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VILLAGE BAXTER

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Productivity Commissioners
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Dear Commissioners

Thank you for the opportunity to contribute to the discussion on the future needs of caring for older Australians. On behalf of the Village Baxter, I am pleased to be able to provide the following matters for consideration and discussion.

The Baptist Village Baxter is a continuing care retirement community located in Frankston, Victoria. Over the last 30 years, the Village has provided a continuum of care to over 800 persons on site each year and, over the last 15 years, another 800 persons in the broader community receive services each year from the Village.

The on-site services have provided a range of accommodation options, from a mixture of bed-sitter, one, two and three bedroom independent units, flexi-care apartments, and low care and high care services in Government funded Hostel and Nursing Home (Village Manor).

In addition to the on-site services, the Village operates a 'HACC' funded day centre to provide support to carers in the community through enabling the carers to have some respite from caring for their loved one and to 'recharge' their spirit for the often challenging demands of care delivery in the home. The day centre provides support for the very frail or those persons with dementia.

Our off site services in the broader community cover an area of some 40 square kilometres and include the following:

- Community Aged Care packages
- HACC services
- Post acute care services for two major hospital networks
- Department of Veterans Affairs Home care services, and
- Private fee paying services

These services cover the full range of community care from daily living activities, housekeeping, shopping and meals, transport and socialisation.

Within the independent / apartment residential settings, residents are able to receive services from any of the programs to enable them to continue to live in their present accommodation. This opportunity delays the necessity to relocate from your home into a residential care setting. However, should the need arise whereby a person's care needs are best met through relocation, this occurs seamlessly and with the surety that the person is still in familiar surroundings. This, of course, has the added benefit of current friends being able to retain easy contact with the person relocating.

With this experience of providing both care and accommodation, we would believe that many of the processes that apply within the Village could be translated into broader Government policy.

In relation to the Productivity Commission enquiry, we have provided the following views for your consideration.

Submission to the Productivity Commission

Inquiry into Caring for Older Australians

Introduction

The Aged Care system in Australia is regulated through a range of different legislations that attempt to provide a framework for the industry, consumers and Government. The principal pieces of legislation cover the following main issues:

- Fees that can be charged to consumers (both recurrent and capital),
- Government subsidies that will be payable for various resident classifications,
- Quality processes that must be followed by the industry,
- Building standards and associated issues that must be met,
- Means by which providers 'enter' the industry and requirements that must be maintained, and
- The assessment processes that apply for people seeking to receive services from the industry.

Despite these various pieces of legislation that attempt to provide a working strategy for the sector, the aged care system is suffering from, amongst other things:

- Ineffective choice of service options being made available to consumers,
- Delays in services being provided to consumers through delays in assessments,
- Inadequate financial returns being generated to meet the expectations of consumers, government and the sector in improving building stock and in the provision of services,
- A quality process that has not met (and will not meet) the needs of all stakeholders in the sector,
- Substantial wage disparities between the acute and aged care sector that make it difficult to attract and retain staff in the industry, and
- Building costs making development prohibitive for providers.

As such, it is time that all the stakeholders concerned for the future of the sector had a reappraisal of the current approaches to aged care delivery in Australia and, took the unique opportunity to establish a significant shift in policy direction with a new focus than can develop long term, sustainable, systemic change within the industry to enhance the sector and services provided to older Australians.

Setting the Scene

The Government currently regulate the number of 'bed places' and 'community care places' that will be made available to the community through a planning ratio. These approved 'places' will then be eligible to receive an amount of Government financial subsidy to provide the support to a person with an 'assessed need' occupying a 'place' suitable to meet their care. In a residential aged care setting, these needs are determined through the application of an 'Aged Care Funding Instrument' (ACFI) as a process to allocate the finite amount of Government finances to the industry to provide care support to the person with the assessed care needs.

Concurrently, a variety of similar programs exist for the delivery of care within the community setting. These programs may be financed directly from the Commonwealth (Community Aged Care Packages or Veterans Homecare), shared with the State Governments and Local Governments (Linkages, Home and Community Care), or financed privately from those individuals unable to enter into a 'funded scheme'.

Access to any of the funded schemes is achieved through an assessment process either from the Commonwealth's Aged Care Assessment Teams or through a local Government assessment process or similar service (i.e. District Nursing Service) for community care services. These assessment processes identify that there are many persons eligible to receive services however, through the limitations on 'bed places' and 'community places', lengthy waiting lists exist in many regions of the country and a person's ability to access such services in their time of need varies substantially across the country. Many stories exist of persons in a particular region of Australia receiving substantially more (or substantially less) 'care support' than their immediate neighbours in the next region. Equity across the country does not exist in being able to match supply and demand.

