Baptcare

Bringing care to life

Baptcare Response

‘Caring for Older Australians’

Productivity Commission Inquiry

July 2010

Executive Summary

This response to the Productivity Commission's public inquiry into aged care outlines the challenges facing the current system of aged care services and highlights some of the challenges and opportunities facing the sector in the future. It makes recommendations that Baptcare believes will improve the current aged care system and assist the development of a resilient and sustainable system into the future.

Baptcare is a large not for profit provider of residential and community aged care based in Victoria and Tasmania. In 1945, a group of Baptist women raised £4,000 to open Australia's first Baptist nursing home. Baptcare now delivers services to over 2,000 people in 29 locations across Victoria and Tasmania.

The Current System

The current aged care system is operating under immense strain. The provision of, and access to, community-based supports remain fragmented and complex for members of the community and service providers. There is an urgent need for streamlined services and supports for older Australians. This situation is predicted to worsen over the next 5 to 10 years as demographic changes exacerbate systemic pressures as the first Baby Boomers start to access aged care.

A major issue is that there are too many barriers between levels of care. The current model does not support continuum of care. There is a requirement for a more iterative approach to funding to support older Australians as their needs for care change.

There is need for interface between points of care throughout the health system. A client might pass through community care, acute/sub acute, respite and residential care on the course of their ageing journey and the ability to access real time information is important especially with the increasing prevalence of chronic disease and use of medications.

Access criteria should be reviewed to better address the complexity of aged related disease and mental health issues that are beyond the resource of a community aged care package (CACP). There is a growing, and increasingly urgent need, to fund more services that provide specialised and accessible mental health support within the community to the ageing population.

The support of people with disabilities as they age is becoming an issue, as the transition from disability-funded services to aged care services is inadequate.

There is a requirement for Government to ensure that the aged care system achieves broad, culturally responsive approaches. Services for older Australians from Culturally and Linguistically Diverse (CALD) backgrounds should be driven by need rather than prescribed funding formula.

In the residential aged care area there is a need to decouple care and accommodation funding. Care funding should be paid by the Commonwealth and accommodation funded by the resident, as it is with retirement living, whilst retaining the safety nets in place for supported residents.

AN AGED CARE SYSTEM FOR THE FUTURE

Baptcare strongly holds the view that quality and adequately supported services should be available to all Australians regardless of their ability to pay. These services should offer a base level of *accommodation* that affords basic comfort, amenity and dignity. The level of *care* provided should be the same for all, irrespective of wealth.

The current funding mechanisms require review and transformation if the needs of older Australians are to be met in the longer term. Baptcare suggests a combination of an increase to the Medicare levy to meet the costs of care, coupled with the quarantine of a proportion of superannuation contributions for the costs of accommodation services, might go someway to funding future needs.

If consumer directed care is adopted as the framework for aged care service provision, Baptcare would like to see case management retained as a core component of the system. A real commitment to transformational reform will require an overhaul of the fragmentation of service system barriers between HACC, CACP, and EACH.

A future accreditation framework should focus on the overall organisational standards, system and continuous improvement framework of each provider through a central organisational review using a risk management approach.

The workforce in the aged care sector will be a major challenge into the future. Shifting demographic change has led to an ageing of Baptcare's workforce and volunteers with 49% of Baptcare staff now aged over 50 years. The combined effect of older workers seeking to retire and increased demand for aged care

services will create an untenable position for most aged care providers unless fundamental systemic change occurs.

Recommendations

1. Iterative approaches to funding of care as opposed to the current rigid division of funding.
2. Management of the waitlist system to monitor clients.
3. Principles to determine which clients are offered services and in what order.
4. Funding made available for interim services for those waiting to be assessed.
5. Funding allocated based on assessed consumer need with a tiered approach to levels.
6. Flexible, iterative funding that supports the consumer's changing needs.
7. Shared electronic information between all parts of the health and aged care systems to facilitate support and treatment of older Australians.
8. Access criteria to better address the complexity of aged related disease, social implications and mental health issues that are beyond the resource of a CACP package.
9. Review interface between the Disability and Aged Care sectors to ensure smooth transition and continuum of care for people with disability who are aging.
10. Add language support to the Aged Care Standards.
11. Have a CALD supplement paid as part of a subsidy and accounted for in Community Care Quality Reporting.
12. Fund CALD responsive training to best support the needs of CALD clients and workforce.
13. Flexibility in funding and packaging is required across aged care and mental health services.
14. Ongoing research into Day Therapy Centres to provide the evidence base on the effectiveness of programs and indicate program improvements.
15. Improved access to Day Therapy Centres on a local government area basis.
16. More focus on the principle of a 'well managed' decline and engaging with the idea of frailty in policy frameworks.
17. Indexation of funding to CPI rate or aligned to the indexation model that is applied to health funds.
18. Decouple care and accommodation funding, with care funding to be paid by the Commonwealth and accommodation to be fully funded by the resident whilst retaining the safety nets in place for supported residents.
19. For the purpose of assessing an accommodation charge or bond, eliminate the distinction between low care and high care and replace with a single classification called Residential Aged Care.
20. Retain the financial safety nets that currently apply for supported residents.

21. For permanent residents, with assets under the partially supported resident threshold, only allow an accommodation charge to be levied.
22. For permanent residents, with assets over the partially supported threshold, allow an accommodation bond to be levied.
23. Retain the minimum assets level that a person must be left with after paying an accommodation charge or bond (currently $37,500) but where a person's assets are ten times greater than this, the bond ceiling should be 90% of their total assessable assets.
24. Review current HACC services unit cost to determine real cost of services.
25. Include transport and food services in cost of HACC service delivery.
26. Government funding to offset the cost of pastoral care services currently supplied by faith-based providers.
27. Fund transport to and from venues for planned activity group services.
28. Grants made available for infrastructure including buildings, building upgrades and vehicles for community based care services.
29. Provide further funding incentives to entice providers to offer more respite care.
30. Legislate for a uniform Retirement Village Act across Australia.
31. Share outcomes of Consumer Directed Care (CDC) activities and pilots in Aged Care and Disability Sectors.
32. Provide funding and resources to assist any transition to CDC service delivery.
33. Retain case management of CDC packages to ensure the potential for elder abuse is minimised or eliminated.
34. Improve information provision to CALD communities about the support options available.
35. Translate all essential materials into at least 10 languages via the Department of Health and Ageing.
36. Provide Government support for the development and evaluation of new applications on available technology platforms to support the care of CALD residents and clients.
37. Encourage regional and rural health workforce attraction, retention and development.
38. Support partnerships between regional hospitals and aged care facilities to share staff and facilities.
39. Offer regional universities financial incentives to set up satellite or mobile campuses in smaller rural and regional towns that have acute hospital and residential aged care providers.
40. Provide financial incentives to residential aged care providers and/or regional training providers to reduce the costs nursing students face with travel and accommodation.
41. Offer subsided housing for health professionals relocating to rural or regional areas.
42. Introduce a risk management framework to the accreditation of providers.

43. Enable 4-year accreditation periods for approved providers.
44. Offer subsidies or interest free loans to those existing residential facilities that have to be retrofitted with overhead hoists.
45. Fund Research to assess prospects for residential aged facility design to accommodate the physical inherent requirements and additional needs of an ageing workforce.
46. Undertake research to determine options for job re-design to lower emphasis on paperwork for Registered Nurses in order to increase time spent on patient care.
47. Commission regular NILS (or similar) aged care industry research to assist workforce planning.
48. Support the aged care sector to prepare, undertake and implement workforce plans.
49. Provide funding to cover backfilling of positions for aged care staff for language and literacy training.
50. Increase direct Government funding to achieve salary parity with the acute sector or allow aged care providers to source alternative means of funding.
51. Undertake detailed workforce analysis to re-design jobs to more effectively use existing people resources in an aged care setting.
52. Fund a project to develop web-based material that focuses on the aged care industry to show the diversity of roles available.
53. Encourage younger people and older career changers to consider a career in aged care. Expand the ‘careers that matter’ aged care project.
54. Encourage university internships or placements in the aged care sector.
55. Create an industry-based Graduate Nurse Program.
56. Assist the development and implementation of ‘career change’ programs for nurses who wish to enter aged care.
57. Support volunteering in aged care with case managers.
58. Offer a tax incentive for family carers of older Australians living with relatives.
59. Support and funding for organisations that have an active commitment to volunteers in the aged care sector.

