Submission to Productivity Commission Inquiry
Caring for Older Australians
by Little Company of Mary Health Care Ltd

Little Company of Mary Health Care (LCM Health Care) is a national, religious, not-for profit provider of health care, residential aged care and retirement services, and community care. It is a service of the Australian Province of the Sisters of the Little Company of Mary.

Under the Calvary banner, LCM Health Care operates 4 public hospitals, twelve private hospitals, three residential aged care facilities with 507 beds, two retirement villages with 200 residents, and a national community care service supporting over 10,000 clients in their own homes.

LCM Health Care employs 9,000 staff and has annual revenue of approximately $850 million.

LCM Health Care serves communities in South Australia, Tasmania, New South Wales, Victoria, Australian Capital Territory and the Northern Territory (including the Tiwi Islands). Many of the services are provided in Regional areas.

The Congregation of the Sisters of the Little Company of Mary provides health care services around the world. The Congregation has an international specialisation in the provision of palliative care services. In Australia, LCM Health Care operates five major specialist palliative care services in the hospital sector, has significant educational and research linkages, employs a highly experienced leader as National Manager of Palliative Care working across all care streams, and within residential aged care employs a professional who has completed the requirements for Nurse Practitioner level in palliative care.

LCM Health Care is also fundamentally concerned with ensuring that people who are marginalised and vulnerable have access to holistic, quality services. Its services include supporting indigenous communities, disadvantaged rural communities and people at risk of homelessness. In its holistic provision of care, pastoral care services are integrated as a vital ingredient in the support and care of people receiving health and aged care services.

The Calvary residential aged care and retirement village services are located in Cessnock, Ryde (New South Wales) and Bruce (ACT).

Calvary Silver Circle provides community care services to 10,000 clients in Victoria, South Australia, New South Wales, ACT, Tasmania and the Northern Territory (including the Tiwi Islands). Many of these services are provided in regional, rural and remote settings.

Context for the Review

The projected growth in the population over 85 years, as the baby boomer phenomenon moves through the population, will place demands on the Australian health and aged care system which are unprecedented in this country. It will require:

- A strategy led by the Commonwealth Government which responds to the demands of an ageing population across the spectrum of relevant portfolios.
- A reliable, comprehensive, flexible, system of health and wellbeing promotion, care and support which can adapt to individual and community needs and preferences.
- The identification and realisation of opportunities to minimise the financial and social impact of the demographic changes.
- A financial strategy to clarify who will bear the costs of the required support, in what form of payment, and when they will be borne.
- The efficient leveraging of every available asset (human, physical, financial and technological) to ensure that this challenge is met in a manner consistent with a society which values and respects its elders.
- Clear and appropriate accountability for the achievement of the desired objectives.

Components of a good system to support older people:

A good system to support older people:

- Integrates aged care, health care, social security, housing, education, infrastructure (e.g urban planning, transport and communications), sport etc policies and programs.
- Deliberately allocates and balances government resources between programs to support older people between:
    - post-retirement transition (e.g part-time employment, volunteering, hobbies, grandparenting, men's shed, gardening, home maintenance, sporting activities, social outings and clubs etc.);
    - active health and wellbeing (including exercise, travel, health maintenance and improvement, social and civil engagement, interests and hobbies etc);
    - support for people who are mainly home-bound (eg programs for rehabilitation and restoration, respite, day centre programs, social engagement and connectedness, home visiting, home maintenance, etc); and
    - care (regular care and support required for the person to maintain their activities of daily living and to manage chronic health conditions); and
    - care as they approach the end of life.
- Allocates Government resources between communities and between various groups of older people (particularly those with special needs) based on need and the impact of those resources on wellbeing.
- Enables consumers to enjoy an informed and affordable choice of options to receive care at home or in an environment as much like home as possible.
- Leverages, recognises and encourages the support of family and other carers for older people.
- Efficiently facilitates the eligibility and availability of services to consumers, without undue complexity or barriers.

- Facilitates the meeting of different needs of different communities, as well as the different needs and preferences of individuals. It identifies significant unmet need and acts where required to facilitate flexible responses to that need.
- Ensures that support for people with special needs, particularly those who are marginalized and vulnerable, is specifically addressed.
- Enables a smooth transition of care as needs increase, decrease or change.
- Enables a smooth transition of care as people approach the end of life.
- Integrates the provision of care and support across aged care and health care systems.
- Enables providers to flexibly adapt their service offerings to the changing needs of the community and the people they serve.
- Establishes standards which must be met in the provision of services in a manner which balances risk and decision-making.
- Ensures that other related standards (eg consumer protection and prudential) are promulgated and met.
- Monitors the achievement of those standards (including efficient and responsive independent complaint mechanisms) and has the authority to rectify deficiencies and apply sanctions.
- Encourages and provides incentives for the provision of effective services and service innovations, including those which minimise or defer the need for care.
- Facilitates an environment where providers are required to operate efficiently and can provide services sustainably through funding to support operating and capital requirements.
- Enables the attraction of people to work in supporting older people by providing access to education and training, offering rewarding and fairly paid roles, in an environment which has flexible conditions to meet the individual needs and preferences of older people.
- Is financially sustainable as the proportion of the population which is represented by older people increases.

Strengths of the current system:

The starting point for this review is an aged care system which is better than many throughout the world. Some of its strengths are that:

- Residential aged care is generally affordable for Australians (except for some having to pay large income tested fees due to circumstances unforeseen by regulators).
- Access to general residential aged care services is generally quite good. (This does not apply in all instances, for example in some rural and regional areas. That general availability also does not apply to specialist services e.g. for people with mental health conditions, older people with disabilities or the ageing parents of people with disabilities, access to Palliative care, or for people requiring specialist respite services in many areas. Access to community care services is also variable).
- There is a high degree of certainty in the cost to consumers on entering residential aged care.
- There is some recognition of the important role of carers in supporting older people.
- There is an increasing and significant breadth and depth of community care services to support people to live in their own homes.

- There are many excellent examples of service innovation by individual providers, including services for people with special needs. Many of these programs have developed with specific support from funding agencies.
- There have been significant improvements in transitional care and hospital avoidance programs.
- Programs such as Multi Purpose Services have been established to address needs of rural communities.
- There has been substantial investment in programs for people with dementia, and in other areas such as diabetes.
- The Aged Care Standards and Accreditation Agency plays an important role in establishing and monitoring service standards.
- Independent complaints resolution processes are available to consumers.
- There has been industry stability for consumers in terms of supply, pricing etc
- The industry participants (industry regulators, quality assurers and providers) operate generally in an environment of desiring to achieve continuing improvement in performance, including quality of care.

