'Caring For Older Australians'

Productivity Commission Inquiry into Aged Care

South Australian Government Submission

July 2010

Introduction

Background

With the oldest population in Australia (15.4% of the population aged 65+ compared with 13% nationally), [1]South Australia is uniquely placed in terms of the Productivity Commission's Inquiry into Aged Care. The citizens of South Australia arguably have much to gain from changed administrative, regulatory and funding arrangements for the aged care system that the Commission seeks to address, as well as much to lose.

The South Australian Government, in partnership with the non-government sector delivers a range of health, housing and aged care services to older South Australians. The Department of Health (SA Health) and the Department for Families and Communities (DFC) (through Domiciliary Care SA), are major, direct providers of home and community care services. Many areas of DFC (e.g. Housing SA, Disability SA, Office for the Ageing, Concessions), the Department of Premier and Cabinet and SA Health, provide policy, funding and direct services for older people across a range of areas, with much overlap in the people receiving services. Other departments, such as the Department of Further Education, Employment, Science and Technology, provide indirect services through the development of an appropriately skilled workforce to enable services to be delivered. Older South Australians are also major users of public transport and other utilities.

This submission represents the South Australian Government's position in relation to the Inquiry and aims to provide insight into the type of aged care system that will best serve the Australian people and its governments. It also recognises the close ties with other areas such as health, mental health and disability.

South Australia supports the Australian Government's proposition for a National Health and Hospitals Network, including the proposal for the Australian Government taking full responsibility for aged care services for people over 65, as well as the reforms around the integration of aged care with the health and hospital system.

The South Australian Government believes that it is essential for any reform of aged care to incorporate health and hospital reform, to ensure a properly integrated continuum of care for older people; from low-level preventative services, through to packaged care, and residential care if required. It is important however, that the system for people aged 65+ appropriately integrates with State-funded systems for people under 65, to ensure equity

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[1] 2006 Census of Population and Housing, Australian Bureau of Statistics

and continuity regardless of age. As with Health any effective and cost efficient aged care system must have supportive interfaces with a range of allied areas such as housing, transport, urban planning, community development and social inclusion.

Principles for the aged care system

The key themes running through the *Aged Care Act 1997*, the accompanying *Aged Care Principles* and the *Home and Community Care Act 1985* are still relevant, as they mandate quality, diverse, affordable, flexible and accessible services that facilitate independence and choice for all older Australians. However, significant reform is needed in the way in which aged care services are planned, funded and delivered. The key areas for change are discussed in more detail in this submission.

The South Australian Government proposes that the existing aged care system is reformed to establish a new aged care system that is underpinned by the following principles and features:

- Services need to be built around individual capacity, not incapacity.

- Services seek to re-establish skills and strengths where possible to enable people to regain, develop or optimise their independence, well being, quality of life and capacity to remain living in the community for as long as possible. There should be a strong focus on preventative and restorative approaches.

- Services need to be structured around a seamless continuum of care, ranging from basic support to high level community and/or residential care.

- There is a right to choose what services are provided, how they are provided, by whom, when and where, through consumer directed care or individualised budget arrangements.

- Access to aged care services should be an entitlement based on a person's assessed level of need that can be increased or decreased to respond to changed circumstances, with an assigned level of funding according to assessed level of need. The assessment should only indicate level of need, not the services to be provided.

- A single, government controlled eligibility assessment process across all levels of need, ranging from low level community care to high level residential care.

- Much greater access to information across all aged care services through 'one-stop-shops' that are designed to assist people with diverse needs and/or from diverse cultural/language groups.

- Services should be provided to support older people to make decisions about the selection of services and to manage their own care situation if that is what they choose.

- Independent advocacy services to support and assist people to access services (including outside of the aged care system) and promote high quality service delivery.

- The need for strong consumer protection mechanisms, such as service provider registration, a star rated listing of services and complaints mechanisms.

In the shorter term, the following are priority actions to address key issues with the current system.

Community Care

- The existing gaps between programs offering low level care (i.e. the HACC Program and other community care programs) and packaged care (CACPs, EACH, EACHD) need to be eliminated in order to provide a seamless continuum of support for people as their needs change/increase. The concept of assessed levels of need ranging from low level, preventative programs to levels which equate with the current EACH and EACH D is supported.

- The assessed level of need does not specify service types for which people are eligible. Consumer choice around what services are provided, how, when and by whom is maximised.

- The community care system needs to be built on individual capacity, not incapacity, with an emphasis on restorative, preventative and strengths based approaches.

- Introduction of a consistent fee structure in order to address inequities with the current system.

Residential Care

- South Australia supports the development of a new planning tool that is responsive to, and reflects, actual community demand. In addition the planning tool should have the flexibility to be responsive to

community experience in relation to the type of care needs there are in the community and the service options available.

- The current ratio of high level packaged care to residential care places needs to be increased to reflect the desire of most people to continue to live in the community.

The Current System

Community Care

As is well documented, there needs to be improved coordination and integration in policy and service system development between the various programs (i.e. Home and Community Care (HACC), National Respite for Carers and other Commonwealth carer support initiatives and Commonwealth packaged care). In relation to services such as respite and carer support, there is considerable service overlap and duplication of effort between programs. Linkages with the health system and primary health care are poor.

The lack of continuity in care between HACC, Community Aged Care Packages (CACP), Extended Aged Care at Home (EACH and EACH D (Dementia) is perhaps the most significant issue for community care. In addition, the exclusion of certain services from packaged care such as nursing and allied health means that these services have to be sourced from other programs such as HACC. In addition, aids and equipment must either be funded directly by the client or through the package, which subsequently reduces the value of the package in the purchase of ongoing services. This all contributes to a system that has multiple gaps, is inequitable, difficult to navigate, administratively burdensome and inefficient.

The delivery of community care and support services in country areas needs particular attention as the demand for community services is increasingly greater than the supply. This gap is exacerbated by the increased cost of service delivery in remote areas.