Acronyms

ACCV	Aged and Community Care Victoria
ACFI	Aged Care Funding Instrument
ACSA	Aged and Community Services Australia
CALD	Culturally and Linguistically Diverse
CACP	Community Aged Care Package
CDC	Consumer Directed Care
COPO	Commonwealth Own Purpose Outlay
CPI	Consumer Price Index
DTC	Day Therapy Centres
EACH	Extended Aged Care at Home
EACHD	Extended Aged Care at Home (Dementia)
GP	General Practitioner
HACC	Home and Community Care
NFP	Not for Profit
NILS	National Institute of Labour Studies
IT	Information Technology
NHHRC	National Health and Hospitals Reform Commission
RTO	Registered Training Organisation

Table of Contents

Introduction

This response to the Productivity Commission's public inquiry into aged care outlines the challenges facing the current system of aged care services and highlights some of the challenges and opportunities facing the sector in the future.

About Baptcare

Baptcare is a large not for profit provider of residential and community aged care based in Victoria and Tasmania. In 1945, a group of Baptist women raised £4,000 to open Australia's first Baptist nursing home. Baptcare now delivers services to over 2,000 people in 29 locations across Victoria and Tasmania.

With 7 residential aged care facilities (4 metropolitan and 3 regional) as well as CAPS, EACH and EACH Dementia packages dispersed across the states, Baptcare employs over 1,000 staff and engage with 450 volunteers. In 2008/9 Baptcare delivered 1,200 Community packages to support older Australians to stay in their homes and cared for 926 residents in our facilities.

Background

An older and more diverse population: Baptcare's clients

In 2008, the proportion of the Australian population aged 65 years and older was 13.2%. In Victoria, people aged 65 years and over accounted for 13.5% of the total population. Melbourne had a lower proportion of older people (12.6%) than regional Victoria (16.0%).[1] Figure 1 illustrates the proportion of older Australians across ABS statistical regions.

By 2021, 17% of Melbourne's population and 23% of Victoria's regional population are projected to be over 65 years of age.[2] The biggest impact on aged care is the demographic changes of an older population requiring aged care services into the future. The 2010 Intergenerational report stated "the number of people aged 85 and over is expected to more than quadruple over the next 40 years to 1.8 million by 2050. Government spending on the aged over the same period is predicted to increase from 0.8 per cent of GDP in 2009/10 to 1.8 per cent in 2049/50".[3]

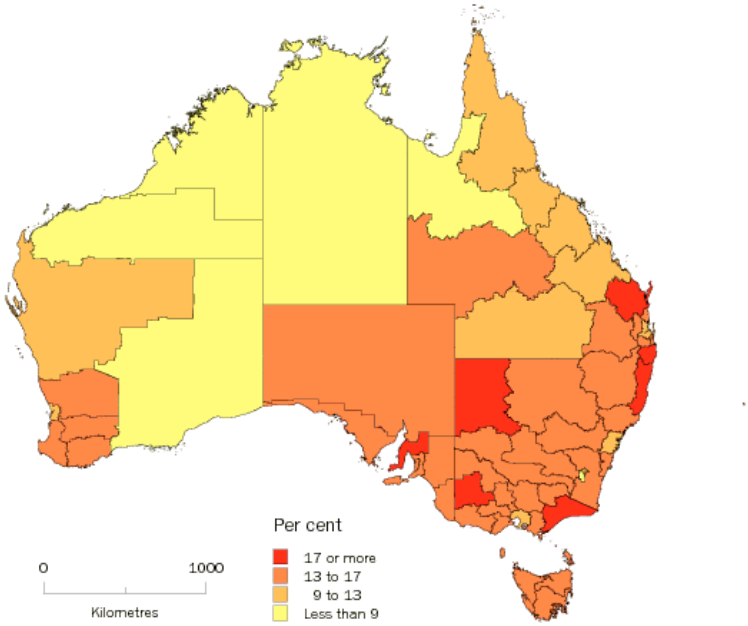

Figure 1: Population Aged 65 years and over (ABS 2008)

The proportion of people from CALD backgrounds is predicted to increase to 22.5% of the total population over 65 years by 2011. By 2021, 30% of older Australians will come from a CALD background.[4] Over the period 1996 to 2026, the proportion of those from CALD backgrounds aged over 80 years is expected to increase from 13% to 25%.[5] The backgrounds from which these older Australians come will begin to change over the period, reflecting migrant and refugee intakes.

The Henry Review into *Australia's Future Tax System* came to the view that:

> Demand for aged care services is expected to become more varied in the future. Aged care recipients are likely to have a wider range of complex or high-level care needs, as advances in treatment enable people with chronic diseases to live longer. Increasing affluence and ethnic diversity are expected to lead to a wider range of client preferences. In particular, demand for care provided at home will increase, due to strong preferences for independent living among the baby boomer generation. Common to all these factors is recipients' desire to exercise greater choice about the care they receive, greater capacity to 'age in place' and better continuity of care.

The impact of the ageing of the Baby Boomers will be felt across the aged care sector in the next 5 to 10 years as the first Boomers start to access care in some form or another. This generation is very different to that which preceded it, they are more likely to question those in power, be better informed about options, be prepared to use different options and have a lower predisposition to save.[6]

When asked about future lifestyle choices, Boomers reported that they preferred solo or independent accommodation as opposed to communal or centralised facilities. They wanted to be close to family and friends, have access to local communities and public transport, whilst living in environmentally friendly accommodation. They also wanted space to have visitors to stay and more than half wanted to keep their pets. Feeling part of a community was also important.[7] However, there is some concern that with 20% of boomers living singly due to divorce, smaller family units that are geographically dispersed[8] and the lower levels of social capital experienced by this generation,[9] that ageing in place may be problematic without some attention to increasing social connectedness.

A number of overseas trends support changing demand in Australia. There appears to be an early indication of a growth in the number of self-organising communities focussed on ageing in place. In *Future Demand for Aged Care Services*, the Productivity Commission found that intentional communities and 'naturally occurring retirement communities', neighbourhoods or buildings where a large segment of residents are older people, were starting to emerge. There is also evidence that older people are pursuing strategies of formal care provision, rather than relying on informal care, to allow them to stay at home. It is expected that this trend will strengthen in coming years with the resultant impacts on Community Aged Care and low care residential places.[10]

Economic environment

From September to November 2008, the global credit crunch and resulting downward spiralling in financial markets created uncertainty. At this time, the economic future is stable though with some residual inclination to volatility in response to international events. The global financial crisis has had both positive and negative impacts on the aged care, health and community sectors.

A negative impact arising out of the crisis was restricted access by aged care providers to funds required to enable its growth plans. Credit to fund capital expansion of large retirement villages and residential aged facilities was restricted or more expensive to purchase. Whilst a deep recession was avoided, government funding to aged care became more restricted for residential and community aged care as other "nation building projects" were funded in response to the global financial crisis. There are currently projections of a 2010/11 Commonwealth

government budget deficit. These negative forecasts are likely to continue to challenge the aged care industry.

The global downturn impacts on the wealth of many Baby Boomers approaching retirement. Fujitsu surveyed Boomers in late 2008, and found that "many were unlikely to support themselves into old age because they had not saved enough, a trend exacerbated by the Global Financial Crisis and consequent fall in asset prices".[11] This may mean that although many Baby Boomers thought they had enough to fund themselves, they may be caught short in older age and become reliant on the pension. With 69% of Boomers expecting to fund their retirement via superannuation,[12] any continuing volatility in global share markets may undermine their ability to be financially self-sufficient as they age.

EMPLOYMENT EXPECTATIONS FOR 2010-2012

Although it is less likely that fluctuations in the Australian and global economy, brought on by the financial crisis, will impact employment expectations in the aged care sector for 2010-2012, there are still challenges. It is anticipated that the employment market for nursing and social work personnel in particular, will remain tight into the future as the country experiences an ageing population; a lower number of new entrants coming into the aged care workforce due to high demand from competing sectors (such as acute health, pharmaceutical, education, pharmaceutical industry etc); and the continued high cost of tertiary education.