Potential Solutions to the current problems

- **Fund the Client Not the Provider**

The Government currently pays a care subsidy to a provider to meet an identified range of care needs for the client. The client, if they wish to receive subsidised care services, firstly must satisfy the eligibility criteria established by the Government (through the Aged Care Assessment Teams) and then find a care provider willing to admit them into residency. The willingness of the provider is based upon current waiting lists, ability of the person to contribute to the capital costs (through payment of an accommodation bond or meet 'exempt bed' requirements), the level of care to be delivered and other stipulations. In reality, the consumer has little effective choice in this process as most aged care providers have few vacancies, which results in the client placing their name on many waiting lists, often far removed, from their ideal location.

If the client chooses to receive care in their existing home, again they must approach the approved providers of community based services in the region and (often) place their names on a waiting list.

This is hardly satisfactory as a client has an assessed immediate need to receive care yet the services may not be available in their area of choice.

It is proposed that Commonwealth funding be considered under two structures:

- Clients be funded directly for those services based in the community (ie non residential services), and
- Providers be funded for residential based services.

Funding community clients directly gives the client power to choose the service provider and also to change the service provider if the standard of service does not meet their needs. This also allows the client to choose the location where the services will be delivered. This could comprise the client's current home, relocation into some form of supported accommodation or anywhere else of the client's choice. From a consumer perspective, such a process should be extremely popular.

To ensure that the Government can be assured that the funding allocated to the consumer is not used for other purposes, it is proposed that a case manager would be allocated within each region to liaise with the care recipients on a regular basis.

A mechanism would need to be established to enable any reporting of issues where the care is found to be not suitable.

For residential based services, the service provider would continue to receive funding based upon the assessed (or re-assessed) need of the client. Funding of service providers is the preferred model under the continuum of care in the short – medium term to ensure that residential based services continue to operate in communities. By totally funding the client from the outset, there may be unintended consequences of such a change whereby residential services may cease to exist as operators change their focus to community based care. Over a longer period this would not be an issue as the Government pricing mechanism for subsidy could be used to change the supply / demand structure of residential and non residential services.

By adopting the more flexible process of 'licenses' discussed in the following section, the traditional residential service provider may willingly move into the provision of more community-based care and separate the provision of care from the provision of housing.

This approach would have minimal impact on Government financial outlays in the initial implementation. Costs would be incurred through the provision of regular health checks for clients however would be offset from the saving made by current review officer costs.

- **Licensing**

Currently, a residential service provider is 'approved' by the Commonwealth as being suitable to deliver services to clients. This approach equally applies for Community Aged Care Clients.

Whilst being an approved provider, this does not mean that the provider will receive an allocation of bed licences or CACP approvals (licenses). These licenses are allocated by the Government on an annual

basis following a call for applications which are then considered by the Department and allocated to one or more of the applicants in a region depending upon the pre-determined number of licences being made available.

These licenses are granted to the approved provider at no cost however, based upon the limited number of licenses in an area, an active secondary market exists for the buying and selling of licenses resulting in the outcome of the licence being provided free achieving a market value representing a windfall gain to the provider.

The potential exists for the Government to be the sole regulator of this function.

If an approved provider wants to establish a service in an area, then the provider could purchase the number of licenses from the Government sufficient for their business needs. The money raised from this process would be allocated to the total pool of money available for the Commonwealth funded aged care financing and would assist in providing an additional source of funds to meet the needs of the sector.

The Government would establish the price of the license, say $5,000 - $10,000 as an illustration and, using the usual numbers of licences allocated annually, would generate a funding stream in excess of $30 million per annum.

This amount would be indexed annually at a nominal increase. If a provider wanted to relinquish some or all of their licences, the Government would buy them back at the current selling price. These relinquished licenses would then be available for resale to other service providers.

This system would enable the Commonwealth to:

- Ensure that the types of services were available to clients in specific regions through allocating licenses in the areas of demand,
- Through the application of a fee for the license, it would ensure that the approved provider was committed to developing the services in a particular area and generate additional funding for services,
- Establish a simple process for allocating and re-allocating licences,
- Remove the existing secondary market for licences.

