
Aged & Community
Services • Australia

# ACSA's Submission to the Productivity Commission Inquiry Into Caring for Older Australians

July 2010

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## Executive Summary

Aged and Community Services Australia (ACSA) has prepared the following submission with a focus on what *Caring for Older Australians* should mean in a future aged care system.

ACSA, along with many other peak bodies, organisations and consumer groups, has made numerous submissions and prepared policies and statements on the failings and challenges facing the aged care system. ACSA's documents can be viewed at www.agedcare.org.au. Key documents will accompany this submission.

It is however, important to highlight specific areas which need to be addressed by this inquiry. They are:

- Funding that doesn't match the cost of care and services
- Unsustainable capital options to build new facilities
- The impact of over regulation on service flexibility;
- Funding for rural and remote services
- Workforce Planning and Development
- Increased demand for community care services
- Gaps in housing for older people
- Services and funding for special needs groups
- Incompatible fees and charges for residential and community care
- The disconnect between aged care and medical services
- Inconsistent assessment processes;
- Technology
- Aged Care Partnerships
- The bigger picture of ageing

**The Future**

We envisage aged care as an entitlement, based on assessed needs, whereby older people can be effectively and consistently assisted to live satisfying, self-directed lives.

The assessment process is particularly important for service delivery to meet the ongoing needs of older people. We propose a staged process which would allow for comprehensive information on aged care services to be provided in addition to identifying measures to foster independence and well being, thereby avoiding intervention when, if, health and social issues arise in later years.

Standardised assessment tools would be adopted throughout each phase of the process and be appropriate for all groups including culturally and linguistically diverse groups and people from indigenous backgrounds. The needs of carers would also be captured.

Electronic records, supported by the Unique Health Identifier, will ensure accurate and current information is there when it is needed, particularly when an older person enters the aged care system following a health crisis.

A combination of government funding and user-pay options will facilitate the provision of ageing care and support services, which older people will be able to select according to their needs in a residential care or community setting.

The Commonwealth Government must have full responsibility for aged care with its funding being channelled through a single consolidated program.

In those areas where there are additional challenges to deliver the necessary services and options for older people, such as rural and remote communities and groups with special needs, a different approach is required. Better resourcing and specialist providers are part of the solution.

Disadvantaged and low-socio economic groups will also require measures to support provision of services including residential care.

Community care will be the foundation of aged care services into the future with residential care catering for more people with high needs. Progressive models providing housing in a community setting with facilities for those with more complex needs will become a more significant component of aged care.

In principle, the proposed health care networks are also a positive move in helping older people maintain good health which often dictates where they live as they age. Linking these new structures with aged care services at the local level will help to make effective health reform a reality.

In the broader context, a whole of government approach is imperative to link all facets of aged care with a range of government portfolios including housing, local government, indigenous and multicultural affairs, planning and infrastructure and employment.

**Funding**

With the demand for aged care services set to rise dramatically in the coming decades sustainable and responsible funding mechanisms are critical. Funding must meet the full operational and capital cost of delivering quality aged care services.

Acknowledging there is an onus for each of us to have some responsibility for our needs as senior citizens, and the likely impact of a reduced workforce due to our ageing population, options for paying for aged care services must be considered.

Paying for our own accommodation is a given at each stage of our lives. However, people should have options for how they pay for accommodation in a residential aged care facility. Options could include paying rent, deferred contributions from estates, a refundable lump sum which in effect is a loan, or other negotiated arrangements.

**Regulation**

Regulation of the aged care sector suffers from a conflict of interest particularly in relation to complaints and quality monitoring. Government has a vested interest in protecting political and bureaucratic reputations as well as resolving complaints to the satisfaction of those involved. Monitoring compliance with the Aged Care Act is subject to the same conflict.

A more appropriate governance structure is needed along with improved fairness and clarity of roles and with a greater level of independence.

Where possible existing regulatory mechanisms should be used rather than aged care specific ones.

**Housing**

Appropriate and affordable housing is a service provided by many ACSA members and is a major consideration for many older people. ACSA and COTA have released a discussion paper calling for a national older persons housing strategy. It focuses on maintaining and enhancing existing housing to ensure it is safe and accessible for older people, as well the need to increase the supply of affordable and appropriate accommodation.

Universal design principles will assist in developing homes suitable for ages, including old age.

Understanding how and where older people want to live is integral to how we plan and develop future communities and housing.

**Workforce**

A sophisticated approach is needed to address workforce issues including staff shortages and difficulties in attracting aged care professionals.

ACSA believes that local avenues should be exhausted for staffing needs but acknowledges that overseas workers are necessary where there are chronic shortages.

ACSA is calling for a new and expanded *National Aged Care Workforce Strategy* that covers all categories of worker and is based on sound workforce planning data.

**Regional, rural and remote aged care**

Regional, rural and remote communities require better integrated health and aged care services incorporating a cross-section of community services including health and residential aged care providers. ACSA supports the development and expansion of integrated health and aged care services that are locally designed and managed (MPS like services) following a national evaluation of the MPS program.

**Special needs groups**

Indigenous aged care has suffered from a lack of comprehensive planning in areas where services are vulnerable to pressures caused by isolation and financial difficulties. ACSA believes that the Remote and Indigenous Service Support (RISS) program should be rolled out urgently with a capacity building and community development focus.

As a principle ACSA believes that any changes to the aged care system should secure improved access to services for those with special needs.

## Recommendations

ACSA recommends:

1) A whole of Government approach, including local government, be taken to prepare, plan and support an ageing Australia and aged care services.

2) That the aged care be an entitlement, based on assessed need.

3) That a tiered system of assessment using a standardised suite of tools be used across settings to establish people's needs and appropriate government funding levels.

4) Consumers be offered personalised information and advice based on their specific circumstances so that they can make informed choices about their care.

5) That all government funding be combined into one program to create funding packages based on individual needs and on the real cost of delivering the care required in the location required.

6) That, if a more market oriented approach is adopted, supply and price controls be relaxed together, in a staged approach.

7) That, if a more market oriented approach is adopted, a range of measures to deal with special requirements be put in place. These need to include:
   - Development of locally managed and supported integrated services
   - Providing additional funding to specialist providers
   - Providing additional funding to support services such as PICACS and AHCA
   - Government purchasing of concessional places at levels required in particular areas.

8) That aged care services be funded to provide restorative care.

9) That further work be undertaken on appropriate links between aged care services and health services at the local level.

10) That implementation of the *Electronic Medication Management in Aged Care* solution be funded.

11) That a coordinated and revamped national approach to the provision of 'aids and equipment', including assistive technology, be developed.

12) That access to capital for residential aged care be enhanced through:
   - Uncapping the daily accommodation charge for those with high incomes and increasing it for those on a medium income so it is equivalent to the average building costs of residential care in the relevant region;
   - Introducing the option of bonds for high care; and
   - Linking government payments (the accommodation subsidy) for concessional residents to the average cost of building residential aged care.

13) That care and support services be funded by a means tested mix of government and user payments.

14) That a new governance structure for the regulation of aged care be developed including:

- The use of existing regulatory structures where these exist rather than developing aged care specific ones;
- Independent assessment particularly for people with more complex needs;
- Independent and transparent setting of prices;
- A more open approach to the provision of accreditation services under the JAS-ANZ system; and
- An independent complaints system.

15) That a partnership relationship between the government and the aged care industry be put in place.

16) That a whole of government housing policy for older people be developed focusing on:
- Maintaining and enhancing existing stock; and
- Increasing the supply of affordable and appropriate housing.

17) That the regulation of retirement villages continue to be separate from aged care regulation.

18) That the *National Aged Care Workforce Strategy* be updated with particular emphasis on:

- Introducing regional workforce planning and projections;
- Broadening the plan to include community care, allied health and ancillary workers;
- Leadership and management development; and
- Redefining the roles of nurse practitioners, registered enrolled nurses, personal carers and community care workers.

19) That a review of the temporary migration program be undertaken to extend the scope of the in-scope workforce to include suitable short-term skilled and non-skilled workers who can provide care services in areas of critical labour under-supply.

20) That a comprehensive national evaluation of the MPSs be undertaken.

21) That the development and expansion of integrated health and aged care services that are locally designed and managed be supported.

22) That the Remote and Indigenous Service Support (RISS) program should be rolled out urgently with a capacity building and community development focus.

23) That a "cultural pool" to fund the additional costs of providing services to CALD older people be established and funded.

24) That, if the ACAR process is discontinued, new methods of giving appropriate priority to services for homeless older people be developed.

25) That additional funds be made available to the ACHA program.

# 1. INTRODUCTION

Australia has a remarkable aged care system which currently provides services, housing and support to approximately one million people per year. Overall, aged care is a $10 billion industry. Residential aged care alone is the 9th largest employer in the country. Aged care providers and their staff strive to provide the highest possible quality of care within the existing program, financial and regulatory regime.

We know that the numbers of older people requiring services and support is increasing and that the numbers of taxpayers to fund the care is shrinking. We know also that the system is under increased pressure and is facing a serious threat to its overall sustainability. The status quo is not an option.

This inquiry is critical and overdue in addressing the growing challenges facing the aged care industry and the provision of quality care to older Australians.

In this submission ACSA wants to focus on what the system should be rather than on the well known failings of, and challenges facing, the aged care system. A brief outline of the issues, including reference to our many previous submissions, policies and statements on these points is included in Section 2. However this submission will focus on outlining possible features of a future ideal system in Section 3.

This submission is presented as only one of a number of interactions ACSA seeks to have with the Commission throughout the course of the Inquiry. We are continuing to work on elements raised in this submission and within the breadth of the Terms of Reference for the Inquiry. It is our understanding that the Inquiry will use an iterative process and will seek to engage with key players, such as ACSA, throughout. We welcome and support this approach.

# 2. THE CHALLENGES AND ISSUES

Australia's aged care system is under ever increasing stress on a number of fronts. Previous reviews, and the Issues Paper released for this inquiry, show just how much is already known about the challenges confronting the aged care system.

This section of the submission will briefly outline some of the key issues which must finally be addressed as a result of this Inquiry and refers the Commission to previous ACSA recommendations on required action.

There are a range of issues that affect the system. The main issues of concern to providers are listed first.