There is a focus and culture of providing maintenance and support in community care rather than the provision of adequate support for people to regain function and maximise independence. An increased focus on prevention, capacity and restorative approaches is essential, including an emphasis on assistive technology, equipment and home modification. This can be achieved through clearer service contract specification, reporting and building in financial incentives for preventative and restorative services.

Although HACC is intended to provide low level support, in reality the level of support provided varies from single service/one off support to levels beyond an EACH D. This has resulted from a range of factors including:

- the lack of availability of packaged care places;

- fee disincentives for people to move from HACC to packaged care because of higher costs; and

- the desire for individuals to remain with an existing service provider.

These issues reinforce the need to abolish boundaries associated with care packages.

While the HACC Program objectives emphasise the provision of flexible and responsive support to individuals, the manner in which services are planned, funded and reported on are very specific, restrictive and service output based. These systems all work against agencies being able to deliver flexible, responsive and client outcome focused services and highlight the need to shift service performance to an outcome based approach.

Residential Care - Aged Care Funding Instrument

Additional cost pressures on operating residential aged care were recently highlighted in the review of the Aged Care Funding Instrument (ACFI)[2]. Funding levels associated with the use of the ACFI have not been adequately weighted relative to complexity of care, particularly in relation to complex behavioural needs and cognitive deficit. Due to the ACFI's limitations in ensuring that the level of funding is commensurate with higher level care needs, the ACFI has negatively impacted on the funding levels of approved providers.

Concerns have also been expressed about the treatment of people who have valid residential low care assessments. Under ACFI, if consumers are assessed as having a low level of need, and thus a corresponding low level of funding, some facilities may deem an admission is not feasible without further contribution from the consumer. For financially disadvantaged people in rural and remote communities SA Health would typically bear the cost of these admissions. The injection of additional high need community care resources would assist with this issue.

Currently a rural and remote subsidy is paid to country aged care providers up to a certain number of places. Essentially this is a component of

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[2] Commonwealth Department of Health and Ageing, Review of the Aged Care Funding Instrument 2010

operational income. Basing the subsidy on number of places is not a true reflection of costs. Locality is a key factor in operating costs for regional facilities regardless of the number of places. Most expenditure lines incur some level of higher cost and these are not necessarily reduced through economies of scale. For example, the cost of food, transport, information technology and related services, staff training and accommodation, plant, furniture and equipment, and general maintenance are all likely to incur higher costs in smaller and more remote localities.

The raising of capital funds continues for the most part, to be via the payment of accommodation bonds by residents entering facilities who require a low level of care. Evidence shows that, increasingly, admissions to residential care are now older people requiring a high level of care who are not required to pay a bond. With the move toward increased home and community care services and a reduced number of people requiring low level care, the consequence is reduced bond payments and an overall reduction to the pool of funds used for capital upgrades.

New aged care licences issued annually by the Australian Government are predominantly taken up by not-for-profit and private-for-profit operators. The take up of these new licences and infrastructure investment does not translate to an increase in residential aged care facilities in the more rural and remote communities, as the costs of this investment are prohibitive for many providers.

South Australia proposes that the ACFI and revenue sources for residential aged care facilities be reviewed to ensure:

- access to residential care is based on need;

- the removal of cross-subsidisation, such bond payments by low needs clients; and

- the financial sustainability for the industry in metropolitan and rural areas.

Interface between the Aged Care and Health Care Sectors

Residential Aged Care

Older people can inappropriately reside in public hospitals for extended periods of time due to a lack of access to appropriate aged care accommodation or other care and support services. This situation is exacerbated in South Australia's country areas where there are fewer aged care providers. However, metropolitan hospitals also experience the consequence of delays in nursing home eligible patients accessing a nursing home placement. These delays in metropolitan areas have a significant impact on public hospital services, as beds are occupied by older people awaiting residential care but not requiring acute care. This creates major blocks for patients needing acute care but unable to access public hospital services. This in turn impacts on activity and revenue for public hospitals. As a consequence, at any point in time there can be considerable numbers of Nursing Home Type Patients (NHTP) residing in South Australia's public hospitals. For country hospitals this has meant that SA Health has had to provide aged care accommodation, resulting in many country hospitals now providing Multi Purpose Services (MPS) for older people.

The number of new aged care places allocated by the Australian Government is calculated using an aged care planning ratio. This ratio is historical and, to our understanding, no research has been undertaken that links it to actual levels of need. The current planning ratio has led to a significant shortage in supply of available places in metropolitan and rural South Australia. On any one day there can be between 80-100 older people in metropolitan hospitals awaiting transfer to a more appropriate facility or service. In country areas there are around 250 beds occupied by older people who do not require acute care. SA Health is currently discussing with the Department of Health and Ageing converting some of these beds to MPS. The National Health and Hospitals Reform Commission (NHHRC) Final Report (June 2009) recognised the inadequacies of the existing planning tool.

South Australia supports the development of a new planning tool that is responsive to, and reflects, actual community demand. In addition the planning tool should have the flexibility to be responsive to community experience in relation to the type of care needs there are in the community and the service options available. This has particular relevance in rural areas where a standard residential aged care facility may not be financially viable.

Government subsidies for aged care need to be more directly linked to people rather than places. Current funding formulas do not capture emerging demographic ageing trends, particularly for states whose 85+ population is higher. Many older people assessed as eligible for aged care are unable to access that care due to inadequate supply. A planning tool should be able to

be adjusted for particular demographic and geographic factors such as premature ageing and shorter life expectancy amongst Aboriginal communities and small rural community service needs.

The current blockage of NHTPs waiting placement has resulted in a trial 'waiting placement' program being established and funded by SA Health. The trial program has been at full occupancy since commencement in March 2010, demonstrating the significant system demand currently being experienced and the need to establish processes to address the timely movement of patients from hospital to residential aged care. The trial has been successful in improving the flow of service, resulting in improved access and saved bed-days.