From a provider's perspective, this approach should ensure that they have access to licenses to enable their business to grow over time for relatively small financial commitment up front. Licenses would be available for purchase at any time depending upon the 'stock' held by the Government.

The issue of the Government taking control of the license 'market' is that many providers have already recorded a book value of their licences in their balance sheets. Through the Government establishing and controlling the price mechanism, this will reduce the notional book value of the licenses and may create issues for financing covenants.

To overcome this, it may be necessary for the Government to indicate that it will be setting a fee for bed licenses for the future and gradually reduce the fee over the next five years until it reaches the target new sales price. During this period, providers have the chance to restructure their balance sheets to minimise the impact. Any provider seeking to relinquish licences during this period should be paid a median rate between the book price and the sell price.

There would be some relatively minor change to cost outlays of the Government under this approach until such time as the book price equals the sale price. Over time, this approach will raise additional income for the sector.

- **Separate the concept of 'accommodation' from 'care'**

Currently, within residential aged care, the Government controls the amount of 'board and lodging' to be paid by the client (both on a weekly fee basis and on a capital retention basis from any accommodation bond) and provides Government subsidy to meet the costs of care services.
Additionally, accommodation bonds are only payable in low care facilities, extra service facilities and high care facilities (if the client transfers a bond from an existing provider). This creates the anomaly with direct admissions into high care whereby the provider cannot access any capital sums to assist in overall financing and the current option is to receive an accommodation charge being an additional amount of

funding in the weekly fees. The current community understanding is that bonds are not allowed in high care facilities where in fact this wrong – they are already in many facilities as extra services places, transfer or through a resident request to pay a bond. The question is not about the introduction of bonds into high care, but rather removing the anomaly of certain providers being excluded from being able to charge a bond.

In simple terms, there are two components to the residential system:

- The Commonwealth provides subsidy payments to support care services.

- The client pays a fee for their accommodation.

As the accommodation component of the payment is made by the resident, the Commonwealth should have minimal role in stipulating the style and structure of an aged care building and how it should, or should not, look in the future. Government's role is to stipulate the general standards for building codes and in establishing minimum standards of accommodation that will be available under 'residential' services.

There must be some recognition that accommodation requirements differ for each person and that each person has a differing capacity to contribute to the cost of that accommodation.

Currently, Government controls the minimum amount that a person moving into residential care must retain from their assets. This is a reasonable approach to ensure that unexpected events can be financed. Additionally, Government regulates the amount of money that a provider can retain from an accommodation bond. This process is also reasonable however the following matters should be considered:

- The amount of money that a provider can retain from an accommodation bond needs to be increased to reflect some return on the investment in the physical infrastructure.
- The retention timescale should be related to the overall time spent in a residential service – not restricted to a five year period as this simply creates barriers to a resident moving between services as they age or family moves etc.
- Accommodation bonds should apply to residential aged care – not simply low care. This barrier creates inequities for consumers and providers and serves no purpose.

For those people who have limited financial assets, the current process of having Government support works well however the amount of the support needs to better reflect the costs of the accommodation service.

The current 'extra service' process works reasonably well however the services required to meet the 'extra' requirements are very superficial and need to be re-examined and perhaps structured around a hotel style 'star rating' type of process.

There are no cost outlays from the Commonwealth for this change.

The subsequent issue that needs to be considered is the process of supporting people of limited financial means.

The requirement of Government under this approach is to ensure that some financial support for those clients in insecure housing is available so that access to appropriate housing is available as chosen by a person. Provision of such 'housing support' subsidy should be made to the client as it will again provide a greater role to the client in exercising choice about where and how they would choose to live.

The current monies allocated by the Commonwealth and State Governments for housing support programs should be consolidated into one program and then priorities determined as to the allocation of monies to people needing support for secure housing. Financial support could range from cash grants for first home buyers thorough to rental support for people in insecure housing and subsidy support for people requiring longer term assistance. Conceptually there would be no net cost to Government outlays but this will vary according to changing Government priorities.

- **Assessment**

The current assessment process of a person is conducted by a Government funded 'independent' assessment team to determine the 'care' requirement of an individual.

The responsiveness of this process varies markedly throughout the country with some assessment teams taking a number of months to assess the needs of a client. This delay creates undue hardship for families seeking support for a person identified as requiring assistance (often from the acute hospital or person's doctor).

The other aspect of the current process is that the Assessment Team service is a monopoly service that reduces client choice.