## Funding which does not meet the costs of the care provided and expected

Recurrent funding for residential care is, for some categories of residents, not adequate to cover the cost of caring for the person. In community care funding is based on arbitrary packaged or unit prices. The real value of residential and community care funding has been declining over recent years. The result is decreasing services for older people.

The current indexation methodology for residential and packaged care is based on the COPO formula. This typically delivers an annual average increase of around 2% (sometimes less, as was the case this year with an increase of only 1.7%) while aged care providers are typically experiencing annual cost increases of approx 5 – 6 %. These increases are largely due to rising wages which represent 75% of a provider's expenditure. The current award modernisation process will increase costs further in some States and utility prices are increasing rapidly in many. Funding for aged care should meet the full recurrent and capital costs of service delivery.[1]

For the most recent analysis and description of the severe financial issues facing aged care refer to the *ACIC 2010-11 Federal Budget Submission (January 2010).*

## An unsustainable capital raising system to build residential aged care homes

The capital cost of aged care homes is financed through a combination of government funding and user contributions. Older people without sufficient assets, as assessed by a Government test, do not have to pay a contribution towards the cost of their accommodation. Government pays $26.88[2] per day for those persons without sufficient means. Independent analysis shows that the cost to build high care beds is at least 50% more than that.[3] Some 72% of new residents in aged care homes require high level care. These clients pay much less than the real cost of the accommodation provided. A sustainable capital system must be created to ensure the ongoing provision of residential care.[4]

For the most recent analysis and description of the capital issues facing aged care refer to the *ACIC 2010-11 Federal Budget Submission (January 2010).*

## Regulation

Giving consumers greater choice is also about giving them greater control of the services they receive to support their lives. It is about respect. In our current system the Government at both political and bureaucratic level tend to speak for consumers; to define their needs for them; and to regulate service quality on their behalf. This is done with the genuine aim of looking after vulnerable older people. The weakness in this system is that the Government – the Minister and the Department of Health and Ageing - has a structural conflict of interest on a number of fronts. These include:

- **Complaints.** The government has an interest in protecting political and bureaucratic reputation as well as in resolving complaints to the satisfaction of the parties to them. It is not a neutral player.

- **Quality monitoring.** While the Aged Care Standards and Accreditation Agency is separate from the Department, monitoring compliance with the Aged Care Act is not and is subject to the same conflict of interest outlined above.

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[2] The rate of payment will increase to $32.30 by 20 September 2011

[3] It has been estimated very conservatively that a 'break even' cost per bed per day is $40.32, not including the cost of the land, care provided or any return on investment. *Economic evaluation of capital financing of high care, March 2009.* Report by Access Economics Pty Limited for Anglicare Australia, Baptist Care Australia, Catholic Health Australia, Churches of Christ Living Care, Lutheran Aged Care Australia, Sir Moses Montefiore Jewish Home, National Presbyterian Aged Care Network, UnitingCare Australia.

- **Price Setting.** The Government's new health and hospital networks are to have the prices set by an independent authority. This idea should also be investigated for aged care.

The aged care system of the future will need a more appropriate governance structure for its regulatory functions.

**Over regulation limiting flexibility**

Aged care is over regulated. Over the years governments have established a number of requirements which duplicate other more appropriate regulation (e.g. certification – which duplicates the Building Code of Australia and is now being removed); confuse compliance and quality (e.g. CIS and the Accreditation Agency); and remove an older person's rights and dignity of risk (eg. compulsory reporting[5]). Aged care staff spend considerable time meeting and reporting on regulatory requirements including aged care specific ones (eg CIS, funding) and generic ones (eg OH&S, privacy, food safety). It is not uncommon for specialist staff to be employed to manage these requirements. The regulatory regime must be overhauled to ensure the right level of safety and security for clients and accountability for public funds, while removing unnecessary and duplicative requirements. ACSA has consistently advocated for the removal of certification and extra service status requirements, an open accreditation system operating under the JAS-ANZ framework[6], and the modification of compulsory reporting, police check legislation and aspects of prudential requirements.

> *One of our Hostels is, today, having an unannounced visit by the Agency. This same Hostel had their N.S.W. Food Authority inspection just yesterday, (which I might add, resulted in an "A" rating). Including today's visit, this brings to a total of the visits from the various regulatory bodies i.e., DoHA, Accreditation Agency, Food Authority, ACFI, our sites have had this year, since January 1st, to today, i.e., 7 months, to 31. I find this a rather extraordinary situation. Particularly coupled with the fact, that, on each visit we are asked what quality improvements we have completed since the last visit! Well, I think given the frequency of their visits, and hence the small window of time between visits, we could be forgiven for thinking this is a somewhat unrealistic ask.*
>
> *Aged Care Provider*

For more detail on ACSA's position on regulation refer to *ACSA's Submission to the Productivity Commission's Annual Review of Regulatory Burdens on Business; Social and Economic Infrastructure Services (March 2009)* and also the *ACSA Submission to the Review of the Accreditation Process for Residential Aged Care Homes (July 2009).*

## Funding for Rural and Remote Services

Rural and remote providers face additional extraordinary costs in providing support that in the cities would be considered to be run of the mill.

Some of the more glaring examples are:

[5] Paul Sadler *Elder Abuse: One Report Too Many* October 2009 (www.agedcare.org.au)

[6] The current aged care accreditation system is program-based, however many aged care providers offer a broader range of services than this. An accreditation system which allows for the whole range of services to be in scope would be more efficient, and more robust in this context.

- The cost of food in remote areas can be up to 70% higher than in metropolitan areas. Around 70% of remote providers deliver meals to clients as part of their care package compared to 29% nationally.
- Travel costs are 3 times higher in remote areas. To balance the books they reduce staff hours.
- Heavy reliance on agency staff who can cost as much as $53 per hour or $500 a day when permanent staff are not available. Others have resorted to fly in/fly out staffing at great expense.

The biggest issue facing rural and remote providers is the recruitment and retention of appropriate staff. Additional measures are required to ensure that essential staff are available. This is well known and understood in the mining industry which build higher wage, housing and travel costs into their budgets. Rural doctors are offered incentives to move to rural and remote areas such as relocation grants, paid locum relief for holidays, personal and family support, such as orientation of the family to the area, housing and school assistance, social activities, assisting partners to gain employment and more.

There is no such recognition of the realities of operating in remote areas in aged care funding. The residential and community care viability supplements do very little to offset these costs. The highest community care viability subsidy rate is 26.6% above the daily care subsidy and for most providers this does not come close to covering the additional locational costs.

Subsidies will need to address the real costs faced by rural providers if they are to remain viable and if clients are to receive the level of service they require and deserve.

For further detail about the funding challenges facing rural and remote aged care services refer to the ACSA paper *We Make Do: A Review of the Community Care Viability Supplement (June 2009).*

## Workforce planning and development

The industry is experiencing increasing difficulties in attracting and retaining all types of staff required to deliver critical services. A quarter of personal carers and community care workers (the largest group of employees) and one in five nurses have to be replaced each year[7]. This difficulty is partially created by workforce shortages and lower rates of pay in aged care than in public and private hospitals. However not enough is being done to secure a committed, qualified and valued workforce for the future.

Service delivery models in residential care are heavily premised on the availability of nurses at a time of international shortage and are based on inflexible roles. The models don't utilise the nurses' skills effectively. New models, such as those which support arrangements with health/medical care staff, which utilise nurses', and all staff, skills more effectively, are required.

In community care, Government program constructs and industrial demarcation create rigidities that work against flexible service delivery.

The key workforce plan, *The National Aged Care Workforce Strategy 2005*, is out of date and only covers residential direct care workers.

[7] Martin B, King D. *Who Cares for Older Australians: A picture of the residential and community based aged care workforce 2007* (2008) National Institute of Labour Studies

For more information on workforce challenges refer to ACSA's Background Paper *Working Together: Aged & Community Care Workforce (September 2007).*

## Increasing demand for community care services

In 2007, the Australian Institute of Health and Welfare (AIHW) reported that 1,004,400 Australians aged 65 years and over needed some form of assistance to help them stay in their own homes. More than 330,000 of these people indicated their care needs were being met only partially, and over 50,000 indicated that their needs were *not being met at all.*[8] In attempts to meet this demand, community care services are being rationed and spread thinly with approximately a quarter of a million older people receiving an average of just 31 hours domestic assistance per year (or 35.7 minutes per week) and 80,028 very frail clients receiving an average of 54 hours of personal care (showering and shaving) per year (or 62 minutes per week).[9] The number of hours being provided in packaged care is declining with most people currently receiving around 5 hours per week from a CACP package. There needs to be more community care available, as well as greater flexibility for services to meet the increasing needs of clients.

For more information on ACSA's position on community care service delivery refer to *New Generation Community Care (August 2008),* and *ACSA's Submission to the Review of Subsidies and Services in Australian Government Funded Community Aged Care Programs.*

## A growing gap in housing availability for older people

The ageing of the population will have significant impacts on the housing sector as the proportion of older households is projected to grow from 19% to 28% of all households over the next 20 years. This represents an increase from 1.6 million households to 3.2 million households. This group is growing faster than younger household groups[10].

Owner occupation will remain the preferred type of tenure but the projections underlying demand indicate that there will be pressures on both public and private rental markets to meet the need of older renters. Over the same 20 year period demand from older renters is projected to rise from 146,200 to 321,400 for private rental and 86,500 to 189,800 for public rental – an overall increase of 120%[11].

Housing options that support independence and/or offer a significant level of care will be in greater demand. The provision of housing for older people is sound public policy as:

- the scarcity of affordable housing is a serious contributor to poverty and disadvantage amongst older Australians;
- accessible housing promotes independence and reduces older peoples' social isolation; and
- well located appropriate housing promotes healthy ageing.

[8] AIHW *Older Australians at a Glance* (November 2007): 102-104.
[9] HACC MDS Statistical Bulletin 2006-07: 13-14 http://www.health.gov.au/internet/main/publishing.nsf/Content/hacc-pub_mds_sb_2006-07.htm~hacc-pub_mds_sb_2006-07-3.htm
[10] The National Housing Supply Council's 2nd State of Supply report 2010
[11] The National Housing Supply Council's 2nd State of Supply report 2010

## Services and funding for special needs groups such as homeless people, indigenous people, and people from culturally and linguistically diverse backgrounds.