Community Care

Transition Care Program (TCP) type services are a critical interface to better support people to live independent and healthy lives. South Australia has experienced steadily growing waiting lists for TCP and other hospital avoidance programs. The success of TCP in SA Health has shown that people with very significant needs are able to benefit from restorative care and move home. Over 65% of all TCP participants in South Australia move home, many of whom require no ongoing support. In SA, TCP use of residential care is often only for a short period. Most people who move to residential care from hospital are, with the assistance of TCP services, then able to move home and onto a home-based support package.

TCP type services need to be part of the aged care continuum. TCP type services align with the principles of building independence and individual capacity, thereby alleviating the health and aged care systems of more costly care options. As with other aspects of access to aged care, timely assessment is crucial. More timely assessments in the hospital environment will enable people to leave hospital when they are ready for discharge.

In particular SA Health has identified a problem for Aboriginal people accessing the TCP due to delays in accessing ACAT assessment. The delay often results in Aboriginal people deciding to return home prior to assessment. This precludes them from the program and access to services that might have improved their health outcomes. Members of the Aboriginal community have said that greater flexibility around eligibility might assist more Aboriginal people to access the program.

Greater system efficiency and community outcomes will be achieved if the community sector is better supported and equipped to assist older people to manage their health care, short-term crises, short-term health management issues, multiple health issues and chronic conditions. This also includes the

need for restorative and rehabilitative services in the community to deal with minor health problems that lead to temporary reduction in level of functional independence which could lead to avoidable hospital admission.

SA Health as a Provider of Aged Care Services in Country Areas

Under the COAG Long Stay Older Patients initiative, (LSOP) the Australian Government provides funding to undertake capital works in country areas to upgrade and develop facilities to meet the 2008 Aged Care Standards. This program establishes Australian Government funded MPS sites that provide access for older people to appropriate aged care services and accommodation in local area hospitals.

Through COAG commitments SA Health has been able to extend the provision of MPS places across country hospitals, adding an additional 137 MPS places as well as enabling upgrades to the privacy and fire safety of existing MPS sites. In addition, South Australia has been seeking further Commonwealth support to convert an additional 217 state-funded long stay older patients places in country public hospitals to MPS places.

If MPS sites are tied to the current Commonwealth aged care planning ratios then this will place severe limitations on the number of places approved.

South Australia proposes that in addition to an improved planning tool, the Australian Government assumes full funding responsibility for NHTPs who have been assessed as eligible for community or residential care. This is in line with the Commonwealth's commitment through COAG to take full funding and policy responsibility for aged care and provides an incentive mechanism for the government to be responsive to actual community need.

Carers

In South Australia, the partners, families and friends of older people make a significant contribution to supporting and enabling them to continue to live independently.

Carers are a critical resource to the system and should be supported through educational programs, information, mentoring, timely advice and, subject to the consent of those they care for, suitable engagement in decisions and communications that have a direct impact on the carer. . Carer support extends to giving carers a choice about their caring role and providing flexible working arrangements to enable provision of care on a long term and sustainable basis.

A large proportion of carers is ageing and finding it increasingly difficult to care for family members. Policy development and resourcing is required to manage this escalating issue, as well as to support the older carers in their role.

Women are the predominant providers of formal and informal care of older persons. About two thirds (71%) of primary carers are women and women outnumber men as carers in all but the oldest age group (aged 85 years and over)"[3] Many informal women carers experience poor health and disability themselves. According to the report *Older Australians at a Glance*, 59%.of women carers had a disability and about 13% had a severe or profound care activity limitation."[4]

Women with caring responsibilities can be financially disadvantaged, as it becomes more difficult to access or continue in paid employment that is open and flexible enough to acknowledge and allow irregular working conditions to assist the carer in their caring role. Consequently, women with care responsibilities are often restricted to part-time or occasional work. This would have an impact on the level of their retirement income and may impact on their social isolation.

The significant ageing of the population has subsidiary effects, including an increasing percentage of carers who are participating in the workforce (employed, underemployed or unemployed). For example, in 2003 there were an estimated 230,000 carers[5] in South Australia with approximately 53%

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[3] Commonwealth of Australia, Australian Institute of Health and Welfare (AIHW), 2007. Older Australians at a Glance (4th Ed.) Canberra, AIHW
[4] Commonwealth of Australia, Australian Institute of health and Welfare (AIHW), 2007. Older Australians at a Glance (4th ed.). Canberra, AIHW, p. 34.
[5] Australian Bureau of Statistics, *Catalogue No. 4430.0: Disability, Ageing and Carers: Summary of Findings* 2003),

of this group in paid employment. The growing proportion of carers in the workforce has implications for skills development in the caring function and maintenance of carer health. In addition, all industries need to consider workforce recruitment, retention strategies and flexible work arrangements to accommodate people in their caring role.

Improved access to respite care arrangements to assist carers sustain their role, and their own health, should also be a priority, as should generalised support for carers. The need for respite must be underpinned by the requirements and circumstances of the carer rather than to the level of care required by the care recipient. The development and implementation of the Carer Eligibility and Needs Assessment Tool (CENA) will lead to increased identification of carer needs, and therefore demand for service.

Of immediate concern is the number of different programs providing respite, the variation and overlap between them, and the lack of a system to assess relative need and equity of services provided. Carers of frail older people and younger people with a disability may be offered anything from an hour of in-home respite every few weeks, to high care residential respite. The system appears to be much like a lottery in regard to who will receive what type and level of service, for how long and at what cost. The 'one- stop -shop' should include services for carers and provide equitable access to respite.

Aboriginal people who are caring for older family members or friends do not define themselves as carers, but more so as fulfilling their family/cultural responsibilities. As such, these persons, and the persons they are caring for do not receive the supports that are available. Caring is also a significant issue for young Aboriginal people. The Social Policy Research Centre, University of NSW, is undertaking a three year study into young carers in Australia, including Aboriginal young carers. The study is scheduled to conclude in October 2010 and the research findings will be valuable in contributing to policy development for young carers.