Areas for improvement in the current system:

The challenges in the current system to support older people relate to;

- The absence of an integrated Ageing policy framework across Government portfolios.
- A focus on care provision without an adequate emphasis on health and wellbeing.
- The current limitations on aged care planning at a local level;
- The inflexibility of supply of services to support older people.
- Lack of easily accessible information, the complexity of programs and rules, and the limitation of choice by consumers.
- Underdevelopment of responses to communities and people with special needs.
- Fragmentation of service programs.
- Underdevelopment of responses to the needs of older people approaching the end of life.
- A high level of regulatory burden which discourages service innovation and increases costs.
- Viability concerns for residential aged care providers, limiting the renewal of old capital stock and the development of new stock.
- The potential development of a two tiered aged care system – one for cities which utilises higher housing values to provide capital funding and a lesser one for rural and poorer communities without the same level of housing-based wealth.
- The lack of coordination of the interface between the aged care and health care systems and resulting unrealised opportunities to minimise or defer the utilisation of health care and aged care services and their related costs;
- An unsustainable workforce, where staff availability is vulnerable to current and future skills shortages and pay rates do not reflect the potential value of roles.
- The failure to prepare for a substantial future unfunded aged care, health care and pension liability for the ageing baby boomer generation.

We make the following recommendations:

1. Responsibility for the coordination of an Ageing strategy across Government portfolios should be allocated to a senior Cabinet Minister.
2. Increase the focus and funding of the Aged Care System on promoting health and wellbeing.
3. Increase the flexibility of supply to enhance the range of potential responses to consumer needs and preferences and reduce barriers to entry.
4. Introduce consumer-directed care packages as a component of care provision.
5. Change the aged care planning process to allocate funding, not only places, based on the varying needs of different communities.
6. The System should facilitate innovative responses to communities with special needs (e.g. communities with higher proportions of older people, or disadvantaged communities) and to special groups of older people (e.g. people with chronic illnesses, at risk of homelessness, with disabilities, of CALD backgrounds etc).
7. Funding for care based on similar assessed need, whether provided in residential or community setting, should be comparable.
8. The System should enable consumers to obtain graduated care and receive associated graduated funding (not necessarily the 64 levels of the ACFI) from a provider in whichever setting care is provided.
9. ACATs should apply a consistent approach to care assessment across the graduated levels of care. They should be relieved of the requirement to authorise changes from low to high care in residential aged care as this function is met by providers and the ACFI validation process.
10. The duplication and complexity of community care (HACC, Veteran's Home Care, CACPs, EACH, EACHD, NRCP etc) programs should be minimised.
11. More funding should be applied to researching and implementing technology and assistive equipment and providing grants to enable older people to have access to this support.
12. The interface between the aged care (residential and community) and the acute health (hospital) system should be improved by:
    - The development of a national intermediate care strategy.
    - Facilitating alternative models for the support and care of sick older people and their rehabilitation outside of hospitals.
    - Facilitating alternative models for the support and care of older people approaching the end of their lives in the community.
    - Funding specialist capabilities to support aged care providers in areas such as mental health and palliative care.
    - Researching the mechanisms which minimise the hospitalisation of older people, including specifically when they are dying, and providing incentives for aged care providers to implement those measures.

- Facilitating greater access to care subsidies for the provision of care and for the establishment of primary care and wellbeing clinics, including podiatry, occupational therapy, physiotherapy, dental, as well as primary care services by retirement village and affordable housing operators

13. Government should meet the costs of providing care to eligible older people.
14. The costs of accommodation and basic living expenses should generally be met by the older person, to the extent that they have the financial capacity to meet those costs, at the time when those costs are incurred.
15. The value and flexibility of accommodation payments in residential aged care should be increased to reflect current costs and the different levels of amenity being provided in different facilities. The form of payment by the consumer for accommodation and basic living services should be flexible between lump sum, periodic payments and payment in arrears.
16. Where the person receiving care in residential aged care has a limited financial capacity to meet the cost of accommodation and basic living expenses, the Government should supplement the amounts payable by the individual so that the reasonable costs of providing those services are met.
17. The discount applied to Government accommodation payments, where the 40% ratio of Concessional/Supported residents is not exceeded, creates additional disincentives to admit financially disadvantaged people into residential aged care, and should be discontinued.
18. A substantial amount of the funding of future aged care, health care and pensions for a projected population with a bulging baby boomer generation of older people should be accumulated while that large generation is still producing taxable income and having significant disposable income. A fund similar to the Future Fund should be established for this purpose.
19. Income-tested fees for older people in residential aged care result in an effective "tax rate" exceeding 100% of each additional $ earned and should be abolished.
20. The Extra Service approvals program is flawed and would be unnecessary and discontinued in an improved aged care system.
21. The current positive workforce initiatives should be built on to provide additional mechanisms to attract and retain a skilled and flexible workforce to meet the needs of older people, regardless of the care setting. Adequate funding should be provided to enable the payment of competitive wages. Continued programs are also required to ensure education and training places are available and attractive to potential applicants, and the development/retention of flexible IR arrangements are required to facilitate emerging workforce roles and to meet client needs and preferences.
22. Careful attention should be given to the timing and progression of changes to the aged care system, and the opportunities for providers to flexibly respond to changing circumstances, so that the stability of aged care provision is not placed at risk. Government may also need to compensate providers for the financial impact of restructuring the sector.

RATIONALE FOR RECOMMENDATIONS

1. Responsibility for the coordination of an Ageing strategy across Government portfolios should be allocated to a senior Cabinet Minister.

Development and implementation of an Ageing strategy requires a broad, integrated response to an ageing population, including strategies for health promotion, primary, intermediate, and hospital-based health care, aged care, housing, infrastructure (eg urban and regional planning, transport, technology), retirement income, taxation, education, communications, sport and climate change. The Inter-Generational Reports provide a starting point for this process, but the responsibility for the overall coordination of this response is unclear or absent, or compromised by short-term political considerations. The portfolio of Minister for Ageing lacks the seniority to fulfill this function, leading it to become a de-facto Minister for Aged Care. It requires a senior Cabinet role to influence the direction of key portfolios as part of a coordinated strategy**.**

2. Increase the focus and funding of the Aged Care System on promoting health and wellbeing.

An effective aged care system will focus on flexible responses which provide desired health and wellbeing outcomes and manage short and long term fiscal risk. This includes minimising and/or deferring the incidence of illness and disability in the population.

The focus of the existing aged care system is primarily on responding by treatment, care and support when levels of disability or illness are present. Government attention and funding is weighted too heavily on residential aged care and hospital care and too lightly on promoting health and wellbeing. This focus limits opportunities to defer or minimise the incidence of illness and disability, and consequently to prevent or defer the human and financial impacts of these conditions.

There is a relative lack of outreach, education, illness prevention, health and wellbeing promotion, early intervention, rehabilitation, counseling, home modification, and social support systems for older people. The difficulty and cost for many older people in accessing dental and basic allied health services also remain significant impediments to an effective aged care system.