Currently the mainstream aged care system does not deal consistently well with all special needs groups. There are some high quality services run by specialist providers, but they are not available in all regions or to all special needs groups. The system needs to be able to provide equally good service to special needs groups throughout Australia.

## Incompatibility of fees and charges across residential and community care programs.

Fees and charges for community and residential care services bear no relationship to each other. Fees for residential care are complex and difficult for consumers to understand. Community care clients pay only a small amount in fees with no one being able to be denied a service if they can't afford to pay. HACC service fees are far lower than packaged care fees and some clients who should really receive a package of care refuse to take them up because of the increased costs. Fees and charges which are transparent and easy to understand need to be introduced. This is increasingly important as, if seems likely, we move to a system which requires a greater level of user pays.

## A disconnect between aged care and medical services including GPs and hospitals

Despite the fact that older people are typically users of the whole range of health as well as aged care services, the two systems are remarkably poorly linked. It is difficult for people in residential aged care to see their GP and difficult for GPs to prioritise such visits. As well as remuneration issues, GPs and their representative bodies cite the lack of consulting facilities in aged care homes including access to their office IT systems, and a lack of staff to support them in such visits. This is a longstanding issue and results in the potential neglect of some medical conditions as well as admissions of people from residential care to hospital because they are unable to access a GP.

Similar issues arise between aged care services and hospitals. Hospitals complain when aged care services send them people who may not require acute, as opposed to primary, care or, conversely, that aged care services have not done enough to respond to medical issues. Aged care services complain about older people being discharged at inconvenient times, without sufficient information about their ongoing clinical needs such as medication (including very limited, if any, supplies of it) and sometimes about pressure sores or other ailments acquired during their hospital stay. Discharge is also a major issue for community care services. Older people need good access to GPs and other medical specialists wherever they reside. The systems need to work seamlessly together.

**Restorative Services**

Unless an older person has acute health care needs to be addressed, hospital is the worst place they can be. However they often end up in hospital or stay there for longer than they need to because of a lack of community and residential care services and a lack of effective transition or sub acute care services.

These services are currently provided predominantly in hospitals or related facilities. There are also Day Therapy Centres based in residential care facilities which provide rehabilitation and maintenance. There is a small number of home based programs. Government has put considerable resources into transition care services in hospitals over recent years.

However, these services are not available in every region and can be hard to access

## An inconsistent assessment process across services

Individual older people can be assessed many times, being asked the same questions and repeating information, to receive the aged care services and support they need. Assessments are necessarily undertaken by many different bodies including service providers, ACATs (for residential and packaged care) and veterans' assessment agencies, as well as occurring in hospitals. There are no standardised assessment tools or processes. People are often assessed in terms of the services and support that can be provided by a particular service rather than the needs they have.

In practice, aged care operates as a continuum of services. Access to the continuum should be easy and there should be good communication and sharing of information between the connected parts.

For further information on ACSA's position on assessment refer to *Connecting & Integrating Health and Aged Care Services: ACSA's Response to the National Health & Hospitals Reform Agenda (December 2009).*

## Technology

### Information Technology

Unlike other areas of the health and care system aged care has had very little investment by Government in information technology.

The Aged Care Industry Information Technology Council, created by the industry peak bodies, has been formed to give a focus in this area. It has provided oversight on a recent major project, funded by the Department of Health and Ageing, to develop an approach to Electronic Medication Management (EMM). This is now ready for implementation and needs to be funded.

Aged care services stand to benefit from improved access to broadband internet which will also support coordination with health services.

### Assistive Technology

Technology that enhances older people's capacity for independent living is 'coming out of the lab' and into aged care services. A small investment by the Australian Government in this area has now been curtailed. A systematic approach to encouraging the development and roll-out of such technologies is now required.

## Aged Care Partnerships

The most effective and efficient aged care services will be developed and delivered when there is a working partnership between the industry, government and consumer groups. For aged care providers the most problematic relationship is with the Commonwealth Government through the Department of Health and Ageing (DHA).

At the operational level DHA often has a poor relationship with industry and sometimes takes a combative approach to working with service providers. The Government has sometimes adopted a 'naming and shaming' approach on service quality issues which contributes to an overall poor community image of aged care providers. This has severe negative consequences for workforce recruitment and also for older people who delay accessing needed services (particularly residential care) or are generally fearful of receiving services. This is, most often, not borne out by their experience as ACSA research has shown that 4 in 5 consumers were satisfied overall with the services they receive including the quality of care and accommodation.[12]

## Government responsibility for aged care services

COAG has determined that aged care services will become the responsibility of the Commonwealth Government. In community care this move will allow consolidation of more than 15 separate community care programs. Government could then create one funding program, including a single quality and accountability regime, producing a much stronger community care system as well as an administrative saving which can be invested in better supporting older Australians. However Victorian and Western Australian state governments are not participating in these changes. It is important that consumers and providers in those states enjoy the benefits such consolidation will offer.

## A Bigger Picture

With the exception of the *National Strategy for an Ageing Australia* in 2001, Government has confined its consideration and solutions to aged care challenges to:

- a small number of specific programs; and
- creating aged care specific parallel systems (for example an aged care specific accreditation agency and an aged care specific complaints process).

In recent times it has also begun to look at ageing within the health system. What is required is a whole of government strategy across many portfolios – health and ageing, housing, indigenous and multicultural affairs, planning and infrastructure, employment etc – to ensure that the policy settings support our ageing population. Perhaps the best example of the need for a whole of government approach is the need to create aged friendly cities/environments. This includes universal building standards (which are now being implemented, voluntarily, in Australia), the need for better lighting in public areas, seating for older people to be able to stop and rest when out walking to name just a few requirements. These things would make it much easier for people to continue to live in their own home but require policy changes in planning and infrastructure rather than in aged care programs.

[12] ACSA Where would we be without them? Research Findings on the Aged & Community Care Industry Image Project (August 2008).

**Recommendation 1**

ACSA recommends a whole of Government approach, including local government, be taken to prepare, plan and support an ageing Australia and aged care services.

It remains critical that the issues facing aged care specific programs – particularly inadequacy of funding and unsustainable capital arrangements – are remedied once and for all.

# 3. DESIGNING AN AGED CARE SYSTEM FOR THE FUTURE

Aged care services will support older people to have a good old age - to live satisfying, self-directed lives to the maximum extent of their capacity. This aim should be the driving force for any changes to the aged care system.

To achieve this aim the aged care service system of the future must deliver older people more **choice** of, and better **access** to, financially **sustainable** aged care services. The system of the future must also address the issues described in section 2 above.

The model we have outlined includes a mixture of firm industry views on some areas and, in others ideas where further consideration is required prior to any decisions being made about the best way forward. [13]

## Key Features of a Future System

- Aged care of the future will be an entitlement, based on assessed need, This could be in an approved residential care setting or in their own home.

- An assessment will identify needs and determine a level of Government funding available to support those needs. Individuals will be able, and encouraged, to use their own resources to purchase additional services and support.

- Consumers will be offered personalised information and advice based on their specific circumstances so that they can make informed choices about their care. [14]

- Aged care services will operate in an increasingly deregulated environment. This is likely to create a more open market economy. Modified arrangements will be put in place for areas or services where a true market will not be able to operate fully or successfully.

- Aged care regulation will largely be based on existing (state based) consumer protection regulations for accommodation and on appropriate standards and accreditation systems for quality of services. There will be independent assessment, complaints and pricing/funding authorities.

This description of the future system commences with the point at which older people first interact with aged care – at assessment.

## The Assessment Process

Assessment needs to be an easy process for individual older people and to support aged care providers to do their jobs. For some older people only a relatively straightforward assessment is required. These assessments can be considered as a first step.

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[13] The ideas outlined in this submission are consistent with the principles espoused in *National Aged Care Alliance: Leading the Way; Our Vision for the Support and Care of Older Australians (September 2009).*

14 In packaged community care case managers (consumer groups prefer the term “navigators” or “concierges”) currently assist an older person to make informed choices on a package or bundle of support. Expansion of this idea could be explored.

*The First Step Assessment*

A range of organisations, including individual approved providers and the Government's proposed one stop shops, carelink etc, would undertake a standardised and consistent intake or triage assessment.

This assessment would determine if a more comprehensive assessment is required; or refer people with low level or simple needs (for example, for meals on wheels) to a provider or service (when this level of assessment has been undertaken by a provider). Where this is the case the provider will monitor the individual and determine and undertake a reassessment or referral for a comprehensive assessment when needed.

This is similar to what occurs now, in community care, where older people and their families present at services, GPs, local councils etc and are then referred on if required.

All older people (aged over sixty five years) are entitled to receive this level of assessment when they feel they need it. At this point too, people would receive general information about aged care services.

*When Comprehensive Assessment is Required.*

An independent skilled and resourced body, with local branches, would undertake the comprehensive assessment for complex needs across all settings. The scope of the assessment is customised to the complexity of the case and identifies what the older person needs.

Many older people need assistance to understand the different types of services and support available to them and make informed choices. Some of this assistance may be provided by the assessment body but much is likely to be provided by service providers who are familiar with both the consumer and the services.[15]

*The Assessment*

There will be a suite of standardised instruments able to be used in any setting. There may be some additional items relating to the setting (e.g. in hospital) or the persons condition (e.g. dementia). The instruments will be suitable for use with CALD and Indigenous people and will include the needs of the carer (where relevant).

The need is determined first and is not constrained by the availability or type of support services that will subsequently be able to be provided.

The need determined will result in an amount/level of Government funding being allocated to an individual.

The assessment information will be used for other essential system purposes including:

- determining what the individual is entitled to in terms of a government funding level.

[15] This is currently an information or service gap and will need to be funded for it to occur

- Providing data to populate planning and data sets, quality and outcomes monitoring/accountability requirements.

**Recommendations 2-4**

ACSA recommends that aged care be an entitlement, based on assessed need.

ACSA recommends that a tiered system of assessment using standardised tools be used across settings to establish people's needs and appropriate resourcing levels.

ACSA recommends that consumers be offered personalised information and advice based on their specific circumstances so that they can make informed choices about their care.

