Submission

To Productivity Commission Inquiry into Aged Care
"Caring for Older Australians"
July 2010

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A. BACKGROUND

Melbourne Citymission operates Eltham Retirement Centre (ERC) in the north-east suburbs of Melbourne as well as a community-based palliative care service covering four municipalities in the north and north-west suburbs. Eltham Retirement Centre (ERC) accommodates approximately 250 – 260 people when full. MCM's Palliative Care service supports over 600 people with end-of-life care and support each year.

The ERC was established in 1956 and is comprised of:

- 120 residential aged care beds (60 high and 60 low) across two facilities on site, plus
- 120 Independent Living Units (ILUs); plus
- a four-day per week Day Therapy Centre (funded through Department of Health and Ageing – DOHA); plus
- an Older Men's Workshop (HACC-funded Planned Activity Group); plus
- Four CACPs packages to support residents who live in the ILUs within the ERC Village.

MCM Palliative Care was established in 1981 as the first community-based palliative care service in Victoria.

Melbourne Citymission also provides a significant range of services and supports for people living with a disability, including acquired brain injury. We offer community support services to clients and their carers as well as operate 12 scattered residential houses for people with a disability. At present 15 of the 60 residents of the Melbourne Citymission CRUs are aged over 60 and effectively ageing in place in services that are not designed and staffed adequately for their needs. Melbourne Citymission will make a separate submission to the separate Inquiry that the Commission is conducting into the needs of people living with a disability.

We welcome the broad scope that has been set by the Commission in framing the field of inquiry. The interfaces which the aged care sector has within its broader context of the health and retirement living sectors are as important to review as the inner workings of the aged care sector itself.

Therefore, Melbourne Citymission is pleased to be able to provide the following input for the consideration of the Commission in this Inquiry.

B. RESPONSE TO THE ISSUES PAPER

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1. OBJECTIVES OF THE AGED CARE SYSTEM

We believe the objectives as currently stated are adequate. The priority objectives within these however should be those that:

(a) Encourage diverse, flexible, efficient and responsive services that facilitate independence and choice;

(b) Facilitate access to the relevant range of care regardless of economic and other circumstances; and

(c) Guarantee an acceptable standard of care through a network of sustainable providers.

The implications of the ageing population mean that co-contributions from clients will become all the more necessary to complement the funding injected by the Commonwealth. In this user-pays environment it is critical that Commonwealth funds be available to ensure equity of access for those who cannot afford to pay large sums for their accommodation or care.

Flexibility and diversity will be important ingredients to help people age in place in their own communities to the extent that they can. But ageing in place in the community should not continue to be the socially isolating experience that it is for many at present.

Six themes that we believe should be reflected in the objectives and the practices of services and supports for older people are:

- ***Equity of access*** – to ensure that disadvantaged elders do not miss out.
- ***Needs-based*** – when you need services you should be able to get them, wherever you are, regardless of your ability to contribute to the cost of care.
- ***Positive Ageing*** – the policy and funding framework should enable greater emphasis on independence, prevention and wellness models of care.
- ***Continuity of care*** – that enables minimal dislocation for clients from their communities of interest or geography in the manner in which they access services. The 'Positive Ageing' framework should strengthen the inter-relationship between aged care and related health services such as sub-acute and restorative services such as Day Therapy Centres, community-based palliative care, and primary care services. This will enable improved continuity of care as well as relieve the pressures on the public hospital system by reduced inappropriate admissions.
- ***Inclusive communities*** – whereby active ageing strategies help people remain connected to and valued by their communities and able to 'give back' to the extent that they wish to. We need an improved nexus between the aged care sector and retirement settings, which can be called perhaps, 'Continuing Care Retirement Communities'.

- ***Sustainability*** – the funding model should enable providers to be resourced to provide high quality care in a manner that is financially sustainable for both annual operating costs and for medium and longer term capital needs. The sustainability of aged care services needs to be secured by setting subsidies and prices based on the provision of flexible services in an open market and requiring those who can afford to contribute to the cost of their care and accommodation to do so.

Service system Interfaces

Australia would be better served by a more broadly conceived ageing and disability policy. Obviously people age with or without 'disabilities' but often the basic nature of the supports and services that they need is very similar. Adaptable housing settings in Continuing Care Retirement Communities plus residential care facilities need to have similar resources, treatments and staffing skills for both groups

Younger people with dementia – these people are not well catered for. The National Hospital and Health Reform process will place younger people with dementia within disability services and exclude them from aged care services. This is problematic. Services for people with dementia are organised within aged care settings. Disability services are not always appropriate with people with younger onset dementia; there is very little on the disability side to assist them. We currently have one resident in our low care facility whose dementia became quite disabling in her early 50's. This lady is extremely disoriented by her dementia and really struggles to survive in the community. Her family were at wit's end trying to keep her safe. The family and we had an enormous battle to have her accepted as a suitable resident for our low-care facility. She has now settled extremely well and the family are greatly relieved about her safety and appropriateness of care.

Exception should be made for younger onset dementia to be eligible for generic dementia services in the aged care system.

The nexus between the residential and community aged care sectors with the HACC service system and the post-acute health and rehabilitation sectors should all be oriented around an "Positive Ageing" philosophy as the common thread.

The recommendations of National Health and Hospitals Reform Commission's should be implemented to increase the provision of inpatient and community-based sub-acute and restorative services and to improve the availability of community-based palliative care services.

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2. TRANSITION ARRANGEMENTS

There are thousands of older people and their families and carers, already within the aged care system. In order to manage the risks to continuity of service for vulnerable people, it is essential that the implementation of the reforms be accompanied by transition arrangements for the phased introduction of greater choice which would allow a reasonable period for adjustment and clear timelines and milestones.

These arrangements should be developed in consultation with consumers and providers. Given the inherent vulnerability of many people in older age, it is also essential that during the reform process careful attention is paid to maintaining cost-effective consumer protection arrangements.