Technological environment

Technological changes are less likely to impact on residential and community care services than other sectors such as manufacturing. The introduction of robotics is unlikely, at least in the short to medium term, and personal contact will remain a feature of the industry in the next 5 years. Over the next 10 years, there is likely to be greater demand for the provision of wireless and broadband internet in residential aged care facilities as Baby Boomers start to access these services.

Increasingly employees in the sector will be required to have at least basic computer skills as personal attendants, and more sophisticated IT skills for nurses, care managers and social workers who are required to report online to government funding bodies, undertake research and learning online, especially in regional areas.

The aged care industry will need to invest in training existing employees in IT skills such as Microsoft Office products and specific industry based databases, internet and intranet searches for policies. Placing computers in staff rooms where employees do not have ready access to computers, such as in residential aged care facilities, is vital to enable access to technology for aged care workers.

Another technological change that will impact the aged care industry in the next five years is the introduction of electronic hand held devices to enter care and case management notes directly into aged care databases from a remote or bed side location. The aged care sector will need to either recruit candidates with greater IT skills or provide more IT training to its existing employees. On-line learning and automated recruitment software are other tools that will be rolled out to enable regional areas to have accessible access to learning programs and people talent management software. Finally, automated rostering for residential aged care through swipe card log on and log off is also a consideration for more providers, though not without its own issues.

Regulatory environment

Federal and state government regulations significantly impact aged care, more than other private sector businesses, as the industry is largely government funded and as such is required to adhere to or exceed the standards set for it in order to maintain or increase that funding.

Previous Reviews of the Aged Care System

The final report of the National Health and Hospitals Reform Commission, handed down in June 2009, made a number of reform recommendations that Baptcare would like to see the Productivity Commission take account of in this Inquiry.

The Recommendations Baptcare supports are listed below.

Linking government funding to people: NHHRC recommended that Commonwealth Government funding subsidies for aged care should be more directly linked to people's needs, rather than places. This would involve removing the current planning ratios, but instead capping the number of aged care subsidies at the point of assessment.

Ensuring government support keeps pace with the number of people needing care: NHHRC recommended that the numbers of people eligible for government support for aged care be linked to the number of people aged 85 or over.

Funding greater choice: NHHRC recognised that aged care providers will need to be able to raise revenues to invest in expanding the number of aged care places in order to offer more choice for older people. They recommended that consideration be given to allowing accommodation bonds, or alternative approaches to payment for accommodation, for people entering high care residential care places, if the removal of regulated limits on the number of aged care places results in sufficient increased competition in supply and price across the aged care sector. In addition, aged care providers should be given the opportunity to convert existing low care residential places to community care in a phased way to free up the choice of care setting for older people.

Adequacy of funding subsidies: NHHRC recommended that the level of care subsidies be periodically reviewed to ensure that they are adequate to meeting the care needs of very frail people in residential settings. Ensuring adequate care subsidies is also essential if aged care facilities are to provide sufficient appropriately trained professionals, including nurses, to meet the complex health needs of residents.

Dedicated funding for medical care: NHHRC recommended that funding be provided directly to aged care providers to organise the provision of

> medical services for their residents, including through 'sessional' (part-time) and on-call arrangements. This does not remove the right of aged care residents to choose their own doctor and to enrol voluntarily with a primary health care service. Instead, this reform is intended to fill an existing gap in the provision of medical services to aged care residents.[13]

We agree that these recommendations would assist the provision of care to older Australians, whilst generating more beds in existing facilities.

The Henry Tax Review, *Australia's Future Tax System,* made a number of recommendations about reform of funding the aged care sector. There were also a number of principles stated in the Review. We support the principle that:

> Equitable provision of assistance for aged care would ensure that recipients of limited means can access an adequate standard of care. To ensure that aged care services meet the needs and preferences of users, funding should be tailored to the needs of users and directed in line with choices. As care may often be delivered effectively in both recipients' homes and aged care facilities, assistance for care should generally not be tied to a particular care setting.

In addition to these findings, this response makes recommendations that Baptcare believes will improve the current aged care system and that will assist the development of a resilient and sustainable system into the future.

The Current System

The current system of aged care services is operating under immense strain. The provision of, and access to, community-based supports remains fragmented and complex for members of the community and service providers. There is an urgent need for simpler streamlined services and supports for older Australians.

There are issues with the timely access to services and older Australians are on extensive waiting lists prior to accessing care, with little or no support for their pressing needs.

- A veteran can receive higher levels of service through Veteran's Home Care but cannot access a case manager. To access a case manager they must accept a lower level of service through a CACPs package.
- HACC clients aren't able to access their established social networks, for example their Planned Activity Groups, once they access a care package. This removes them from a vital support.

There are too many barriers between levels of care at the moment. The current model does not support continuum of care. There is a requirement for a more iterative approach to funding of care as opposed to the current rigid division of funding between Home and Community Care (HACC), Care Packages and the Department of Veteran's Affairs. The lack of a flexible approach for utilising funds disadvantages our clients.

There is, in practice, no equity of access via the waitlist. Aged Care Assessment Services rank people according to a priority tool as high, medium or low. However, there have been cases where a client has waited 2 years marked as a 'high' and another may be picked up very quickly although rated as 'low'. There needs to be more flexibility built into the system to place people with a 'high' rating more quickly.

The existing lack of oversight for the months or years someone is on the waitlist is causing issues, as there is no responsibility for how those people are managing without care. There is a requirement for case management to monitor clients, a need for interim support services for those waiting, and a revision of the principles around who gets offered services in what order.

Once a person is in the system, there is a lack of continuity of care. Community Aged Care Packages (CACPs) funding is limited to low level care. As a client's need increases clients can require higher levels of care, but might not yet meet the criteria for EACH or EACHD funding. This has a direct impact on the appropriate level of care they receive. There is a need for more responsive and flexible service delivery as a person's need for support changes. There is also the requirement for the allocation of funding to be more flexible, for example, respite funding be accessible at home or in a facility. The Department of Veteran's Affairs (DVA) has this flexibility for their clients but others do not.

There is need for an interface between points of care throughout the health system. A client might pass through community care, acute/sub acute, respite and residential care through the course of their ageing journey and the ability to access real time information would be very useful, especially with the increasing prevalence of chronic disease and the use of medications.

Recommendations:

1. Iterative approaches to funding of care as opposed to the current rigid division of funding.
2. Management of the waitlist system to monitor clients.
3. Principles to determine which clients are offered services and in what order.
4. Funding made available for interim services for those waiting to be assessed.
5. Funding allocated based on assessed consumer need with a tiered approach to levels.
6. Flexible, iterative funding that supports the consumer's changing needs.
7. Shared electronic information between all parts of the health and aged care systems to facilitate support and treatment of older Australians.

Complex Case Management

Access criteria should be reviewed to better address the complexity of aged related disease, social implications and mental health issues that are beyond the resource of a CACP package. There is also the need to review the criteria to gain access to high care package. See Case Study 1 for an example of the type of complex care cases likely to emerge in coming years.

Recommendation:

8. Access criteria to better address the complexity of aged related disease, social implications and mental health issues that are beyond the resource of a CACP package.

CASE STUDY 1

A current client with complex case management needs is a 49 year-old female with a history of:

- Psychoses and depression
- Mood affective disorder
- Phobic and anxiety disorder
- Chronic lower respiratory diseases
- Heart disease
- Osteoporosis
- Transient ischemic attacks
- Fractured tibia

Management and support issues include personal care, transport for shopping and regular social engagement and family connectedness. In addition, there is a need for liaison with mental health outreach.

Regular services include:

- Home care
- Meals on wheels
- Community access transport
- Carer assistance
- Support re medication compliance/monitoring.

Direct care for this client is over 33 hours per month from services. The required Care Manager facilitation is, on average, 2-3 hours per week plus 1-2 home visits per month. As this client ages, they would not substantiate the criteria for a higher-level package, but clearly the support required is above that stipulated in a CACP package.

Disability Services

The ageing of people with disabilities is becoming an increasing issue and the transition from disability-funded services to aged care services is inadequate. There is limited interface between disability services and aged care.

Recommendation:

9. Review interface between the Disability and Aged Care sectors to ensure smooth transition and continuum of care for people with disability who are aging.

Indigenous Australians

Current application of existing flexible care options to facilitate support to indigenous clients can be successful where there are key contacts/roles to support the package facilitator and the client: for example, HACC Aboriginal Liaison Officers.

