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Caring for Older Australians
Productivity Commission
PO Box 1428
Canberra City ACT 2601

Dear Sir/Madam

RE: Caring for Older Australians

I am pleased to forward a submission in response to the Discussion Paper "Caring for Older Australians" on behalf of Helping Hand Aged Care. The paper outlines the key elements of our vision for the future of aged care in Australia:

- Individuals will have choice and control over care they receive and will be resourced to purchase that care
- Entitlement and funding for care will be separated from any required entitlement and funding for accommodation
- New workforce models will be implemented to respond to the new system of care
- Carers and informal providers of care will be acknowledged and supported
- Regulatory systems will be efficient and promote quality as well as monitor compliance
- Older Australians living in rural and remote settings will have access to an equitable level of support
- Sector intersects and transitions will be transparent, respectful and functional

The submission provides an overview of these elements. I am happy to discuss in detail any questions or comments you have about the Submission.

Yours sincerely

Ian Hardy, AM FUniSA
Chief Executive Officer

Response to
Productivity Commission Issues Paper

Caring for Older Australians
July 2010

Introduction

This submission to the Productivity Commission's inquiry into aged care provides an overview of a possible future for aged care in Australia. It does not provide detailed analysis or description of that future. Rather it provides a starting point for a longer conversation about the changes required and the way in which those changes could be achieved.

Why change is needed

We believe that significant change needs to occur in order to address the major challenges facing the aged care industry.

A range of reviews over the last decade have identified the key drivers for change as:

- clearly stated preferences by many older people to have choice AND control over where, when and how care is provided to them
- changing demographics - increasing demand for services, change in the nature of that demand and increasing complexity of health needs leading to increasing dependency of people requiring care
- increasing cost of aged care service delivery without a corresponding increase in funding to meet these costs
- workforce challenges in terms of availability of appropriately trained and qualified staff in the right place at the right time
- changes in the availability of informal care and the need to support informal carers in better and different ways
- need for clear pathways to and through care, including transition from one sector to another: eg, hospital to home, disability support to aged care, mental health services to mainstream care services
- increasing evidence that the current planning and funding regimes are inadequate to respond to these challenges
- current regulatory and compliance frameworks are burdensome, costly and not always working in the best interests of older people

What change is needed

We propose that an aged care system for the future should be based on the following elements.

1. Consumer choice and control will be fundamental to any model of care

The current aged care system, while claiming flexibility, is highly prescriptive in regard to what can be provided; by whom it can be provided; the location in which it can be provided (for example, home versus institution in this region but not that region). Consumer choice and control is the way for the future. There are current practices, both in Australia and overseas, which demonstrate how this can be achieved. A consistent, home grown Australian model which reflects our culture and context should be developed.

We believe a system based on consumer choice and control principles should not prescribe how things are done but should prescribe the framework for how care is made available. This framework should include:

- Individuals will be resourced to purchase their own care and supported to decide how to do that in the way which best meets their care, lifestyle and family needs
- Services will be based on enabling and building capacity of individuals and families to remain in control of their life and care choices, rather than services the take over and create dependency
- Even though older people may have complex needs and/or life situations, the systems we set up to respond to those needs will be simple to find, to get into and to understand
- Processes to access the system (eg ACAT in the current system) will, in the first instance, assess for eligibility, rather than prescribing the services to be provided
- Systems will include self-assessment by older people and their carers/families, supported by quality information and advisory services to support self-assessment and decision making
- Formal, professional assessments will be available as needed and on request (eg specialist assessment for more complex needs or as needs change), rather than as part of the standard entry and assessment processes.

Assessment remains a challenging component of the aged care system. Even many proponents of entitlement-based, single entry/assessment systems advocate extensive assessments relying heavily on complex tools which, again, divide people's lives up into "domains" or "components". We need to move to assessment which determines a broad entitlement and places equal value on self-assessment - what the older person and their family say they want/need ie build consumer choice and control in at the earliest point.

A corollary to this approach is a need for a robust discussion about what the community expects from the aged care system. Bringing the broader community into discussions such as who should be responsible for care, the role of family and informal care networks, how much is the community prepared to pay and related issues will have a two effects. It will help to define the parameters for government in developing the aged care system and it will help to achieve realistic expectations about what is possible.

Special needs groups will benefit in a consumer controlled system through access to flexible, individually focused resourcing which will help to address people's needs taking account of additional barriers to care, special requirements, cultural context and so on.

2. Entitlement to and funding for care will be streamlined

The current planning ratios have not provided Australia with a comprehensive or fair aged care system. In particular, the current levels of available care do not meet current needs in terms of overall numbers, distribution of places or types of services available. For example, there are significant gaps in the levels of care available, most notably in the gap between CACP level and EACH level care. Further, there is limited flexibility and significant inefficiencies in the gate keeping (ACAT) arrangements for consumers to move between levels of care (up or down) as their needs change. The residential funding system enables more flexibility in care but is overly complex and restrictive, with multiple categories which are highly prescriptive and do not adequately translate identified need into cost of care.