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3. RETIREMENT LIVING

Recommendations:

1. *The 'Assisted Living' accommodation and support model (what we would call a 'Continuing Care Retirement Community') should be recognized as an essential interface component of the aged care system.*
2. *A national funding scheme, perhaps similar to concept of the National Rental Affordability Scheme, should be established to help NFP providers build "Assisted Living Units" within aged care sites to establish/extend Continuing Care Retirement Communities (CCRC).*
3. *Providers that are prepared to cater for those older people with encroaching or advancing frailty within a CCRC setting should be financially supported to do so.*
4. *Activities and 'lifestyles' programs that can help older people maintain skills and social relations and feel valued and competent and maintain their sense of 'meaning' in life should be resourced as part of the 'Positive Ageing' framework of caring for older Australians.*

Background:

Melbourne Citymission operates a mixed service retirement/ aged care complex at Eltham in Melbourne's north east. This Village comprises 120 independent living units (ILUs), a Day Therapy Centre serving the broader Nillumbik & Banyule communities, plus 120 residential age care beds, offering a mixture of high and low care.

Most of the residents in the ILUs have selected this Village because they see it as a setting where they can 'age in place'. Of the current residents, 60% are aged over 80 and 47% over 85 years of age. The majority of the people on the waiting list are pensioners of little or no means.

Physical frailty and social isolation

Forecasts about the rising proportion of Australian households that will be lone-person households are relevant to this issue. With the ageing population this proportion will grow even more so in this age cohort. The risk that this presents is an increasing number of older people experiencing social isolation.

Social isolation for older people arises not only through diminished social networks as their extended families become scattered around Australia and the world, but also through their limited ability to physically move around as they become more frail. This

isolation associated with frailty can be as relevant in a retirement village setting as elsewhere in the broader community.

As people become more frail, they can find it hard to physically get to external support such as Planned Activity Groups (PAG), and/or find the nature of the activities available not suitable for their situation. There is sometimes a gender bias to the activities in PAGs that can make them uncomfortable spaces for older men.

At MCM-Eltham, a HACC-funded PAG in the form of an Older Men's Workshop Cooperative has been successful for many years in engaging socially isolated older men, some of whom may be experiencing early stages of dementia. It's like their version of a *Men's Shed*. In this workshop the men make wooden items of value around the community or help repair some of the wooden outdoor furniture around the MCM Village. The local Bunning's store gets behind the program by providing timber off-cuts for the men to work with. Products of the workshop include tonally correct wooden Marimbas which are gifted to local schools and kindergartens. For the men involved, it helps them feel personally valued and still 'useful' in society, plus it helps break down their social isolation.

Two recent partnership projects at Eltham Retirement Centre in Melbourne's north east have focused on some of the impacts of isolation in retirement village settings. Both projects highlight the need for policy, planning and resourcing to enable older people to still live meaningful and valued lives as key aspects of an active ageing strategy on the part of governments and service providers.

- ***Nillumbik Active Ageing Project*** - Melbourne Citymission partnered with Nillumbik Shire Council and Nillumbik Community Health Service in the *"Active Ageing project"* to examine the plight of older people who are not frail enough to be assessed for CACPs services but for whom the supports available through the HACC program are insufficient to meet their needs.

This project examined how the principles of the Active Service Model in HACC can be incorporated to enable these people to continue living independently within their community. *A copy of the report from Phase One of the Nillumbik Active Ageing Pilot Project is attached for information.* This highlights many of the barriers ascertained from assessments of residents' circumstances and recommends an Integrated Model of Care, with greater outreach capabilities, to address those needs.

- ***The 'Texture of Memories' project*** – Melbourne Citymission recently partnered with Nillumbik Shire Council to pilot an 'artist-in-residence' project. For many people, transfer to a retirement village can lead to isolation and depression, symptoms that can accompany ageing and feeling less valued in your own community.

The '*Texture of Memories'* project was an extraordinary success in the way that it engaged residents from across the ILUs and high & low residential care. The project broke down isolation for many, gave everyone involved a strong sense of being valued and still able to contribute in a busy world that seemed to be passing them by. *A copy of the report and the project rationale are both attached for information. A DVD of the residents' participation is also available.*

The most salient point of this project was the need for older people to have the means for finding meaning and self worth in the activities of their lives. This impacts on their physical and mental wellbeing. It represents one of the persuasive arguments about

why the aged care system needs to be more broadly conceived as a psycho-social-physical health system.

Ageing in Place within retirement villages

Whilst much of the public promotion of retirement villages presents itself as an active retirement lifestyle for the over-55s, the reality for most of the Not-For-Profit (NFP) providers is that people want to enter retirement communities at a much later age and do look for an 'ageing-on-site' setting. The For-Profit providers may wish to remain focused on the over-55s, active-lifestyles market, but even their experience is often of people seeking a Continuing Care Retirement Community (CCRC) rather than a "retirement lifestyle' setting.

There is clearly a large cohort of older people who will continue to seek the ageing-on-site retirement community that will enable them to remain in their village as they become frail in later life. But the NFP-Continuing Care Retirement Community operators need the capability to support residents and keep them safe in independent living.

Within a CCRC model we have the potential to have community facilities and activities, Day Therapy Centres, Assisted Living and Care Homes plus Nursing Homes all co-existing. This would create community hubs, full of life and with visitors feeling a part of the place. Residents would feel connected to their community and participate in a manner appropriate to their health and level of frailty.

The role of 'Assisted Living' options – 'Continuing Care Retirement Communities'

In the accommodation options available for many older people, there is a big gap between being able to successfully live independently in the community (whether it be a retirement village or the general community), and the option of a low care residential facility or CACPs support. Current HACC provision is not flexible enough to provide for the needs in this gap. The continuum of aged care services needs to incorporate a way of funding for 'Assisted Living' units within retirement villages.