The flexibility of package provision is paramount to success, as the supports required do not generally fit the same model of support services for generic aged care packages.

Culturally and Linguistically Diverse Communities (CALD)

CALD being characterised as a 'special need' is actually a misnomer, as many areas have a large proportion of CALD clients and residents. Baptcare has a number of sites where care is delivered to populations with a high percentage of CALD communities.

Services for this group should be driven by need rather than prescribed funding formulas. There is a requirement for Government to ensure that the aged care system achieves broad, culturally responsive approaches. CALD clients have diverse needs and require flexible-funding streams to accommodate those needs for example; a CACP client who is CALD should have an allowance for use of interpreters. A CALD supplement could be paid as part of a subsidy and accounted for in Community Care Quality Reporting.

Given the diversity of CALD communities, both in our client base and our workforce, there can be communication challenges. Older Australians from CALD backgrounds generally present at later stages of age-related conditions, such as dementia. Research has shown that bilingual older migrants may revert to their native language[14] and that for those suffering dementia, the most recently acquired language is the first lost.[15]

Research has found that older Australians from CALD backgrounds "appreciated those workers who had developed some cultural knowledge and very basic language skills of their country of origin."[16] Providers require funding for engaging staff in training around CALD support to enable them to interact better with clients and residents.

If CALD client support is done correctly, then many needs will be better met in areas such as dementia care, for example, where the behavioural manifestations of people's inability to communicate will be lessened, and even cases of apparent incontinence that are actually due to communication difficulties.

Recommendations:

10. Add language support to the Aged Care Standards.
11. Have a CALD supplement paid as part of a subsidy and accounted for in Community Care Quality Reporting.
12. Fund CALD responsive training to best support the needs of CALD clients and workforce.

Older People with mental Illness

Clients with mental illness that are aged are presenting as packaged clients and therefore generally disconnected from formal medical mental health support. While their primary diagnosis is not the mental health condition, as they meet the eligibility requirement for flexible support in the aged care system, they have a need for ongoing mental health support. Their access to this support becomes very fractured with the general option limited to Aged Psychiatric Assessment Treatment Teams that have limited access for community clients after the initial assessment and discharge, and limited ongoing support.

There is a growing, and increasingly urgent, need to provide more services that provide specialised and accessible mental health support within the community to the ageing population. The current reliance on General Practitioner management is not a satisfactory fall back point.

Recommendation:

13. Flexibility in funding and packaging is required across aged care and mental health services.

Day Therapy Centres

The Day Therapy Centres (DTCs) undertake rehabilitation and restorative work involving a blend of physical/ functional therapy work with sensitive motivational input. A psychological approach is of key importance among frail older people with multiple and complex health needs; it is essential in supporting people to make decisions and adaptive changes and combines well with short-term case-

management interventions. For example, people who have had strokes grapple with big issues and often experience some degree of depression. If this is not dealt with, then their physical and functional therapy interventions will be less effective.

DTCs are different from other service types as being both programs and centres of excellence in wellbeing in older persons, independence and adaption to degenerative health processes. The DTC target group is often not a well group. Some people are frail and will require long-term support “in situ” in the community. There are essentially three client groups within DTCs:

- People who will recover lost independence or functions
- People who will be able to ‘stay the course’ in their ageing journey
- People who will need some support to psychologically adjust and adapt their living to declining function or health.

Therefore, in contrast to Community Rehabilitation Centres, Community Health Centres and HACC Allied Health, which are relatively very short term in their interaction with clients, DTC clients are able to benefit from longer term engagement. This enables the building of relationships, which complements the psychological approach. This long-term approach is, of itself, a foundation for longevity for some people. DTCs are specialists in chronic and complex support, co-morbidity and frailty. When other services say, ‘there’s nothing more we can do after 8 sessions’ and clients are scoped for discharge, DTCs will continue to work with their clients. This expertise is workforce strength that is highly valued and will become increasingly necessary as the population ages and the prevalence of chronic disease increases.

There are cost savings that DTCs can, and do, achieve for the community and taxpayer. DTCs can improve independence or arrest slow decline. One outcome of this is a reduced need for more intensive care services. For example, programs such as continence retraining and bladder strengthening reduce the need for continence aids.

DTCs do not want to create service dependence but achieve the right milieu and balance of professional and peer support to give people time and encouragement to continue their ageing journey, be it transitioning to the next level of care, re-engaging with the wider community, or entering mainstream programs.

The National Hospitals and Health Reform Commission almost completely ignored prevention, health promotion, wellbeing in older people, yet DTCs can help keep people out of hospitals. There has been little research or real evaluation of the services provided by DTCs. Statistics are constantly submitted to Government with no feedback to the sector or community. Ongoing research is needed to evaluate the effectiveness and possible improvement of current programs.

Allied Health Professionals and the Allied Health Assistant workforce is an important component of supporting an ageing population. Like the rest of the aged care sector there is the need to competitively remunerate, as there is competition from acute care, sub-acute care and private practice sectors. Day Therapy Centres are not attracting new graduates, however, once people arrive at working in aged care they find it very rewarding.

At times is it has been suggested that DTCs should integrate with HACC. An alternative option would be for Planned Activity Groups and HACC allied health and chronic health programs to integrate with DTCs. Day Therapy Centres will welcome accountability and quality improvement if it is meaningful, appropriate to resourcing and the program, and truly intended to assist growth, development and improvement. In spite of their lack of funding and strategic attention, DTCs have benefitted from a low regulation approach and have been allowed to be flexible and innovative within available funding.

Coping with frailty is a poorly understood area. There is a need to generate greater acceptance of this part of the human condition. This will assist the support of those who experience long-term frailty, and at the same time, enable them to feel more at ease.

Recommendations:

14. Ongoing research into Day Therapy Centres to provide the evidence base on the effectiveness of programs and indicate program improvements.
15. Improved access to Day Therapy Centres on a local government area basis.
16. More focus on the principle of a ‘well managed’ decline and engaging with the idea of frailty in policy frameworks.

Changes Required to the Current System

FUNDING

The current indexation based on Commonwealth Own Purpose Outlays (COPO) is not adequate. Providers are constrained by static revenue flows based on subsidies and periodic adjustments by mechanisms such as COPO. The current indexation formula does not adequately take into account the cost drivers for aged care providers, in particular wage increases.

There is a need to decouple care and accommodation funding, with care funding to be paid by the Commonwealth and accommodation fully funded by the resident (as it is with retirement living), whilst retaining the safety nets in place for supported residents. The market, underpinned by the maintenance of minimum standards set out under the Certification Instrument, will drive the standard of accommodation provided.

For the purpose of assessing an accommodation charge or bond, it is imperative for the continuity of care to eliminate the distinction between low care and high care and replace this with a single classification called ‘Residential Aged Care’.

For the application of charges upon entry to a residential facility, the Government should retain the financial safety nets that currently apply for supported residents. For permanent residents with assets under the partially supported resident threshold, only an accommodation charge should be levied. For those permanent residents, with assets over the partially supported threshold, an accommodation bond should also be levied. However, there is a need to retain the minimum assets level that a person must be left with after paying an accommodation charge or bond (currently $37,500) but where a person’s assets are ten times greater than this, the bond ceiling should be 90% of their total assessable assets.

HACC SERVICES

HACC services are in need of review to assess if unit cost does actually cover cost of service. It appears many Councils are ‘topping up’ with rate revenue. HACC services auspiced by NFP organisations cannot support a ‘top up’ system therefore infrastructure and resources can be at an inferior level. Current levels of funding do not sufficiently cover basic service elements. A funding system that provides for the real staffing unit costs including assessments which may take up to 6 hours from first contact to the client commencing, and service delivery costs, with

transport and food services included, must be implemented to ensure the unit cost adequately covers the support services provided.

Government grants should be made available for infrastructure including buildings, building upgrades and vehicles. There is little or no ability, with both HACC and National Respite for Carer Program funding; to apply for associated infrastructure grants to assist with the growth of integrated services and supports.