Our preference is to move to an "entitlement" system, based on notional or actual budgets for different levels of care. The levels would be determined by a simple, access-level assessment of need (not assessment of type of care required). Features of this approach should include:

- covers low to high levels of need without gaps
- is simple (between 5 and 7 levels)

- does not require complex, multiple assessments and prescriptive interpretations of practice
- does not prescribe the intervention
- applies wherever a person chooses to live, eg residential facilities, other supported accommodation, independent living or retirement accommodation, homes the community
- facilitates consumer choice and control.

As indicated in previously, the entry assessment should be for entitlement to and level of need not a prescription for care. The care response should be developed by the older person in consultation with the provider. Accountability measures should be broad - supported to remain at home; enhancement of quality of life - rather than detailed prescription of what activities occur or are in/out of scope and requirements for justification of every activity. Specifically, the ACFI should not be adopted as the model for funding.

3. Funding for and entitlement to care and accommodation will be separated

We believe that care entitlement/funding should be separated from accommodation entitlement/funding.

There is a need for change in the assumptions underlying the aged care system. Specifically, the bulk of aged care funding is directed to residential care which is based on the assumption that if people need a certain level of care, they also must need accommodation. Provision of accommodation and provision of care should be separated, so that residential facilities become an accommodation choice, rather than a "compulsory extra" provided in tandem with particular types of care.

The starting point should be that older people are able to provide/look after their own accommodation, regardless of the level of care they need. Residential care then becomes one of the choices they can make, rather than the current model which forces people to move to residential care if they need a particular level of care in a particular region.

This approach could then lead to the emergence of different types of accommodation options (eg as in Sweden; smart house units) and/or changes in the way existing accommodation options are accessed/used.

Retirement villages are an example of this. It would be a mistake to increase regulation of retirement villages to make them more like current residential care. The starting assumption should be that older people can manage their own accommodation, not the reverse.

To achieve this result, the housing supply issue needs to be addressed, ie, ensuring that there are sufficient flexible "liveable" housing options in the market. This is a particular issue for older people from disadvantaged backgrounds.

4. Government policy and funding will properly balance lifestyle and care

We believe that there is clear evidence that building and maintaining an individual's resilience and capacity to manage their own life (including any care which is required) has a positive impact on the health and wellbeing of older people, including on their need for care and support.

Aged care is about more than packaged care/units of care to provide support for functional activities such as shopping, cleaning, personal care. There are a wide range of services currently in place which are not attached to individuals, such as programs to address social

isolation, to create neighbourhood connections, to provide counseling services. It is critical to maintain dedicated funding for these services, outside of the packaged care approach. Any aged care reform needs to include funding to continue these lifestyle/social programs and other specialised programs, including social work/counselling, physical and psycho-social rehabilitation, community nursing, health promotion and illness prevention, continence management.

Example.
An older person who is feeling very low after the death of a spouse and who is starting to withdraw from social connections but who otherwise can care for themselves (ie, does not need help with housecleaning, personal care, shopping), would not need a "package of care". However they may benefit from contact with a specialist worker who can help them work through their grief and loss and support them to re-connect with previous community activities and/or join new ones. These services need to be in existence for people to access as needed, not reliant on people paying for them.

5. The aged care workforce will be sufficient and appropriate to the needs of the older people

We believe that, in the same way as there needs to be a new approach to aged care, there needs to be new workforce models in aged care.

Challenges facing the aged care sector with respect to workforce include the image and status of the industry, low wage/salary levels, limited funding to increase wages/salaries, lack of consistent standards and expectations regarding skills, knowledge and expertise.

These challenges apply differently across different areas of the workforce. For example, tertiary trained professionals, such as nurses and allied health professionals, may be more affected by sector-specific wage differentials and the community perceptions of the status of the industry. There are current strategies, such as scholarships and, in organisations such as Helping Hand, comprehensive, innovative and supportive student placement programs which are helping to overcome these issues. These initiatives need to continue.

A more urgent need relates to the largest part of the workforce, that is, careworkers who work in both community and residential settings. There is a need for this largely unregulated workforce to be placed on a more "professional" standing through introduction of minimum standards across the country, driven by the needs of older people and the sector.

At the same time, there needs to be reflection on the workforce models currently used in aged care. There needs to be recognition that services and service models in aged care are different from those in the acute care sector. Thus, the staffing requirements are different. We believe that there is a need for an exploration of a para-professional workforce consisting of multi-skilled workers who can undertake a range of tasks. These workers would provide support to nurses and allied health professionals and would have a higher skill level than care workers. These roles would provide more flexibility in future staffing models and provide pathways for care workers who want more challenging work but do not want to become nurses/allied health professionals.

With respect to funding, there are two main issues. The first is increased funding to enable aged care providers to pay competitive salaries and wages and to match conditions in other, competing industries. Secondly, there needs to be increased funding to meet the costs involved in mandatory training.

6. Carers and informal care providers will be acknowledged and supported by the system

We believe that any redesign of the aged care system needs to give explicit consideration to the role of informal care providers. Service models at the moment are often predicated on family/carer involvement which cannot be assumed into the future. Conversely, research indicates the key roles that informal carers play in maintaining older people in their own homes.