To support this assessment process, a single assessment system should be established with a number of services capable of undertaking the role. The assessment team would be retained but additional options for assessment would include the person's usual medical practitioner, or community nurse. A community nurse would also include the Director of Nursing (however titled) at a residential facility.

This would require a change to the Medicare reimbursement schedule to compensate for the work undertaken by doctors however would provide a cost effective alternative.

For assessments undertaken by a community nurse, a scheduled amount of reimbursement would be provided by the Government.

Both of these alternatives to the current assessment team provide options for a more responsive service for consumers and give choice in the assessment procedure according to client need.

The other issues surrounding the current assessment process concerns the lack of accountability by the assessment teams for their decisions.

At the time of the assessment, families may 'control' the information flow to the assessor to portray a higher (or lower) impairment than actually exists. Based upon this decision, the person may then enter an aged care facility and the level of assessed impairment is significantly different than assessed, yet the service provider may suffer financially from this change in actual level of care if the care needs are less than the assessment. This should not occur as the provider has taken the 'assessment' in good faith and the Government should honour the assessed level if higher than the actual level.

The cost to the Government should be minimal. To provide a better service than currently exists would require additional staffing to ACAT services than presently allocated. To implement the alternative solutions would provide a more flexible use of Government monies as the only cost would be upon provision of service by a doctor or community nurse and may reduce the need for additional permanent ACAT staffing levels.

- **Quality**

One of the important roles of any Government system is to ensure that services are, firstly, being appropriately provided and, secondly, that systems of continuous improvement are in place. The current accreditation system does not meet either of these requirements for a variety of systemic reasons.

When the accreditation system was first proposed, the system was welcomed by the industry as a positive means by which the previous 'outcome compliance' model of Government control could be eliminated.

Regrettably, the way in which accreditation has evolved has largely resulted in the Accreditation Agency assessors imposing their view as to the style of services that an organization should be providing and their view as to what comprises 'best practice'. Neither of these views is relevant, as any good quality system focuses on 'what works for the organisation and the customer'.

Additionally, the way in which accreditation currently operates, it imposes an enormous cost impost on service providers and actually detracts from the money available to provide services to clients.

Under the above solutions to the aged care sector, the only role of a Government 'quality' system should be based around the services being provided by way of care subsidies to a person, as this is the only aspect

being funded by the Government. Government does not have a role in the quality of the building stock being provided in a 'housing environment' and there is no requirement for action from Government.

Should a licensing system be developed for the service provider, then the 'quality' system focuses on the provider's ability to deliver the level of services required.

The role of the 'quality' process will change to meet this new obligation and will result in a better and less expensive model that can be sustained for the future. There are a variety of accreditation schemes currently available throughout the world and a number of aged care organizations are working towards the internationally recognised 'Business Excellence Framework' as a sustainable, focused program in improving outcomes for staff and residents.

The intention of this alternative to the existing system is to reduce the costs to Government and the sector.

- **Value of the Care Subsidy**

The Government currently structures their subsidy payments over a sixty four tier system (ACFI) for residential providers. Community care providers are subsidised at separate rates under the CACP program and a variety of rates under the HACC program. These 'systems' should be developed into a single simpler subsidy system covering all of the current programs. The care needs of a client do not change simply by their location and the development of such an instrument (over, say, a twenty point scale) would enable all clients to be assessed according to common criteria and be able to move seamlessly through the scale over time.

The role of Government under such a system is to determine a fair and consistent price for the various levels of subsidy that is sufficient to meet the legislated level of services expected to be provided for the subsidy amount. It is pointless to provide a level of funding subsidy at a 'basic level' and then legislate for a 'premium level' of care to be provided. Similarly, there is no point in paying for a 'premium level of care' and then witnessing a 'base rate' level of service. Transparency in the rate of subsidy and the services provided is a key fundamental role of Government.

Through this mechanism, the Government has the opportunity to shape (and control) the industry and the Commonwealth's financial commitments. It also has the capacity to affect the ability of the sector to attract and retain those staff with a skill base that is deemed appropriate to the needs of the services. Such ability will be fundamental for the future as aged care continues to evolve and becomes more aligned to some of the stresses of the acute care sector.

Having established the role of Government in determining the value of the care subsidy, the issue then revolves around the process that will be used to determine the level of subsidy to be paid to an individual client. As an assessment of client need has made on the level of care required by a client, then the initial subsidy should be based on this assessment. Should a client's needs change, then the service agency should be able to simply document this change for subsequent audit by the Government.