## Funding For Services

The Commonwealth Government has full responsibility for aged care and operates one consolidated funding stream including current packaged care, HACC, residential and veterans funding. The funds are used to construct packages/bundles of support for an individual older person. The package or bundle can be spent on residential care, other forms of supported accommodation, "hotel" type services and all community supports (packaged care, HACC program). One off expenses – like home modifications and aids and equipment including assistive technology can be funded as an identifiable part of the packages. Where funding is provided for one off supports it can only be used for that purpose.

Service delivery organisations can choose to provide all of the services and supports or specialise in one type.

Packages or bundles amount to a weekly/annual funding amount based on the level of need the person has. The price for this funding is set by an independent body and is based on the real costs of delivering that level of care in the location in which it will be provided.

There are several ways in which such funding could be managed and administered.

- An individual care budget could be allocated to a consumer to direct but with funding going directly to the provider[16].
- Consumers could be allocated the funding directly to purchase services from a provider.[17]

Whatever model is adopted there would have to be an identifiable proportion provided to fund the organisational and service system infrastructure required to deliver quality services. These costs include training, service networking and emergency services[18].

In addition to the infrastructure costs there are broader or external service system resourcing components such as support for culturally diverse or indigenous support services, which also need to be funded. It is suggested that these may best be funded directly by Government.

[16] This is similar to the recently announced CDC packages

[17] This model is used in some other countries. For a more detailed analysis of these options see ACSA's discussion paper *Consumer Directed Care in Community Care* (Novemner 2008) and our Positiion Paper *Guiding Principles for Consumer Directed Care* (April 2010)

[18] For example to provide care during the illness of a carer.

The directions outlined here suggest a possible move in the direction of a more market-based approach to aged care. This can only be successfully achieved if supply and price controls, currently held by Government, are relaxed at the same time. A staged approach is required to get to this point.

**Recommendations 5-6**

ACSA recommends that all government funding be combined into one program to create funding packages based on individual needs and on the real cost of delivering the care required in the location required.

ACSA recommends that, if a more market oriented approach is adopted, supply and price controls be relaxed together, in a staged approach.

## Special Market Requirements

There are areas and service types and people, where markets will not operate successfully because the necessary conditions cannot be met.

**Regional, Rural and Remote Areas**

This is the case in a number of regional, rural and remote areas. Providers will not necessarily be able to operate viable mainstream services in all locations decreasing choice and access in these areas.

The development of integrated health and aged care services that operate to support the well being of the older person and add a range of community and health services as adjuncts is required in these areas.

This is similar to multi-purpose services (MPS) but with a shift in focus. They would be:

- developed locally;
- based on identified local needs and existing service provision;
- operate as part of a co-operative network of services; and
- have strong local governance.

**Special Needs Groups**

Market approaches don't just fail on a geographic basis. There are some services which are only provided by a limited number of services and/or where provision is not financially viable and therefore is not an attractive proposition for many. Indigenous services and services to homeless people are examples of this.

ACSA believes that the Government's two pronged policy approach is correct but it requires better resourcing to ensure that these older people get access to an appropriate service and receive good quality, culturally sensitive care.

The elements are:

- providing additional funding to specialist providers (including capital where relevant) to ensure that specialist services exist; and
- providing funding to support services such as PICACs or ACHA to assist mainstream services to become more culturally sensitive. These could be separately and directly funded by Government.

Currently the Government includes the nature and regional location of the services for special needs groups that are required in the ACAR. If supply is opened up then a new mechanism will be required to replace the ACAR to ensure that these services are developed. For more details see the Transition Section (Section 5).

There are other older people who might have difficulty accessing aged care services without special measures such as those with dementia and mental illnesses. As a principle ACSA believes that any changes to the aged care system should not reduce their access but should actually secure improved access and services for these people in need.

**Concessional Clients/Residents**

Special arrangements need to be put in place to ensure that disadvantaged and low socio – economic groups are able to get the supports they need.

Currently Government is able to mandate a level of provision within aged care homes for "concessional" residents and additional funding is provided to organisations to ensure availability. A different approach will be required to ensure equity of access for concessional residents in the new system.

It is proposed that Government would continue to purchase places for concessional residents to meet regional targets based on the socio-economic profile of each area. The care funding these residents receive will, of course, be the same as any other person at a particular level of assessed need. However, Government will also pay any associated fees and accommodation costs (in residential care) at a rate that reflects the cost of accommodation in the area where they reside.

**Recommendation 7**

ACSA recommends that, if a more market oriented approach is adopted, a range of measures to deal with special requirements be put in place. These need to include:

- The development of locally managed and supported integrated services
- Providing additional funding to specialist providers
- Providing additional funding to support services such as PICACS and AHCA
- Government purchasing of concessional places at levels required in particular areas.

## Service Delivery

The fundamentals of the current system remain, but it is likely that the emphasis and roles of different types of services will evolve as outlined below.

**Community Care – The System Foundation**

Community care currently supports approx. 800,000 older people to live in their own homes. It is the base on which the system currently operates and this will be even more so in the future. Community care will continue to provide a range of services to help people manage their own environment such as "hotel" services (cleaning, gardening etc) where the individual can no longer manage and would have to move if they were not assisted with these tasks. In addition social support, nursing, personal care and meals remain strong components of service provision.

**Future Housing Solutions for Older Australians**

ACSA members provide housing, most commonly in a village setting with residential facilities onsite. Many also provide community care to residents of their villages as well as to the general community. Aged care providers are now beginning to respond to the wishes of potential residents and are looking at more progressive models.

Examples of models already in Australia or likely to come are:

- The Dutch Humanitas 'Apartments for Life' concept. This has attracted some interest in Australia and is being piloted by the Benevolent Society in Sydney.
- Intentional communities where people come together by virtue of a common interest. For example there is an Artist Colony in the US where older people on mixed income levels participate in a range of artistic pursuits. National Lifestyle Villages in Western Australia operates villages that are specifically geared to people who are interested in environment sustainability issues.
- Concierge models where an apartment building, or a virtual building, is supported by a concierge who assists residents to live their lives independently with support. This model places the power and control with the resident.
- Multigenerational projects where a range of services such as pre-schools, day care and sporting facilities would operate from a campus with housing for older people.

Research shows "that on average, seniors living in a purpose built community require access to residential and community services later in life. For admission to residential care the purpose built environment added an extra four years on average, while those requiring community services were two years older than their peers in the broader community" [19].

This is a strong economic argument for Governments assisting people to move into older persons' housing and in encouraging the development of a range of models to meet older peoples' wishes.

**Residential Care**

As at June 2009 permanent residential aged care was provided to around 147,000 people[20]. People now generally enter residential care at an older age, when they are more frail. The average length of stay is 147.8 weeks (nearly 3 years). The average length of stay includes two distinct groups of residents:

[19] Research conducted by the Illawarra Retirement Trust NSW
[20] Respite care is also provided to 42,000 people

- People with dementia who are physically well and have an increasing length of stay
- People without dementia who enter care with higher acuity levels, and anecdotally, have a shorter length of stay.

Residential care services will need to be able to provide a mix of short term episodic services and long term accommodation and support.

*The changing face of high level residential care*

Given the above resident profile, it is likely that high level residential care will also become the venue for more short term and health related supports – transition care, rehabilitation, step down health services, palliative and respite care. A number of these services are almost exclusively funded and provided by the health system and there is limited and uneven coverage around the country. Generally such services can only be accessed once you have had a stay in hospital.

There is an increasing need for services which support and maximise peoples' independence. Access to such services should not be determined purely on where you live or whether you have experienced an acute health episode. People who can benefit from such services need to be identified, referred and supported to maintain their independence. An effective system of restorative, transition and sub acute services would maintain the optimum level of independence for each individual, supporting them to be their best regardless of whether they live at home or in a residential care setting.

Refer below for more details of how this could be achieved.

*Low level residential care*

Low level residential care will always be required to support older people with lower level care needs. It is also more likely that alternative forms of support for older people with lower level care needs such as supported accommodation/housing with care and support attached will develop in this area. This could include combinations of community care services with current retirement living services and the types of models of supported housing outlined above.

## Restorative Services

Aged care services can be effective and accessible restorative care providers. They should be eligible for transition care funding currently only made available to hospitals. Residential care facilities could be funded to provide transition care beds and supports. Community care services should be funded to undertake low level rehabilitation type services, and Day Therapy Centres should be funded appropriately.

By enabling residential and community aged care providers to provide an increased range of these health interface services, access for older people would improve. Aged care services are distributed more widely and locally than hospitals which means that people can receive care closer to home with the potential benefit of their own family doctor as a partner in the care.

Aged care is a specialist setting. Aged Care nurses, allied health professional and care workers are attuned to providing optimal clinical and personal care where older people are concerned. They have specialist expertise in health conditions and consequent problems found in higher prevalence

among older people including continence challenges, cognitive disturbance, nutrition deficits, movement and mobility problems, sensory and communication problems, and skin trauma and chronic wounds.

**Recommendation 8**

ACSA recommends that aged care services be funded to provide restorative care.

## Interfaces with Health Care Services

The Government's health reform agenda is a positive step towards improving health care for older people and in creating better links between primary, acute and aged care services.

Much of the specific detail of the proposed health care networks and Medicare Locals is not yet known. The aged care service system will need to co-ordinate and work with these networks but the lack of detail means we have not been able to articulate how this would occur. That it does is absolutely essential.

Aged care providers and their representatives need to be involved in the development of these new structures to ensure that they can be properly linked. . There is scope too for e-health initiatives such as the Electronic Medication Management in Aged Care project to significantly contribute to better management of service linkages between health and aged care services.

**Recommendation 9**

That further work be undertaken on appropriate links between aged care services and health services at the local level.

## Technology

The role of technology in supporting the delivery of aged and community care services and in supporting the independence of older people is an area of great potential.

### Information Technology

Use of information technology has been increasing in both residential and community aged care services. Funding to ensure this growth can continue is critical to create greater efficiency and transferability of information.

The Government's health reform agenda envisages a closer relationship between aged care and health services. Electronic Medication Management (EMM), Unique Health Identifiers (UHI) and other such developments are likely to be at least as important in supporting this as the introduction of new structures such as health or primary care networks.

Initiatives such as EMM have enormous potential to make client-centred health and aged care reform a reality. Further investment in capacity building within the aged care industry, and the

other stakeholders, is an integral requirement for the successful implementation and has been recognised in this project.

**Recommendation 10**

ACSA Recommends that implementation of the *Electronic Medication Management in Aged Care* solution be funded.