While many excellent examples of wellbeing and health promotion, outreach and early intervention services exist (for example dementia education and monitoring programs, outreach programs for people who are homeless, strengthening and falls prevention programs, men's sheds, gyms for older people, ethno-specific social support services, and various programs for diabetes education and support, continence management etc), the overall balance of services and funding is weighted too heavily to residential aged care and hospital care. Access to funding for wellbeing and early intervention programs is very limited and sporadic. There are many effective wellbeing programs developed by individual providers which are not utilised across the aged care system. Innovative programs which are proven to

be effective and capable of replication, should be actively supported and funded by Government, as part of an overall health and wellbeing strategy.

An extract from The Gerentologist Journal in December 2009 explains one such program emerging in the United States : *The Active Start program developed by the Administration on Aging in the United States is an excellent example of the types of health promotion programs that can be developed when there is a commitment to enhancing the wellbeing of older people. Active Start combines exercise and behaviour change classes that help sedentary adults increase their physical activity levels while building self confidence and improving overall wellbeing. The classes are taught by lay leaders who are often seniors themselves. Active Start was selected by the US Department of Health & Human Services as one out of nine programs nationwide that represent an innovative health promotion program.*

Similarly, in Australia there are large numbers of very effective social support, physical exercise and wellbeing programs which could be broadly applied if funding was available.

One of the best vehicles available for many of these activities is the day centre and programs that can extend to the community from them. This is particularly the case when it is part of a comprehensive integrated social and primary care service focused on maintaining the health and wellbeing of older people. This vehicle has been a very effective but underutilised component of the aged care system in Australia. It should be a key leverage point for the implementation of outreach, health promotion, illness and disability prevention, early intervention, rehabilitation, education, information dissemination, counselling and carer support services. Commonly, these day care models are provided as part of an integrated model of community care, day centre, and residential care model of service provision.

3. Increase the flexibility of supply to enhance the range of potential responses to consumer needs and preferences and reduce barriers to entry.

The inflexibility of supply of aged care services inhibits innovation and new entrants.
One of the challenges in the planning of aged care services is to assess whether aged care planning should be undertaken centrally by Government, by consumers via a market, by informed purchasers (such as Local Government or other authorised brokers) planning and negotiating on behalf of consumers, or by providers responding to either consumer, purchaser or government signals.

Currently, the allocation of the largest component of aged care Government spending (residential aged care) is determined centrally by Government through its ACAR process and the approvals process for the transfer of residential aged care places. The Government attempts to ensure that all regions are well-supplied without being over supplied. The limited "choice" (ie which licensed residential aged care facility to apply for) is made by consumers. The benefit is that there is stability in supply, which limits provider risk. That lower risk in turn enables Government to pay low prices, and ensures that the rate of provider failure and consequent disruption to consumers is low.

The cost of this market stability is that consumers' choice is limited in both the number and type of services available in any community. The Government sets the price payable by both Government and consumers, except in relation to the quantum of accommodation bonds payable by consumers. In relation to accommodation bonds, the Government still sets many of the rules – for example the maximum retention charges and the value of assets to be retained by the consumer. Even in relation to Extra Service places, the Government approves the consumers' daily care fees and sets the rules regarding maximum price increases.

In addition, substitution of services (eg through in-home provision or by provision in retirement villages or other accommodation formats) by current providers or new entrants is severely inhibited. This is because the potential service substitutes generally are ineligible for government care subsidy, which represents the majority of the price received by the provider. In addition, substitute services may not comply with the large quantity of regulatory requirements applied to residential aged care.

The current system of tightly controlled supply, with an institutional model of residential aged care, is outdated at a time when choices abound for consumers in most areas of their lives.

The ability for consumers to have greater capacity to choose, as far as possible, the place in which care is received is important. It would have two benefits:

- Community care services would be enhanced, with greater accessibility and variety of services, and a greater likelihood that services will be tailored more closely to the person's needs and preferences; and
- It is the only way that many residential aged care providers and government regulators will vary the existing rigid institutional stereotype of residential aged care services.

Residential aged care in Australia generally operates under an institutional model, where residents have a limited say in the decisions that affect their wellbeing and lifestyle. The current model of residential aged care provides reasonably good care. However, it does so in a model that significantly limits the choices of consumers. In observing alternative models from overseas and the difficulty in achieving their application in Australia, we can see the rigidity of the current Australian regulatory environment.

For example, the well-known Humanitas model in the Netherlands is one model of a less institutional housing and care approach.

Humanitas offers the opportunity for older people to live in a housing complex comprising normal apartments and to receive all levels of care that they require. They can have partners live with them and have pets. They can also engage in the significant variety of available community activities within and outside the complex, to the extent that they desire and are able to participate. This housing and care model mixes physically-able older people with people of differing levels of care needs and younger people with disabilities.

This type of service also empowers the consumer to make choices regarding their lifestyle and care. This works well for cognitively able people and does not suffer from the burden of extreme regulation which applies to the operation of residential aged care in Australia.

This approach requires flexibility of the licensing arrangements, where some apartments are used by people requiring care at some times, while at other times the apartments are occupied by a person(s) without any care needs, or who may not be older. It also requires the ability to provide incremental increases in services from minimal to very high levels of care. These features are not easily achieved in the Australian regulatory context.

Also in the Netherlands, Corona Cared Living operates single floors of apartment buildings where care staff are present to support residents with high care needs. This is similar to the Group Living Model operated by Catholic Health Care on the floor of a public housing apartment building in Waterloo in Sydney. Again, such models require special approval in the Australian context, and the ability to obtain graduated funding as care needs increase is extremely difficult in Australia.

Ultimately, in a more flexible aged care system it becomes difficult and unnecessary to determine where supported housing finishes and residential aged care starts. Instead, it is the ability of the consumer to decide where and how they wish to receive care, and the appropriateness and quality of care in each setting, which are important. That view of aged care challenges the high level of regulation and the compliance focus which currently applies to residential aged care in Australia.

Increased flexibility is required by residential aged care service providers, so that the environments in which care and support services are provided, and the rules under which aged care services are delivered, can be tailored to meet individual needs and preferences. The current situation, including the regulatory environment, is generally too institutional and rigid.

Lessons can be learnt from the Flexible Aged Care Service (FACS) for Aboriginal and Torres Strait Islanders which are just that - flexible- responsive to the needs and custom of the communities where they operate. LCM Health Care manages the FACS in Bathurst Island where residents go out into the community during the day- some to socialise with others, some to have lunch and time with family, bush tucker is provided when available. Families may stay with the resident at critical/end of life times. Shared bedrooms are available to meet the preferred custom.

The current inflexibility is costly as it encourages the use of residential aged care services, because it is the only place where medium to high level care is readily accessible.