The SA Carers Charter is a schedule of the SA Carers Recognition Act 2005. Principles of the Charter identify young carers and Aboriginal carers for specific attention. Relevant Government Departments are required to report compliance with the Act and the Principles annually.

South Australia proposes that:

- an integrated carer support and respite system be developed, taking account of all carer support and respite needs and services provided;

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http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/978A7C78CC11B702CA256F0F00 7B1311/$File/44300_2003.pdf

- this system is accessed through a one- stop-shop arrangement, sits alongside, and is closely aligned to, the broader community care sector; and

- services provided are based on assessed carer needs including cultural factors, and are additional to identified care recipient community care needs.

Older People and Disability

The following points are made in relation to older people and disability:

- The aged care system needs to be flexible enough to respond to the needs of both ageing people with a disability and people who acquire a disability after the age of 65.

- There is significant diversity of need in the older population with a disability, including Aboriginal people, people from CALD backgrounds and people with mental health issues.

- Older people with a disability need to have the choice to stay where they are being cared for if possible, i.e. to age in place and to have aged care services come to them if they require them.

- The lack of services in rural and remote areas is compounded for older people with a disability by virtue of their more complex needs. This reinforces the need for increased flexibility in the way services are delivered in these areas.

- Staff working with ageing people with a disability need to have knowledge about the specific disability/ies of the person they are working with and the effect of that disability on their lives, both in a functional and general sense. Co-morbidities among adults with intellectual disability are high and increase with age.

- While ACAT assessments include assessment of function, they do not take into account the effect of intellectual ability and brain injury on the other needs of people with a disability.

- More consideration needs to be given to appropriate residential care for ageing people with a disability. People with a disability are often admitted to residential care at a much younger age that the average age of 83.5 years for a frail older person. They are also more likely to have a significantly longer stay than the average of 34.4 months for a frail older person. Younger residents face a range of problems including:

- social isolation, resulting from having nothing in common with fellow residents;
- loss of contact with friends, as visitors are often deterred by the aged care setting; and
- the need for appropriately trained staff and activities.

- People should be supported to remain living in the community with appropriate support, rather than enter a residential care facility that is unsuited to their needs.

Gender Issues

Health and Disability

There are many more older women than older men. On average, women have a longer life expectancy than that of men (81 years compared with 75 years). Women aged 80+ currently outnumber men in the same age group by 2:1.

Although older men and women generally suffer the same types of health problems, their patterns of ill health show gender differences. Older women experience longer periods of chronic ill health before death than older men, who tend to have acute illnesses followed by a relatively short period of chronic ill health before death.

Women experience higher rates of profound or severe core-activity[6] restriction than men. At retirement age (60-65) 10.3% of women have a profound or severe core activity restriction compared with 9.5% of men. In the 80-84 years age bracket this figure rises to 40.5% of women and 27.3% of men. In the 90+ age category 79.1% of women and 59.4% of men experience a profound or severe restriction in their abilities to communicate, be mobile and care for themselves.[7]

In summary, there is a need for gender analysis in any consideration of the aged care system in Australia because of the gendered differences between men and women's experiences of ageing. Women outnumber men as consumers and providers of aged care services. Women live longer, but are more likely to experience disability and poverty in old age than men. Failure to account for gendered difference in experiences of ageing could potentially lead to greater disadvantage being experienced by older women and their carers.

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[6] Core activities are communication, mobility and self-care.
[7] ABS Stats cited in: Tually, S., Beer, A., and Faulkner, D. (2007) Too Big to Ignore: Future Issues for Australian Women's Housing 2006-2025 pg. 13.

Older Women, Finances and Retirement

Women earn, on average, less than men across their working lifetime, both as a consequence of the gender wage gap and because of interrupted patterns of workforce participation due to caring duties (both of children and older family members).

Research has shown that women are often significantly disadvantaged when it comes to superannuation. The Association of Superannuation Funds of Australia (ASFA) reported that in 2005-06 average retirement payouts of women were $63,000 compared with $136,000 men.[8]

Women are poorer in retirement than men and are more likely to be reliant upon the Aged Pension. The Women's Budget statement for 2010-11 stated that 71.8% persons receiving the single age pension rate are women.[9]

Despite women's increasing participation in the workforce:

> *"Research by Kidd and Shannon (2002, p.173) projecting the future gender wage gap in Australia- based on ABS data and population projections- finds that 'gender wage convergence will be slow… , with a substantial gender wage gap remaining in 2031"[10]*

Women will continue to earn less over their lifetimes and have smaller incomes in retirement than men for the foreseeable future.

Special Needs Groups

Mental Health Care for Older People

South Australia has previously advised the Australian Government that there is the need to consider further the High Dependency Units proposed in the Report on Residential Care and People with Psychogeriatric Disorders[11]. The report proposes an optimal service model for people who have moderate to severe behavioural disorders which includes the provision of high dependency units operating as longer-term transition services.

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[8] Clare, Ross, 2008, The Age Pension, superannuation and Australian retirement incomes. Sydney, Association of Superannuation Funds Australia.
http://www.superannuation.asn.au/ArticleDocuments/116rc0901-age-pension.pdf.aspx
[9] Women's Budget Statement:
http://www.fahcsia.gov.au/about/publicationsarticles/corp/BudgetPAES/budget10_11/Documents/women/part_2.htm
[10] Tually, S., Beer, A., and Faulkner, D. (2007) Too Big to Ignore: Future Issues for Australian Women's Housing 2006-2025 pg 33.
[11] Australian Government Department of Health and Ageing Report to the Minister for Ageing on Residential Care and People with Psychogeriatric Disorders 2008.

