About HammondCare

Established in the 1930s, HammondCare is an independent Christian charity specialising in dementia care, palliative care, rehabilitation and older persons' mental health services. HammondCare is acknowledged as Australia’s leading provider of dementia-specific aged care services and is dedicated to research and supporting people who are financially disadvantaged. HammondCare’s mission is to improve quality of life for people in need, regardless of their circumstances.

We currently operate 800 residential aged care places across New South Wales and Victoria, 80 per cent of which operate in specially designed dementia-specific cottages. We also provide Special Care Programs for people displaying severe behavioural and psychological symptoms of dementia. On any given day, HammondCare provides home care services to 2,000 people. Our HammondCare At Home services provide care for older people, people living with dementia, palliative care patients, and respite and counselling for carers. HammondCare’s Dementia Centre is recognised in Australia and internationally for its high quality research, consultancy, training and conferences in the area of best-practice dementia care.
Whether unmet demand has been reduced

It is not possible to accurately assess the demand for aged care services and the extent to which it is being met using available data. There are no real measures of aged care demand currently taken and the proxy measures are limited in their application.

The existing planning ratios, based on the population aged 70 and over, which have been used historically to determine supply are not necessarily linked to current or future demand. In addition, changes that have come about as a result of the current round of reforms may also have influenced resident and client patterns in using and accessing care, and these must be considered as well.

Timeliness in accessing care

One way to measure whether supply for aged care places is meeting demand is to look at trends in the time it takes for residents to enter residential care or commence on a home care package after being approved for care by an Aged Care Assessment Team (ACAT). The tables below show the time taken by prospective residents and clients to commence care after receiving approval from the Aged Care Assessment Service, (ACAS) from 2011-12 to 2014-15 (adapted from AIHW 2016a & 2016b). Insert text here

Table 1: Elapsed time between approval and entry into residential aged care

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<tbody>
<tr>
<td>≤ 7 days</td>
<td>18.2</td>
<td>18.1</td>
<td>16.0</td>
<td>9.8</td>
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<tr>
<td>≤ 1 month</td>
<td>44.3</td>
<td>43.9</td>
<td>41.2</td>
<td>30.6</td>
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<tr>
<td>≤ 3 months</td>
<td>69.9</td>
<td>69.2</td>
<td>66.7</td>
<td>58.4</td>
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<tr>
<td>≤ 9 months</td>
<td>89.3</td>
<td>88.2</td>
<td>86.7</td>
<td>81.3</td>
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Table 2: Elapsed time between approval to Community Aged Care Packages (CACPs)/Level 1 & 2 Package and commencement

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<thead>
<tr>
<th></th>
<th>2011–12* (%)</th>
<th>2012–13* (%)</th>
<th>2013–14** (%)</th>
<th>2014–15** (%)</th>
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<tr>
<td>≤ 7 days</td>
<td>10.7</td>
<td>9.9</td>
<td>8.2</td>
<td>9.4</td>
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<tr>
<td>≤ 1 month</td>
<td>39.1</td>
<td>35.1</td>
<td>31.0</td>
<td>33.6</td>
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<tr>
<td>≤ 3 months</td>
<td>69.5</td>
<td>65.4</td>
<td>59.5</td>
<td>57.6</td>
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<tr>
<td>≤ 9 months</td>
<td>93.6</td>
<td>92.1</td>
<td>87.1</td>
<td>80.1</td>
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*CACPs
**Level 1 & 2 Packages
On the surface, these tables appear to indicate an increase in unmet demand for aged care services. However, there are a number of significant limitations in using this data as a proxy measure for unmet demand.

As the Productivity Commission has noted (2016; 13.23), the measure of elapsed time must be interpreted with caution. Time elapsed between approval and commencement of service does not directly correspond to time spent actively waiting to commence a service, as people may receive approval with no intention of accessing a service immediately.

It may even be that recent reforms have increased the time taken by residents and clients before they commence services. The stronger emphasis on choice, coupled with greater levels of information about services, may well have prompted people to begin investigating aged care options earlier and to spend more time deliberating over the available options.