SUPPORT OF CARERS AND CLIENTS WITH COMPLEX LIVING SITUATIONS

It has been the experience of Baptcare workers that carers often come to Planned Activity Group workers for emotional support as they have day-to-day contact with the team. This has an increasing impact on staff resources with clients looking for guidance on a range of issues such as changes in health or cognitive status; living arrangements; client's safety issues observed by workers when client lives alone; personal care issues and transport. Medication support is also a concern in social support settings. The outcome is that support workers in Planned Activity Group settings are now doing case co-ordination with complex care clients and their carers.

Transport is not at present included in the unit cost of a Planned Activity Group and the majority of services provide transport via centre vehicles or costly taxi service. With the merging of councils the geographic areas of some local government areas is quite expansive therefore transport becomes a large unfunded cost to providers.

PASTORAL CARE

In 2008/9, 16,000 hours of pastoral care was delivered to clients and residents across Victoria and Tasmania. Pastoral Care is provided to Baptcare residents at the current time at no cost. The organisation is spending 1% of turnover to provide this service and would like to see some Government support for this. Pastoral care plays an important role in service delivery and social connectedness for our clients, giving them social and spiritual support.

RESPITE CARE

Many providers still do not embrace respite care, despite incentives payments. Further incentives are needed to ensure there is enough care for those who need it, as this is central to allow many older Australians to age in place.

Respite care is important not only for clients of community care, but also those who act as their informal carers. Providing care can be very demanding and stressful,

and for many family members it is close to a full-time role. Respite care provides informal carers with a much-needed break, without which they may not be able to continue, and clients would have to turn to formal care for greater support. In this way, respite care can help to reduce the demands on the community care system.[17]

Further funding incentives are required to entice providers to offer more respite care. Such incentives could be to align the basic subsidy to the highest Aged Care Funding Instrument rate, and to remove the 80% threshold for incentive payments.

Recommendations:

17. Indexation of funding to CPI rate or aligned to the indexation model that is applied to health funds.
18. Decouple care and accommodation funding, with care funding to be paid by the Commonwealth and accommodation to be fully funded by the resident whilst retaining the safety nets in place for supported residents.
19. For the purpose of assessing an accommodation charge or bond, eliminate the distinction between low care and high care and replace with a single classification called Residential Aged Care.
20. Retain the financial safety nets that currently apply for supported residents.
21. For permanent residents, with assets under the partially supported resident threshold, only allow an accommodation charge to be levied.
22. For permanent residents, with assets over the partially supported threshold, allow an accommodation bond to be levied.
23. Retain the minimum assets level that a person must be left with after paying an accommodation charge or bond (currently $37,500) but where a person's assets are ten times greater than this, the bond ceiling should be 90% of their total assessable assets.
24. Review current HACC services unit cost to determine real cost of services.
25. Include transport and food services in cost of HACC service delivery.
26. Government funding to offset the cost of pastoral care services currently supplied by faith-based providers.
27. Fund transport to and from venues for planned activity group services.

28. Grants made available for infrastructure including buildings, building upgrades and vehicles for community based care services.
29. Provide further funding incentives to entice providers to offer more respite care.

An aged care system for the future

The 2010 Intergenerational report stated “the number of people aged 85 and over is expected to more than quadruple over the next 40 years to 1.8 million by 2050.[18] The Productivity Commission model of aged care places in 2030 suggests that an increase of 108% over current levels will be required to meet demand.[19] The current system and frameworks will not be sufficient to deal with this growth in numbers of Australians aged over 85 years and the intensive care levels that may be required for them as they move into advanced age.

Equitable Provision of Aged Care

Baptcare strongly holds the view that quality and adequately supported services should be available to all Australians regardless of their ability to pay. These services should offer a base level of *accommodation* that affords basic comfort, amenity and dignity. All residents should contribute to this through a standard daily fee, and those with higher incomes should pay more.

The level of *care* provided should be the same for all, irrespective of wealth. All should contribute to this through a daily care fee. Those with higher incomes should pay more for the same service levels.

Baptcare supports market reform to provide greater choice as to standard of accommodation and extra services. Providers should be able to provide ‘extra services’ and charge what will end up being a market-driven price.

The market should be freed up to provide incentives for providers to invest in new offerings and for entrants to exercise greater choice. Underpinning this needs to be a safety-net system that ensures those dependent on the State live with security, dignity and amenity in their old age.

Baptcare’s Residential Aged Care facilities have Board approved “tithing” targets applied to our Independent Living Units. In effect, Baptcare allow access to a proportion of our Independent Living Units to financially disadvantaged people and discount to people with a significant Baptist connection.

Retirement Villages and Aged Care

There is a trend within Australia of ageing people choosing a number of retirement living options including retirement villages, Independent Living Units and serviced apartments that allow them to age in place to quite high levels of dependency.

At this stage there is limited legislation and quality frameworks that apply to this growing industry. The benefit of aligning retirement living to aged care would provide clearer expectations regarding the standard of care/service provided and accountability. The majority of the retirement village industry is private for profit based on a user pays framework.

With the incidence of housing stress increasing, many older people experience uncertainty regarding accommodation options and it is a concern for aging people and their families. The current system works for people who can afford to pay for services, but the financially and socially disadvantaged are vulnerable with limited independent quality processes to ensure a reasonable standard of care.

Given that there is no Commonwealth/State funding for retirement villages, then the regulatory compliance that applies to licensed aged care places should not be aligned to retirement living. Whilst most villages do not offer ageing in place, Baptcare is in the minority that do. When residents require ageing in place in other villages, there is anecdotal evidence to suggest that they move them on.

The sector does require more compliance, particularly around resident contracts*.* There are various types of contracts within the industry. These could be regulated more tightly. To assist with this are compliance elements within the Retirement Villages Act. There should be one Retirement Village Act across Australia, to introduce uniformity across the country.

Recommendation:

30. Legislate for a uniform Retirement Village Act across Australia.

Alternative funding arrangements for aged care

The current funding mechanisms require review and transformation if the needs of older Australians are to be met in the longer term. The Productivity Commission should be open to a variety of possible funding methods.

The Henry Review investigated possible ways of funding the future aged care needs of Australians. One idea canvassed by the Review was the idea of using superannuation to fund care costs.

> As the superannuation guarantee scheme matures, cohorts of older people should have larger assets balances available to them at retirement. However, these assets will need to provide an adequate stream of income over a person's retirement, the duration of which is uncertain for individuals. The expected increase in average life expectancy is likely to add to this risk. Further, the use of aged care services is particularly intensive for people aged 85 and upwards, once many have been retirement for 20 years or more.[20]

The Review also investigated the role longevity insurance could play in the funding of the aged care system.

> The development of longevity insurance products is another means of improving the adequacy of the retirement income system. If a person knows they can rely on a particular level of income to support them until they die, they can make better decisions on how to manage their assets over their retirement.[21]

Baptcare agrees that many people may not have adequate superannuation for their needs in the long term or may choose to utilise their superannuation payout to live well for the period whilst they are fit and healthy. To combat this, we suggest the Government extend the Medicare levy to cover aged care costs. This could be applied to all taxpayers, with an additional impost on high-income earners who do not choose take out private insurance for aged care costs, such as the longevity insurance products suggested by the Henry Review.

The addition of 0.5-1.0% to the basic Medicare levy may cover older Australians for all basic aged care costs. In addition, 1.5% could be added those earning over $150,000, who do not have private longevity insurance. This insurance would guarantee all aged care costs for ten years of high care.

In addition, the Government should quarantine part of current superannuation contributions for the costs of accommodation services for aged care. If 0.5% to 2% was contributed over a lifetime (modelling will be required from the Productivity

Commission) individuals could develop their own Aged Care Annuity Fund that could only be used for community aged care costs or the cost of residential aged care accommodation. This could go someway to offsetting the costs of the complex health needs that arise as people age. If unused, the Aged Care Annuity Fund could be passed down to the beneficiaries of an estate to be placed in their Fund.

For example, Greg Smith contributes to his superannuation Aged Care Annuity Fund from the time he begins part time work at 16 years of age. By the time he is frail and requires assistance, he may have amassed up to $400,000 in care funding that can be used to purchase services to allow him to age in place or will fund his accommodation costs in a residential facility.

The benefit for government would be that even if Greg Smith utilised all his private superannuation travelling the world on his lump sum payout, there would still be self-funded contributions for aged care available. Under this scenario, the family home is protected for his beneficiaries because they do not have to raise the accommodation bond as it currently applies. The Medicare levy, or privately purchased longevity insurance, would support the costs of care and the Aged Care Annuity Fund would cover the accommodation costs.