The need for enhancements to the ways in which and the extent to which, HACC, community health services and Day Therapy Centres can cover this gap has been clearly exposed in the Nillumbik *Active Ageing Project* outlined above. This gap could fill the services/supports gap that is not currently provided by HACC or CACPs. It could assist ageing-in-place strategies in a retirement community setting whilst maintaining independent functioning for as long as possible.

The 'Assisted Living' accommodation and support model is an essential facet of what we would call a 'Continuing Care Retirement Community'. This title distinguishes these villages from the mainstream of what currently constitutes retirement villages, especially in the For-Profit sector. The funding model could be a hybrid of the old aged care hostel model (covering RCS resident categories 6, 7 and 8) and some of the ILU funding models used in the retirement villages by the NFP sector.

'Assisted Living' accommodation options need to provide or enable access to most of the supports and services for Activities of Daily Living (ADLs) for people who are now excluded from low care residential facilities. Built adjacent or in close proximity to a low-

care residential care facility, the services, supports and the community connections available to hostel residents could be accessed by the residents in ‘Assisted Living’. This ‘Continuing Care Retirement Community’ concept is akin to the notion of *‘Apartments for Life’* that has proved so successful in the Netherlands.

This could in part be achieved via the separation of the accommodation component from the care and daily living expense components that remain in the current ACFI funding formula. Great care must be taken however, for government subsidy funding to still enable access for financially disadvantaged elders. In a user-pays environment for financing of the accommodation component (which is essentially what retirement villages currently are), the disadvantaged will miss out. So the government safety net is required to assist these people.

This Continuing Care Retirement Community (CCRC) setting could draw upon the same personal supports, rehabilitation and lifestyle programs that currently assist residents of low-level care facilities.

For this concept to work well, the Commission may need to consider whether the funding support streams or the regulatory or legislative base for such Retirement Communities should be aligned more closely with the rest of the aged care sector under a Federal jurisdiction.

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4 ROLE OF DAY THERAPY CENTRES

Recommendations:

1) *Accessibility - DTC services should be available on an equitable basis to all older people. This may mean reviewing where services are located, and it will mean a financial and strategic investment in the growth of DTC services. In the Victorian context, a minimum of one DTC per municipality would seem to provide a reasonable basis for access.*

2) *Managing longer term health decline - With an ageing population we need to re-visit seemingly “unfashionable” “maintenance” approaches and within this, reframe well-being goals to include “a well-managed decline”. People struggle to be adequately maintained in the community if they only have access to short-term, episodic allied health services.*

3) *Volunteers and community connections – There is great potential with incentive funding, to work with older people as peers and volunteers in running and supporting programs and groups. A volunteering component will also require practical support to enable people to contribute in this way such as transport or defrayment of costs (eg, Community Volunteer Grants Scheme).*

4) *Demographic basis for funding allocation – a more sophisticated basis for allocation of growth funds is needed in order to ensure service access for disadvantaged older people living in municipalities that otherwise rate low on the SEIFA Index.*

Background

The Day Therapy Centre program is a comprehensive but poorly understood and valued program. This is even reflected within the "Figure 1 – Modes of Care" triangular representation of the aged care system – Day Therapy Centres do not even appear.

Day Therapy Centres (DTCs) provide *access to a mixture of allied health services in the community.* These slow stream rehabilitation and body maintenance programs are an integral ingredient for many older people to remain living independently. This can apply to assist recovery after an injury or for management of chronic ailments as part of the active ageing strategy. As complementary therapies DTCs support older people in residential low-care facilities as well as in retirement villages and the general community.

The *co-contribution funding model* in DTCs is appropriate and should continue. With the co-contribution from clients set at affordable levels, it still gives people the feeling of empowerment as service users.

Experience shows that many of the current client group utilizing DTCs would be on CACPs or in higher levels of care in residential low-care settings if not for the *rehabilitation/ body maintenance* they receive from allied health professionals in DTCs.

DTCs can integrate well with other services across the sub-acute and primary care service networks. They play an important role in assisting older people to transition to other services, supporting rather than delaying the transition.

Social work is under-represented. Rehabilitation and restorative work involves a blend of physical/ functional therapy work with sensitive motivational input. The psychological approach is of key importance among frail older people with multiple and complex health needs. This approach is essential to supporting people to make decisions and adaptive changes. It combines well with short-term case-management interventions. DTCs provide very good mental health services, eg, people who have had strokes who grapple with big issues and often experience some degree of depression. If you don't deal with this, then physical and functional therapy interventions won't be as effective.

There are very *concrete cost savings that DTCs can and do achieve* for the community and taxpayer. DTCs can improve independence or slow decline. Very concrete outcomes of this are in a reduced need for more intensive care services, or even by way of some programs such as continence retraining and bladder strengthening programs, the need for continence aids.

Practical examples of what happens on the ground

- Individual therapy - Physiotherapy, Occupational Therapy, Speech Therapy, Counselling, Podiatry
- Cooking groups for older men and "men's sheds" as OT and social connection activities
- Stroke groups
- Rehabilitation following cardiac & respiratory episodes and fractured hips
- Upper limb function groups
- Falls and balance

- Continence retraining and bladder strengthening programs
- Parkinson's and movement disorders
- Strength training
- Community access and public transport and walking
- Physio-chi
- Communication groups
- Social support
- Depression, grief, bereavement, emotional and mental health
- Access to equipment from local community
- Short term case management
- Referrals and collaborate with other services and GP's