SA Health has in place a Health Services Framework for Older People and has developed an Older Persons Mental Health Service (OPMHS). This model will enable the management of mental health clients in Commonwealth funded aged care facilities throughout South Australia. This model has similar transitional care services to those proposed in the Report on Residential Care and People with Psychogeriatric Disorders[12]. SA Health's service model also proposes intensive care behavioural units which enable people to have longer lengths of stay or permanent stay if required. These services are proposed to be co-located on large non-government residential aged care facility sites across metropolitan SA, which will build capacity and support mainstream aged care services in dealing with this client group.

Aboriginal People

At the 2006 Census, Aboriginal and Torres Strait Islander (ATSI) people accounted for about 26,000, or 1.7% of South Australia's population. ATSI people aged 50+ constituted 1.3% of South Australia's total older population. In 2006, almost 50% of the ATSI population lived in metropolitan or the greater/outer regions of Adelaide, with the remaining 50% living in rural and remote locations.

The South Australian Government recognises that ATSI people disproportionately experience early onset chronic disease and disabling health conditions than non-Aboriginal Australians often resulting in premature ageing and early death. Programs and services for older Australians must be accessible for Aboriginal people much earlier than the Australian standard of 65 years of age. There needs to be an increased focus on prevention and early intervention to reduce or delay the onset of chronic disease and disabling health conditions amongst Aboriginal people.

The following issues need to be taken into account in addressing the needs of frail older Aboriginal people:

- Older Aboriginal people have a strong preference to remain in their community of origin, often at the cost of their health as a result of limited access to medical services. There is a strong case for improved integrated services between health aged care and other relevant services in remote communities.

- Older Aboriginal people are more likely to choose living with relatives or friends over being placed in a residential aged care facility.

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[12] ibid

- Aboriginal women often take on a lot of caring responsibilities within the family structure, which may include bringing up grandchildren. This needs to be considered when they need to move from the community to the city for health treatment.

- Lack of access to programs and services is impacting on the quality of life of Aboriginal people. Too often, people are unaware of the services and support that are available, experience difficulty navigating the system and are reluctant to ask for help.

- Community care programs are currently not adequately resourced to provide individualised care to older Aboriginal people.

- For remote communities there may continue to be a need for low care residential places as social admissions for older people isolated on properties can be necessary. Consideration needs to be given here to the ratio of residential places per head of population. It may well be that a higher ratio of residential places is required in more remote communities. This is the case where people do not have access to the community care services they need to remain at home or where they live in conditions which make the delivery of community care services impractical or unsafe.

- There is a need for additional funding to increase the frequency of tertiary and allied health care visits to remote communities, as well as increased investment in workforce development to ensure visiting staff have the knowledge and experience to provide adequate care.

- Limited paid and unpaid workforce, and limited resources to recruit and train staff. There is a need for significant investment in training to develop capacity of community workers to provide high quality service, and to support unpaid carers.

- Aboriginal people of central Australia regularly travel across Western Australia, South Australia and the Northern Territory. The focus should be on a regional service, with the ability to access services in any of the three states rather than being limited to accessing services in the home state/territory. Resettlement support must also be available and take account of the extended family and community members who will relocate to care for or visit their loved one.

- An increasing number of frail aged from remote communities come into regional or metropolitan areas to access medical services. There are few facilities in regional and metropolitan SA that adequately cater for the needs of this group. There is a need to review the appropriateness and availability of existing services and plan for increasing demand.

- The choice of aged care services available to Aboriginal people is limited, particularly in remote and very remote communities.

People from Culturally and Linguistically Diverse (CALD) Backgrounds

In 2006 it was estimated that there were nearly 49,000 people in South Australia aged 65+ who were born overseas in a non-English speaking country, representing 21% of the total older population. By 2016, this figure is projected to reach nearly 58,000. Over this period, the 80+ CALD population will increase significantly, both in number and as a proportion of the total 80+ population, which has significant implications for the demand for services by this target group.

South Australia has a very well established and long-standing CALD community aged care service delivery sector. Through the HACC Program, some 45 ethno-specific agencies are funded, covering more than 20 CALD groups. These agencies range from well-resourced, large organisations delivering a range of services across the full aged care spectrum (from HACC to residential care), to very small, solely volunteer based associations which receive about $5,000 per annum in HACC funding.

About one quarter of the CALD HACC funded agencies are volunteer based groups providing social support, friendly visiting, transport and centre based meals in a club environment. Most of these services are managed and administered by ageing volunteers who are often well into their 70s and even 80s.

Many of these agencies see their roles as an integral part of the community. The role of "service provider" is not well understood or performed in a way that mainstream agencies perform it (particularly when it comes to formal issues of quality and accountability). These groups have voluntary boards of management, many of which struggle with the focus that government puts on standards and accountability requirements. The boards of management are usually comprised of well meaning community members, but sometimes they do not have a good understanding of governance standards, government requirements, the community care system or the formal aged care sector (including residential care).

Paid staff in such organisations are often not well supported by their boards and as a consequence conflict can often arise where workers and committee members differ in their priorities, interpretations and loyalties. Additionally lower levels of pay compared with other non government organisations create difficulties in attracting appropriately skilled staff and their retention.

Despite these inherent difficulties, the ethnic community sector plays a very important role in assisting their older members to continue to live in their own communities. This in turn helps people to maintain their physical and emotional well being, perhaps delaying or reducing the need for formal services.

It is critical that an aged care system for the future supports small volunteer based organisations as they are most likely to be responsive to the needs of their community and deliver a cost effective service. Support includes ensuring that the regulatory administrative and reporting burden is sustainable and that governance and training support is provided to assist in both the delivery of quality care services and their sustainability.

Culturally appropriate care extends to residential facilities. There has been a consistent message from the multicultural communities in South Australia about the need for improved service responses to older CALD people in residential care. In particular, there are issues around the isolation of residents who are in facilities in which no-one speaks their language. Another frequently cited issue is the need for culturally appropriate food.