Alternatively, if Greg Smith dies at 70 years old, and he has not used any aged care, he has a $400,000 Aged Care Annuity Fund which can then be divided to the beneficiaries of his choosing (for example, partner and children) to be set aside in their Aged Care Annuity Funds.

Consumer Directed Care

One potential way of managing the provision of aged care services into the future is the system wide adoption of consumer directed care (CDC). Allen Consulting undertook research into the *Future of Community Care* in 2007, they found that a number of different models of consumer-directed care have been adopted overseas.

The models vary in terms of how much decision-making, control and autonomy are shifted from community care professionals and agencies to clients. Three main models are:

- *Cash or vouchers* — clients receive periodic cash allotments or community care-specific vouchers and are given discretion to select those services or

goods they deem most essential. They can either manage the funds themselves or pay a small fee for an agent to manage the funds instead.

- *Assisted choice of provider* — case managers are assigned to clients to assess which programs they are eligible for, and how many hours of service they can receive. With this determined, clients are free to engage the providers of their choice to deliver services they have selected as best meeting their needs. The case manager assists them with these choices. Unlike the cash model, funding is distributed to providers.
- *Monitored choice of service and provider* — clients are able to engage the providers of their choice to deliver the clients' chosen services, with mandated guidance from case managers who not only determine their eligibility and assist them as above at the beginning of their care program, but also then monitor the quality and effectiveness of service provision over time according to an approved care plan.[22]

Baptcare would prefer to see case management as a core component of whatever system is chosen for the future. Case management is a cornerstone of the successful management of complex care. Case management would also remove the need for the direct employment of carers by clients.

It is important that the lessons from the operation of CDC in the disability sector (for example, Individual Support Packages in Victoria) are shared. The expectations of disability clients will become increasingly important as these clients age and transition to service provided under the umbrella of aged community care. At the same time this is an opportunity to improve the Ageing-Disability interface.

In addition, CDC needs careful monitoring and oversight to ensure that the potential for elder abuse (misuse of government funds, syphoning of funds into areas not directly related to the care needs of clients by family members or carers) is minimised. Baptcare has at times had to intervene in community client's family situations where there has been evidence of the suspected or actual elder abuse by carers or extended family.

In residential aged care, deregulation of service delivery may create a risk for the capital side of the sector. In community aged care the potential is there that a poorly handled transition to a more de-regulated approach will be result in the loss of valuable human and organisational capital, knowledge and capacity which has

been built up over the years. There may also be risk associated with limited consumer understanding of legal Fair Work Australia frameworks and that they, as the consumer, may not be fully able to exercise hiring and firing responsibilities, depending on the model adopted.

If CDC is accepted as a new framework for service provision, it is imperative that resources are provided to assist the transition to this way of managing service delivery.

A real commitment to transformational reform will require an overhaul of the current funding of an incremental model. Baptcare would expect to see a review of the fragmentation of service system barriers between HACC, CACP, and EACH.

Recommendations:

31. Share outcomes of Consumer Directed Care (CDC) activities and pilots in Aged Care and Disability Sectors.
32. Provide funding and resources to assist any transition to CDC service delivery.
33. Retain case management of CDC packages to ensure the potential for elder abuse is minimised or eliminated.

Culturally and Linguistically Diverse (CALD) Communities

Government must provide older Australians with CALD backgrounds with more support to become informed about the various lifestyle, support and care options available to them. A community education program conducted in multiple languages is needed through the communication channels people use. Electronic media, especially radio, is an important medium when there are literacy issues.

The Department of Health and Ageing website, especially those areas directed to consumers, needs to provide a range of language choices with intuitive language selection options. The Department of Health and Ageing could translate all essential materials into at least 10 languages. This would include client agreements, assessment tools such as pain, mood, nutrition status and wellness tools. This is far more cost effective to the taxpayer and aged care consumer than each individual provider doing this.

Available off-the-shelf technology such as electronic translators and IPod ‘apps’ could be integrated into the care and support of older people. Such technology

could yield great benefits over a short period of time if Government were to invest in incentives to support the purchase/uptake, training in its use, demonstration pilots and research evaluation.

Recommendations:

34. Improve information provision to CALD communities about the support options available.
35. Translate all essential materials into at least 10 languages via the Department of Health and Ageing.
36. Provide Government support for the development and evaluation of new applications on available technology platforms to support the care of CALD residents and clients.

Future Workforce

The combined effect of older workers seeking to retire and increased demand for aged care services will create an untenable position for most aged care providers unless fundamental systemic change occurs. Since 2006, Baptcare's HR strategic plans have focussed on determining and meeting our people needs, including the retention of valued employees. Shifting demographic change has led to an ageing of Baptcare's workforce and volunteers, with 49% of Baptcare staff being over 50 years old.

Limited government funding, a desire as a not for profit organisation to assist the poor and marginalised, and structural barriers that hinder alternative funding revenue streams, all combine to limit Baptcare's ability to remunerate and reward people effectively in comparison with the acute health public sector. Currently, tertiary education and graduate training providers are not keeping the supply of registered nurses matched with the demand from the health and community sector. These trends have combined to adversely affect Baptcare's ability to attract and retain its people.

Most of Baptcare's managers report difficulties in recruiting qualified people across all our sites but especially in rural and regional areas. The reasons for this difficulty are described fully in the Workforce section. This situation will only worsen in the next 5 to 10 years unless steps are taken.

CASE STUDY 2

Baptcare encourages internal career development and promotion. Personal care traineeships for unqualified personal carers are encouraged and nursing scholarships are promoted widely.

Feedback from staff has included: "I am too old to become a qualified PCA" (Baptcare's response, you are never too old! We have 70+-year-old staff who remain loyal employees).

"I have to travel over two hours to get to my course, then I have to find money to stay overnight as it is a two or three day training block" (northern regional Victorian PCA training to be a Enrolled Nurse).

"I can't travel up to two hours to get to my course – I have a young family" (regional enrolled nurse based in Northern Victoria considering registered nursing training).

"The registered nursing training is very demanding. I am studying by distance education and cannot get clinical placements. I am finding it very difficult to keep working as a enrolled nurse" (enrolled nurse studying part time to be a registered nurse. It took four years part time.)

Other enrolled nurses who been fortunate enough to secure a scholarship inform us that the course is so demanding they cannot work as well and they resign.

One solution to these issues could lie in the development of a rural and regional employment market for aged care. This could be achieved by encouraging regional and rural health workforce attraction, retention and development.

Currently, it is almost impossible to find registered nurses in some regional Victorian communities. Support is needed to develop partnerships between regional hospitals and aged care facilities to share staff and facilities by providing a reward system for residential and the acute sectors to encourage secondments.

Training in the residential aged care sector remains an issue for many aged care providers, as positions have to be backfilled in order for staff to be released for training purposes. There has been much internal feedback in Baptcare around access to training and the impacts further training has on staff and their families (see Case Study 2).

Regional universities should be offered financial incentives to set up satellite or mobile campuses in smaller rural and regional towns that have acute hospital and residential aged care providers as regional workers report there are significant barriers to accessing nursing training. Financial incentives could be extended to residential aged care providers and/or regional training providers to reduce disadvantages nursing students face with travel and accommodation costs by reimbursing travel to nursing training blocks. In addition, subsided housing for health professionals relocating to rural or regional areas might encourage internal migration.

Recommendations:

37. Encourage regional and rural health workforce attraction, retention and development.
38. Support partnerships between regional hospitals and aged care facilities to share staff and facilities.
39. Offer regional universities financial incentives to set up satellite or mobile campuses in smaller rural and regional towns that have acute hospital and residential aged care providers.
40. Provide financial incentives to residential aged care providers and/or regional training providers to reduce the costs nursing students face with travel and accommodation.
41. Offer subsided housing for health professionals relocating to rural or regional areas.

Regulation

The amount of regulation covering the aged care sector can result in a large compliance burden for providers. Whilst Baptcare agrees that there is need for the consumer to be protected and supported, there is also a balancing need for providers to operate under frameworks that gear regulation to risk.