### Assistive Technology

Technology that directly supports clients to maintain their independence will become more important in future. Remote monitoring for example can extend the reach of services, reduce the need for face-to-face consultations and thereby contribute to maintaining older people's independence. This can apply anywhere but has particular significance for rural and remote services. Assistive technology, by extending the reach of care professionals, can help deal with workforce pressures though it cannot remove them on its own. A strategy to encourage the further development and roll-out of assistive technology needs to be developed as part of the overall reform program.

**Recommendation 11**

ACSA recommends that a coordinated and revamped national approach to the provision of 'aids and equipment', including assistive technology, be developed.

## Who Pays?

Aged care costs are currently met by users and through Government expenditure financed through general taxation revenue.

### Funding the System

It seems likely that there will need to be a greater personal responsibility for paying for required services if increasing demand is to be managed in a fiscally responsible way. A social insurance scheme is currently being investigated for disability services. Such a model may have applicability in aged care as a future option.

### Individual Payments

People should continue to meet their own accommodation/housing and associated living costs as they do throughout their lives. Where a person is required to pay a fee for their accommodation/housing they will have a choice of how to pay – such as paying rent, deferred contribution from their estate, a refundable lump sum (loan), or other negotiated financial arrangements.

For people who remain living in their own home Government concessions and rental assistance are provided, if assistance is needed to meet these costs. For people who require residential care and are unable to meet the cost of their accommodation Government should pay on their behalf.

To ensure equity of access, the payment would be at a comparable rate to that paid by people with their own means.

Support, care and respite services would all be eligible for government subsidies. There would be a means testing process to determine the level of government subsidy provided or allocated[21] to each individual. Over and above that amount the individual would be required to pay for their own needs. This is currently the case for other services including those funded through Medicare.

**Recommendation 12**

ACSA recommends that access to capital for residential aged care be enhanced through:

- Uncapping the daily accommodation charge for those with high incomes and increasing it for those on a medium income so it is equivalent to the average building costs of residential care in the relevant region[22];
- Introducing the option of bonds for high care; and
- Linking government payments (the accommodation subsidy) for concessional residents to the average cost of building residential aged care[23].

**Recommendation 13**

ACSA recommends that care and support services be funded by a means tested mix of government and user payments.

## Regulation

The aged care system of the future will need a more appropriate governance structure for its regulatory functions.

*Approved Provider Status*

DHA's responsibility would be to approve providers to deliver government subsidised services. They would confer "approved provider" status in a streamlined fashion which avoids the need for duplicated information and separate registration for different service types.

*Consumer Protection & Quality Assurance*

Having adequate consumer protection and quality assurance/improvement systems in place and monitored are absolutely critical elements for an aged care system. These functions however will be better performed by bodies independent of Government with appropriate expertise.

[21] i.e.this payment could either be made directly to consumers or on their behalf as discussed earlier.

[22] Building costs include land, construction, fit out and financing costs, figures can be obtained from a variety of independent sources including Rawlinson's Survey of building costs and a variety of valuation reports. The daily charge would be akin to a rent based on these costs.
Rawlinson's construction cost guide for housing, small commercial & industrial buildings, Rawlhouse Publishing, 1993

[23] As above

In the case of aged care building and accommodation services the existing protection, afforded by the Building Code of Australia[24], relevant state residential tenancies and consumer protection of money spent on accommodation would be used for regulatory purposes.

Similarly monitoring of quality standards for care and support services would occur through certified accreditation bodies and the JAS-ANZ system and be separate from Government. JAS-ANZ will be responsible for overseeing those accreditation bodies providing services to the industry, including their decision making, review, complaints and appeals. Providers would choose who they would be accredited through and would be able to have all of their services accredited through one body where appropriate. Accreditation could be for set periods of time as per the current model or be continuous, subject to satisfactory performance by the provider. The best and most efficient model needs to be determined.

Aged care standards would be prescribed by the Government in consultation with stakeholders including consumers and providers.

Government would be able to access housing/accommodation and quality reports in a prescribed format and time frame, and take action as appropriate. The type of action available to Government needs further consideration and should be determined in consultation with stakeholders.

*Assessment*

Comprehensive assessment, resulting in significant government resources being made available to an individual, is undertaken by an independent body. It assesses for need and applies an agreed calculation to determine a level of government funded support to individuals initially. This may be varied by the provider as a person's needs change and criteria for these variations will need to be developed.

*Pricing/Funding*

The level of resourcing required is determined by an independent pricing/funding authority which determines how much it costs to deliver care based on real costs (rather than arbitrary methods which are based on the funding available). Pricing is no longer equalised geographically as there are differential costs to deliver services in different areas or to different types of services. Currently there is a system of supplements which compensate for equalised, and inadequate levels of, funding. Pricing would take these differences into account and set differential pricing based on geographic location and other variables such as special needs costs.

Regular reviews of pricing to ensure the level of funding provided continues to meet the real costs of providing care and support would occur.

*Complaints*

An effective complaints mechanism is essential to any well-functioning service system. The complaints mechanism will be independent, unbiased, free and accessible. Existing complaints mechanisms will be used or enhanced for aged care.

[24] Government has agreed to this and is currently negotiating the removal of certification

An independent ombudsman function would be used to investigate aged care complaints. It may be part of the existing Health Ombudsman role. If the complaint can not be resolved through conciliation and mediation then the Ombudsman could refer complaints to organisations that are empowered to take further action such as the Australian Health Practitioner Regulation Agency (if the complaint relates to a health practitioner) or to the licensing authority (if it relates to a service complaint).

For all complaints an appropriate appeals mechanism will be required. The Administrative Appeals Tribunal is an option but a more accessible, lower cost mechanism akin to, or even based on, the Social Security Appeals Tribunal is likely to be more appropriate.

**Recommendation 14**

ACSA recommends a new governance structure for the regulation of aged care including:

- The use of existing regulatory structures where these exist rather than developing aged care specific ones;
- Independent assessment particularly for people with more complex needs;
- Independent and transparent setting of prices/subsidy levels;
- A more open approach to the provision of accreditation services under the JAS-ANZ system; and
- An independent complaints system.

## Relationship with Government

With greater transparency and clarity of roles Government and industry should be able to move to a partnership approach. Together they should plan the future development of the aged care system[25] and promote aged care services in a positive light assisting with recruitment and retention of staff as well as community and consumer confidence.

**Recommendation 15**

ACSA recommends the development of a partnership relationship between the government and the aged care industry.

## Benefits of the System

The system ACSA has described is designed to ensure aged care services are sustainanble and can meet growing demands into the future.

Vulnerable groups are protected with equity of access, choice and quality of services.

The proposed system removes much of the over regulation by DHA and delivers adequate funding to provide quality care – funding that matches the cost of what providers are required to deliver.

The greater independence and clarity of roles in the proposed system should also change the relationship between service providers, funders and regulators. It is important that all work in partnership to deliver the best outcomes for the older people we serve.

[25] With other stakeholders.

## Summary - A New System

ACSA suggests that in designing the future aged care system, the following features should be incorporated:

- Aged care becomes an entitlement, based on assessed need, for all people over 65 years of age.
- Assessment determines an individual's needs and a level of government funding for each individual.
- A standardised suite of assessment tools are developed and used across the system.
- Older people are assisted to make informed choices about their care.
- Progressively de/re regulate services and largely use existing (often state based) consumer protection regulations and appropriate standards and accreditation systems for service quality.
- Commonwealth Government has full responsibility for aged care and operates a consolidated funding program encompassing all community (including HACC and DVA) and residential care programs.
- Funding methods which meet the cost of care delivery are designed and implemented.
- Specific arrangements are put in place to support rural and remote areas and services for special needs groups to ensure effective operation.
- There is specific funding provided directly to system wide resourcing services such as PICAC, volunteer support programs and indigenous support services.
- Greater responsibility for individuals to pay for their own services.
- An independent complaints system.
- An independent price setting mechanism.

# 4. SPECIFIC CONSIDERATIONS

There are a number of additional points that need to be considered in designing a good aged care system. This section of the submission outlines areas which require a broader than aged care only approach to ensure the most effective arrangements are in place for older people.

## A National Older Persons Housing Strategy

ACSA and the Council on the Ageing (COTA) produced a discussion paper in March 2009 that outlined some of the elements that should be incorporated into a national strategy for older person's housing and many did not involve large injections of new funds. They focused on maintaining and enhancing existing stock plus increasing the supply of affordable and appropriate housing.

The overwhelming majority of older people choose to live independently in general purpose housing that they own or rent. The discussion paper asked for:

- action to support and upgrade the 30,000 independent living units built with Commonwealth Government assistance between the 50s and the 80s as they are at risk of being lost as a source of affordable housing;[26]
- upgrade and maintain stock and support of older tenants in public housing; and
- Government to fund a national approach to home maintenance, modification and energy efficiency services as these services can reduce risk and costs and in many cases greatly improve the quality of life in a cost effective manner.

In relation to increasing the supply of stock ACSA and COTA called for:

- the NRAS to be broadened to be more relevant to older people's housing eg to enable ILUs to be upgraded and developed in small clusters;
- to improve older people's access to public housing; and
- Government's to adopt universal design principles in built environments and urban design.

ACSA members have approximately 42,000 ILUs and many of these are reserved for people on low incomes. This is more housing units than the entire community housing sector across Australia.

The strongest growth in income support payments over the next 40 years will be to the aged. Baby boomers are not as rich as many imagine and they are better spenders than savers. Demand for rental will particularly increase for single person households, many being older women who are on lower incomes due to divorce and/or low superannuation as a result of generally lower wages and time out of the workforce for family responsibilities.

Despite these two factors, aged care providers are not routinely recognised by Federal and State Governments as legitimate players in the provision of housing for people on low and medium incomes. Aged care providers should be able to compete on a level playing field with other housing providers for government funding and asset transfers. A whole of Government housing

[26] *AHURI* – Final Report: No. 053: Independent living units: the forgotten social housing sector

policy for older people would help to break down the silos that Government programs still operate within and provide greater focus on outcomes – the successful housing of older people.

**Recommendation 16**

ACSA supports the development of a whole of government housing policy for older people focusing on:

- Maintaining and enhancing existing stock; and
- Increasing the supply of affordable and appropriate housing.