Funding for Aboriginal and CALD community organisations

In 2006, as part of a funding allocation reforms process introduced for the HACC Program in South Australia, DFC introduced Direct Allocation as the method of allocating growth HACC funding to Aboriginal and CALD community organisations. Direct Allocation is a process whereby the funder negotiates with an identified service provider to deliver identified services. A funding submission is jointly developed by the funder and service provider for Ministerial approval. Until these reforms were introduced, the HACC Program in SA had only used Open Submission processes to allocate growth funding. This process had disadvantaged Aboriginal and CALD community organisations, which usually do not have the same level of infrastructure or resources as other service providers and find it difficult to compete with them for funding.

The use of Direct Allocation for Aboriginal and CALD organisations is strongly supported by the HACC sector in South Australia. The South Australian Government proposes that specific funding streams for Aboriginal and CALD community organisations are maintained and that the Direct Allocation model is used as the means of allocating growth funding to these organisations.

Retirement Villages

In South Australia the retirement village industry generally interacts well with the aged care system, with residents being able to access HACC and packaged care within their homes.

The *Retirement Villages Act 1987* regulates the content and operation of residence contracts, dispute resolution processes and provides for proper consultation between operators and residents. When a resident of a retirement village needs to move into an aged care facility, the Act provides for the early repayment of the premium to enable the accommodation bond to be paid without causing the resident financial hardship.

In South Australia retirement villages predominantly fall in the category of Independent Living Units and in the vast majority of villages are cluster groups of housing. Of the 483 villages in South Australia 399 (83%) contain less than 49 residences on site. There are only 14 broad-acre type villages. There has been 5.2% growth in retirement villages in South Australia over the past three years. This growth is expected to continue as the industry adapts its product to appeal to the newer retiree, with a focus on remaining in the local community, active ageing and provision of lifestyle villages.

The regulation of retirement villages should not be aligned more closely with the aged care system. Rather, the investigation of the introduction of an accreditation system for retirement villages may be of more practical use and benefit residents. There is a voluntary accreditation system operated by the Retirement Villages Association (RVA). It is noted that there are minimal complaints regarding village practices from member villages of the RVA. The RVA promotes best practice within the industry. The vast majority of complaints coming from independent villages relate to the interactions between the village manager/staff and residents. The development of an accreditation system which incorporates best practice might assist in alleviating such concerns.

Although retirement villages are an independent living option, one of their greatest strengths is that they are often a source of strong community support to residents. The value of such support cannot be overestimated in contributing to the wellbeing of older people. In South Australia, only 8% of villages provide home support services to residents. These are predominantly serviced apartments or flexi-units, where residents are able to purchase additional services such as meals, laundry and linen changes.

Housing and Community Planning

Housing is a Key Theme of *Improving with Age*: *Our Ageing Plan for South Australia* (the Ageing Plan). The availability of affordable, appropriate and well-located housing is the benchmark, and supporting people stay in their homes is the goal. The Ageing Plan acknowledges that housing needs change with changing life circumstances. The Plan affirms that the State will collaborate with the Australian Government and non-government sectors to identify ways to reduce the need for institutional care and investigate and develop options for ageing at home, rehabilitation and transition care.

Housing affordability has decreased dramatically in Australia, with many lower income earners (especially women) locked out of the housing market. Traditionally, home ownership has been seen as a way to save for the provision of care in retirement and old age:

> *"[T]he Australian Welfare System is predicated on the assumption that older persons will be owner occupants and that their tenure will lift them out of poverty in their older age. For an increasing number of Australians though this is not a reality, with many people falling out of home ownership through divorce… especially women… many low income older tenants [have] insufficient income to cover their food and other living costs and [look] to nursing home accommodation as a solution to their housing needs in the near future."[13]*

Along with the decrease in housing affordability, there is also a lack of accessible housing suitable to the needs of persons experiencing age-related frailty or disability. While there has been a growth in private sector accommodation, e.g. self funded accommodation in retirement villages, very few parts of this market provide for low income individuals who are not home owners, and able to sell their home to finance their entry into such accommodation.

Increased options for low cost social housing also needs to be factored into planning to ensure that the most disadvantaged older people in our community are appropriately housed, whether in community or residential care settings. At the same time, holistic urban planning should ensure that such housing is well integrated within the planning for well located social services, safe and accessible public transport and community facilities.

It is important that alternative, affordable retirement specific housing models are developed to complement the traditional retirement village accommodation. Such models must also cater to the needs of Aboriginal people and people from CALD backgrounds. There are a diverse range of best practice examples of housing models for older people which can be

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[13] Tually, S., Beer, A., and Faulkner, D. (2007) Too Big to Ignore: Future Issues for Australian Women's Housing 2006-2025 pg 56.

drawn on. These include Wintringham, Victoria; Burbank Artists Colony, California; Humanitas – Apartments for Life, the Netherlands; National Lifestyle Villages, WA; ExtraCare, UK; and Darwin Court, UK.

Universal housing design is important in supporting older people to remain in their own homes for longer and delay their entry into residential aged care. Universal design in housing will be increasingly important to meet the housing needs of our ageing population over the next 40 years. It is acknowledged that National Guidelines for Universal Housing have recently been released. South Australia proposes that work be pursued collaboratively across jurisdictions on strategies to increase the supply of universal design housing.

Universal design in the public realm (i.e. footpaths and public spaces) is also important to ensure that older people with limited physical mobility (and no access to a motor vehicle) can still walk or use a gopher safely to access local services. This is supported strongly by the South Australian Government through the *30 Year Plan for Greater Adelaide.*

Who Should Pay and What Should They Pay For?

Clients who can afford to pay should make a contribution to their care costs. Co-contribution increases the resources and sustainability of the sector. Within this, safeguards will always be needed including waivers or adjustments for people unable to pay contributions so that no person is denied a service due to inability to pay.

