Sustainable high quality aged care

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Summary

This is a submission to the Royal Commission into Aged Care Quality and Safety, made on behalf of consumers. It addresses the revised funding, financing and prudential regulation propositions, and takes into account evidence at the September 14 to 22 hearings.

Major threats to sustainable aged care include poor quality measurements, poor assessment processes, uncontrolled financial reporting and provider failures.

We have proposed that automatically monitored care data be transmitted to a central agency and the provider, together with automatically-generated messages to the provider where help to a person seems needed. The Department of Health should lead research on automatic monitoring and data analysis, bearing the development costs, and paying providers to instal equipment.

Activity based funding arrangements have the potential to provide fair stable funding. But the 2019 AN-ACC proposal is complex, inadequately based, and may disadvantage persons with dementia or obesity.

Standardised reporting, and restrictions on provider structures and related party transactions, are needed to prevent under-reporting of profits. Profits and capital adequacy should be publicly reported each quarter.

Increased supply of home care, and more stringent quality and financial prudential requirements, may result in more failures of residential care providers. Better support of regional providers is needed, together with plans to deal with large provider failures.

1. Introduction

1.1 Purpose of the Sydney hearing from 14 to 22 September 2020

The Commission is required to inquire into “how best to deliver aged care services in a sustainable way” (term of reference f).

In its “Revised funding, financial and prudential regulation hearing process - 13 September 2020”, the Commission said [1, p1]

“This hearing will inquire into the financing and sustainability of future improvements in the aged care system…

The hearing will also inquire into…

- *Whether sustainable high quality care is best secured by funding from consolidated revenue…*
- *Whether the funding available to providers under the current aged care system is sufficient to support the provision of high quality aged care…*
- *Whether the prudential regulation system … is adequate to ensure the sustainability and stability of the aged care system…"*

1.2 Threats to sustainability

This submission considers the following threats

- Poor measurements of aged care quality can lead to uneven quality, with public disclosures of unacceptable care reducing confidence in the system
- Poor assessments of the care needed by individuals can lead to continuing increases in Commonwealth funding, in excess of anything justified by recipient numbers, wage inflation or acuity increases
- Uncontrolled financial reporting can lead to under-reporting of provider profits, creating an exaggerated need for more funding
- Failure of a large provider can lead to difficulties caring for residents.

Some of these threats, such as failure of a large provider, can create large short-term problems, which could be described as instability. But we prefer the term sustainability, which applies to all the above threats. An unstable system is likely to be unsustainable.

1.3 Modification of proposition FF7

Proposition FF 7 suggests the use of casemix adjusted activity based funding. In 3.3 we suggest the reference to casemix is undesirable, as there are many statistical ways of linking funding to the characteristics of individuals.

1.4 Unacceptability of proposition FF12

We do not accept proposition FF12. It seems inconsistent with the provision of care by for-profit providers. The quality of the care provided should be carefully measured, with penalties for care below a high standard. Requiring acquittal of input funds could be a reversion to the litigious CAMS system applying before 1997.

1.5 Other funding, financing and prudential regulation propositions

We have not had time to consider the propositions in any depth, but they seem reasonable. We would like to see much more information provided to consumers, particularly about capital adequacy, quality of care and residential occupancy rates.

2. Aged care quality measurements

2.1 Better quality control from better quality measures

In a submission to the Commission in February 2019, Richard Cumpston and Kasia Bail said

"Better quality control needs to come from better quality measures. The Commission should seek advice from health care professional bodies about measures which can be quickly implemented, at reasonable cost." [3]

They suggested that good quality measures should be

- Reliable (for example, they are not affected by personal biases of the measurer)
- Comparable (so that measures can be compared between homes)
- Repeatable (so that a repeated measurement will give a similar value)
- Low cost, both for regulators and providers
- Fair (to avoid legal disputes between regulators and providers)
- Frequently available (so that corrective actions can be quickly taken)
- Reflections of different aspects of care and quality of life
- Published for each home (so that consumers can better choose between homes, and providers can see how they compare).