## What older people want

The research and consultations undertaken with older people about where they want to age is not surprising but is often overlooked by planners and policy makers. People want to age:

- in their neighbourhoods as part of their communities, close to family, friends and the community links they have developed over decades;
- close to amenities such as transport, medical services, shops and other community facilities;
- in safe and secure accommodation that supports their independence and allows them to remain in their chosen home for as long as possible; and
- in affordable accommodation even if their income is modest.

For some Australians this may mean a retirement village but for the vast majority it does not. While the market penetration of the retirement living sector has doubled in recent years it still only houses 5.5% of people over 65. Older people want a range of options to choose from and the broad acre retirement villages on the outskirts of large cities or in retirement centres are not the solution for all. Research conducted by ECH and Flinders University found that current market trends in the provision of housing for older people often fit poorly with their needs and aspirations.[27]

We now have the unusual coming together of agendas with consumers and funders both wanting to see outcomes which support older people to remain as independent as possible for as long as possible. This alignment of interests should support the development of innovative housing models that foster independence but examples of these are slow to emerge in Australia.

## Retirement Village Regulation

As a principle we have argued elsewhere in this submission that existing regulatory mechanisms should be used in relation to services for older people unless there is a good reason not to. Residents in retirement villages already receive protection via Retirement Village legislation if they pay an entry 'premium' with or without a deferred management fee or via Residential Tenancy Legislation if they rent their unit. ACSA believes that regulation of retirement villages should retain this consumer protection focus and that nothing will be gained by bringing retirement village regulation in line with aged care regulation.

[27] Beer, Baker, Tually, Raftery, Cutler*, Our Homes, Our Communities: The Aspirations and Expectations of Older People in South Australia,* Flinders Institute for Housing, Urban and Regional Research, ECH report, May 2009

Similarly we believe that it is appropriate for the development of villages to be regulated by existing planning and building codes and any Government funded community care programs provided to people living in such villages, whether by the village operators or by independent approved service providers, should be regulated by whatever mechanisms regulate all other community care services provided into people's own homes. Where the care services are not Government funded the usual consumer protections should apply.

**Recommendation 17**

ACSA recommends that the regulation of retirement villages continue to be separate fro aged care regulation.

For further information on ACSA's position on housing please refer to: *ACSA's (as a member of the Older Persons Affordable Housing Alliance) A Fair Share for Older People: The Need for a National Older Persons Housing Strategy; Discussion Paper (March 2009).* [28]

## Workforce Planning and Development

Action is needed on a range of fronts to resolve aged care workforce shortages. To be effective activity needs to be well targeted and be based on sound evidence and data.

The industry is fortunate to have the NILS surveys and census. For the residential care workforce the data was collected in 2003 and 2007 so some analysis can be made of changes over that period. The first community care workforce survey was in 2007. However the weakness with the surveys is that they provide a snapshot in time and are by design looking back to the past rather than making predictions about the future. Also there has been limited regional analysis and we know that staffing shortages vary considerably across the country.

### Workforce Planning

A more sophisticated workforce planning approach is required that ensures the workforce is both dynamically and directly linked to the future of the organisation/industry.[29] Workforce planning is both strategic and operational. It needs to be managed and resourced accordingly for it to be successfully integrated into overall industry strategies and corporate objectives. The increase predicted in service and knowledge industries means that people are an increasingly critical resource in delivering business outcomes. Skills Australia and the National Health and Hospitals Reform Commission are supportive of enhanced workforce planning. The newly formed Health Workforce Australia (HWA) should take responsibility for driving the adoption of workforce planning at organisational and regional level.

ACSA has attempted to use the existing data to make rough calculations of the potential gap between supply and demand of three critical aged care occupations – registered and enrolled

[28] For further housing information refer to:
The National Housing Supply Council's 2nd State of Supply report 2010
*AHURI* – Final Report: No. 141: Service integrated housing for Australians in later life
*AHURI* – Final Report: No. 053: Independent living units: the forgotten social housing sector
*AHURI* – Final Report: No. 123: The role of home maintenance and modification services in achieving health, community care and housing outcomes in later life
2010 Built Environment Effect: IRT Research Report, (Illawarra Retirement Trust) Unpublished

[29] Australian Standards – Workforce Planning

nurses and personal care workers. The figures are calculated using information from a variety of sources and are estimates only – hence the wide variance in the figures. Some factors and assumptions in the calculations include:

- Projected requirements are based on a 3.5% per annum growth in requirements which incorporates recent changes in the uptake of residential aged care places, including the shift toward high care residents.[30]
- Nurses as a proportion of the aged care workforce and age component remains constant. ie. no further decline.
- The starting figures of numbers employed are taken from *Who Cares for Older Australians*.[31]
- Average turnover of approximately 21.5% per year for Registered Nurses (RNs), 20% for Enrolled Nurses (ENs) and 26% for Personal Carers (PCs).
- The average time taken to recruit an RN is 4.8 weeks and 2.8 weeks for an EN and PC.
- The numbers reflect actual positions and not FTEs as part time employment is common in the industry.

**Aged Care Workforce Supply Gap**

| | Number Employed as reported in the NILS report 2008 | Projected Requirement 2014 | Estimated Supply Gap |
|---|---|---|---|
| RNs | 29,953 | 35,574 | 4,000 - 9,000 |
| ENs | 18,267 | 21,695 | 700 - 3,800 |
| PCs | 145,346 | 172,625 | 7600 - 32,000 |
| Total | 193,566 | 229,894 | 12,300 - 44,800 |

The first figure in the estimated supply gap assumes the industry is able to grow its workforce to accommodate the additional places and the gap reflects the turnover and recruitment lags. The second figure assumes an inability to grow the workforce over the current numbers so that the overall numbers employed may actually decline.[32]

This rough analysis supports the thesis that we are facing a crisis in filling critical positions and there are no measures in place that are likely to change this. The situation will be more difficult in certain areas, such as in mining regions and remote areas, which means that workforce development strategies are urgent and will need to be tailored locally.

**Workforce Development Strategies**

There is a plethora of reports that point to the strategies that need to be embraced in order to create an inspired, skilled and valued workforce. Recruitment and retention strategies, improved training and training providers and the development of meaningful career paths are some of many and we will not canvass them all here. Instead we wish to highlight a few of critical areas:

[30] PWC. *Aged Care Nursing Supply and Demand Projections* Draft – Unpublished February 2010
[31] Martin B, King D. *Who Cares for Older Australians: A picture of the residential and community based aged care workforce 2007* (2008) National Institute of Labour Studies
[32] Using the *Workforce Planning Australia – Supply Gap Calculator*, available online

- People have a variety of motivations for working in aged care and money is not the key deciding factor for most. However, there is currently a disincentive to work as a nurse in aged care as a nurse can earn more in the acute care system for a similar type of work. Compared with the minimum wage of $14.31 personal carers and community care workers receive a base rate of $16.60 and $16.13 respectively. Under the current system providers can not afford to pay higher rates to staff. A better funded system is essential to providing better wages for workers thus removing a barrier to working in aged care.

- The key document capturing the workforce development strategies for the industry is the *National Aged Care Workforce Strategy* 2005. While it is a useful document it is out of date and only addresses direct residential aged care staff. It fails to plan for community care, allied health and ancillary workers. This document should be updated and made more inclusive of all health care professionals that work in the industry as a matter of urgency. It would capture the myriad strategies that are required to address this multifaceted problem in a practical way within a broad environmental analysis. For the first time it would be a whole of Government plan that would also need to address:

  - Which industries are competitors for the aged care workforce and what is the aged care point of difference;
  - A risk assessment of how services can operate when critical staff are not available,and;
  - Strengthening partnerships with health networks, training agencies and other Government programs.

  Whether the ongoing responsibility for this workforce plan sits with DHA or Health Workforce Australia (HWA) is up for debate.

- For many years there have been discussions about remodelling and redefining the roles of workers in aged care to increase flexibility, to better meet the expressed needs of older people and to use the clinical skills of qualified workers more appropriately – nurses to be nurses rather than administrators. A number of providers have trialled new approaches, some with great success but there is no systematic evaluation and dissemination of these approaches. The industry needs a national discussion of possibilities through the development of the New National Workforce Strategy. The potential benefits are significant. For example the NSW Department of Health has estimated that it saves $1.5million a year by employing a Nurse Practitioner who is a specialist in ageing and treating chronic illness. She helps to keep older people out of hospital by providing support to older people in their homes.[33] A key issue in both residential and community care is the over-regulation of nursing work, particularly in relation to medication administration and management. The new national licensing arrangements for health professions must address this issue.

- Effective management and leadership in the aged care industry are important and outstanding issues. Small attempts have been made - a specialised management course, young managers groups and funding of Frontline Management courses - rather than systemic solutions. However standards have not been identified nor clear expectations expressed about the nature and level of management required. HWA should be charged with the responsibility of working with industry to develop and implement these standards.

[33] Sydney Morning Herald – "She's the super nurse who saves millions" April 11 2010

**Overseas Workers**

Some aged care providers have looked overseas for workers to fill long term vacancies, particularly in nursing positions, with mixed success. Generally the providers have used the 457 visas after navigating the complex procedures alone.

ACSA believes that all avenues should be exhausted locally before looking overseas for staff and there are some ethical issues to address when considering attracting staff from third world countries that have invested in their training and need their input locally. It is reasonable to note that some countries rely heavily on the remittances sent home from their overseas workers.

However, there is an important role for overseas workers in areas where there are chronic shortages.[34]

Under the current rules it is almost impossible to recruit personal carers (PCs) from overseas as it is not seen as a skilled occupation. Registered and Enrolled Nurses s are listed in the occupations for nomination in relation to the subclass 457 Long Stay temporary visa (Group 2 and 4 respectively). Also the temporary skilled migration income threshold of $47,480 per annum is higher than a PC's income.

Labour agreements are another mechanism that the industry is exploring. An agreement can be negotiated for the entry of overseas workers to work in Australia where the business/industry can demonstrate that there is a labour market need and there are no appropriately qualified Australian workers readily available.[35] It also mandates the training of Australian workers and sets the skill level and salary for the overseas worker.

Many aged care facilities and service providers lack the skills and resources to individually navigate the complex pathways through the immigration system. Industry peaks such as ACSA are well placed to work with the various government authorities to develop labour agreements that not only help to service the growing supply gap, but also ensure all workers are treated fairly in accordance with Australian workplace law.