The changes in care levels as the result of the recent reforms – such as the removal of the distinction between high and low care and the transition to four, rather than two, levels of home care packages – have also reduced the usefulness of comparisons over time. While acknowledging that, these trends may still give some indication of changes in demand and should continue to be monitored.

Looking to the future, it is important to obtain a clearer understanding of the true level of demand for aged care services and the extent to which it is being met. The introduction of the prioritisation process for accessing Home Care Packages in February 2017 will also help to determine the demand for those services and the extent to which it is being met. To address the data gap further, the Australian Government should do more to determine the actual demand for aged care services.

This process could include a voluntary survey among prospective residents and clients (or their representatives) who are seeking approval to access aged care services through My Aged Care to determine whether they were able to access services when and where they were needed in a timely manner. Such a survey could provide new insights into the demand for services that could assist in formulating future aged care policy.

Responses to reforms transforming aged care demand

HammondCare believes that a number of changes brought about by recent reforms will have a significant impact on the nature of aged care demand more generally, and this should be considered in the current review process. One example of a change brought about by current reforms is the ‘banking’ of home care package budgets by clients with higher care needs.

HammondCare has increasingly noticed that under a consumer directed care (CDC) approach, a number of home care package clients are focusing on building or maintaining balance in their package budget, potentially at the risk of their own wellbeing. This practice of holding onto large portions of package budgets is particularly common among the higher package levels, with unspent funds for Level 3 and 4 packages currently in excess of 11 per cent nationally, according to an analysis by Stewart Brown (Belardi 2016).

This is particularly concerning given that high level home care packages were originally designed to provide care and support to people who would otherwise require permanent admission into high level residential aged care. An evaluation of the pilot of the Extended Aged Care at Home program – Australia’s first ever high level home care program – found that the program was delivering a
level of care equivalent to high level residential care (in Garland 2009, 10). At the time, a key
differentiating feature of this innovative approach was the significant amount of direct care hours it
enabled.

If Level 3 and 4 clients continue to ‘bank’ their care hours, we believe there is a significant risk that
they will undermine the effectiveness of their care package. Should this trend continue, increasing
numbers of high level care recipients could be admitted prematurely to residential aged care,
altering the flow on demand for those services. Given that the majority of older Australians wish to
remain in their own homes for as long as possible and policy decisions have been made to support
this, it would be a perverse outcome. At this stage, there is insufficient data to determine the extent
to which this is occurring however, HammondCare will continue to monitor new data as it emerges.

Another aspect of the current reforms that has influenced demand is the move to individual
budgets, coupled with the requirement, from 27 February 2017 to return unspent funds to the client
or their estate and the Commonwealth Government when they finish using a package. Previously,
when a community care client’s needs increased, service providers were able to cross-subsidise or
use unspent funds to meet their increasing care needs. However, providers are now unable to
provide a level of care above the client’s allocated budget amount. For higher level home care
package clients, the inability to extend a care budget using unspent funds can increase the risk of
admission into residential care.

Recommendations

That the Australian Government conduct surveys among people seeking approval to receive care
(and their carers) in order to determine the extent to which demand is being met.

That the Australian Government monitor the effects of ‘banking’ CDC package budgets on
admission to residential aged care.

Approved providers should be able to retain the Commonwealth portion of unspent funds for
clients who have left the Home Care Package program. This would serve as a mechanism for
meeting sudden increases in demand, reducing the risk of premature admission to residential aged
care.

Whether the number and mix of places should continue to be controlled

HammondCare supports the opening up of the aged care market. In accordance with its goals of
improving quality of care and increasing choice for service users, the Australian Government
should move towards loosening the control over the distribution of aged care places. This will help
to increase much needed choice and competition in the aged care sector more broadly.
HammondCare encourages the removal of the rationing of aged care places by geographic region,
enabling providers to offer services where they identify a need.

HammondCare welcomes reforms which allow Home Care Package subsidies to ‘follow’ the client.
This gives them greater control over their package, and more opportunities to change providers if
they are unsatisfied with their care or wish to move.