They quoted Donabedian (1966)

"*Outcomes, by and large, remain the ultimate validators of the effectiveness and quality of medical care*." [4]

2.2 A data-based aged care system

In April 2020 we proposed to the Commission a data-based aged care system allowing for

- rapid detection of individual health problems, and prompt help to individuals
- prompt help to providers, and well-based regulatory action where needed
- rapid detection of system health threats
- quality of care measurements to help consumers, providers and regulators
- appropriate Commonwealth subsidies for each care recipient
- well-timed transitions between care levels
- research on the cost-effectiveness of different monitoring systems
- research on the needs for different levels of care staff
- data access for treating professionals
- data access for researchers [5].

The key to this proposal was automatically monitored care data, transmitted to a central agency and the provider, together with automatically-generated messages to the provider where help to a person seemed needed. Our proposal was directly based on that of Cumpston and Bail, but extended to give immediate help. We noted the potential advantages of automatic monitoring as speed, accuracy, fraud-resistance and staff safety.

2.3 Value of a data-based aged care system in pandemics

In a submission to the Commission in September 2020, we suggested that a data-based aged care system could

- provide earlier detection of infected staff and residents
- allow better planning for the use of emergency staff
- provide emergency staff with medical histories in familiar form
- provide some of the health measurements needed in pandemics
- allow research into better procedures
- reduce the need for on-site visits by quality regulators [6].

The most common symptom of COVID-19 is a cough, followed by a fever, sore throat, headache and runny nose [7, p28]. Coughing might be detected by audio analysis, and fevers by temperature or pulse measurements. While not as reliable as individual testing, such automatic measurements could provide valuable early warnings.

2.4 Forms of automatic monitoring

Modern technology should make a wide range of automatic measures feasible at low cost. We made indicative data size estimates [5] assuming the following were recorded each minute:

- Weight
- Movement
- Geographic co-ordinates
- Falls
- Pulse rate
- Body temperature
- Odours.

Recording weight each minute while residents are in bed could be valuable in detecting sleep patterns, and perhaps overuse of sedatives. Call bell systems are commonly used in aged care homes, and could provide data on the extent to which resident calls for help are promptly answered. Staff logons and logoffs should be centrally recorded, to help research into relationships between quality of care and staff levels.

The Commonwealth holds large amounts of information about aged care recipients, including needs assessments, pharmaceutical prescriptions, pathology tests, and treatment by doctors and allied health professionals. Such information would sometimes be needed to determine appropriate responses to monitored data.

2.5 Automatic monitoring in home care as well as residential care

Giving evidence at the research, innovation and technology workshop on 16 & 17 March 2020, Jennene Buckley referred to

"*…technology that we put into in the homes of clients that can inform us … a lot of medical devices that take vital signs that come back to our virtual care team…"* [8, p7946]

Automatic monitoring devices suitable for residential care use may not always be suitable for home care. But using as much common monitoring as possible should help protect persons in home care, and facilitate transitions between the two forms of care.

2.6 Defining aged care quality

Asked about sustainability, Linda Mellors said

"*…from Regis' perspective, what we would like to see is that firstly aged care quality is properly defined, because I can't find a definition of what quality looks like in aged care and I think we should be able to come up with it so that everybody knows what it is we are aspiring to."* [2, p9522]

Nick Mersiades said

"I agree with Dr Mellors in that one of the critical things that must occur is an expression of what is quality. It needs to be defined because to date, there has been no real description as to what's been funded in respect to that particular issue." [2, p9524]

We suggest that quality be defined as the extent to which each of many separate quality measures is achieved. For example, an acceptable time to respond to call buttons might be derived by surveying residents. A quality measure might then be the proportion of responses within that acceptable time.

Quality of life measures, such as those obtained since 2017 from consumer experience reports, would be relevant. Richard Cumpston noted that rising satisfaction levels may reflect better quality of life, but may also reflect providers finding ways to artificially improve responses. [9]

3. Activity based funding arrangements

3.1 Proposed Australian National Aged Care Classification

The University of Wollongong has proposed an Australian National Aged Care Classification (AN-ACC), for use in a residential aged care funding model [10]. To avoid the instability evident under ACFI assessments, they propose that assessment of the care needs of persons entering residential care be made by independent assessors. Commonwealth subsidies for each person would be based on the measured staff times for persons with similar needs, with some regional loadings.