Accreditation

The current accreditation system has inefficiencies and is actually difficult and costly for the accreditation body to manage and staff. The accreditation body is required to analyse the quality system for each facility. In the case of larger organisations, these systems at each facility are identical from a systems viewpoint. This scenario has significant corresponding organisational inefficiencies,

as the orientation and accreditation of its quality system and approach requires repetition for each accreditation.

An alternative is to conduct the accreditation of the overall organisational standards, system and continuous improvement framework through a central organisational review. This would then be supported by periodic review or audits at facility level to confirm the quality systems' application and understanding. This option could be the standard approach or be available to organisations that nominate to participate in such an approach. This would enable these facility based period reviews or audits to adopt a very focussed approach based on a statistically valid sample of that organisation's aged care facilities. This method has the potential to be less disruptive to residents' care as well as assist in identifying potential facility-based issues and/or more systemic issues associated with the organisation's overall quality framework and systems. The adoption of longer accreditation periods, up to 4 years, would be supported by the above approach, and it would assist in accurately targeting the granting of such extended periods.

An organisation with mature and well implemented quality systems might achieve a 4 year accreditation for the majority of its facilities, whilst a particular facility within that organisation may have a variation, could be accredited for a shorter period.

Such an approach to accreditation periods provides incentives for facilities to improve practice in an evolutionary sense as well as encourage facilities to seek the recognition contained with better practice awards. The powerful effect of financial incentives may also be harnessed in extended accreditation periods through a reduction or minimisation of accreditation audits and hence the cost associated with the preparation and involvement.

Recommendations:

42. Introduce a risk management framework to the accreditation of providers.
43. Enable 4-year accreditation periods for approved providers.

The Workforce Environment

Aged care as an industry

Workforce issues are one of the most critical operational challenges that confront aged and community care providers in Australia. The whole sector is facing a critical labour shortage, driven in part by the following factors:

- Changes to the global economy and national workforce requirements.
- The mining, resources and associated construction boom in Australia.
- Skilled workers are in short supply particularly in the health and community services industry, including aged and community care.
- There are fewer younger workers entering the market due to changes in our ageing population.
- The inability of the aged and community sector to compete for labour with funding levels that don't allow it to compete on wages with other health industries due to revenue constraints.
- The public has unfavourable perceptions of the nature of aged and community care work.[23]
- Research has indicated that nurses feel most dissatisfied when they are disempowered in their work through the lack of access to organizational resources, opportunity, support and information to accomplish their work.[24]

An older population: the nursing workforce in general

The shortage of division one/registered nurses is well documented. Since 2002 the shortage of nurses was exacerbated by fact that the number of nursing workers per 100,000 of the population steadily declined. The average age of nursing workers has increased, with the proportion aged 45 and over rising from 20%-37%.[25]

In 2002, Karmel and Li projected that 180,522 nurses would be required by 2010;[26] the projected shortfall is around 40,000. An increased graduate output of 120% would close the gap but it is not feasible for the education sector to expand to this degree. Increasing the supply of enrolled nurses by 17% would balance the workforce at 2010 and perhaps even create a surplus unless demand increased;[27] hence recent government support package announcements have sought to

increase funding for enrolled nurses training. Of the 14,000 applicants who enrolled in enrolled nursing training, only 5,000 enrolled nurses completed, which equates to a 35.7% completion rate.[28] The Department of Health and Ageing commissioned Access Economics in 2004 to analyse the supply and demand of nurses between 2003 and 2012. The resulting report found that the gross replacement requirement for the nursing workforce between 2003 and 2013 was 78% of the total 2002-nursing workforce.

CASE STUDY 3

Baptcare's HR staff and managers shudder when registered nurses in residential aged care resign, particularly in regional areas and some inner Melbourne suburbs. Talented registered nurses with experience in aged care are very difficult to attract.

Baptcare remunerates its registered nurses at higher grades than sections of the acute sector (grade 4a and grade 5) with a certified agreement in place, generous paid parental leave, flexible working conditions, salary packaging, extensive training, development and leadership development programs but still we find that it can take three to six months to fill some registered nurse positions in regional areas and difficult to fill metropolitan shifts (night shift primarily).

This places incredible workload pressures on other staff. Temporary agency staff tend to be avoided due to the high costs of temporary agencies. Agency staff cannot provide the same continuity of care that permanent staff provide to residents. They are also relatively unfamiliar with Baptcare's facilities and internal systems, so we rely on the generosity and flexibility of existing staff to step in.

Similarly, 'Director of Nursing' roles are challenging to fill due to the level of responsibility of the roles (being at all times responsible for up 110 very frail and vulnerable residents) and the (at times) isolated and demanding nature of the work.

Demographic changes impact the workforce because as the population ages, so does the workforce. Residential aged care work is physically demanding with manual handling requirements. Nursing employees stand for long periods of time, and walk from one resident's room to another. With increasing social demand for individual rooms and bathrooms, residential aged care facilities will continue to become physically bigger, covering greater distance and requiring more walking from its staff. That means that the aged care nursing population ideally require a higher level of fitness than perhaps more sedentary roles of work.

BAPTCARE'S WORKFORCE

Shifting demographic change has led to an ageing of Baptcare's workforce and volunteers with 49% of Baptcare staff now aged over 50 years. In the residential

care area, 56% of staff are aged over 46 years, of which 27% are over 56 years. This is positive in terms of client or resident care as older workers are generally able to relate sensitively to older people, but it will be a major issue for workforce planning in less than 10 years.

Workcover Impacts

Older workers seem more susceptible to manual handling injuries. There are emerging issues of stress; age related degenerative injuries; gradual age deterioration leading to injury; and unexpected manual movements leading to injuries due to the ageing of the workforce. Baptcare is fortunate to have a historically lower than average industry injury rate but have found that all but one of the Workcover claims in the past three years involve staff over 45 years of age.

The aged care sector will need to alter its working processes to ensure manual handling, particularly of an increasingly overweight client and resident population, is minimised. Strategies to deal with this situation might include investment in more lifting machines and hoists and the implementation of a health and wellbeing program to assist employees maintain their strength and fitness. These efforts could be supported by research funding to determine optimal building and job designs for an ageing workforce.

Building design should also receive greater scrutiny to minimise workforce fatigue levels. Designing workplaces to attract nurses would enhance the aged care industry as having great physical environments in which to work. In residential aged care, the layout of the work environment could be designed in such a way that the nurses' station is central to the resident rooms around it to minimise walking distances and ensure residents have rapid access to a carer. Rubberised or spring floors are being built into new acute settings to minimise worker fatigue. This idea should be extended into aged care.

Recommendation:

44. Offer subsidies or interest free loans to those existing residential facilities that have to be retrofitted with overhead hoists.
45. Fund Research to assess prospects for residential aged facility design to accommodate the physical inherent requirements and additional needs of an ageing workforce.

Employee Turnover

A positive result of the global financial crisis was that, temporarily at least, many aged care HR professionals reported in industry meetings that there was lower employee turnover in 2008/2009/2010. Existing employees found it more difficult to seek employment elsewhere and faced increased personal costs which rendered them reluctant to change employers. Baptcare experienced reduced turnover rates and an improved ability to attract particularly corporate and personal care based (not nursing) roles. Baptcare also experienced a larger labour pool to choose from when recruiting, as employees were made redundant in other sectors. Baptcare is now experiencing difficulties attracting talented people for some of its roles (mainly nursing related).

Job Redesign

Regulatory changes impact workforce planning, as the changes require assessment, consideration, training development and delivery, to ensure all affected employees are informed. Qualitative comments from staff and academic research[29] indicate that the time spent 'completing the paperwork' takes carers away from the reason they choose to work in aged care, that is, caring for the clients and residents. Reorganising documentation practices to allow more time for direct care was reported as most meaningful to nurses' roles and access to information, opportunity, resources and support is considered vital to ensure nurses feel respected and ultimately more committed to the organisation.[30]

Recommendation:

46. Undertake research to determine options for job re-design to lower emphasis on paperwork for Registered Nurses in order to increase time spent on patient care.

Workforce Planning

Workforce planning is a specialised discipline that undertakes proactive steps to ensure that aged care providers have the right people, in the right place, with the right skills, at the right time to reduce business strategy execution risks associated with workforce capacity, capability and flexibility.[31]

It takes into account internal and external drivers of change (such as government policy, legislation, business strategy, labour market conditions, demographic

changes, trends, individual preferences, lifestyle preferences, and generational differences) and undertakes supply and demand workforce analysis to project and plan future workforce needs.

