gain access to such support?
• improved access to e-health, online and telephonic health advice for older people and their carers and home and personal security technology;	Supporting a person in their own home with assistive technologies and electronic health records will add to the capability of service providers and workforce efficiency	There is currently no funding mechanism available in Australia to support consumers or their care providers to procure and deploy many assistive technologies currently available. What strategies do aged care providers suggest should be employed?
• increased use of electronic clinical records and e-health enablers in aged care homes, including capacity for electronic prescribing by attending medical and other credentialed practitioners, and providing a financial incentive for electronic transfer of clinical data between services and settings (general practitioners, hospital and aged care), subject to patient consent; and	Recent uptake by aged care providers of a range of IT technologies can clearly demonstrated the industry is using such technologies to improve performance and achieve workforce efficiencies. Enabling e-prescribing, electronic dispensing and supported electronic medication administration will further improve efficiencies, productivity and avoid adverse medication administration events.	What type of assistance would aged care providers need to participate in a broad range of IT initiatives
• the hospital discharge referral incentive scheme must include timely provision of pertinent information on a person's hospital care to the clinical staff of their aged care provider, subject to patient consent.	Hospital/aged care clinical documentation transfer is a constant problem for aged care staff. An electronically enabled discharge/referral system would improve workforce productivity.	It is assumed a solution to this issue would receive universal support?

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ISSUE 7: Staff Training **Recommendation 51** That all aged care providers (community and residential) should be required to have staff trained in supporting care recipients to complete advance care plans for those who wish to do so.	Advanced care plans have been demonstrated to reduce end of life admissions to hospital and to receive favorable responses from the families of care recipients as a preferred to course to end of life care.	Does this represent aged care providers view of future service provision?
ISSUE 8: Funding for sessional and on-call medical care **Recommendation 52** That funding be provided for use by residential aged care providers to make arrangements with primary health care providers and geriatricians to provide visiting sessional and on-call medical care to residents of aged care homes.	Attracting and retaining sufficient servicing GPs in aged care is proving difficult in many parts of Australia. ACAA has argued for some years that the existing funding arrangement with GPs needs to be restructured to allow a bulk contract or service retainer to be negotiated.	Are there any reasons why aged care providers would not support this recommendation?