The University concluded that functional assessments could effectively be completed by external assessors, generally in less than one hour. Registered nurses with at least 5 years of experience were used as assessors. These assessments were completed face to face with the resident, or by observation of the resident, contact with family and/or friend carers, gathering information from facility staff or other sources, such as notes and documents. No measurements appear to have been made of inter-rater reliability.

3.2 Potential problems with classification structure

The proposed AN-ACC classification subdivides residents into 13 payment classes, using complex criteria. For example

"*The not mobile branch has five classes and splits on function and pressure sore risk, along with compounding factors for the lower branches. The compounding factors in the not mobile branch include the Braden total, AM-FIM eat, AM-FIM transfer, disruptiveness, falls in the last 12 months, obesity flag, daily injections, and complex wound management."* [10, p37]

Persons requiring a lot of individual care may find themselves at risk in the proposed system. For example, dementia or obesity may sometimes, depending on many other factors, cause an increase in the calculated subsidies. Taking into account the chances of getting the increase, and the heavy costs of care for the condition, providers may decide not to admit persons with these characteristics.

In a submission to the Department of Health in May 2019, Richard Cumpston said

"Residential aged care providers are generally smaller than hospitals, residents tend to stay much longer, and providers can often choose which applicants to admit. There is thus less ability to average out, and a strong need for payments matching the costs of care for each resident." [11]

Nick Mersiades said in evidence to the Commission

"*…there would need to be some adaptation in terms of the methodology that's applied in the aged care sector compared with the hospital sector. In aged care you're looking at long-term care, you're looking at quality of life…"* [2 p9524]

Ian Thorley said

"…unlike the hospital system that is relatively transactional, short stay and fairly predictable outcomes, that is very, very different to the sort of whole-of-life services that we provide…" [2, p9531]

3.3 Finding a robust activity based funding arrangement

Proposition FF 7 suggests that casemix adjusted activity based funding arrangements should be used to fund aged care services, where a single provider will be responsible for delivering services to the person, and people can be classified into groups that have similar characteristics and similar costs associated with providing aged care services.

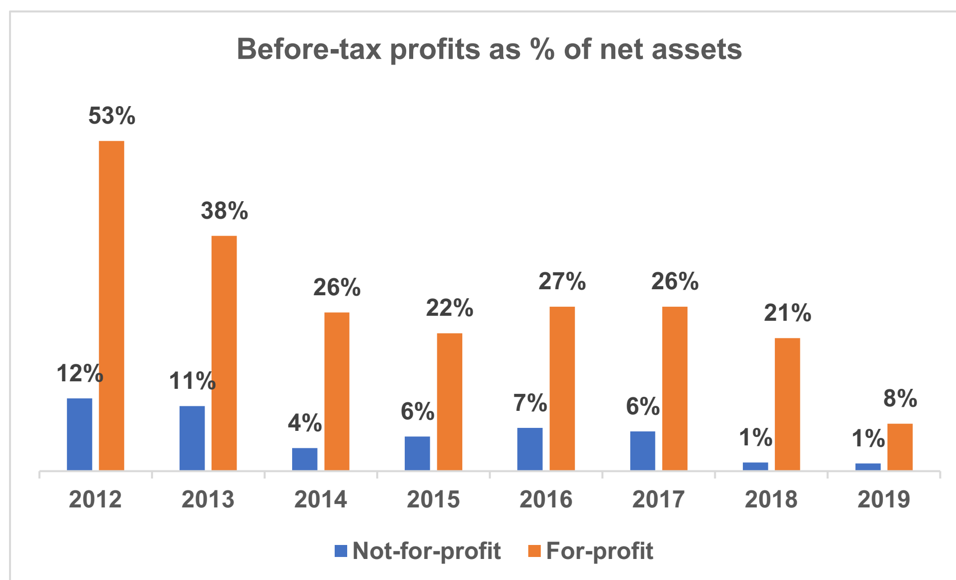
Some of the complexity of the AN-ACC proposal seems to have arisen from the small number of resident assessments (1655) on which the classification was based. A much larger number of assessments might have allowed a casemix model with many more classes, and no regression equations.