<u>Differences to other programs</u>

- There are essentially three groups within DTCs
    - people who will recover lost independence or functions;
    - people who will be able to "stay the course"; and
    - people who will need some support to psychologically adjust and adapt their living to declining function or health.
- Therefore, in contrast to Community Rehabilitation Centres, Community Health Centres and HACC Allied Health which are relatively very short term in their engagement with clients, DTC clients are frequently characterized by and still able to benefit by the slow-stream approach. This enables the building of relationships, which complements the psychological approach.
- This long term approach is of itself a foundation for longevity for some people
- DTCs are also different from other service types as being both programs and centres of excellence in older person's wellbeing, independence and adaption to degenerative health processes. This expertise is a workforce strength.
- DTCs do not want to create service dependence but achieve the right milieu and balance of professional and peer support to give people time and encouragement to stay their course, be it transitioning to the next level of care, re-engagement with the wider community, mainstream programs or both.
- DTCs are specialists in chronic and complex support, co-morbidity and frailty.
- When other services say "there's nothing more we can do after 8 sessions" – clients are scoped for discharge, DTC's will continue to work with their clients where the need is indicated.
- DTCs offer a more holistic approach than hospital outpatient therapy departments because of the smaller, inter-disciplinary team model they apply.

<u>Case examples</u>

<u>Mr E</u>

- *Longstanding osteoarthritis of knee*
- *Recently widowed*

- *Decreased confidence & motivation*
- *Living alone / socially isolated*
- *Unable to access community gym groups*
- *Has had HACC funded Physio but now discharged*
- *Is reluctant to attend HACC Planned Activity Groups (PAG) or senior citizens*
- *Referred to DTC by LMO (Local Medical Officer) with concerns re above.*
- ***Since attending, his confidence has improved markedly. Attending weekly for physiotherapy & occupational therapy. Arrives early, leaves late, mood level improved as has his motivation & purpose***
- ***Is becoming more active in the community***

Mrs N

- *L MCA infarct (stroke) in January 2010 causing Right Hemiplegia and Aphasia. Cognitively intact & very aware of what has happened and what is happening to her. Because of aphasia is unable to communicate verbally at all, but has good comprehension.*
- *Initially assessed as high level care. Family was very keen to take Mrs N home.*
- *After 6 weeks inpatient rehab, she was discharged home under Transition Care. Had in home physio twice-weekly during this time. Transition Care now completed with no other follow up physio, occupational therapy, social work or speech pathology.*
- *Mrs N was feeling very down & expressing that she does not want to live. Very anxious about leaving home for any reason.*
- *Referred to Day Therapy. Since attending therapy, mood level has improved. Now happy to attend. Muscle strength in left leg improving, which enables transfers with supervision rather than assistance.*
- *Confidence has improved although with no verbal communication. She is comfortable in a group situation and now feels comfortable being a part of the community.*
- *Mrs N has accessed Physio for muscle strength to help maintain balance & transfers. Can walk small distances with supervision.*
- *Occupational Therapy has been re-educating her in purposeful activities. Now able to partially remove jumper if feeling hot. Can assist with basic cooking*
- *Speech Pathology is assisting with non-verbal communication skills*
- *Social work has assisted family with counseling, POA etc*
- *Nurse has assisted with continence issues and referrals to CAPs*

If not for DTC, Mrs N would not have any access to these services. Finances prohibit private allied health. She would not be accessing the community & her family would be trying to cope with managing her at home. Apart from her physical condition, her mood level was making it difficult for her family to manage at home.

Mrs G

- *Stroke 5 years ago*
- *Referred to DTC 18 months ago.*
- *On initial assessment, Mrs G was High level care, totally dependent on permanent carers in her home for all ADLs (Activities of Daily Living)*
- *Limited mobility & balance*
- *Neck flexed, so unable to stand straight, impacting on balance. Required supports when sitting.*
- *Incontinent*
- *Poor communication skills, showing signs of depression & worthlessness*
- *Unable to access community due to limited mobility, incontinence.*

Since attending DTC,

- *Mobility improved to requiring distant supervision only*

- *Transferring independently*
- *Communication skills improved*
- *Now accessing community events regularly and initiating outings and involved in decision making. Attended a book launch at Crown Casino, which would have been impossible 18 months ago.*
- *Assisting with cooking, dressing, grooming*
- *Continent, although wears pad;, can self initiate going to toilet.*
- *Now could be assessed as Low level care for respite.*

This has all been made possible by the multi-disciplinary team work at DTC. The only other option was private physios to come to the house which again were cost prohibitive. Mrs G had accessed HACC allied health several times in the past, but these services, do not provide the ongoing, intensive therapies available at DTCs.

Mrs H

- *Suffers dementia & osteoarthritis.*
- *High falls risk*
- *Lives with daughter, who works full time, so Mrs H is home alone all day.*
- *Has CACPs supports & attends a PAG at local council.*

Day Therapy has maintained Mrs H's mobility, reducing her falls, improved her confidence and given her another social activity within the group therapy of DTC. Again no other therapy is available to Mrs H through HACC or privately.

Some crucial questions and issues

Diversionary potential

The policy thrust inherent in the rhetoric of the "active ageing strategy" is very sensible. DTCs with their mix of therapy services have a great potential to promote active ageing, independence and capacity building. In this they represent a diversionary service to limit the demand for more frail aged beds and inappropriate hospital or mental health admissions.. But this diversionary potential needs to be more systematically realized and funded. It can save governments very significant dollars in the public physical and mental health systems and residential aged care.

Inconsistent and limited access

There is lack of universal access in metropolitan or rural areas - a very patchwork distribution. We need to rationalize where DTC's are and have a planned strategy to address the profound gaps in access.

A clear focus and commitment to the program's potential

The DTC program appears to have been little understood within the aged care service system and its nexus with the health care system.

There has been long term policy indecision with:

- No growth in global programmatic funding or geographic coverage,
- No strategic approach,
- No innovation funding,
- Increased but confused accountability that does not reflect outcomes achieved,
- No security for services,
- Low annual indexation, almost designed to encourage centres to close down

- Centres generally paying for their infrastructure costs above and beyond both poorly indexed funding and what can be collected through limited client fees.