Such an approach focuses on a risk management approach to auditing care requirements by the Government. This process may require additional review officers who would be sourced from those staff formally used on bed licence rounds etc.

To compound the problems of subsidy rates in the sector, the current process of subsidy 'coalescence' whereby all of the States will be funded at the same financial amount for residents assessed at the same funding category fails to recognise that there are very real cost differences between the States. If the Government focuses its attention to funding the 'care' component only, then some of these differences are eliminated or reduced (providing the Government allows the service provider to develop the type of housing stock and financial arrangements appropriate to their clients) which will assist the Government to then recognise true cost differentials between the States on a much narrower basis.

Additionally, the Government has established, by a separate process, how much they are prepared to contribute to meeting this care need from Commonwealth monies. It makes no difference whether a person has substantial assets or no assets in the delivery of the actual care. Every client should be eligible to receive the same level of support regardless of their capacity to accumulate assets and income. It is also true that, with the need to target Government expenditures on those persons who do not have the capacity to fund their own needs, some form of means test should apply to the payment of Commonwealth monies.

If the Government applies such a means test, then it should affect the client, not the provider as currently applies with care subsidy reductions being based upon the assets of the person.

Whilst this may have an impact on Government outlays, the extent of the impact can be managed by Government simply through the rationing of the services that Government is prepared to fund. The downside to rationing the level of services is that Government is exposed to public criticism.

- **Future Style of Aged Care**

Currently, the focus of much of the aged care sector is based around a 'medical model' of service delivery. There is an approach, currently being used by a small number of facilities in Australia, and certainly by over 400 facilities in America, whereby the medical model has been transcended in preference for a lifestyle model which is delivering tangible benefits to clients and causing a reduction in all of the 'medical necessities' of the current aged care system (medication, infection rates, falls incidences etc). The Government should actively encourage organizations to explore this approach and should be prepared to promote the concept if the benefits can be specifically quantified. The recognition that the medical model is only part of the solution to meeting the needs of older persons could result in cost savings for the future delivery of aged care in Australia.

By developing a lifestyle-focused model of care, the current difficulties being experienced around the world in attracting and retaining qualified nursing staff is reduced. There will inevitably be a role for qualified nursing staff to deliver those technical aspects of care within a residential setting, however the current 'medical focus' fails to recognise that holistic care can be provided by a variety of staffing options all of which are to the advantage of the client.

The model, known as the 'Eden Alternative' focuses on the issues of 'loneliness, helplessness and boredom' as the greatest plagues affecting the elderly and develops appropriate responses to help overcome these issues. The thrust of the approach is to give older persons a reason for living as opposed to simply waiting to die. A dramatic, but nonetheless factual, reality in the current system.

The debate should be about what type of aged care services can respond to the very different needs of every client and the particular staffing skills required to meet those needs.

By shifting the focus to a non medical model, this has the potential to offer a lower cost option for age care services and may change the mix of staff required to provide service to clients under a lifestyle focus of care services.

- **Other Issues**
    - **Staff Training**

The current process of Registered Training Organisations being accredited to deliver skills based training to the Australian workforce is a reasonable concept however the inconsistency in actual training delivered to students almost renders the process useless whereby a student exits the course with a certificate which may not be recognised by an employer as the RTO is not capable of delivering a suitable standard of education. This problem needs resolution across all sectors.

Compounding the issue of staff training is the investment made by aged care services in training staff to Division 2 and Division 1 Registered Nurse standard which is then often wasted due to poaching of these staff by the acute health sector. The immediate need is to create a system that recognises and rewards staff to remain in aged care and create value for training investment. Such a scheme could include scholarships, relief from higher education debts under proviso that the person remained employed with the sector.

    - **Workforce support**

There needs to be some recognition that the staff actually employed in providing care services to older persons are themselves an ageing workforce. Government policy now encourages people to work longer to reduce the financial burden on the social security system however working in aged care is physically demanding which increases the risk of injury / claims by older employees, or alternately forcing experienced employees out of the workforce.

This potential injury rate has two effects:

- The injury may create a longer term demand on acute health / rehabilitation services which is a high cost component of medical services, and
- May create the situation whereby the person becomes dependent earlier in their retirement years.

As such, the promotion of working longer in the aged care sector may produce an adverse financial outcome for Government outlays.

Additionally, should these injuries become compensable under State Workcover arrangements, the cost impost on the service provider will be substantial.