CACPs, EACH and EACHD are also allocated on the basis of the same ratios across all communities. The flexibility of the offering is greater due to the inherent nature of community care, the lesser regulatory burden and that the site of care and support is controlled by the consumer. However, providers and Government regulations determine limits on the range of assistance provided. Again, substitute services (other than the Government's alternatives under HACC, Veterans Home Care etc) are inhibited by the inability of the consumer or providers to access Government funding for alternative services. The inability of providers to obtain additional funding and increase services as a client's needs increase also limit the flexibility of service provision.

The fundamental difficulty in the current situation is the inflexibility of the care and support offerings which are eligible for funding and the high barriers to entry.

4. Introduce consumer-directed care packages as a component of care provision.

Consumer-directed care packages would facilitate individual consumers establishing their own care package requirements, which may be arranged by them or a case manager on their behalf, as a substitute for the formal packages of care (residential and community) currently available. In some of the international applications of this model (eg the Netherlands), Governments save money through this approach by paying consumers a level of funding which incorporates a discount (of 25% in the Netherlands) against the formal package value.

Even though the consumer-directed community care models for older people have a take-up rate of only 15%-20% of older care recipients in countries such as the Netherlands and the UK, they represent a very important psychological shift from the previous situation where providers determined the range of offerings and the rules under which services were provided. The high levels of satisfaction recorded in the international consumer-directed models indicate that these should be part of Australia's response to the inflexibility and high barriers to entry of the current arrangements. Provision of greater direct control of consumers over care subsidies should occur in conjunction with the strengthening of case management capabilities of those organisations which will be available to assist consumers in this process.

In considering consumer-directed care, it is necessary to understand that the opportunity for older people to access a package (of funds) will not necessarily by itself promote functional independence. It will not alleviate the need to fund specific programs, rather than consumers, in areas such as health promotion and rehabilitation. It will also not ensure that all needed services in a region will be available to consumers.

5. Change the aged care planning process to allocate funding, not only places, based on the varying needs of different communities; and

The current aged care system provides limited planning of aged care services at a community level.

While acknowledging that there have been many very good initiatives undertaken for special needs groups in various communities, the current planning framework at face value treats all communities as the same by applying the same ratios to all communities. Those ratios are for the allocation of residential and community care places, rather than a totality of funding for services to older people.

The ratios operate on the basis of the number of people over 70 years. They ignore other major drivers of demand for such services, such as socio-economic and health status, and the availability of alternative accommodation and care options. They also ignore the variability of local service infrastructure (for example, basic HACC services, dementia education, respite availability, support for carers, health promotion services, affordable housing etc).

The Department of Health & Ageing is genuinely concerned with improving services and access. However, it is limited in its ability to plan services to meet local community needs. The resources available to undertake such planning are limited. Information sources used by the Department to assess need (eg ACATs, local hospitals and aged care providers) are often too narrow to inform the Department fully of unmet needs at a granular level.

This can result in situations where needs which could be addressed remain unmet. For example, where in some large regional towns with a number of residential aged care providers, there is an absence of low care or high care dementia respite, and residents and relatives have to travel long distances to obtain that service. We have also seen difficulties in Supported (financially disadvantaged) prospective low care residents accessing low care services, as residential aged care providers give preference to people able to pay accommodation bonds. In both instances, the Department was either unaware of, or unable to do anything to address, those access issues. The Department lacks information in some cases, and in other cases it lacks the freedom to apply a broad range of possible incentives to address unmet needs.

The ratios applied for aged care planning by the Department are currently for places (residential aged care, CACPs and EACH/EACHD) rather than a broader view of aged care resources for that community. The inclusion of HACC services into a single aged care system enables this planning process to be improved and a total resource approach to be adopted. Planning by Government needs to occur from that broader view.

6. The System should facilitate innovative responses to communities with special needs (e.g. communities with higher proportions of older people, or disadvantaged communities) and to special groups of older people (e.g. people with chronic illnesses, at risk of homelessness, with disabilities, of Culturally and Linguistically Diverse backgrounds etc).

LCM Health Care operates a 296 bed residential aged care service and 45 community aged care packages from Cessnock, in the lower Hunter Valley of NSW. The Supported/Concessional resident ratio in Calvary Retirement Community Cessnock is 46%, and 56% of residents admitted since March 2008 are Supported residents.

The surrounding Regional community has a low socio-economic status (Decile 3 on the national socio-economic index) and extremely high levels of population obesity and diabetes. It is relatively underserved in relation to basic outreach, counselling, education, preventative and early intervention services across a range of health and age-related conditions for older people.

For this community, and for similar financially disadvantaged and underserved communities, the resources provided by Government to support older people should be greater than in locations which do not have those socio-economic and health challenges. The funding ratios should reflect those community differences.

In addition, a provider such as LCMHC should have the flexibility to redirect some of its residential aged care funding (ie reduce the number of RACF beds) to work with the community to enhance outreach, illness and disability prevention, early intervention, education, rehabilitation and convalescent care, community care, respite and other programs (including the provision of care in suitable affordable housing) to achieve a greater impact on the health of the community and reduce the use of hospital and residential aged care services. At present, the regulatory environment prevents this from occurring.

It is this recognition of the different needs of different communities, and the flexibility to adapt to those needs, which LCMHC seeks from improvements to be made to the aged care system as a result of this Inquiry.

This type of understanding of the different characteristics and needs of different communities and facilitation of flexible responses are evident in the Naturally Occurring Retirement Communities (NORC) Supportive Services Program of the United States Administration on Aging, and in similar approaches in Europe. These programs recognise that certain communities (which may be apartment buildings, suburbs, towns or parts of cities) have a disproportionately high prevalence of older people. A lead agency approach is used to coordinate a range of social engagement, health promotion, support and care services designed to enhance the independence, health and wellbeing of older people living at home in that community. There is a focus on engaging with and empowering the senior citizens and identifying and addressing unmet needs in those communities.

A similar approach to supporting older people in neighbourhoods through a variety of social engagement, support, accommodation and care activities is applied in the Netherlands through organisations such as Corona Cared Living.

In addition to recognising that different communities will have different levels and types of needs, it also important to recognise that certain groups of people have distinctive needs requiring specialised programs of support.

One key group of older people is those with chronic illnesses. Our current community care system is based on service requirements, rather than diagnosis. This precludes our ability to identify and manage this group of people in the most effective and coordinated manner. General practitioners play the key role in enabling this to occur.

In the United States, there is an excellent program which manages comprehensively and efficiently the care and support needs of older people with chronic conditions. The Program for All Inclusive Care of the Elderly (PACE) operates in 30 American states (72 programs). PACE uses day centres as part of a comprehensive health and wellbeing program. The following is a summary of the philosophy and services provided extracted from the US National Pace Association website:

The Program of All-inclusive Care for the Elderly (PACE) model is centered around the belief that it is better for the well-being of seniors with chronic care needs and their families to be served in the community whenever possible.