Within the current community care system there are disincentives for people to move to more appropriate care levels if their needs increase (i.e. from HACC to CACPs) because of higher fee structures for similar services. This either results in people receiving insufficient care for their needs or in high levels of support being provided through HACC, thus reducing the capacity of the program to support people with lower level needs. Reforming current community care programs and packaged care and establishing a continuum of care based on assessed levels of need would assist in resolving these types of barriers to appropriate care.

In relation to residential aged care, the current difference in payment arrangements for people entering high and low level care is an anomaly and creates inequities for clients and financial difficulties for residential care providers. Low level care clients are often unable to raise a bond. This includes low income, non-home owners as well as those where family members may remain in the family home, thereby preventing its sale. There are multiple scenarios where access to residential care is critical for a low needs client, such as when the home is not a safe place or services can not

be delivered to the home due to location such as remote and rural communities. High needs clients by virtue of their level of need should have guaranteed access to the required level of care, either in the home or in a residential care setting.

Consistency in a fees framework across community and residential care is essential for a national system. The actual schedules are unlikely to be identical across all levels of care, but transparency and equity of like contributions for like needs and services provided should be applied. National research needs to be undertaken to ascertain the true cost of care in order to determine funding for care levels.

Different models of publicly funded, consumer-directed aged care programs exist in various countries including the Netherlands, Germany and England. These range from programs funded through non-means-tested social insurance programs financed by national premiums to means-tested programs operated by local governments, largely funded by national governments[14]. Such models need to be explored in the consideration of any consumer-directed care program for Australia.

What Role for Regulation?

Regulation for aged care should be focused on consumer protection through service standards, accreditation, and complaints mechanisms. Regulation needs to accommodate consumer driven service provision and support small and volunteer organisations.

The introduction of Common Community Care standards is welcomed by South Australia as a step toward standardising regulatory requirements in terms of quality standards. However, the new standards and associated appraisal procedures are yet to be introduced and will need to be monitored to ensure that they do deliver promised outcomes in terms of streamlining and red-tape reduction for service providers.

A robust regulatory system needs to be complimented with an accessible and responsive complaints and advocacy mechanism. There are robust complaints mechanisms in place for residential care, which are planned to be further strengthened as a part of the NHHRC process. However, the same cannot be said for community care services, where there are no centralised or standardised complaints processes.

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[14] Wiener, J et al, Consumer-Directed Home Care in the Netherlands, England and Germany, October 2003

One difficult form of regulation is HACC funding and reporting by designated service types. This leads to contracts with funded service providers where the provider is locked in to the provision of a particular service type, rather than being able to respond freely to the needs of older people. It is questionable whether it is, or should be, of interest to Government whether the service provider provides more or less of domestic assistance or personal care or social support. It is of more interest that the consumer's needs are being met, rather than the minutiae of 'how' the needs are being met.

As presented above in this submission, residential aged needs to be reformed to enable a more responsive service that meets demand.

Older people and their families would be able to compare and choose aged care providers on the basis of quality as well as price, location and facilities if the aged care providers made publicly available standardised information on service features. This increase in transparency of service provision will require further work and considerable debate on practicality, quality of information, fairness and potential for the distortion of service delivery (e.g. services self selecting clients with less complex needs). The responsibility of the Commonwealth and Aged Care Standards and Accreditation Agency to ensure objective, comparable and reliable appraisals will be even more critical.

Roles of Different Levels of Government

The reforms to the roles and responsibilities of the Australian and State and Territory Governments as agreed at the April 2010 COAG meeting is strongly supported. However South Australia remains an important stakeholder on the delivery of aged care and support. South Australia will continue to be a provider and funder of services, including allied services such as transport, health, housing and urban planning.

As a key stakeholder in the delivery of aged care services to our citizens and having strong knowledge of the needs and resources across our diverse communities, it is important that the Government of South Australia retain a role working with the Commonwealth Government on the planning and service management for aged care.

The South Australian Government along with other jurisdictions retain primary responsibility for services delivered to people with a disability up to age 65, at which point a person's care will become the responsibility of the Australian Government. This interface will be critical in delivering the care needs for this cohort. Accessing the State's expertise in the needs of, and service delivery to, people with a disability will be a vital element to delivering high quality and continuity of care.

South Australia proposes that State and Territory Governments continue to have a key role in supporting the Australian Government to plan and deliver high quality and responsive aged care services. This should extend to ensuring allied State and Territory based services such as housing and transport, support aged care objectives.

A Workforce to Care for the Elderly

According to the Australian Bureau of Statistics, there were about 19,500 people employed in the aged care sector[15] in South Australia in 2009. Over the past 10 years, employment across the sector has grown by about 7,000 (or more than 55%). The aged care workforce is predominantly female (accounting for more than 85% of employment) and is older than the all-industry average (56 per cent of the workforce are aged 45+ compared to all industry average of 40 per cent).

The aged care sector in South Australia has a higher proportion of the workforce with a qualification, with over 60 per cent holding a non-school qualification – compared to the all industry average of 52 per cent. The main qualification held within the aged care sector is a Certificate III, although there is a large proportion with higher education qualifications.

Given South Australia's older and faster ageing population profile, the aged care sector is expected to continue to grow in the future. According to the South Australia Training and Skills Commission[16], there will be about 6,500 job openings (from employment growth and the replacement of older workers) in key occupations[17] aligned to the aged care sector over the next five years.

Within the broader health and community services industry, increasing levels of chronic disease and increased focus on prevention are providing a major impetus for change. Other drivers for change include redesign of services to be more client-centred and better integrated, increased provision of care in home and community settings, and technological innovation.

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[15] For the purposes of this paper, the aged care sector has been defined by ANZSIC 860 *Residential Care Services*. Residential Care Services includes both aged care and other care services; however, based on Census information aged care accounts for more than 95% of employment in the Residential Care Services sector.