We also encourage similar arrangements in residential care. With nationwide occupancy for
residential care at 92.4 per cent (DoH 2016, 44), prospective residents and clients have very little
true choice. HammondCare believes that high quality care can only be achieved when competition
increases and overall occupancy levels diminish. A removal of the allocation of residential places in specific geographic regions would enable providers to establish services in new locations in response to emerging and identified needs.

An opening up of supply, with continued protections such as approval for providers and accredited services, will also filter out poor quality providers and put pressure on underperforming organisations to improve their services.

Historically the Australian Government has ensured that its outlays remain within the fiscal envelope by limiting the number of licences to operate aged care places and beds. This approach is a legacy of the pre-digital age and is now outdated, imposing an artificial restriction on supply. A more appropriate approach to allocating care resources, while still protecting the federal budget, is to maintain an upper limit on the number of clients and residents who will be eligible for aged care subsidies at any point in time, irrespective of how many places exist. This means supply, competition and choice and control for prospective service users can all increase, while remaining within the fiscal envelope. We therefore support maintaining caps on the number and mix of subsidised places available by controlling the number of clients or residents approved for care.

Before an opening up of supply in residential care occurs however, measures must be developed to ensure there is adequate supply of services for older people in rural and remote locations. With smaller, more dispersed populations, these areas are often not capable of sustaining a genuine aged care market. HammondCare supports Assistant Minister for Aged Care, Ken Wyatt’s commitment to establish a secure model for residential aged care in rural and remote areas (O’Keeffe, 2016) before freeing up supply more generally.

As the removal of the artificial restraints on supply for residential care is a crucial step in reforming aged care, a sustainable model that ensures adequate supply in rural and remote locations must be developed as a priority. There is merit in considering baseline subsidies for aged care providers operating in areas that are unable to support a sustainable aged care market. Elsewhere in the health system, the government provides incentives for the provision of services in rural and remote locations and this should be considered for aged care services in these areas as well.

**Recommendations**

*The Australian Government should remove the licences and allocations process for providing aged care places while maintaining caps on the number of clients and residents who are eligible to receive Government-subsidies.*

*Alternative approaches must be developed for residential care in rural and remote locations that are unable to support a sustainable aged care market as a priority. These could include baseline subsidies and government incentives.*

**Further steps towards a demand driven model**

A key assumption underpinning current discussions about a demand driven approach to care is that aged care ‘consumers’ will be able to choose the setting where they receive care: either in their own home or an aged care home. HammondCare believes this is a false choice. For the vast majority of older Australians, a permanent move into residential aged care is a matter of necessity rather than a true choice.
The purpose of residential care is to support people who are no longer able to live independently at home, even with support from family members, friends and home care services. In effect, it is a decision of last resort.

According to Australian and international research, the most common reason for permanent admission into residential aged care is a growing burden on the informal or family carers who support them (McCallum et al 2005, 171). This is particularly the case for people living with dementia. In fact, there is a general consensus that dementia is one of the main reasons why people require the type of around-the-clock supervision and support provided by residential aged care (Yates 2010; Kendig et al 2010, 347).

While few people choose to move into permanent residential aged care, those that do often report significant improvements both for themselves and their family carers. It is important not to dismiss or downplay the value of residential care as it improves the quality of life for many older people – particularly those living with dementia – and their carers when life at home becomes overwhelming. However, we do not support the notion of a single aged care system where people are given a care budget and simply told to ‘choose’ the type of services they use and the setting where they access them.

If older people or their carers reach a point where remaining at home is impacting adversely on their wellbeing, they should be able to enter the residential aged care service of their choice. However, the decision to opt for care at home or in an aged care home should be guided by need and expert advice, and not simply be seen as a matter of personal choice or ‘preference’. This is why the role of aged care assessors and care coordinators working for approved providers remains fundamentally important.

**Recommendation**

*That approval for access to permanent residential care on the basis of need should be maintained.*

The effectiveness of means testing arrangements

**Standardised means testing**

Means testing for aged care services should be standardised so that contributions from clients and residents are based on an assessment of the client’s income and assets. Sustainability in the aged care sector demands that those who can afford to do so, should contribute to the cost of their care. HammondCare supports this direction however stresses that any changes in this area must be made in a staged progression and that provisions must continue to be made for those with low or limited means.