In this policy vacuum however, DTCs have still taken the initiative to respond better to client need. In spite of their lack of funding and strategic attention, DTC's have benefitted from the low regulation approach and been allowed to be flexible and innovative – within funding.

- **Yet demand is increasing - something is not right.**
  Most DTCs struggle to keep up with demand. As a highly effective and cost efficient, universal service focused on the fastest growing age cohort, this has presented a golden opportunity for a better response to the ageing population that has been flagged in three Inter-generational reports to Parliament so far..

- **Growth funding**
  Despite the demand growth there appears to have been no program growth funds for the DTC program in many years. HACC has been resourced with growth funds; CACPs has extra licences issued each year. But a key support service like DTC has had only minimalist indexation to existing funds levels for many years despite the 85+ target cohort being the most rapidly growing age cohort.

- **Research and evaluation**
  The National Hospitals and Health Reform Commission almost completely ignored prevention, health promotion, wellbeing in older people, yet DTC's can help keep people out of hospitals – an expressed policy goal of government.

  The rest of the health system is catching up with the holistic and restorative approach which has been used for decades in DTC's. But the DTC services are in a holding pattern brought about by successive governments' long term "set and forget" approach to programs.

  There has been little research or real evaluation of outcomes achieved. Statistics are constantly submitted with no feedback to the sector or community. Ongoing research is needed to see if programs are as effective as they could be and how they might need to improve. Day Therapy Centres welcome accountability and quality improvement if it meaningful, appropriate to resourcing and the program, and truly intended to assist growth, development and improvement.

- **Workforce issues for DTCs**
  Allied Health Professionals and the much valued Allied Health Assistant workforce is critically important with an ageing population. Like the rest of aged care there is the need to competitively remunerate as there is competition from acute care, sub-acute care and private practice sectors. Key professional disciplines such as physiotherapy, occupational therapy, speech therapy and podiatry are enormously hard to recruit into DTCs. The Allied Health Professionals Award that covers DTCs has lower rates than the acute sector, plus a number of these professionals are increasingly establishing themselves in private practice.

  Aged care has not attracted new graduates and this includes Day Therapy Centres. However, once people arrive at working in aged care – they find it very rewarding.

  We need to invest more deliberately in diversionary and prevention/maintenance programs such as DTCs. <u>The sector and government need to do a better job of</u>

promoting aged care careers. But the fundamental wage disparity needs to be addressed via Awards and funded by Government in a revised funding model.

- **Services to slow deteriorating health**
  The DTC target group is often not a healthy group. Some people are frail and will require long term support "in-situ" in the community. Yet both community and government seem to somehow be very afraid that people may not get better, become frailer and deteriorate. We forget that not all older people will get better.

  Coping with frailty is a poorly understood area. We need to promote greater acceptance of this part of the human condition. This way we can also embrace supporting people better who experience this and at the same time enable them to feel more at ease. DTCs, with their inter-disciplinary teams, are well-placed to provide the slow-stream rehabilitation and maintenance programs in accessible community settings that can assist older people at this life stage.

- **Demographic basis for funding allocation**
  Current approaches to funding allocations across a number of aged care programs nominate financial and social disadvantage as well as CALD representation as priorities for allocation.

  However whilst a simplistic application of the SEIFA[1] Index of relative socio-economic disadvantage might suggest that Local Government Areas (LGAs) such as Nillumbik or Stonington might be low on the index of disadvantage, this can disguise the fact that there can be neighborhoods within these municipalities that are pockets of significant financial and/or social disadvantage. Additionally, some residents in these areas can be asset-rich but cash-poor.

  Continuing denial or limiting of funding growth over the years for these areas can add to the disadvantage for these people because of the lack of or limitation of the service growth that is needed to cater for their needs.

[1] The Australian Bureau of Statistics – Socio-Economic Index for Areas

5. WORKFORCE FOR A CHANGING CARE NEED

Recommendations:

1. *Government to expand recognition of the long term value of investing in a campaign to promote working in the aged care sector – especially targeted to new graduates.*
2. *A national workforce strategy should incorporate training in a palliative approach as a core competency to be demonstrated by staff from their training.*
3. *The availability of the knowledge base and therefore efficiency of the Registered Nurses Division One and Enrolled Nurses, whether Authorised or not, should remain a requirement in the forefront of the better aged care facilities in the interests of not only resident care but also service efficiency and legal & financial management.*
4. *The promotion of private for-profit operators as providers of aged care be reviewed to ensure that health care is not overlooked in the interests of profit making.*
5. *Funding should be provided to cover the ongoing costs of the re-introduction, through industry consultation, of the nurse/resident ratio to provide a degree of certainty in planning care*
6. *Given that much of the real workforce development occurs 'on-the-job', additional workforce-related funding should be provided to allow adequate coverage by senior nurses for supervision of staff as well as resident care and communication with their relatives, to further encourage registered nurses' employment in the aged care industry.*
7. *The Personal Care Worker staff role should have a Professional Code of Ethics and that all current PCW staff should be required to take further training to upgrade their own skills and practices.*
8. *All staff, including Registered Nurses, Enrolled Nurses and PCAs should be provided with a higher level of basic training by competent nurse educators rather than relying, as is the case now, so much on the individual aged care facility staff, many of whom may not have been sufficiently up-skilled through a personal Continuing Professional Education (CPE) commitment.*
9. *The recent introduction of the mandated CPE program for registered Nurses should be strongly supported and resourced. A similar, mandated CPE should be introduced as part of the framework of a professional Code of Ethics for PCAs.*
10. *The enrolment for training as a Personal Care Worker be better monitored by an external body to avoid the employment of people who are not committed to providing on-going care, and/or who are not able to speak, read, understand and write the English Language as part of meeting the Accreditation Standards.*
11. *The training of Personal Care Workers be driven from a national perspective and that the standards be raised through consultation with researchers, educators and the workforce representatives to include components that meet the real world requirements of providing care for older people with complex needs.*
12. *The cost of pastoral care should be recognised and funded as a legitimate workforce cost element in the funding of aged care services.*

A key ingredient for success

Fundamentally however, the aged care sector will continue to struggle to maintain the necessary upgrade of a skilled workforce whilst the existing remuneration gap exists between the acute health and the aged care sectors.