[16] South Australian Training and Skills Commission, *Skills for Jobs*, November 2009

[17] Key occupations include: Registered Nurses, Aged and Disabled Carers, Nursing Support and Personal Care Workers and Enrolled and Mothercraft Nurses.

Workforce Challenges

Attraction and retention of staff is an on-going challenge for the aged care sector, particular issues are:

- pay is relatively low e.g. nurses earn significantly more in acute care than in aged care, carers are low-paid;

- image of the sector is not as appealing, due to prevailing stereotypes and negative attitudes toward ageing;
- perceptions that the aged care industry has a flat career structure, with busy, demanding and repetitive work;

- age of workforce affects retention, people tend to enter the sector at an older age part-time and casual employment negatively affect capacity to use traineeships;

- the ageing workforce also contributes to potentially higher rates of injury for direct service delivery staff, due to lifting etc;

- increased skill requirements including medication management, dementia care, falls prevention, pressure care, infection control, oral health, nutrition, palliative care; and

- the need for a culturally diverse workforce to match the diversity of the client base.

Industry Workforce Planning and Development

Government policy, regulation and funding substantially shapes and controls the nature of services delivered in the sector, including the occupational profile for services. The Council of Australian Governments (COAG), the Australian Government and the South Australian Government have embarked on key reform agendas with significant workforce implications, in areas such as health, mental health, early childhood development, Aboriginal health and well being, housing and homelessness services, aged care and disability services.

From a workforce perspective, it is important to consider the aged care sector in the context of the broader health and community services industry, as there are interdependencies of services and occupations. There are significant areas of interface between ageing and other needs such as disability, health, mental health, Indigenous and CALD community needs.

There has been a significant shift in the service mix over the last decade with a much greater emphasis on community based services and ageing. Workforce planning[18] has identified a number of workforce issues relevant to, or directly associated with the aged care sector. These include:

- services need to be reshaped, with greater focus on health promotion, restoration and rehabilitation and a more holistic approach to the evolving needs of older people;

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- the changing needs and expectations for older people, for example, older people accessing services have more complex needs: chronic disease, depression and dementia (the number of people with dementia will double by 2030);

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- interface with other sectors is becoming increasingly important, for example health, transport, housing; and

- use of technology to assist staff (administratively and in other aspects such as manual handling and outreach services for ageing in place).

Other issues are:

- the re-design of services toward a client-centred approach should lead to greater workforce productivity. It will require enhancing coordination and effectiveness of existing institutional systems and practice through the development of new models of care[19];

- importance of the sustainability of services;

- the need to develop and promote positive brands and career pathways between sectors, being mindful of the diversity of the existing and prospective workforce and the need to promote career pathways;

- the need to develop, promote and evaluate sector-specific attraction, orientation and transition resources and programs, targeted to a variety of key population groups (eg older men, younger men, women returning to work, people from CALD backgrounds, Aboriginal people, people with a disability); and

- the need to identify and promote positive examples of organisational policies and workplace practices that support:

    o work life balance, including for carers and mature workers;

- o workforce diversity and inclusivity across both culture and age;

- o resilience, openness and agility in the change process;

- o recognition of and rewards for high performance;

- o management of the impacts of work in challenging fields;

All of these shifts have implications for the staffing mix and for skills, as well as for service design. There will be continued need for up-skilling, and the broadening and deepening of skills for all staff. This does not necessarily mean higher qualifications, for example, there is a greater need for skills in lifestyle support, health promotion and an increased role for allied health professionals.

There is also a significant need to increase leadership and management skills, including areas such as, risk management and occupational, health and safety management. The promotion of positive examples of organisational development strategies that impact on employee engagement and retention (for example, work life balance) are also seen as very important in aged care as part of a cultural shift.

As previously mentioned, there is also a significant unpaid carer and volunteer workforce engaged in aged care in South Australia which suggests that official statistics of the workforce may significantly underestimate the total quantum of effort required to deliver the services needed, including the quantum of education and training for unpaid carers and volunteers.

South Australia proposes that the Australian Government develops a workforce strategy that includes:

- recruitment to address the forecast industry needs;

- building the sector's skills and capacity to meet community expectations and work effectively with allied sectors;

- cultural service delivery for CALD and Aboriginal people;

- promotion of the sector as a rewarding career;

- building career pathways with allied sectors; and

- tailored support for volunteers including carers.

More broadly a more robust and sustainable approach also needs to be developed to support the increasing demands on informal carers, particularly those who are employed in the broader workforce, to enable them to manage their caring responsibilities and remain in employment. This is a key issue for the future to minimise any adverse affect on national productivity as our population ages.

Transition Issues

The primary issue at this stage with regard to transition relates to continuity of services, for both clients and service providers. The focus of any transition needs to be on the experience of the client – i.e. that there is no disruption to their service, and that the outcome is an improvement in system response.

Already, uncertainty regarding the transition arrangements has led to a reduction in the length of funding contracts that States are able to offer service providers, which has led to uncertainty in the sector and a reduction in the length of employment contracts some employers are able to offer employees. This has direct flow on effects for clients. The Australian Government has also indicated that they will not be able to take over State funding contracts, without a procurement process to decide which services can be provided by which providers. This will create further instability in the sector and leaves open the possibility of some people being unable to continue services with their current provider as well as the need to source alternate providers for some services which may not be possible if they are highly specialised (e.g. CALD, Aboriginal).

It is critical that transition is preceded by developing a clear view of the model or models to which the sector is moving, taking account of the best features of the current system and learnings from previous consultations, studies and reviews. Transition needs to take account of related critical interfaces, especially including health and disability.

In South Australia, the HACC Program funds several small, volunteer based ethnic community groups, as well as Aboriginal community organisations and non government services for other specialised groups, such as people in supported residential facilities and homeless people/people at risk of homelessness. The South Australian Government has invested a lot of resources into building the capacity of such groups so that they can receive funding and address government accountability requirements. Such groups add significant value to the service system and it is important not to lose this capacity when the program transitions to Australian Government control.