The Australian Government should encourage the development of different mechanisms to assist older Australians to access equity in their homes, while providing more public information about these options. This may include the development of a government-backed equity release scheme and should have the aim of helping older people with low incomes expand their care options and choice, while balancing sustainability in the sector.

**Alignment of charges**
As previously stated, the idea that aged care clients have ‘choice’ between home care and residential care is misleading since the service they use ought to be based on need, according to expert guidance from assessors and approved providers.

HammondCare believes that ‘type of care’ ought to be directly correlated to determined need. In our experience, residential and home care services are designed around different needs, offering distinct services and therefore having very different costs associated with them. For example, the nature of the services and the level of input required to deliver them is not equal. The around-the-clock nature of residential aged care makes it much more responsive to resident needs than home care services could be, providing greater levels of care to more people. As a result, the costs and financial modelling underpinning these services are distinct.

It follows that charges should not be aligned between residential and home care services. Charges should not only be based on a person’s means, but should also reflect the type of service that is being provided.

**Recommendations**

Means testing should be standardised and service users who can afford to do so, should contribute to the cost of their care.

Charges should not be aligned since residential and home care services are distinct services with distinct outputs relating to need.

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The effectiveness of arrangements for regulating prices for aged care accommodation

HammondCare supports the arrangements for regulating prices for aged care accommodation that began in July 2014. The current arrangements enable prospective residents and their families to make informed decisions about aged care homes based on their price while providing a clear starting point for discussions with providers. The role of the Aged Care Pricing Commissioner ensures that residents can be confident that higher prices have a fair and reasonable justification. At the same time, providers with differentiated residential aged care offerings are able to set prices that reflect that difference.

The effectiveness of workforce strategies

In parallel with the trajectory of Australia’s ageing population, the aged care workforce must continue to grow for decades. The Productivity Commission estimated in 2011 that close to a million additional aged care workers would be needed by 2050 (2011, Vol. II 367), a figure which may also be impacted by the projected decline in the ratio of informal carers to older people. It is also clear that changing care models and responses to the current wave of reforms will impact on future workforce requirements. Given this, aged care planning and regulatory frameworks must be flexible enough to consider new and innovative care approaches.

At the same time, education for nurses and other care staff should provide opportunities to develop specialised skills and knowledge in areas relevant to aged care. Currently, significant numbers of registered nurses complete their degrees with minimal training in aged care and dementia.
However, nurses should be given the opportunity to develop expertise in areas of practice that are relevant to aged care, including dementia and mental health nursing. Once they have graduated, registered nurses should be able to be recognised as specialised aged care nurses who provide clinical leadership and consultation as part of multidisciplinary teams working within innovative models. This will help to redress the negative perceptions of aged care nursing by recognising the skills and leadership that nurses can bring to bear in the aged care environment.

There is also a significant opportunity to develop a pipeline of care service employees among senior secondary students and school leavers who do not wish to pursue tertiary qualifications with an academic focus. To do this, it is important to have strong links between vocational education providers and high schools in conjunction with messages which highlight that technical training is a valid pathway into the workforce – and not just a fall back option for people who ‘miss out’ on a place at university.

Further work must be done to monitor the impact that a market approach has on the aged care workforce. Researchers in the UK have examined the way that consumer driven approaches to care have affected the care workforce. They have found that employees working for services providing individualised budgets are anxious about increases in fragmented hours and split shifts (Cunningham & Nickson 2010, 14). At the same time, other researchers have found strategies to promote relationship building and consistency of care staff (for example, regularly matching care workers with the same clients or residents) are critical to improving both the quality of care provided and the job satisfaction of care staff (Castle 2011). It is essential that the transition to a market-based approach does not have unintended consequences for aged care staff at a time when the workforce must grow significantly.

Recommendations
Any aged care workforce strategy must include the need to:

- develop targeted training about dementia and aged care in undergraduate nursing courses; and
- forge links between aged care vocational education providers and high schools.