This activity requires excellent sources of data for it to be effective. For example, the NILS (National Institute of Labour Studies) report into the aged care sector through Flinders University in 2008 was invaluable in generating key findings to assist with workforce planning. More research of this type is needed across the sector. The National Health Workforce Taskforce and INFORM could support this activity.

Capability in workforce planning appears to be sporadic for aged care providers. Anecdotal feedback from industry meetings is that larger providers have at least commenced workforce planning, with some providers further along the way. Baptcare has a workforce plan in place but the specialised workforce planning training to support managers to create, access and execute individual workforce plans is not readily available across the aged care sector at present. There is a need to improve aged care industry education around workforce planning. The opportunity also exists to negotiate bulk purchase or license of software tools, with the assistance of industry associations such as ACSA and ACCV, to support the aged care industry to prepare, undertake and implement workforce plans.

Recommendation:

47. Commission regular NILS (or similar) aged care industry research to assist workforce planning.
48. Support the aged care sector to prepare, undertake and implement workforce plans.

Language and Literacy Training

Baptcare has piloted a successful language and literacy program for CALD staff at respite facilities that aims to supports their English language development. It was not possible to extend the Workplace English Language and Literacy program to residential facilities (though there is considerable need) as direct care staff who attend training require backfilling to ensure the standard of care does not drop for clients. The cost of backfilling is high. It requires roster changes and higher costs as agency staff may be required to backfill the roles of Baptcare staff that are

attending the training. This is a large impost as Baptcare effectively pays twice for the same position for the period of the training.

Recommendation:

49. Provide funding to cover backfilling of positions for aged care staff for language and literacy training.

Aged care as an industry of choice

Aged care has much to recommend it as an industry of choice for those looking to start or change careers. It can offer improved career paths, less bureaucracy, long term caring relationships with residents/clients, good communication with an accessible senior management, excellent non-salary employment conditions, greater work/life flexibility and an opportunity to make a difference to the vulnerable in local communities. Many Baptcare staff report that one of their main motivations for moving into the sector was the close location of the workplace to their homes. This may be because the sector is relatively low paid and employees will seek to avoid the cost of travelling significant distances to reach their work sites.

A viable career path is needed to strengthen our industry's capacity to attract the right people and to ensure the great knowledge and expertise over the longer haul of people's career journeys is retained. Detailed workforce analysis is also needed. A funded academic research project, or a seconded occupational therapist and HR professional, could re-design jobs to more effectively use existing people resources in an aged care setting.

The Community Services and Health Industry Skills Council has supported an initiative to create an excellent website http://www.careersthatmatter.com.au. The website is widely promoted in schools to promote the industry as a place to work. A project should be funded to professionally showcase the diversity of aged care roles in the industry: for example, community aged care case manager, quality managers, Directors of Nursing roles, registered and enrolled nurses, office managers, HR specialists, personal care workers, diversional therapists, occupational therapists, physiotherapists, respite coordinators, day therapy workers. Such a project could develop a high quality YouTube video that focuses on aged care and shows the fun that is had within the industry; the breadth of rapid career paths; the career opportunities and the benefits overall of working in aged

care. Ideally a range of actual workers in the aged care industry would be portrayed as role models.

Salary parity and working conditions with the acute sector remains a key and repeated concern for health professionals working in aged care but there is insufficient funding to provide parity with the acute sector for both working conditions (that is comparative staffing levels in the aged care sector to the acute sector) and salaries, even when the benefits of salary packaging are considered in those providers who have not for profit status. This is a very difficult issue to overcome without either additional direct government funding or allowing aged care providers to source alternative funding means.

Recommendations:

50. Increase direct Government funding to achieve salary parity with the acute sector or allow aged care providers to source alternative means of funding.
51. Undertake detailed workforce analysis to re-design jobs to more effectively use existing people resources in an aged care setting.
52. Fund a project to develop web-based material that focuses on the aged care industry to show the diversity of roles available.
53. Encourage younger people and older career changers to consider a career in aged care. Expand the 'careers that matter' aged care project.
54. Encourage university internships or placements in the aged care sector.

Nursing Programs

Barriers to entry into nursing remain high (a minimum of a three year degree for nurses, two years for workers who have an existing degree and one year for social workers). There is a desperate need for industry-based graduate nursing programs. This will not possible without appropriate Government support. Graduate nurses need adequate mentoring and support.

The Government should create, with the assistance of the aged care peak bodies, a graduate nurse program that the aged care sector can access. This program should have a minimum of a three months acute rotation and involvement in the acute graduate nurses monthly training session if that is appropriate.

CASE STUDY 4

Baptcare created an internal graduate nursing program for four people as a trial in 2008. It was launched at the Nurses Expo and received a lot of interest. It was based on the following premise: graduate nurses were to be employed as additions to regular rosters to ensure the graduates could be adequately supported.

There was a 4 by 3 month rotation system that included the opportunity to experience a regional residential facility rotation; an acute gerontological rotation, brain injury or sub-acute hospital rotation, a metropolitan aged care facility rotation and a community aged care rotation.

The challenges faced included that Baptcare had difficulty gaining formal agreement to link into acute based graduate training and clinical rotation in a major acute hospital (there was such an agreement with a major acute hospital initially but staffing changes resulted in the agreement being withdrawn). It was Baptcare's view that an acute rotation was essential to maximise the breadth and depth of the program.

Baptcare also did not have the infrastructure at that time to support overseas graduate nurses who sought be sponsored with visa to enter the graduate program. Hence the program was unfortunately postponed.

Aged care providers who link into the program could commit a subsided fee for entry to the program and have the graduate nurses, ideally as supernumerary, in their facilities for the 12-months. In return, the acute sector could assist with preceptors, an acute rotation and training.

Industry assistance should also be provided to set a formal 'career change' year for nurses who wish to enter aged care. This could include formal one day per week off the job training, ideally through the training organisations established with the aged care peak bodies, mentoring and preceptor support.

Recommendations:

55. Create an industry-based Graduate Nurse Program.
56. Assist the development and implementation of 'career change' programs for nurses who wish to enter aged care.

Volunteers

The ageing of the population is changing the profile of volunteers willing to support the aged care sector. The hours volunteers are willing to donate seem to be decreasing. Early retirees, who tend to have been a well represented among volunteers, now have different pressures and choices to previous generations. Their family obligations may well be different; this can include aged parents who

are still alive and grandchildren with both parents working. Coupled with this, early retirees have broader life style choices including travel and a wide range of volunteer opportunities.

There is a need for more data about potential volunteers through survey and qualitative approaches. A national approach to volunteers for aged care could be driven as a sub-strategy of the Federal government volunteer grants scheme.

CASE STUDY 5

Baptcare created a volunteer friendly visitor program in a regional area to visit socially isolated aged clients living in the community. It required two staff members to carefully assess, match, monitor and support both the client and the volunteer. Clients received a variety of different forms of assistance such as shopping, playing card games and support with visits to the cemetery to a deceased loved one.

Careful matching of interests, likes and personality was important to ensure a long-term successful match with vulnerable clients. It was very intensive work and whilst incredibly popular with volunteers and clients, the program declined as the intensive nature of the support, management and administration behind this particular volunteer program was unsustainable in a geographically dispersed regional area without any funding.

With the Federal Government social inclusion policy, specifically the national volunteering strategy, there will be increasing pressure to provide higher levels of support to volunteers with disability, mental illness or long-term disadvantage. Whilst this is an opportunity to provide greater access to the community, it is challenging to provide sufficient support services and training to those volunteers with special needs who are volunteering with frail elderly residents and clients.

Volunteers require active case management, particularly those with additional needs. Not for profit organisations frequently do not have the resources to provide active case management for volunteers. If volunteering is to be encouraged through the social inclusion policy, they must be supported by active and individual case managers to support organisations in placement.

Another strategy might be to offer a tax incentive for family carers of older Australians living with relatives. This would provide encouragement and assistance for the time that Australian carers spend caring for their loved ones (usually either a partner or parent) at home.

Recommendations:

57. Support volunteering in aged care with case managers.
58. Offer a tax incentive for family carers of older Australians living with relatives.
59. Support and funding for organisations that have an active commitment to volunteers in the aged care sector.

Notes

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