A key strategy for supporting carers has been the provision of respite. However, recent reports have indicated that current respite strategies may not be providing the relief/support that was expected and that carers need additional or more flexible supports in order to maintain their caring role. We believe that respite and carer support needs to be integrated rather than separated. Again, flexible funding entitlements could do much to allow the consumer and their supporting carer(s) to tailor respite to their individual circumstance. The health impacts of caring also have been highlighted.

7. Regulatory systems will be consistent and promote quality

We believe that there is need to re-focus regulatory activity towards improving quality and to be streamlined to reduce the current burden on aged care.

As has been demonstrated in an earlier report by the Productivity Commission, there is a significant regulatory burden on the aged care sector. For example, over 12 months in 2009/2010, Helping Hand senior staff on residential sites spent, in total, 1,079 hours (the equivalent of 28 weeks full time) supporting on-site visits from regulatory bodies, primarily the Aged Care Standards and Accreditation Agency. This does not include the time spent preparing for these visits (eg writing self-assessment, organising the logistics associated with the visits, responding to written requests for more information). Nor do these statistics reflect the time burden on our community based services, which currently are accredited by four different systems. These statistics do not reflect the time and other resource input from the accrediting bodies. We believe that there must be a more efficient and effective approach to regulation which in turn would free up resources to enhance care. This burden needs to be addressed by adopting a consistent, single set of standards across the industry

We also believe that, while the regulatory approach uses the language of quality improvement, in practice, the primary focus is on compliance. We believe that there should be a streamlined, efficient regulatory approach which not only measures compliance focuses but also promotes quality improvement through an educative approach and rewards for innovation and good practice.

In terms of business management, there needs to be consistency in contract management and reporting to reduce the number of different data, financial and accountability report mechanisms which exist across the different programs within departments.

8. Older people living in rural and remote areas will have the access to equitable, adequate and appropriate care

We believe that where you live should not determine the care you receive.

There are significant challenges in providing adequate and appropriate services to older people living in rural and remote settings. These include the differences in community infrastructure (eg health and community facilities), workforce and cost. The advantages of the simplified, consumer directed model which we propose is that it will enable the flexibility required to design and implement innovative, responsive approaches to specific

circumstances. However, it is imperative that, in this or any model, the additional costs of service delivery are incorporated into funding, to address issues such as the higher cost of goods, particularly petrol; time and other costs resulting from the distances which need to be travelled; and costs associated with new technologies which can overcome distance and time barriers.

Workforce issues also are a critical challenge for services in rural and remote Australia. Whereas in the metropolitan/semi-rural areas, the challenges relate to shortages, in some rural and remote areas the challenge is no staff at all, forcing older people to move in order to receive care. Funding is one solution but the issues facing the aged care workforce in rural and remote areas include other elements (eg distance, lifestyle) which also need to be addressed.

9. Sector intersects and transitions will be seen

(a) Primary and acute health systems

In general terms, there is a need to map access and use of primary heath care, acute care and aged care from the older person's perspective to see where the "joining up" of systems needs to occur ie design the system from the older person's perspective, not the funder/provider perspectives. From this process, we will identify where there are unnecessary barriers/silos or where the silos need connectors, and reduce the artificial walls/gatekeepers which get in the way of holistic, comprehensive, person-centred care.

Specifically, ***health and hospital reform needs to recognise the aged care sector's capacity to provide primary health care services -*** what we currently provide and the potential to do more in the future, in areas such as, health coaching, mental health services for older people , groups which build individual capacity and resilience, and falls and balance groups. This recognition needs to include funding to provide primary health care.

Conversely, primary health care services should not opt out working with older people, just because aged care is involved. We need a much more mature understanding and practice of the two systems working together and complementing each other rather than "either/or" approaches. This involves a more sophisticated understanding of primary health care than it simply being the "entry level" health system or "the simple end" of the health systems.

The hospitals and health regions currently control what happens on the ground through funding devices such as provider panels and sub-contracting arrangements. The result is the creation of silos of service, rather than connected services. This may be exacerbated under the new Health and Hospitals Network. There needs to be discussion of principles to ensure consistency of access across the country

Finally, there needs to be a change in the dialogue with respect to older people's access to the acute sector, that is, a move away from language such as "bed blockers" and "older people use too much of the system". The focus of reform and interaction should be on efficiency based on the right care in the right place at the right time to achieve best outcomes for individuals, rather than efficiency in one sector.

(b) Disability

People with a lifelong disability or acquired disability are living longer than ever before, leading to increasing pressure on both disability and ageing sectors to respond to their needs. The debate about how to best meet these needs has largely focused on jurisdictional issues about responsibility and funding. ***There is urgent need for a more coherent discussion with the focus on continuity of care for people as they age, access to***

appropriate services at the right time and in the right and adequate funding. The proposed changes to disability funding through an insurance scheme need to include discussion on how that system will connect with the aged care system. But again, a focus on resourcing the individual has great potential to minimise the current disconnections between service funding and delivery.