PACE serves individuals who are age 55 or older, certified by their state to need nursing home care, are able to live safely in the community at the time of enrollment, and live in a PACE service area. Although all PACE participants must be certified to need nursing home care to enroll in PACE, only about seven percent of PACE participants nationally reside in a nursing home. If a PACE enrollee does need nursing home care, the PACE program pays for it and continues to coordinate the enrollee's care. Services provided include delivering all needed medical and supportive services. The program is able to provide the entire continuum of care and services to seniors with chronic care needs while maintaining their independence in their homes for as long as possible. Care and services include:

- *Adult day care that offers nursing; physical, occupational and recreational therapies; meals; nutritional counseling; social work and personal care*
- *Medical care provided by a PACE physician familiar with the history, needs and preferences of each participant*
- *Home health care and personal care*
- *All necessary prescription drugs*
- *Social services*
- *Medical specialists such as audiology, dentistry, optometry, podiatry, and speech therapy*
- *Respite care*
- *Hospital and nursing home care when necessary*

While the PACE approach requires adaptation to the Australian context, the opportunity to develop comprehensive approaches to the care of older Australians is consistent with the aims of the National Health and Hospital Reform Commission Report. The outcomes in the US have been improved client satisfaction and wellbeing, and reduced costs of care. This approach also highlights that there are people with chronic conditions who require different approaches to holistic care along the care continuum, rather than having to navigate the service silos which frequently exist within the health and aged care systems. Any new aged care system must facilitate such comprehensive care and support programs for people with chronic illnesses.

Continuity of care is important for all service users. This is particularly the case for people with special needs. People within a number of special needs groups (eg indigenous people, older people at risk of homelessness, older people with mental health conditions, and people with dementia who live alone at home, older people with disabilities) often benefit from continuity of care from outreach services through to varying levels of care and support by the one provider. This includes support and care as people approach the end of life up until the time of their death. This is because significant time and effort is required to establish personal relationships of trust which enable effective intervention and support services to be offered and accepted. Those relationships are the platform for the ability to provide ongoing assistance. For these groups of people, the requirement for providers to separately tender for various service components along the continuum of care in the same geographical area risks compromising continuity and quality of care.

7. **Funding for care based on similar assessed need, whether residential or community, should be comparable;**

8. **The System should enable consumers to obtain graduated care and receive associated graduated funding (not necessarily the 64 levels of the ACFI) from a provider in whichever setting care is provided;**

9. **ACATs should apply a consistent approach to care assessment across the graduated levels of care. They should be relieved of the requirement to authorize changes from low to high care in residential aged care is this function is met by providers and the ACFI validation process.**

In order to promote better choice in where care may be received, it will be necessary to ensure that there is symmetry between the funding of various care options available to consumers. A simple example of this current lack of symmetry is that a person who requires oxygen will receive an oxygen supplement in low care residential aged care, but not if they are receiving a Community Aged Care Package. Funding for such supplements should be similar for people with similar levels of care, irrespective of the setting in which the care is provided.

Another example is that there are incremental levels of funding for care in residential aged care settings, while in community care there is a huge gap in care funding between Community Aged Care Packages (CACPs) and Extended Aged Care at Home (EACH) packages. The ability to offer graduated care and receive associated graduated funding (not necessarily the 64 levels of the ACFI) should apply in whichever setting care is provided. As people move through the various levels of care, up until and including the time of their death, it is also important that they can continue to choose to use the same provider.

The role of ACAT has a direct impact on access to services and the effectiveness of the funding arrangements in residential aged care. There is currently significant variation in the approaches and performance of ACATs in different regions. The role of ACAT for residential aged care should be of gatekeeper for eligibility purposes (ie entry to residential aged care rather than to high care or low care). The leader of the ACAT in the lower Hunter Region of New South Wales, which provides excellent support to the community, recently advised us that half of that Team's requests for assessment were for re-assessment from low care to high care for residents in residential aged care. That represents a significant waste of ACAT resources. Inevitably, in such situations the ACATs properly prioritise their assessments so that those activities which have a direct impact on the wellbeing of older people are undertaken first. The reassessments of residential aged care residents, which do not affect the wellbeing of the residents, are a lower priority. As well as being a low value use of the expertise of the ACATs, this delay can cause unnecessary frustration and a significant loss of income to residential aged care providers. That function should be met solely by providers and the ACFI validation process.

10. The duplication and complexity of community care programs should be minimised.

A key challenge in efficiently providing accessible community care programs is that HACC, Veterans Home Care and CACPs may all provide similar levels of support. This results in duplication of similar services and lack of coordination between providers. The main difference is that CACPs incorporate a case management function. There are different criteria for each program, and varying rules about eligibility, assessment and co-payments, all of which are confusing, limiting for client choice, as well as being administratively inefficient. These programs should be streamlined within a graduated funding model based on assessed need. Often community care programs are not able to be accessed at a sufficient level to support people who would like to remain in their homes, including when they approach the end of their lives, resulting in inappropriate admissions to hospitals.

11. More funding should be applied to researching and implementing technology and assistive equipment and providing grants to enable older people to have access to this support.

Another major challenge in a future system for maintaining people in the community is that so much of the support is physically provided by other people because older people can't manage functions themselves. More funding should be applied to researching and implementing technology and assistive equipment, and providing grants to enable people to have access to this support.

The NBN will provide a level of national communication infrastructure through which a range of health assessment, monitoring and support systems can be delivered. It also will facilitate a range of social networking applications to enable isolated older people to maintain social contact in an affordable and accessible manner. Providers will need special funding to develop or access such systems, rather than the reimbursement of such costs being incorporated in the cost per visit or client package funding. Consumers will also require funding to access these services.

Significant improvements in supporting people at home could also come from greater funding assistance for improvements to people's houses, which are currently often very poor environments for ageing in place and increase the dependence on human services. There is also scope for housing regulations that ensure future housing enables people with disabilities to manage in their houses without major renovations.

12. The interface between the aged care (residential and community and the health (hospital) system should be improved by:

- **The development of a national intermediate care strategy.**
- **Facilitating alternative models for the support and care of sick older people and their rehabilitation outside of hospitals.**
- **Facilitating alternative models for the support and care of older people approaching the end of their lives in the community.**
- **Funding specialist capabilities to support aged care providers in areas such as mental health and palliative care.**
- **Researching the mechanisms which minimise the hospitalisation of older people especially at the end of their life and providing incentives for aged care providers to implement those measures.**
- **Facilitating greater access to care subsidies for the provision of care and for the establishment of primary care and wellbeing clinics, including podiatry, occupational therapy, physiotherapy, dental, as well as primary care services by retirement village and affordable housing operators**

In addition to considering greater flexibility within the aged care system, there are also opportunities to improve the interface between aged care (residential and community) and the health (medical and hospital) system.