But casemix models are just one of many statistical methods to calculate a fair payment for a person with known characteristics. While casemix models have a 40-year history of use in Australia for hospital payments, they may not necessarily be the best statistical method for residential aged care.

We recommend that a much larger activity based study be carried out, testing several different statistical methods of calculating payments for persons with different characteristics. The results should be independently peer-reviewed. The study should be done with data from aged care homes providing reasonable quality. As more reliable quality data become available, the study should be updated.

4. Prudential controls

4.1 Reported provider profits as a percent of net assets



Profits and net assets are from ACFA [12, p79 & 96], and similar earlier reports. Not-for-profit providers exclude government providers. For comparison, over the decade to 17-18 returns on equity varied between 10 and 15% for authorised deposit-taking institutions, between 9 and 17% for general insurers and between 8 and 20% for life insurers [13, p17, 19 & 23]. For-profit providers reported returns above 20% in all years except 18-19.

Not-for-profit providers reported much lower returns on net assets than for-profit providers, in all years. Reasons for this may have been

- the much lower levels of net assets of for-profit providers
- the much greater share of residential places provided by not-for-profit operators in regional and remote areas, where viability supplements have been too low.

4.2 Potential under-reporting of provider profits

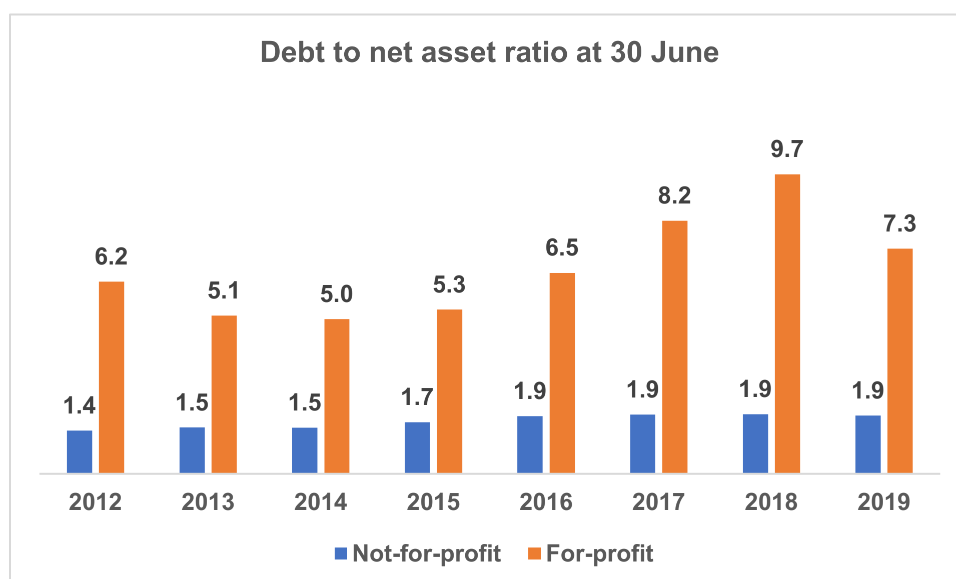
In evidence, Jason Ward [2, p9306-11] referred to the need for transparency and accountability on how public money is spent.

"…some providers don't have any financial statements whatsoever, and there is a huge range in terms of reporting standards within the financial statements that are available. And most do not file full financial statements, what's called Tier One financial statements… For one example, related party transactions are much more fully disclosed under Tier One reporting…"

"…it's a common practice in market-driven private provided aged care throughout the world in situations where an operator will pay rent to a related party and that rent is basically a way to transfer their revenue, the profits of that entity into another entity that may have more favourable tax treatments…"

While such arrangements may largely exist to minimise tax, they may also be reducing the profits reported to the Department of Health, and thus exaggerating the need for funding increases.

4.3 Debt to net asset ratios of providers



Debts and net assets are from ACFA [12, p96] and similar earlier reports. We do not know why for-profit providers increased their debt to net asset ratios from 30 June 2015 to 2018, or dropped them at 30 June 2019.