- **Volunteers**

Our society needs to address the changing attitudes of "baby boomers" who are not looking to participate in the traditional roles of volunteerism. This will impact on service provision as time progresses and reduce the quality of services that are provided to older persons. If volunteerism cannot be encouraged, then the only alternative is to provide additional paid services which would be a further drain on the public purse

- **International Considerations**

At an international level, two specific issues should be considered for relevance in the Australian context:

- Private expenditure on aged care in many European countries is fully tax deductible. This obviously enables the Government to expand the aged care program at a lower net cost to the overall Commonwealth expenditures. Such a process is used for both residential and community care and is well worth considering for the future.

  This has the benefit for Government of expanding the total service delivery of aged care services co-jointly with private expenditures. Good simple low cost solution to expand total services.

- The current focus of Government is in addressing the issues of aged care (amongst other issues) whereas the focus should be on achieving systemic change in our lifestyle to delay the need to have Government subsidised programs. One such program has been investigated in detail in a complete region in Japan and focuses on the 'wellness' concept of reconnecting older persons (in particular) with the community. The social isolation currently being experienced by older persons in society creates an environment wherein medical expenditures increase, aged care needs increase and general dysfunction is allowed to become systemically entrenched. By addressing the source of these issues, the study region has shown a remarkable reduction in a vast array of programs and this model should be explored with some haste. Under the current HACC program, the operation of Day Centres could be claimed to be meeting this aspect but this is not correct. We need to examine the means by which wellness is integrated into various societal models to ensure that people remain connected with their communities. For example, the greatest concentration of older people in Australian society is at a shopping centre. We need to both recognise this fact and then provide suitable opportunities to enhance the interactions at such places.

  The experience around the world is that shifting the current treatment model of health to a preventative model achieves 'whole of Government' savings over many programs. In the first instance, the establishment of selected areas for a pilot program would best quantify the outcomes. Such pilot programs could be undertaken in specific regions or smaller groupings of people if more targeted outcomes are required.

Conclusion

In relative terms, Australia has an aged care system that is the envy of many countries. However when the systemic issues are considered, our program is in danger of not being able to meet the needs of future generations, let alone solve the current issues within the sector.

- By funding clients instead of providers, a fundamental shift in empowerment of community care clients is achieved – a good outcome for consumers and minimal cost to Government.

- By changing from a 'bed licences' level of control to a more flexible licensing arrangement by Government through the 'sale' of bed licences, the sector will be in a position to provide alternative styles of accommodation and settings and to improve and develop facilities to meet client need. This will have minimal short term cost to Government in establishing the 'license market' however this approach provides an ongoing source of funds generated through the 'sale' of licenses.

- Government needs to focus on 'care services' as a statutory role and simply establish minimum requirements for accommodation. There is no cost to Government from implementing this change.

- By changing the current Government regulations on accommodation bonds, a variety of responses can be developed by providers to meet the needs of the clients in each segment of society. Such regulation change also ensures financial viability of the accommodation component of the sector. There is no cost to Government from implementing this change.

- By developing a continuum of care funding scale, consumers can receive the financial support necessary to receive care in their setting of choice. May have cost implications to Government over time however these costs can be controlled through reducing the level of services that the Government will be prepared to support.

- Development of a funding scheme based solely on 'care needs' allows the Government to specifically target, and reallocate, funding priorities. This may have funding implications over time.

- Elimination of the current myriad of funding and assessment schemes will facilitate more dollars being dedicated to actual service delivery. There is minimal or no cost to Government from implementing this change.

- Provision of an alternative assessment services to ensure enhanced client responsiveness and choice. There is minimal cost to Government from implementing this change.

- Recognition that alternative styles of aged care from a medical model to a social model will assist in enhancing the experiences for clients and assist in alternative staffing models. There is no cost to Government from implementing this change.

- Establishment of pilot projects to determine the benefits of a preventative service delivery model in lieu of the existing 'treatment' model of care. There are some short term costs to Government but potential cost benefits to total 'whole of Government' spending if pilots can produce good outcomes to clients.

The role of Government is ultimately focused upon ensuring the money outlaid from Government sources is appropriately spent as part of accountability to the taxpayer.

A fundamental review of the program can achieve positive outcomes to the issues and hopefully, the above paper will assist in this process. If any matter requires clarification or if you should wish further discussion on the issues, please contact me as required.

Yours truly,

Stuart Shaw
General Manager