In this context it is also counter-productive to contemplate mandating of ratios for nursing-to-resident numbers in residential care settings. There are simply not enough nurses prepared to work in the aged care industry whilst there is a financial disincentive.

Similarly, the cost of wage parity with the acute health sector for nurses must be recognized by government in increased subsidy levels sufficient to pay this workforce.

As the population ages and the role of residential aged care is re-focused to concentrate on those with high and complex medical needs and/ or severe cognitive impairment, the skills and training necessary for the workforce in aged care also changes significantly. Later in this and other sections of this submission, there is further comment about the nature of the skills change required.

Pastoral Care in Aged Care

Melbourne Citymission invests a significant sum in funding of Pastoral Care staff to ensure the spiritual and welfare needs of our residents are met. These pastoral care roles are extremely beneficial for the quality of life that can be enjoyed by residents in aged care at whatever level of frailty or functioning they may be. We see amazing stories of personal strength, life satisfaction, self-esteem and reconciliation every day in the work of these staff. Visiting residents who may be temporarily in hospital means an enormous amount for their will power for recovery. Facing end-of-life with a sense of completion can make this phase easier to bear for families and residents. Pastoral care provides this support to people at the times of what can be felt as their greatest vulnerability.

These pastoral care roles should be resourced through the government funding formula for high and low-care facilities and also be available for Continuing Care Retirement Communities, in recognition of the contribution they make to mental and spiritual health for older Australians.

Palliative Care in Aged Care

Importantly, futures thinking about aged care must recognize the importance of a palliative approach in the quality framework for end-of-life care. As argued by Palliative Care Victoria, “A failure to provide optimal palliative care and end-of-life care for older Australians and their families has adverse consequences on their quality of life and also impacts on the wider community through preventable admissions to acute services, which reduces the cost-effective use of health resources”.

The National Health and Hospital Reform Commission stressed that strategies to increase the competence of the aged care workforce in the area of holistic end-of-life and palliative care are urgently required.

An ageing workforce
The existing workforce in aged care is itself ageing and retirements over the next 5 to 10 years will present significant loss of experience and learning from the field. Strategies are needed for transferring this learning to the upcoming generations of the workforce.

A Workforce Strategy

Workforce planning, introductory and ongoing training, skills in a palliative approach, etc all need to be handled as part of an integrated public health and aged care system. An efficient and effective aged care sector is vital to minimize preventable admissions of older people to hospitals and to enable throughput through acute beds in the public health system. Successful admission-prevention strategies and a sound throughput capability in aged care bed spaces are vital for governments to achieve policy objectives in many aspects of the health care system, especially in emergency departments.

The nature of the nursing skills required in residential aged care in particular will not be found among basically-trained Personal Care Workers. Nursing and daily living needs of residents in high care increasingly need a palliative approach.

Solutions will come from recognizing a palliative approach as a *core competency* for all who work in aged care. It should be incorporated into curricula and skills assessment in entry and ongoing training for all direct care staff. A national framework should incorporate a palliative approach as a core competency to be demonstrated by staff from their training.

Aged care staff needs to have access to ongoing support and training to build these palliative approach competencies into aged care practice. Examples such as the role of Link-Nurses who can provide the in-built link to specialist palliative care services for consultation, education and support have much to recommend them[2]. As the volume of need generated by the ageing population escalates, these roles can be part of pragmatic solutions to enable enhanced quality in end-of-life care. They are also consistent with the policy directions foreshadowed in the national and Victorian palliative care strategies[3].

Again - A key ingredient for success

Fundamentally however, the aged care sector will continue to struggle to maintain the necessary upgrade of a skilled workforce whilst the existing remuneration gap exists between the acute health and the aged care sectors.

In this context it is also counter-productive to contemplate mandating of ratios for nursing-to-resident numbers in residential care settings. There are simply not enough nurses prepared to work in the aged care industry whilst there is a financial disincentive.

Similarly, the cost of wage parity with the acute health sector for nurses must be recognized by government in increased subsidy levels sufficient to pay this workforce.

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[2] Miller, S., 2010, *A Model for Successful Nursing Home-Hospice Partnerships,* Journal of Palliative Medicine, Vol 13, No 5
[3] Refer – Victorian Department of Health, 2010, *Palliative Care Service Delivery Framework and Funding Model Review*, http://www.health.vic.gov.au/palliativecare/sdffmr.htm

WORKFORCE – SECTION 2

Preamble:

This section is written by a Registered Nurse who has Gerontological and Health Administration qualifications with a wide range of experience in both acute hospital and aged care facilities. The increasing demands on the workforce as it is currently planned are alarming in the face of the growing numbers of older people who will have a high expectation of care in their later years. I believe that the communication between Government and aged care providers is increasingly hampered and not in the interests of older people who require residential care.

Background:

It is well documented that Australia's older population is in fact getting older. Although many older people will receive assistance with daily living from informal caregivers or from community care services, many will require a higher level of care in a residential aged care facility.

There is a concern regarding the overall ability of aged care providers to provide the expected level of care. The impact on the providers of residential aged care in meeting complex care needs at the care-giving, supervision or administration level has been a concern for many years, particularly as the Aged Care Act has provided a focus for meeting the required Accreditation Standards and therefore retention of ongoing funding.