4.4 Intangible assets and loans to related parties at 30 June 2019

Type of asset	Not-for-profit $b	For-profit $b
Bed licences	1.1	2.3
Other intangibles	0.4	1.8
Related party loans	0.4	5.2
Intangibles and related loans	1.8	9.3
Net assets	9.8	2.7
Intangibles and related loans, as % of net assets	19%	344%

Intangible assets and loans to related parties are from ACFA [12, p96].

EY [14] recommended that intangible assets, other than bed licences, be excluded from eligible capital in a capital adequacy requirement. Michael Woods and Grant Corderoy [15] have recommended that the cap on the supply of residential care places be removed, and that places be assigned directly to eligible consumers. If accepted, this recommendation may see the value of bed licences drop sharply.

APRA excludes intangible assets and loans to related parties when measuring the capital adequacy of banks and insurers. If similar exclusions had applied for aged care providers at 30 June 2019, not-for for-profit providers would have had eligible net assets of $8.0 billion, and for-profit providers eligible net assets of -$6.6 billion.

APRA's prudential requirement for banks and insurers are sometimes said to be too strict, resulting in inadequate competition and excessive returns on net assets. Given the existence of the guarantee scheme to protect consumers, it may be reasonable to have less strict prudential requirements.

5. Provider failures

5.1 Provider failures up to 2016 leading to guarantee scheme refunds

Provider	Entered liquidation	Places	Location	State	Amount refunded $m
Lifestyle Care Providers Pty Ltd	14/1/008	38	Carrara	Qld	0.6
Vitality Care Commissioning Pty Ltd	5/11/08	102	Roxburgh Park	Vic	8.4
Kendalle Pty Ltd	11/6/09	62	Ringwood North	Vic	9.8
Drysdale Aged Care Hostel Pty Ltd	25/11/09	50	Drysdale	Vic	2.8
Hirange Management Pty Ltd	24/12/09	38	Berwick	Vic	2.9
Viva Care Pty Ltd	27/11/13	60	Essendon	Vic	5.1
De Ryan Pty Ltd	14/11/13	60	Brunswick West	Vic	2.3
Nepean Hospitals Pty Ltd	11/4/14	46	Bendigo	Vic	3.5
Nepean Hospitals Pty Ltd	11/4/14	125	Safety Beach	Vic	7.3
Kalinda Craft Pty Ltd	3/2/16	60	Greensborough	Vic	0.1
D&R Community Services Pty Ltd	7//6/16	12	Collinsville	Qld	0.2
Total		**653**			**43.0**

The above details are from an ACFA report on the guarantee scheme in 2017. Reading contemporary reports about these failures suggests that most were the result of poor management.

5.2 Recent provider failures

Note 27 of the Department of Health's annual report for 2018-19 says

"The Guarantee Scheme was not activated during the period ended 30 June 2019, however the Department is aware of the potential for it to be activated in respect of one provider currently in administration. The quantum of potential refunds cannot be estimated at this stage, but the total value of accommodation bonds held by the affected provider is estimated as $130m."

The provider involved appears to have been Berrington Care Group Pty Ltd, which is in liquidation. The two Perth homes involved are now being run by Bethanie. The Department of Health's report for 2019-20 is likely to show the amount of refunds made by the guarantee scheme.

Separately, a grant of $400,000 was given by the Department of Health in 2019 to assist the administrator of a small home in Murchison, Victoria. That home no longer operates.

The Commission heard evidence about the abrupt failure of Earle Haven on the Gold Coast in July 2019, where about 70 residents had to be transferred to other aged care homes or to hospitals.

5.3 Quality problems before insolvency

Nick Mersiades said in evidence

"…much of the harm that's done to residents, families and workers happens probably over the last year before a provider does become insolvent as people are rapidly making changes to try to save their business" [2, p9541]

5.4 Plans to deal with the failure of a large provider

At 30 June 2017 there were 13 providers with 2000 or more places [16]. Larger providers tend to have higher debt-to-asset ratios and more complex structures, and may thus have higher failure rates. There needs to be a process to ensure continuing care for the residents if a group with say 7000 residents collapses.