The impact of a CDC approach on aged care staff in Australia must continue to be monitored.

The effectiveness of arrangements for protecting refundable deposits

The Aged Care Accommodation Bond Guarantee Scheme has so far proved to be a successful mechanism for protecting refundable deposits and accommodation bonds. The National Commission of Audit (2014) reported that since its introduction in 2006-07, the Scheme has been brought into play on only five occasions, paying out a total of around $25 million. The Australian Government is currently able to impose a levy on all providers holding refundable deposits to recoup the shortfall should a provider default – but has not yet done so.

In recent years, the amount of refundable deposits being held by residential aged care providers has been increasing significantly. On 30 June 2015, approved providers held close to $18.2 billion in refundable deposits (ACFA 2016, 156), up from a figure of $10.6 billion five years earlier (DoH 2011, 84). In response to this trend, the National Commission of Audit (2014) recommended that the Australian Government either:
• Issue a fee to aged care providers to access the guarantee scheme; or
• Require that they obtain insurance from the private sector.

Originally, the Australian Government also planned to require residential aged care providers to take out private insurance for any refundable deposits they held. However, after receiving feedback, it concluded that there was a lack of appropriate insurance products available (Australian Government 2013, 7).

HammondCare has adopted a sound prudential approach to managing the risks associated with accommodation bond liabilities by establishing a financial reserve. The levels of this financial reserve are based on independent actuarial advice and are subject to external review at least every three years. HammondCare has also developed a number of liquidity performance measures to ensure it has the ability to meet its short, medium and long term financial obligations based on this same expert advice. Taken together, these measures serve as a form of self-insurance.

Whatever approach the government adopts, we believe providers that have adopted robust measures to manage the risks associated with their obligations arising from refundable deposits should be exempt from any fee or requirement to obtain private insurance. HammondCare supports an approach that assesses the financial strength of residential providers, rather than imposing additional cost burdens arbitrarily. Even with an insurance-type approach the assessment of the cost of insurance for each provider would be subject to question, unless there was clear transparency around the determination of risk and related cost for each provider according to their level of potential exposure. Providers that can demonstrate that they have taken adequate steps to insure themselves against any risks related to refundable deposits should not be required to participate in any additional scheme.

The Australian Government’s aim should be to ensure that aged care providers are managing their respective financial exposures so there is certainty of their future ability to provide quality care and pay any obligations to residents.

**Recommendation 1**

Those providers that have taken adequate steps to manage the risks associated with refundable deposit liabilities ought to be exempt from any fees, levies or insurance requirements.

**Other comments**

**Balancing choice with need**

HammondCare supports initiatives that give aged care service users greater choice and control in the delivery of their services. However, it is essential that choice and control for residents and clients are balanced and influenced by identified need.

HammondCare believes it is important to maintain the role of aged care assessment services and providers in assisting service users to understand their individual needs and to navigate the complex range of aged care services. If older Australians do not receive sufficient guidance in making choices about aged care and their needs remain unmet, the result will be a poorer quality of life at the individual level, and an unnecessary increase in the demand for more intensive and costlier care services.
Clients and residents should continue to have a relationship with a primary provider to maintain a level of professional accountability for the care and services they use. As reforms to the aged care system open up greater opportunities for choice, the Australian Government should continue to recognise the value of guidance and support for service users through arrangements such as case management and care coordination.

In a home care setting for instance, case managers work with clients to better understand their needs and preferences, assist them to identify achievable goals, network within the local area to efficiently and effectively utilise their budgeted care amounts and deliver on individual choices.

The value of case management is supported by a range of studies. There is evidence that older people living in the community who access care through a case management approach have improved function, better medication management, have greater use of community services and are less likely to be admitted to residential aged care (Low et al 2011, 3). In addition, studies looking specifically at case management programs for people with dementia have found that they have lower rates of institutionalisation and report higher health related quality of life. There is also some evidence that informal carers who are using a service with case management had higher confidence in caring (Low et al 2011, 5-6), reducing the risk of permanent admission to residential aged care.