It is important to recognise that the aged care system is not the same as, or a simple extension of, the general medical and hospital system. The focus of aged care is on the holistic enablement of people to live their lives to the full, which incorporate a significant range of support arrangements, only some of which are directly related to their health.

However, the health of older people is fundamental to their overall wellbeing and there is a substantial and important intersection between the aged care and health systems. The aged care system (including HACC) provides support to approximately 800,000 older people at any one time. It represents a significant component in the primary and intermediate care of older people. It also represents a mechanism which can be utilised to minimise and/or defer the costs of older people in the health system. A seamless transition and interaction between those systems can create huge benefits for older people and significant efficiencies for the aged care and health systems.

There has been substantial investment in transitional (post-hospitalisation) care services by Commonwealth and State governments and these have been very welcome and have made a difference in the experiences of many older patients. So have the varied approaches to hospital avoidance and hospital stay minimisation for older people which have been implemented. There are opportunities to build on these approaches to facilitate improved experiences and outcomes for older patients, including as they approach the end of their lives.

Specialist palliative care services have been developed to meet the needs of patients with cancer, and more recently end stage chronic illnesses. These models are not well suited to

meet the end of life care needs of the frail aged and older person. Consideration should be given to the use of innovative pool funds to support the development and testing of flexible models of service delivery that support the care of older people as they approach the end of life. In addition, the establishment of transitional care services to support the post hospital care needs of older people at the end of life would enable many of these older people to be cared for in environments that were better suited to meet their needs. Such services may also allow for closer integration with specialist palliative care services.

While aged care providers would prefer to avoid the hospitalisation of residents and clients, there are no financial incentives for either residential aged care or community aged care providers to put in place the resources, systems and processes which will minimise the hospitalisation of their residents and clients. Hospitals also make decisions about what support they will provide to residential aged care providers. For example, in Cessnock the community palliative care team will assist in supporting residents in low care facilities (although the resident may be classified as high care) but will not assist residents in high care facilities. Similarly, in the ACT, the Hospital in the Home program, which provides IV antibiotics and other support to enable ill people to stay in their home, will support residents in residential low care facilities, but not in residential high care services or wings.

There is also an absence of financial incentives for hospitals which are funded on outputs to invest in hospital avoidance programs. In addition, there is limited access to transition care funding by patients of private hospitals, which represent a major source of hospital discharges.

There is a need for empowered hospital- based professionals who can authorise access to community support at a designated level for a specified time to avoid admission, expedite discharge and optimise recovery to avoid readmission. Ideally, this should be an extension of the ACAT function.

In addition, the process of assessment and admission of older people to hospital and the process of residents/clients returning from hospital to residential aged care and to the community are still often unplanned. This situation is a particular problem for older people approaching the end of their life and for people with special needs (eg people with mental health conditions, people with dementia, people from CALD backgrounds etc).

In the ACT, LCM Health Care operates a residential aged care service, community aged care services, a public hospital, palliative care service and two private hospitals. LCM Health Care believes that the opportunity exists, in collaboration with general practitioners, geriatricians and other professionals, to demonstrate the benefits of further developing multi-disciplinary intermediate care services to assess, monitor and support sick older people and people requiring rehabilitation with a view to avoiding, as far as possible, their admission to hospital and/or admission to a residential aged care facility. This would be particularly important for people with dementia for whom acute hospital experiences can be very distressing.

The “care hotel” concept applied by Humanitas in the Netherlands is one example of an approach which may be considered in Australia. This residential aged care provider operates

a small sub-acute medical ward for older people (other than its residents) from its local community.

Another potential opportunity is for the greater use of specialist assessment and monitoring clinics, separate from the general hospital Emergency Departments, for older people.

Applying existing research and engaging in further research on how to reduce rates of hospitalisation of residents and clients receiving residential aged care and community care, and other older members of the community, would lead to opportunities to create financial incentives for providers to acquire or access those service capabilities which are proven to reduce hospitalisation. For example, facilitating access to nurse practitioners in aged care services and participating in effective intermediate care networks.

The current funding system also makes it difficult for aged care providers to fund the development and maintenance of specialist skills in areas such as palliative care, mental health, support for people with disabilities etc. LCM Health Care would like to use its organisational depth in palliative care expertise to develop specialised capabilities in palliative care to support older people who are dying and their families. It is difficult to achieve this in the current funding regime.

Further opportunities relate to the potential benefit of a range of restorative and rehabilitation programs. There is an absence of rehabilitation resources in many residential and community aged care programs. In residential care, while ACFI funding has encouraged greater use of physiotherapists, the role of rehabilitative allied health services, such as physiotherapy and occupational therapy, are often restricted to assessment activities. This results from an acute shortage of professionals with those skills in aged care, particularly in regional and rural areas, and financial constraints on providers.

While some HACC programs are moving towards a rehabilitative approach and attempting to enable and move people through the system, overall in community care there is also very little focus on rehabilitation.

The development of programs which better integrate health and aged care services would demonstrate the capacity to create benefits which cannot be achieved without being able to work across current care boundaries. Beyond transition care and demonstration projects, further development is required in Australia of a coherent strategy for intermediate care which encompasses the health and aged care systems. That process would benefit from the evidence available from the UK, some of which is published in:
Intermediate Care – Halfway Home
Updated Guidance for the NHS and Local Authorities – July 2009

An example of the application of this intermediate care strategy in the UK can be found in the following extract from the 2005- 2008 accountability document of Mayday Health Trust in Croydon, London:

Standard Three: Intermediate Care

Older people will have access to a new range of intermediate care services close to home and to promote their independence. These services prevent unnecessary hospital and Care Homes admissions and enable early and safe discharge from hospital, by providing a short period of intense support and rehabilitation.

Croydon PCT, Mayday Healthcare Trust and Social Services have made a considerable investment in intermediate care services in Croydon. Through this investment and redesign Croydon have been able to increase both home based intermediate care and residential intermediate care. The START team support discharges from out of borough hospitals and support transfers out of hospital back into the community or into residential placements. The Community Intermediate Care Service (CICS) can support 70 people in their own homes and 10 people in residential settings. In 2005 the management of health and social services intermediate care were integrated bringing the START and CICS service together under one manager on a pilot basis.

Homefield House, a Local Authority residential home has been developed to provide short term intermediate care, transitional and respite care. Croydon also provides intermediate care in two sheltered housing units.

Between November 2004 and October 2005 CICS (including Emergency Department liaison and Community liaison) received 1549 referrals, 33% to support early discharge from hospital and 62% to support hospital avoidance, with 3% for rehabilitation or other purposes. In the same period 119 patients were rehabilitated in intermediate care beds.

Following CICS input 56% of patients required no further service and only 6% of patients needed social service input. Only 1% of patients were discharged to residential/nursing home placements following CICS input. CICS is therefore very successful in supporting or re-enabling independence for its patients.