An industry consortium, formed by Mission Australia, the Benevolent Society, the Brotherhood of St Laurence and Social Ventures Australia, took over 570 ABC Learning Centres after the company went into receivership in November 2008 (Wikipedia 19 June 2018). A similar industry consortium may be needed to provide continuing care when a large provider collapses.

Glossary

ACFA	Aged Care Financing Authority
AN-ACC	Australian National Aged Care Classification
APRA	Australian Prudential Regulatory Authority

References

[1] Royal Commission into Aged Care Quality and Safety. *Revised funding, financial and prudential regulationhearing propositions - 13 September 2020. https://agedcare.royalcommission.gov.au/system/files/2020-09/RCD.9999.0523.0001.pdf*

[2] Royal Commission into Age Care Quality and Safety. *Transcript of Sydney hearing 5*. https://agedcare.royalcommission.gov.au/hearings-and-workshops/sydney-hearing-5

[3] Cumpston R & Bail K, 12 February 2019. *Data on residential aged care quality.* Submission to the Royal Commission into Aged Care Quality and Safety. Available from https://www.australianprojections.com.au/publications/data-on-residential-aged-care-quality

[4] Donabedian A, 1966. *Evaluating the quality of medical care*. The Milbank Quarterly 44 (3), Pt 2.

[5] Cumpston R, Sarjeant H & Service D, 9 April 2020. *A data-based aged care system.* Submission to the Royal Commission into Aged Care Quality and Safety. Available from https://www.australianprojections.com.au/publications/a-data-based-aged-care-system

[6] Cumpston R, Sarjeant H & Service D, 4 September 2020. *Better aged care data for pandemics.* Submission to the Royal Commission into Aged Care Quality and Safety. Available from https://www.australianprojections.com.au/publications/better-aged-care-data-for-pandemics

[7] COVID-19 Australia: Epidemiology report 23. Downloaded 4 September 2020 from https://www1.health.gov.au/internet/main/publishing.nsf/Content/novel_coronavirus_2019_ncov_weekly_epidemiology_reports_australia_2020.htm

[8] Royal Commission into Age Care Quality and Safety. *Transcript of research innovation and technology workshop propositions, 16-17 March 2020*. Available from https://agedcare.royalcommission.gov.au/media/27017

[9] Cumpston R, 25 December 2019. *Residential aged care consumer experience reports.* Submission to the Royal Commission into Aged Care Quality and Safety. Available from https://www.australianprojections.com.au/publications/residential-aged-care-consumer-experience-reports

[10] Eagar K, McNamee J, Gordon R et al. (2019) *The Australian National Aged Care Classification (AN-ACC). The Resource Utilisation and Classification Study: Report 1*. Australian Health Services Research Institute, University of Wollongong. ISBN 978-1-74128-295-5

[11] Cumpston R, 31 May 2019. *Submission on proposed residential aged care funding model*. Submission to the Department of Health. Available from https://www.australianprojections.com.au/publications/submission-proposed-funding-model

[12] ACFA, July 2020. *Eighth report on the funding and financing of the aged care sector.* Available from https://www.health.gov.au/resources/publications/eighth-report-on-the-funding-and-financing-of-the-aged-care-industry-july-2020

[13] APRA. *17/18 annual report*. Available from https://www.apra.gov.au/sites/default/files/2017-18_apra_annual_report.pdf

[14] EY 2017. Review of aged care legislation which provides for the regulation and protection of refundable accommodation payments in residential aged care. Report to the Department of Health May 26, downloaded 20/6/18 from https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/08_2017/review-legislation-refundable-accommodation-payments-in-residential-aged-care.pdf

[15] Woods M & Corderoy G, 30 January 2020. Impact analysis: alternative models for allocating residential aged care places. Report to Department of Health. Available from https://www.health.gov.au/resources/publications/final-report-impact-analysis-alternative-models-for-allocating-residential-aged-care-places

[16] Cumpston R, 15 March 2019. *Transparency and financial control of aged care providers*. Submission to the Department of Health. Available from https://www.australianprojections.com.au/publications/transparency-and-financial-control-of-aged-care-providers