The employment of a workforce that is able to provide an optimal level of care has been an ongoing concern for many years and has not been adequately addressed. In part this is the result of the multiple sources of providers of aged care. The excellent aged care providers in the acute health setting are able to attract better qualified nursing staff through a higher salary component and staff/resident ratio and through the close availability of well qualified medical and allied staff.

This is not the case for the private operators. The not-for-profit sector struggles to provide services within the funding structure. The for-profit providers aim to make a profit within the same funding.

There has been no precedent in history for best care of older people. Despite available research and rising standards of living in Australia, the health care system for the older person in Australia remains as yet unable to provide optimal solutions to care.

CONCERNS THAT NEED TO BE RELAYED TO THE PRODUCTIVITY COMMISSION ARE MULTIPLE

THE RESIDENT

Increased longevity contributes to the increasing medical frailty of the target population. Care recipients, especially residents in aged acre facilities require an increasingly higher level of care.

What is not well documented with any concentrated impact is that many older people who receive residential care will most often have varying degrees of multiple co-

morbidities and/or severe cognitive impairment. In addition, it remains well documented both internationally and in Australia, that pain remains under-treated for a high percentage of older people living in an aged care facility, .although a high percentage of older people are estimated to have pain-generating musculoskeletal disease,

In meeting complex medical care requirements arising from co-morbidities, caregivers also aim to provide best outcomes in relation to quality of life as residents are moving toward the end stage of life and receive pastoral and palliative care. The complexity of care needs for older people in aged care facilities, who are indeed medically frail, can often place a high demand on providers of care, many of whom do not have a background that promotes an understanding of the health care needs.

THE WORKFORCE

Registered Nurses

Currently, Registered Nurses Division One identify, establish and manage the care need of a diverse range of residents with a wide range of diagnoses requiring medical interventions. They are required to supervise the care provided by junior staff, manage the concerns of relatives and maintain document care requirements, accreditation and continuous improvement strategies within ever-increasing financial constraints and legislative requirements.

The essential service of the registered nurse that is required by aged care providers has been overlooked for many years despite the awareness that the numbers of older people are increasing. Nevertheless, over the past years in view of the ageing population, there has been a financially motivated decision to reduce the number of registered nurses and to increase the numbers of the lower paid personal care workers.

It is recommended that:
*the availability of the knowledge base and therefore efficiency of the Registered Nurses Division One and Enrolled Nurses, whether Authorised or not, remains a requirement in the forefront of the better aged care facilities in the interests of not only resident care, efficiency and legal and financial management.
* the promotion of private operators as providers of aged care be reviewed to ensure that health care is not overlooked in the interests of profit making.
*funding be linked to the re-introduction, through industry consultation, of the nurse/resident ratio to provide a degree of certainty in planning care.

Personal care workers

Firstly, personal care workers are currently trained to provide assistance with activities of daily living for residents in today's aged care facilities. However, the requirements of an older person in Australia for a safe end-of-life as they have come to expect in earlier years, are also linked to personal, emotional and cultural needs and more essentially, the diagnosis and management of special care needs and the presence of pain. These are not understood and are indeed overlooked by inadequately trained staff. The personal care worker may identify a problem using 'intuition' rather than evidence-based practice. As a result, the supervision of work practice required by personal care workers is high. This situation is difficult for a resident and the employee as well as the supervisor of care who is ultimately responsible for the complex care of a large number of residents.

Currently, best practice appears to be overlooked in the interests of providing cheap labour.

Secondly, there has been much industry discussion by aged care and education providers regarding complaints of perceived lack of time available to personal care workers. ***The time has come to take notice of those in the workplace****. In part, the recently trained staff are unable demonstrate efficiency in the workplace for the above reasons. Consequently, the morale and self respect of a committed personal care worker, who is providing an essential and difficult service remains low as does the salary. In addition, the daily demands of care-giving for high number of older people, many of whom are unable to communicate or have behavioural differences, prohibit efficient practice in an ongoing manner.*

It is recommended that:

**** additional workforce-related funding to allow adequate coverage for resident care and staff supervision is essential to further encourage the employment in the aged care industry.***

Employment

Employment as a personal care worker is often sought as a stepping stone toward further qualifications, not necessarily in health care, and thus may not be 'committed' to caring for another person. Due to the low base salary, some employees may work at multiple facilities, often leaving one to travel to another on the same day and increasing the risk of injury to themselves of those for whom they care.

Training

The vast majority of recent applicants for the position of personal care worker have limited English speaking and reading skills. However, it is essential for best practice in each aged care facility that, as well as reading and understanding care plans, policies and procedures and the outcomes required for Accreditation purposes, staff are able to communicate with the older person for whom they provide the most intimate of care. This is not only difficult for the staff member but also for the older person who in turn is unable to communicate their requirements with the employee.

It is recommended that:

****all staff, including Registered Nurses, Enrolled Nurses and PCAs are provided with a higher level of basic training by competent nurse educators rather than relying, as is the case now, on the individual aged care facility staff, many of whom may not have been sufficiently upskilled.***

**** the enrolment for training as a Personal Care Worker be better monitored by an external body to avoid the employment of people who are not committed to providing on-going care, are not able to speak, read, understand and write the English Language as part of meeting the Accreditation Standards.***

****the training of Personal Care Workers be driven from a National Perspective and that the standards be raised through consultation with educators and the workforce representatives to include components that meet the real world requirements of providing care for older people with complex needs.***

**** the Personal Care Worker have a Professional code of ethics and that all current PCW staff are required to take further upgrade their own training.***