Between January 2005 and October 2005 START received 713 referrals. 24% of those seen required no further services and returned to full independence. 31% required some ongoing home care and only 7% were admitted to long term care.

In relation to retirement villages, we make the following comments:

- Retirement villages are principally private dwellings and the consumer protection responsibilities for various tenure arrangements rightly rest with the States and Territories.
- There would be value in the harmonisation of retirement village legislation between States and Territories, but we see no benefit in Commonwealth oversight of that legislation.
- Given that the average age of retirement village residents generally exceeds 80 years, retirement villages are obvious candidates for sites of substitute care for people who would otherwise occupy residential aged care places. Retirement villages represent an important mechanism to provide a flexible range of services for residents, and members of the surrounding community, to avoid or defer entry to residential aged care.

Government support for the establishment of primary health and wellbeing clinics with podiatry, occupational therapy, physiotherapy, dental, as well as primary medical care services, in retirement villages could also have a significant beneficial impact on the cost and timing of care for those older people.

- The Commonwealth can enhance the attractiveness and effectiveness of retirement villages as part of the broader accommodation and care system by enabling village operators greater access to care subsidies for the provision of care to eligible residents. Under a consumer-directed care model, it may be the operator of the retirement village which is asked by the eligible older persons to provide a range of services with their subsidies. It is common in retirement villages for various community care providers to come and go to individual residents, with little thought about how services could be organised collectively to maximise client/resident benefits. For example, if the residents who are receiving a package of support agree, consideration could be given to whether a shared meal preparation service in one of the resident's villas, or in a communal dining room, which may be preferable to multiple occasions of individual meal preparation support. Similarly, where the people choose to do so, the pooling of the community care support subsidy for various individuals may enable those who need support to have an extended on-site presence by paid carers for no greater cost to the Commonwealth or residents. These types of models exist, but their application is very limited under the current regulatory regime. However, in providing such flexibility, it is essential that the choice of care and support mechanism remains with the older person.
- One of the great needs evident in many communities is for affordable housing for older people. The provision of greater access to NRAS-type housing subsidies for financially disadvantaged older people entering retirement villages would make a real difference to both the availability of secure affordable housing and to the related wellbeing of those people. The ability to facilitate access to care subsidies in this environment would further enhance this opportunity.

13. Government should meet the costs of providing care to eligible older people; and

14. The costs of accommodation and basic living expenses should generally be met by the older person, to the extent that they have the financial capacity to meet those costs, at the time when those costs are incurred; and

15. The value and flexibility of accommodation payments in residential aged care should be increased to reflect current costs and the different levels of amenity being provided in different facilities. The form of payment by the consumer for accommodation and basic living services should be flexible between lump sum, periodic payments and payment in arrears; and

16. Where the person receiving care in residential aged care has a limited financial capacity to meet the cost of accommodation and basic living expenses, the Government should supplement the amounts payable by the individual so that the reasonable costs of providing those services are met.

A financial strategy is required to clarify who will bear the costs of the required support, in what form of payment, and when those costs will be borne.

The question of who will bear the costs comes down to the contributions of the taxpayers (the broad population) and the person who requires the service.

In relation to care costs, it is not possible to determine who will need care and who will not, or the length and extent of care required. It is preferable that this risk is borne collectively via taxation. We believe that the Government should meet the costs of providing care to eligible older people.

The costs of accommodation and basic living expenses should generally be met by the older person, to the extent that they have the financial capacity to meet those costs, at the time when those costs are incurred.

In determining a person's financial capacity, the value of the person's home should be taken into account (except in instances where there is a remaining partner/spouse or other dependent using that accommodation). Given that approximately three-quarters of older people in Australia own their own home, this most important source of funding cannot be ignored.

The current accommodation charge and accommodation supplement of up to $26.88 per day are inadequate to support the development of new high care services or the renewal of old facilities. It results in providers adapting to the system (eg via the development of ageing in place facilities where residents all enter at low care). In other instances, some ACAT teams will assess a person on the border of high and low care as high care, because they know a bond will not be payable. There is a need to increase the value and flexibility of accommodation payments to reflect current costs and the different levels of amenity being provided in different facilities. It is illogical that the same (single) price applies to residential aged care in a fifty year old facility, with four bedded wards and multi- resident bathrooms as it does in a new, single-room with ensuite facility, and water views. The complexity of the funding system is also extremely and unnecessarily complex and confusing

The form of payment by the consumer for accommodation and basic living services should be flexible between lump sum, periodic payments and payment in arrears. It should be negotiated between the consumer and the provider.

The legislated inflexibility in the current rules around retention charges for accommodation bonds, which was intended to be a consumer protection measure, at times works against the interests of consumers. By establishing a maximum accommodation bond retention of $36,900 over a maximum of five years, or no more than $307.50 per month, the Government has eliminated options for consumers to pay lower bonds and higher retention charges. These restrictions should be removed.

Where the person receiving care in residential aged care has a limited financial capacity to meet the cost of accommodation and basic living expenses, the Government should

supplement the amounts payable by the individual so that the reasonable costs of providing those services are met. The current maximum Supported Resident Accommodation Supplement is inadequate to meet the cost of establishing new facilities or renewing old facilities.

17. The discount applied to Government accommodation payments, where the 40% ratio of Concessional/Supported residents is not exceeded, creates additional disincentives to admit financially disadvantaged people into residential aged care, and should be discontinued.

In instances where less than 40% of residents in a residential aged care facility are Supported (financially disadvantaged) Residents, the Government currently reduces the $26.88 per day accommodation supplement by 25%. This creates a significant disincentive for many providers, who will not reach the 40% level, to accept financially disadvantaged people. It also enables the Government to avoid its obligation to meet the reasonable costs of those residents. That discounted funding arrangement should be discontinued.

18. A substantial amount of the funding of future aged care, health care and pensions for a projected population with a bulging baby boomer generation of older people should be accumulated while that large generation is still producing taxable income and having significant disposable income. A fund similar to the Future Fund should be established for this purpose.

The funding of future aged care, health care and pensions for a population with a bulging baby boomer generation of older people should occur while that large generation is still producing taxable income and having significant disposable income. The inevitable consequence of waiting until the liability arises is that there will be heightened inter-generational tension, as younger people react to the burden of funding the support of the older generation through their taxes at that time. We can learn from the Japanese experience, where 22% of people are already aged over 65 years, that the later that provision is made for the cost of care, the more challenging the meeting those costs will be. This situation should be viewed as a much larger but similar issue to the unfunded superannuation liability of Public Service employees and Defence personnel, which the Future Fund was established to address. A similar but much larger response is required to address the financial implications of the ageing of the population.

19. Income-tested fees for older people in residential aged care result in an effective "tax rate" exceeding 100% of each additional $ earned and should be abolished.

20. The Extra Service approvals program is flawed and would be unnecessary and discontinued in an improved aged care system.