For some groups, including people who are homeless or at risk of becoming homeless, concerns have been raised about a reduction in case management under CDC, including the face-to-face contact hours which helped to build trusted relationships. This was found to negatively impact both clients and staff (KPMG, 2015, 50). It is crucial that any moves to give older people greater choice and control do not inadvertently disempower them, by undermining the valuable guidance and support offered through services such as case management.

**A CDC approach in residential care**

Decision makers have begun to explore options for adopting a CDC approach in residential aged care. Early discussions in this area have considered individualised budgets in residential care, but have achieved little consensus (KPMG 2014, 4). HammondCare supports the right of aged care residents to exercise choice but we strongly believe that introducing care budgets in a congregate living environment such as residential aged care setting is not the way to achieve this.

Our primary objection to introducing an individualised care budgets in residential care is that it relies on the assumption that a person’s care and accommodation in a residential care setting can somehow be separated in a congregate living environment. For individualised budgets to work, an aged care home becomes a mere housing destination into which care can be delivered – by any number of providers.

Yet while it is appropriate to set separate prices for care and accommodation, the reality of service provision demands that they work together. HammondCare believes that the care environment and the model of care in aged care homes ought to be complementary. A well-designed environment will not achieve its intended therapeutic effect unless it is coupled with an appropriate and interrelated care model. If the accommodation and care components within a residential aged care setting were to be separated, with itemised individualised care delivery, the model of care would be diluted.

Individual care budgets are also poorly suited to congregate living arrangements, where the rights of each individual must be balanced with the rights of others and the collective rights of the group.
of residents. They would make it more difficult for providers to effectively meet the fluctuating needs of all residents within a home. If introduced to residential aged care, individualised budgets would also increase costs for residents, providers and government alike, by raising administrative costs and preventing economies of scale from being achieved.

Many permanent aged care residents do not have the cognitive ability to manage budgets on their own. More than 50 per cent of residents have a formal diagnosis of dementia (AIHW 2016c) – but it is likely that there are many more living with dementia. As another experienced aged care provider has suggested, the overwhelming majority of people entering residential care are not seeking to coordinate or manage their care arrangements at a budget level but rather, value the opportunity to choose the way their care is delivered and how they interact with care providers (ACH in KPMG 2014, 18).

Regardless of setting, it is critical to remember that the reason for introducing individualised budgets is to facilitate choice; individualised budgets are a means to a greater end – choice and control – and are not an end in themselves. In a residential aged care setting, we believe there are many more appropriate and effective ways of enabling resident choice, control and autonomy.

With a supportive model of care, residents already have the opportunity to display autonomy, exercise choice and communicate with care staff without having to introduce individualised budgets. The focus in residential care should be on maximising choice, autonomy, citizenship and rights rather than introducing individualised budgets.

Choice without budgets

Attempts to conceptualise CDC in a residential aged care setting have identified a number of characteristics that enable greater ‘consumer direction’ (KPMG 2014, 15-16). They include:

- Returning control and decision making to residents in all areas of life, including daily routines.
- Allowing residents to engage in the ‘dignity of risk’ in an individualised manner.
- Empowering direct care staff and equipping them with the skills to make decisions on behalf of and with residents.
- Transforming facilities into homelike environments.
- Incorporating a restorative care approach.

HammondCare strongly supports these principles which broadly align with our organisation’s model of care. We aim to enable choice and autonomy for residents in all our aged care services. Any effort to improve choice in residential aged care should focus on these objectives rather than the narrow pursuit of individualised budgets.
References


Australian Institute of Health and Welfare (AIHW), 2016a. *Residential aged care and Home Care 2014–15 supplementary data: Figure 1: Elapsed time between approval and entry into permanent residential aged care, as a cumulative proportion of first admissions in a year, 2005–06 to 2014–15.*

Australian Institute of Health and Welfare (AIHW), 2016b. *Residential aged care and Home Care 2014–15 supplementary data: Figure 2: Elapsed time between approval for and entry into CACP (up to 2012–13) and Home Care levels 1–2 (from 2013–14), as a cumulative proportion of first admissions in a year, 2005–06 to 2014–15.*