In a political climate where immigration levels are being scrutinised Government's need to consider where the workers are going to come from to care for older people in areas with stressed labour markets. Overseas workers are a legitimate source of labour.

**Recommendation 18**

ACSA recommends the updating of the *National Aged Care Workforce Strategy* with particular emphasis on:

- Introducing regional workforce planning and projections
- Broadening the plan to include community care, allied health and ancilliary workers
- Leadership and management development; and
- Redefining the roles of nurse practitioners, registered enrolled nurses, personal carers and community care workers.

[34] For example in Western Australia which is anticipating an overall shortfall of workers of 150,000 by 2017.

[35] DIAC Labour Agreement Information Pack

**Recommendation 19**

ACSA recommends a review of the temporary migration program to extend the scope of the in-scope workforce to include suitable short-term skilled and non-skilled workers who can provide care services in areas of critical labour under-supply.

## REGIONAL, RURAL AND REMOTE AGED CARE

This submission identifies that rural and remote areas are not likely to be able to operate effectively in an open market. We have advocated for the development of integrated health and aged care services and in this section we outline how these would operate.

**Multi-purpose services**

The integrated service is similar to multi-purpose services (MPS) but with a shift from the more traditional health focus. It would have the support and wellbeing of the older person as its primary focus and may offer a range of community and health services as adjuncts. Local communities and service networks would decide if an integrated service is appropriate for their area and individual services could choose whether or not to join or remain as a stand alone service.

The MPS program has not undergone a national evaluation since its inception in the 1990s so it is difficult to determine whether the purported strengths of the model have been fully realised. The Australian College of Health Service Executives and the Australian Healthcare and Hospitals Association released an issues paper in 2009 that profiles a selection of the 126 MPSs. Typically they would provide:

- Accident & emergency services
- Acute beds
- Aged care beds
- GPs
- Home support
- District nursing
- Allied health
- Day activity programs
- Health promotion and prevention programs – perhaps via visiting services
- Some retirement living

We believe that critical elements of a successful integrated aged care model would be:

- Local service planning that is accepted by funding bodies;
- Strong local relationships between all health and aged care services in the region (including stand alone aged care services) and effective community engagement strategies;
- Strong local governance;
- Commitment from the 3 levels of Government to funding being pooled and used to implement an agreed service plan; and
- Streamlined reporting that replaces programmatic reporting.

**Recommendation 20**

ACSA recommends that a comprehensive national evaluation of the MPSs be undertaken. Some of the issues that should be addressed include that:

- The vast majority are state Government services managed in Health Departments with local boards of management. The evaluatuion should examine the impact of MPS arrangements on existing stand-alone aged care services. Consideration should be given to different forms of development with existing not for profit providers or new community based bodies auspicing the services. This may ensure that the MPSs reflect the needs of the local community rather than running a state health agenda.
- Some MPSs have found that they can not afford to support older people as their needs increase as the cashed out funding levels do not meet their needs. Residents should be able to age in place. Also there is no annual indexation of grants.
- Government policy suggests that Primary Care Centres will be developed across Australia and it is not clear how these will relate to MPSs and local health networks in regional, rural and remote areas.

**Enhanced role for residential facilities**

Some consideration should also be given to the enhanced role that residential aged care facilities could play in regional, rural and remote areas even when they are stand alone services. They are valuable contributors in that they provide employment to local people and support the local economies through their purchasing. In many locations they would be the only 24 hour, 7 day a week operation. With appropriate support they could take on a range of different roles without losing sight of their core business such as:

- becoming the base for telemedicine where specialists could see clients remotely
- monitoring telehealth devices that are with community care clients to monitor chronic diseases such as Chronic Obstructive Pulmonary Disease and Chronic Heart conditions and take action where necessary
- providing rooms for visiting allied health specialists

For further information on how aged care can best be delivered in rural and remote areas please refer to *ACSA's (with NRHA) Older People and Aged Care in Rural &Remote Australia; National Policy Position (September 2005)* and the *Joint Australian College of Health Service Executives & Australian Healthcare and Hospitals Association Working Group Issues Paper: Multi-purpose Service (2009)*

**Recommendation 21**

ACSA supports in principle the development and expansion of integrated health and aged care services that are locally designed and managed.

## SPECIAL NEEDS GROUPS

### Indigenous Elders

Since the late 1980s the Commonwealth has funded an increased number of aged care services for indigenous people. This was done by changing aged care planning ratios so that the aged care places made available is based on the number of Aboriginal and Torres Strait Islander people over 50 years of age, not the 70 year benchmark used for the rest of the population.

As a result there are now around 200 aged care services directly funded by the Commonwealth that target indigenous people or are in remote areas (or both). About 70 of these have a residential care component and 30 are known as "Flexible Aboriginal aged care services," which are not funded under (nor must they comply with) the Aged Care Act (1997).

These services have been vulnerable over the years to service and financial difficulties for a range of reasons, most notably that they are small and located in remote areas where staff are hard to attract and retain. They are also vulnerable to the limited governance and management capacity in the same remote and disadvantaged communities.

There have been several concerted attempts over the years to address the continuing problems these services have confronted.

In the 2007 Budget, the then Government announced that $42.6m would be available over five years to establish the Remote and Indigenous Service Support (RISS) Initiative with three broad components.

1. Improving the physical infrastructure of Aboriginal and remote aged care services

2. More effectively developing and supporting care, management and organisational capacity, including day-to-day management, financial, governance and locum services

3. Developing a more sophisticated and shared understanding of service delivery models and quality frameworks in Aboriginal and remote aged care

ACSA, and the industry at large, fully supported this initiative but unfortunately the implementation of the program has been delayed by 3 years. In addition the proactive supportive and capacity-building emphasis of the program has been watered down. Early this year the Department released a tender to establish a panel of people/organizations who could provide support services on an ad hoc basis.

The Department has largely ignored the advice of consultants engaged to assist with the design of the program. Most of those involved in the discussions with the consultants supported a community development approach.

It is not likely that any single measure will provide for all needs. A menu approach, where staff in remote areas are aware of a range of support services they can access, with an agent to whom they can talk to define their own individual needs and seek support seems most likely to be effective. This would include a range of options such as locum support to enable key staff to take holidays; staff housing; financial management expertise; clinical guidance.

Strong community engagement is essential to gain clear ownership of the decisions made about the scope and nature of the services required. Flexibility in the application of Departmental timeframes and funding models to accommodate the professional and community decision making process is also essential.

No comprehensive planning for indigenous aged care has happened since 1994. ACSA believes that part of this reform process should include a reshaping of this policy, including some growth commitments given that a market driven supply will not provide growth.

The Government has also allocated indigenous specific community aged care packages funded at the standard rate in some areas. Providers who operate both the indigenous specific and mainstream packages report that it costs the service more to provide support to an indigenous elder. This is because indigenous clients do not pay as much in fees due to their income levels and they can have culturally specific needs that can increase costs. Therefore a new indigenous aged care policy should address the flexible services plus those provided under the Act with formula funding.

For more information on indigenous service issues and solutions refer to *Remote and Indigenous Service Support Initiative Report* by Robert Griew (not publicly released by DHA) and the *ACSA: National Indigenous Aged Care Issues paper.*

**Recommendation 22**

ACSA believes that the Remote and Indigenous Service Support (RISS) program should be rolled out urgently with a capacity building and community development focus.

**Culturally and Linguistically Diverse (CALD) Older People**

In 2006 ACSA released a policy document *Strength through Diversity* that outlined what we believed needed to happen in service provision and support services to address the rapidly increasing number of older people who will require aged care services. By 2011 it is projected that 653,800 or 22.5% of people over 65 will be from CALD backgrounds. This is a growth rate of 66% over a 15 year period, compared with only 23% for the Australian born population.[36] The rate of growth will slow by 2026 with older people from CALD backgrounds numbering 21.2% or 939,800. Similarly, people from CALD backgrounds over 80 will increase from about one in eight in 1996 to one in five in 2011 and one in four in 2026. These populations will be unevenly distributed and concentrated in Australia's capital cities.

Services that are funded on a formula basis, such as residential and packaged care, do not necessarily have the capacity to cover the additional costs that can result from caring for clients from a great diversity of cultural backgrounds. These costs can be substantial. For example, as at May 2007, the Telephone Interpreter Service (TIS costings via personal communication) provides on-site translator/interpreter services during business hours at a rate of $141 for the first 90 minute block plus an additional $46 for each subsequent 30 minute block. These rates increase to $225 and $74 respectively outside of business hours. These are substantial costs considering the (highest) day rate per person in residential aged care was funded at around $175/day in 2007

[36] Older persons from CALD backgrounds are defined by the AIHW as persons aged 65 and over, born overseas in countries where English is not the main language spoken.

(Government contribution plus client contribution) and make the provision of such services 'cost-prohibitive.' Some ACSA members have estimated the cost of providing the listed components at between three and five per cent of total budget, with community care estimated to bear the largest expense.

In the first instance ACSA suggests that creation of a cultural pool, initially for 5 years, to fund these additional costs be established. A 3 year research and evaluation project should be attached and finalised in time to inform how the service should be funded into the future. Details of how the pool could operate are contained in ACSA's *A Cultural Pool for Aged & Community Care 2007*. This approach fits well with the service system resourcing model advocated for a future aged care system.

**Recommendation 23**

ACSA recommends the creation of a "cultural pool" to fund the additional costs of providing services to CALD older people.

**Homeless Older People**

Over 18,000 people aged 55 or over were homeless on Census night in 2006. That's 4,000 more than in 2001. Older homeless people are more likely to have experienced mental illness or cognitive impairment, often as a result of alcohol and substance abuse. Many have been homeless for many years. They may have more complex health and support needs and often do not have family support.[37]

ACSA's policy in relation to homeless older people has been that the most effective way to ensure that the needs of homeless (including at risk) older Australians are addressed is for the Aged Care Allocation Round (ACAR) guidelines to explicitly prioritise services for this target population (which includes many under 65 years) where a demonstrated need can be shown. If supply is opened then this option will not be available and a new mechanism will be required.

**Recommendation 24**

ACSA recommends that, if the ACAR process is discontinued, new methods of giving appropriate priority to services for homeless older people be developed.