6 WHO SHOULD PAY & WHAT SHOULD THEY PAY FOR?

Recommendations

1. *Those who can afford to pay should contribute to the costs of their care and the costs of their accommodation where that is provided. Government subsidies should ensure an adequate safety net for all.*
2. *The funding model should enable providers to be resourced to provide high quality care in a manner that is financially sustainable for both annual operating costs and for medium and longer term capital needs.*
3. *The sustainability of aged care services needs to be secured by setting subsidies and prices based on the provision of flexible services in an open market and requiring those who can afford to contribute to the cost of their care and accommodation to do so.*
4. *Means testing and the role of Centrelink should continue. Providers need an independent, external body for the net assets assessment, which is the basis for the determination of accommodation bond amounts.*
5. *A relevant external benchmark for monitoring inflation impacts on aged care sector costs should be agreed between the Government and the industry and set as the basis for annual indexation of subsidy levels.*
6. *There should be a graduated range of subsidy levels for Supported Residents Supplements that removes the single step 35% financial penalty that currently applies when a facility falls below the 41% occupancy threshold for Supported Residents.*
7. *The Government should examine introduction of an Aged Care Levy in the taxation system, as a social insurance levy similar in function to the Medicare Levy.*
8. *For capital and infrastructure funding needs, the current model of accommodation bonds and Supported Resident Supplements should be extended to all admissions to residential aged care by abandonment of the distinction between low and high-care entries for these purposes.*

Capital Funding

The lifting of the ceiling on Accommodation Bonds for low-care has been a good move. However, maintaining the low ceiling on maximum amount of retentions per month is still an impediment in the revenue streams that providers have available to recover the costs of capital outlays and ongoing major maintenance of facilities.

The level of Accommodation Charges set for high-care is grossly inadequate to cover the capital costs of residential facilities.

Capital and infrastructure funding needs (ie, annual contributions to the cost of providing the accommodation) would be better served by abandoning the distinction of low and high care. The accommodation contributions could still come from residents electing to pay an accommodation bond via any of the current arrangements, ie, either in full, via instalments or to make Periodic Payments. The Periodic Payments would be sufficient to cover the normal retentions value at a monthly rate plus the deemed

interest on the bond at the MPIR (Maximum Permissible Interest Rate). This facility is already available within the options for low-care bonds. It would simply be a matter of extending it to all residential aged care admissions. It may be anticipated that many residents/families will elect Periodic Payments as their choice for payment where the admission will be effectively for high care.

Government subsidies will need to be maintained as part of the safety net model for citizens of low or no means. However, please refer to comments below about the shortcomings of the current approach used in the Supported Residents Supplements ratio-based payments.

Importantly, the assessment of net assets for means testing should remain with Centrelink, as an arm's length external body independent of the aged care provider.

Operating Costs

Government subsidies under the ACFI formula are simply not adequate to cover the costs of high quality care, regulatory compliances and the costs of in-service training to maintain an adequately skilled workforce.

Supported Residents Supplement

Funding adequacy is undermined for those providers that seek to make residential care accessible for supported residents. The "sudden death" nature of the funding supplements for supported residents being discounted by 35% once the 41% occupancy threshold is not achieved is too severe. There should be a graduated range that can at least better recognize financially when providers are considerably in excess of the regional base occupancy percentage for Supported Residents but not quite at the 41% level.

We are regularly moving backward and forwards across this 41% threshold level, at times achieving only 38% to 40.7%. In these situations, the Supplement rate that we currently receive is only $12.31 per day rather than the $18.82 full rate. This represents a 35% penalty.

For Melbourne Citymission, the annualized impact of this penalty is $42,000 reduced Supplement payment for these 24 residents in a 60 bed facility. For the sake of having one or two residents below the 41% threshold, this is a severe penalty.

The risk is that this sets up a potentially perverse, reverse incentive for providers to only accommodate the regionally designated minimum level of Supported residents (eg, 23% for Melbourne Metro NE Region) if they cannot be regularly achieving the 41% threshold or above. Ultimately this reverse incentive can undermine the policy objective of ensuring sufficient places are available for Supported Residents. This is of particular concern to Not-For-Profit providers as a social justice issue.

Annual Indexation of Government funding

The government's practice of maintaining continuous annual 'productivity cuts' to subsidy levels for many years by always setting the annual indexation rate well below the CPI or any other more relevant index of inflation has further undermined the financial sustainability of the aged care sector.

The nature of the nursing skills required in residential aged care in particular will not be found among basically-trained Personal Care Workers. Nursing and daily living needs of residents in high care increasingly need a palliative approach. Therefore to benchmark the annual indexation of ACFI subsidies, etc on the determinations of the movements in the 'minimum wage' by the Fair Work Australia pitches the indexation at the wrong level in the labour market. Pitching the subsidy level at the lowest common denominator in the labour market will not help aged care providers to employ a workforce with sufficient skills to respond to the increasing complexity of care and daily living tasks needed.

The 1.7% indexation in the current year is indicative of this point. It is hard to understand in the midst of the Government finally establishing this Productivity Commission Inquiry in response to advocacy from the aged care sector for a number of years. A more relevant external benchmark for monitoring inflation impacts on aged care sector costs should be agreed between the Government and the industry and set as the basis for annual indexation of subsidy levels.

Whilst a significant level of co-contribution will still be needed from those who can afford to pay, the Government's 'Safety Net' payments for the financially disadvantaged should continue through Supported Residents' Supplements. These supplements however, need to be increased to enable improved provision of allied health services and lifestyle programs, especially for residents in high care.

Government funding sources – A Social Insurance Levy

The Government may wish to consider implementation of a social insurance levy as an adjunct to the income tax framework, similar to the Medicare Levy. Australia currently has transparent mechanisms to help fund the public health system and citizens' retirement. Why not introduce an Aged Services Levy in addition to the Medicare Levy?

A recent study by KPMG suggests that a new Aged Care Levy of 1.41% on total Australian income in 2010, rising to 2.32% in 2050 would raise $8.9 billion initially, increasing to $115.7 billion by 2050.

A transparent Levy such as this would give governments a predictable revenue stream from which the rising costs associated with the ageing population could be covered.