As well as broader issues in the funding system, there are specific issues which are inequitable or ineffective. Two of these are income-tested fees and Extra Service approvals.

The current application of income-tested fees to residents to offset care subsidies is an unfair approach to charging residents in residential aged care, with unintended consequences. Income tested care fees are charged at the rate of 5/12 (41.7%) of assessable fortnightly income over $816.50 (single) or $798.50 (each member of a couple) to a maximum of $62.11 per day ($22,670 per annum).

Those income tested fees are on top of the tax payable (15% or 30%), and the loss of pension of 50% of pension income (where applicable) for every additional $1 of private income.

This means that the effective cumulative "tax rate" for residents receiving the aged care pension in residential aged care services of each extra dollar earned of private income within those thresholds can be as high as 107% and 122%.

The impact of the burden of income tested fees can also be seen acutely in non-pensioner families. In situations where younger people are admitted to residential aged care, for example if one member of a couple has a condition such as Early Onset Dementia, Stroke, Motor Neurone Disease etc., and the other member is working (and often supporting their children), the income tested fees are simply not affordable. It is also seen when a member of a couple enters residential aged care and the other member is receiving a significant government or private pension. In the above instances, it is not uncommon for the agonising consideration of legal separation of the couple for purely financial purposes.

The testing of personal income should occur within the taxation and social security systems and not in the aged care funding system. The interaction between the various systems should operate fairly and transparently. This unfair income-tested fee arrangement should be discontinued.

In addition, the operation of Extra Service approvals for residential aged care is a flawed approach to assisting providers to provide choice to residents.

LCM Health Care provides a component of Extra Service places in Calvary Aged Care ACT. The inclusion of those places enabled the cost of a new facility to be met. One difficulty with Extra Service is the requirement to provide various items which are meaningless to many of the residents. For example the choice of multiple puree meals or access to wine and beer for non-drinkers is of limited value. Extra Service residents would often prefer to see more therapy services or recreational activities for all residents than adherence to their frills which may offer little value.

Extra Service Places are the only means for providers to obtain higher daily care fees in residential aged care and to obtain accommodation bonds in high care services. In order to build new services, providers are having to choose between developing ageing in place low care facilities, where the vast majority of residents enter at low care levels and accommodation bonds are used to meet the building construction costs, or to include a component of Extra Service Places. This limits access to services for people with limited financial means or with high care needs.

The failings of this approach are now becoming increasingly evident. The Department of Health & Ageing stated in early 2010 that in some areas (eg the Eastern Suburbs of Sydney) are "well supplied" with Extra Service Places, and that it does not intend to make further Extra Service approvals in those areas in the near future. The Department's view is that access for general residential aged care places is being affected by the proportion of Extra Service Places in those localities. This position has directly adversely affected the likelihood of planned new developments, which included general and Extra Service Places, proceeding to construction. This situation highlights the inadequacy of Extra Service approvals as a source of consumer choice and as a safety valve to remedy a deficient funding system.

21. The current positive workforce initiatives should be built on to provide additional mechanisms to attract and retain a skilled and flexible workforce to meet the needs of older people, regardless of the care setting. Continued programs are required to ensure education and training places are available and attractive to potential staff. Funding is required to enable the payment of competitive wages. The development/retention of flexible IR arrangements are required to facilitate new emerging aged care roles and meet client needs and preferences.

There are many current positive initiatives promoted by the Department of Health & Ageing to educate and train care staff, registered nurses and senior nursing professionals. These initiatives, including those directed specifically at regional and rural areas, are very welcome and should be built upon.

A basic issue for attraction and retention is the low rates of pay for aged care staff. The current pay of direct care staff is not sustainable. The levels of pay ($17 -$19 per hour in NSW) are too low in relation to the remuneration of other roles in the labour market (eg retail and hospitality sectors) to enhance attraction and retention of staff. Those pay rates also do not recognize the potential value of those roles. The current rates of pay represent less than 60% of ordinary time weekly earnings ($1243.10 per week or $32.71 per hour in February 2010 per ABS). The rates need to increase by approximately 20% to reach 70% of AWOTE, which represents a reasonable short-medium term target.

Similarly, Registered Nurses should be paid at parity with their peers in hospitals. This is rarely the case in aged care. The resolution of this problem does not rely entirely on increased government funding, although achieving fair subsidies and sustainable subsidy indexation arrangements are crucial to such an outcome. Achievement of these desirable outcomes will also require restructuring of staffing models and roles. In that process, it will be important to maintain flexibility in staffing arrangements, rather than locking in fixed staffing ratios.

The current staff skill-mix within residential aged care settings creates difficulties in providing access to care that meets the needs of older people, especially as they approach the end of life and have enhanced medical and nursing care needs. The increasing acuity of

people receiving aged care services, and the growth in residential high care requires a review of the adequacy of current workforce models, including the competency levels, education and skill mix to provide safe, high quality care.

Recognition of upskilling/credentialling of staff to meet the increasingly complex care needs of clients is also required ie breaking down professional territory/barriers.
For example, the opportunity for RNs to upskill community support staff to support high needs clients choosing to remain living at home, as well as developing residential aged care direct care staff to enhance their skills and undertake more responsible roles. This approach recognises the expected workforce shortfall as baby boomers age and become service users, enables continuity of care and efficient use of scarce resources. It also contributes to staff engagement with and retention in the role.

Flexibility in IR agreements is required, especially in the community sector, to enable services to effectively meet the needs and preferences of clients. Our experience indicates this flexibility and variability in employment arrangements suits sections of the workforce and is essential to address the individual requirements of clients.

22. Careful attention should be given to the timing and progression of changes to the aged care system, and the opportunities for providers to flexibly respond to changing circumstances, so that the stability of aged care provision is not placed at risk. Government may also need to compensate providers for the financial impact of restructuring the sector.

Improving the flexibility of the aged care system to respond to the needs and preferences of consumers and to improve the efficiency of the system in supporting older people is desirable and can reap substantial improvements. However, in a transition from the current arrangements to potential future flexible and more consumer-directed models, there are significant potential risks and costs to providers, Government and consumers:

- Any deregulation of supply could have a significant potential impact on the occupancy and viability of existing residential aged care facilities, in which there is an inherent significant investment in human and building infrastructure.
- Similarly, for community care, if packages are not allocated to a provider, then funding would come through client choice after their assessment for eligibility. This means that there is no guaranteed funding. This will create greater uncertainty regarding the levels of revenue to support fixed costs and staffing in each region.

Transition to new arrangements could cause significant disruption to providers, and consequently to their residents, clients and staff.

For these risks to be managed, the timing and progression of such initiatives, and the opportunities for providers to flexibly respond to changing circumstances, will be critical. In that process, the Government may also need to compensate providers for the financial impact of restructuring the sector. How overall system stability is maintained during

transition will be an important measure of the success of the implementation of any changes to the system.