*The ACHA Program*

The Assistance with Care and Housing for the Aged (ACHA) program provides a range of support programs to link homeless older people and those at risk of homelessness to health and community services, as well as directly to secure housing. ACHA services support mainstream community and residential aged care programs with their most complex cases.

The ACHA program is a proven, cost effective means of improving the lives of older homeless people and people at risk of homelessness by supporting them to access services to which they are entitled. The benefits of a pro-active response to the needs of older Australians at risk of

[37] The White Paper, *The Road Home: A National Approach to Reducing Homelessness*, Commonwealth of Australia, 2008

homelessness include slowing the onset on premature ageing, reduced chronic and acute mental and physical health care costs, and cost savings due to later entry into high cost residential care. ACHA requires a substantial injection of funds to increase its coverage and viability.

**Recommendation 25**

ACSA recommends that additional funds be made available to the ACHA program.

# 5. TRANSITION TO TWENTY-FIRST CENTURY AGED CARE

This submission outlines a vision for a qualitatively better system of care and support for older people. Many of the ideas we have advanced will require further exploration and discussion before they could be adopted as firm policy. Some of this may occur during the course of this Inquiry.

Full realisation of the vision can only occur progressively, though the commitment needed to make it happen needs to be pledged up front.

Reform of aged care needs to make it:

- more responsive to the increasingly diverse needs of larger numbers of older people;
- better articulated with the health services that older people will also typically be using; and
- financially sustainable now and into the future.

This requires staged, monitored and managed action to ensure that reform goals are achieved without adverse consequences for consumers, the aged care workforce or the sustainability of the aged care industry.

Change of the depth required is not an easy process. However with careful planning, staging, management and governance headaches can be minimised.[38] Support for aged care services in the change process will be required to avoid disruption including advice, assistance and financial incentives.

Change needs to occur in a number of related areas. It also needs to start.

## Giving Consumers Greater Choice - Freeing up Supply and Pricing

ACSA has suggested a package of measures in this area. Moving from a system of supply regulated by licensing places to one based on a needs-based entitlement for individuals is coupled with the introduction of a revised assessment process, which will determine needs and resourcing levels and the provision of a high quality information service for consumers. Funding is proposed to be consolidated into a single, multi-layer aged care program.

Movement to such a model would need to progress in stages, over a number of years.

Concern has been expressed in some quarters about the disruptive effect of abolishing bed licences on service continuity. It has been argued that this will destroy balance sheet value and inhibit providers' ability to raise debt finance. ACSA has undertaken some investigation of this issue and has sought the views of bankers, financial analysts, auditors and valuers on this proposal. This process has concluded that relaxing price controls (including the abolition of the currently separate Extra Service system) will counteract the negative effect of removing supply controls and the introduction of more competition. These two measures must be taken together however for this to be the case and we suggest that this be done in several stages as outlined above.

[38] This section draws on a paper prepared by an aged care working group in response to *ACIC 2010-11 Federal Budget Submission*

## Reforming System Governance

Changes to the Aged Care Act to establish an independent complaints body should occur immediately. Consideration of the advantages and disadvantages of sharing functions such as complaints, pricing and accreditation with the broader health system should be finalised in 2010-11.

Mooted changes in the broader health system also raise questions about how aged care services will link, as they must, with hospital and healthcare networks and Medicare Locals. Some of these changes will require legislation, while others may require thinking through, developing guidelines and briefing service providers about the opportunities in the new health system. Communicating the need for all participants in the care of older (and all) people to work together will also need to be a performance measure for system governance.

## Supporting the Roll-Out of Information Technology

Investment in information technology to support aged care service delivery including seamless navigation through the system for consumers and reliable and accurate communication between service providers is fundamental. As a first stage the Electronic Medication Management system designed for aged care should be rolled out, commencing in 2010-11 and to be completed by 2012.

## Supporting Change in Rural Areas

The small scale and finite service catchments of many rural aged care services, as noted in Section 4 above, pose particular challenges. It will be important to ensure that resources and expertise are made available to the sector and to individual organisations to evaluate their current position; examine their options and take action to stabilise and secure aged care services in their local community. Such assistance could usefully build on the project, funded by the Department of Health and Ageing, in North West Tasmania.

## Change Management

The changes in scope for aged care reform are potentially far reaching. Our aged care system is also implicated in the changes already announced, but still being developed, in our health system. A staged reform package, including a plan to develop industry capacity to respond to relaxed supply and pricing regulation in a competitive market, accompanied by a structural adjustment package, must be put in place to support this change.

To manage this important and complex work it is imperative that key aged care stakeholders - providers, consumers and professionals – are part of the governance structures that need to be established to oversee the reform process. It is not sufficient for discussion to take place only between levels of government with no such input. This is unlikely to produce optimum results.

### A New Model of Public Administration

The aged care system we have today and the way it is managed and governed is subject to influences and pressures that are wider than just aged care. The model of the relationship between aged care services, government and consumers is, in part, the product of a particular paradigm of public administration popularised in the 1990s when the current Aged Care Act was written. The catch phrases of 'steering not rowing' and 'arms length' symbolise this approach. As this paper outlines, this model has succeeded in separating the Government as funder from the detailed consequences of its funding decisions.

It has not however finished the task of separating the policy and funding Department from detailed involvement in the management of safety and quality, possibly due to a small number of spectacular quality failures early in this process such as the notorious 'Riverside' affair. The relationship between the Department of Health and Ageing and aged care providers is quite unlike that of health departments and health services in the States and needs to change if our aged care system is to be able to respond effectively to the challenges of our ageing population

A new paradigm for the relationship between the parties is now required.

## Conclusion

This Inquiry is absolutely critical. Over many years and reports it has been widely acknowledged that aged care needs to be reformed. The breadth of this inquiry provides an opportunity to pull the threads together and create a plan, with appropriate supports, to make far reaching changes that will deliver better, and more sustainable, aged care to older Australians.

## APPENDIX 1

# AGE LEVELS

One of the issues raised in the report of the National Health and Hospitals Reform Commission, and elsewhere, was the question of what age should be used to define 'aged care'. The purpose of this brief appendix is to outline some of the issues and considerations around the use of age levels in the planning and administration of aged care.

**Background:**

The two most common ages used for various purposes by statisticians and governments to define ageing are 65 and 70. Sixty five is used by the ABS in many of its standard tables and is therefore widely reproduced. Traditionally it was also the pension age, though this is planned to rise. Seventy is used by the Department of Health and Ageing for its *calculations* of the future supply of aged care places and their actual *allocation* to States and planning regions[39].

Many commentators have questioned the relevance of these ages, usually on the basis that perceptions of age have changed along with rising life expectancy and the age at which consumption of aged related services starts, including retirement villages, community care and residential care, is much later than either of these. The typical age of entry is in the very late 70s, for retirement villages to the early-mid 80s for both community and residential aged care. Following this logic, the National Health and Hospitals Reform Commission recommended allocating aged care resources on the basis of the number of people aged 85 and over[40].

It is important to draw a distinction between the use of age bands as the basis for planning, and as a basis for eligibility for service. The border between aged care and disability services, defined as age 65, has been the subject of some policy attention in recent years. For example:

- The presence of some 6,000 'younger people' in nursing homes is seen to be a problem requiring a policy response on the grounds that nursing homes are not appropriate for younger people. The arguments about appropriateness were commonly about the mixing of younger and older residents from the standpoint of the younger ones. 'Younger' for this purpose was defined as less than 65.
- The recent COAG decision to allocate responsibility for all aged care programs with the Australian Government a means that the care of people aged under 65 will be the responsibility of State and Territory Governments.

Notwithstanding these examples, you don't have to be 70 or over to access the Commonwealth aged care program.

[39] Age 50 is used for planning resource allocation for specific indigenous services as a proxy for the poorer health status of these communities.

[40] This had the effect, theoretically, of increasing the availability of and total expenditure on aged care. This recommendation was costed by the NH&HRC at an average of $580 m pa over 10 years, offset by a large reduction in hospital bed days of between 277,000 and 547,000. *A Healthier Future*… p254

**Measurement Issues:**

Using 70+ as the measure of demand for aged care services is argued to have the following shortcomings:

- In areas which have an older average population (including whole States like South Australia and Tasmania) it can lead to undersupply of places relative to other States. Data about occupancy levels and waiting time gives some support to this argument. The converse is theoretically also true and may apply in some planning regions.

- It is likely to underestimate demand associated with dementia since this tends to be a late-onset condition and prevalence increases with age.

- Conversely it has been argued that using 85+ as the planning measure might tend to put additional resources into more affluent areas which enjoy greater longevity at the expense of poorer areas which have poorer health status.

- It has also been argued that because the number of people aged over 70 is considerably higher than the number over 85 it is possible to estimate regional variations more *reliably*. However if this is at the expense of *validity* little has really been gained.

- There are now more than 3,000 centenarians in Australia, many 90 year olds and it has been observed that that people's needs for service do not cease to change as they get older. A 100yr old's needs may be as different from a 70 year old's as a 40 year old's are from a 10 yr old's. In principle such considerations could be used to fine tune estimates of age related demand for services[41].

- Currently aged care places are allocated to 78 planning regions and cannot be moved without the approval of the Department of Health and Ageing. Places cannot be converted from one mode of care to another without approval either and the status of the planning region concerned in terms of the service provision ratios is held to be highly influential over any decision in this regard. ACSA has concerns that there may be some artificiality in this at the expense of meeting actual expressed need.

All of these issues are amenable to measurement and it is ACSA's view that some quantitative work on the impact of using different age levels for planning purposes, including testing some of the hypotheses outlined here, should be undertaken. This would establish the relative weight of different factors and their net effect on likely demand.

**Policy/Service Issues**

ACSA argues that aged care services should be allocated on the basis of assessed need, as an entitlement. Age-based calculations of demand should therefore only be used as a guide to resource allocation, not as a limit or quota. Rationing aged care in circumstances where using aged care services can avoid or defer more expensive hospital stays (for example) is not an efficiency gain.

[41] By eg weighting the relevant population numbers.

More work is required to ensure the newly-agreed re-allocation of responsibilities between the Commonwealth and the States on age lines does not result in service discontinuities or anomalies for clients. Age is a rather arbitrary criterion and its use in determining eligibility for care services is, in principle, fraught with risks for service continuity.