Caring for Older Australians

Australia – Ageing Well

An informed submission from IRT.

July 2010

IRT 40 YEARS
engaging hearts & minds

Initial submission to the Productivity Commission Inquiry – Caring for Older Australians.
Current at 28th July 2010

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About IRT:
IRT is Australia's largest not-for-profit, community based aged care and retirement living provider*. It has been providing care, services and accommodation to older Australians for 40 years. IRT manages villages more than 30 locations across the Illawarra, South Coast of NSW, Sydney and Canberra. It serves the needs of more than 5000 residents and clients.
(*BRW Nov 2008)

IRT 40 YEARS
engaging hearts & minds

Executive Summary

IRT has a vision where older people within our community can easily access the care and support they need to live enriched and fulfilling lives in an environment which encourages independence.

To make this possible, Australia needs one integrated aged care network which is accessible to every senior regardless of their background, health needs, financial capacity or where they reside.

This clear framework would provide ageing people with real choices and self direction through a journey often marked by significant and compound challenges and change.

While less than 10% of older Australians will ever require support from an aged care service, their care is becoming a prominent issue in the wake of our growing aged population and media reports highlighting nursing home breaches – frankly, it's about time.

We would all agree that supporting our seniors, particularly our more frail elders, to the highest standards of dignity and respect is a societal responsibility and a best measure of a humane society.

But providing quality aged care requires a whole-of-government approach to create visionary policy that empowers yet protects our seniors, and consumer directed funding that is responsive and flexible to the individual needs of each person. Older people are not a homogenous group – their individuality does not cease the day they require care.

There is no doubt our current system is failing our seniors, particularly when it comes to residential care.

When a "nursing home" is not reaching aged care standards, the media, politicians and accreditation bodies are quick to jump in "to protect our frail and elderly citizens". There are truths behind "the story" that are never revealed because it's complicated and politically unpalatable. Yet this is the very reason why many providers struggle to stay afloat and provide the care our parents and grandparents not only need, but deserve – let alone the capacity to explore innovative solutions to assist them to age actively, independently and with dignity.

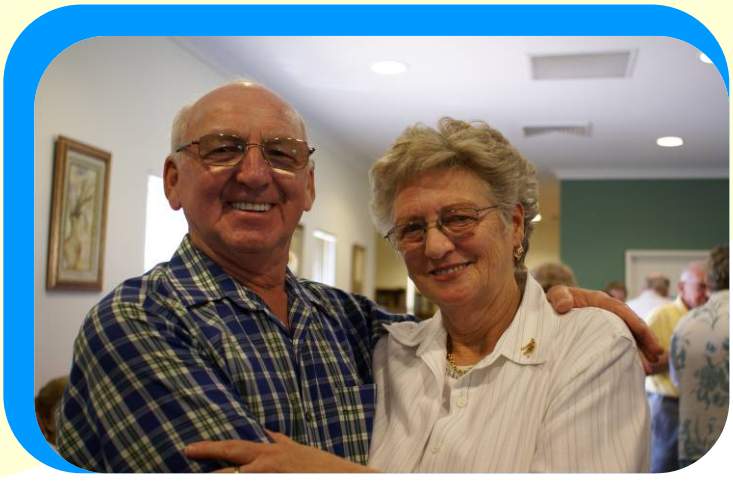
Fact 1: The Federal Government is the dominant funder of care for aged people either within their home or in a facility and yet the funding provided doesn't match the cost of care, let alone keep pace with annual rising expenditure such as recruiting, retaining and training staff. As an example, this year aged care funding was increased by 1.7% with great fanfare by the Minister, however, the common man knows that the cost of living increased by 2.8%. This disparity has been consistently the case for more than a decade. The maths is simple; the real dollars available to care for frail seniors continues to be eroded.

Fact 2: In order to receive care, an older person must negotiate a complex matrix of assessments and prove they need assistance. It's a system that can delay appropriate care for months, no matter whether they start the journey at home, in hospital or in an aged care facility. If that isn't bad enough, the older person must then jump through the hoops again every time their ageing body tells them they need a little bit more help. If they don't do this they don't get funded to receive care.

Fact 3: Aged care facilities must meet remarkably onerous safety and health standards when caring for ageing people. Whilst providers, residents and their families would not dispute the need for high quality, the checks and balances should be streamlined and focused on empowering the resident to make choices, not take their independence away. The current system talks of individual choice for residents, but in practice inhibits standard liberties, such as the choice to eat soft boiled eggs, rockmelon and strawberries because they cannot be sterilized to meet stringent Food Standards.

IRT welcomes this opportunity to assist with the reform of aged care and recommend areas for investigation or solutions that focus on empowering older people; that support independence rather than dependence and fund a collaborative approach to supporting seniors in our community.

We submit the following proposals to facilitate reform that enhances the sector so that our seniors can easily navigate and celebrate the journey of ageing whilst remaining in control of their lives.



- Nieves Murray, IRT Chief Executive

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A Vision

IRT has a vision for one integrated Australian Aged Care framework which is accessible to every Australian senior, regardless of location, needs, or financial means, with a clear framework that provides real choices and self direction, and principles which promote independence and wellbeing. This vision also acknowledges the key role accommodation plays in the life and wellbeing of seniors, from 55 years to 105 years, and through a journey often marked by significant and compound changes in lives and health. Every Australian senior should be empowered by the aged care system to have access to suitable accommodation, and the choice of where and how they receive any services they require.

IRT welcomes the opportunity to discuss and assist with the reform of the aged care system and submits the following proposals to facilitate this reform.

> "one integrated Australian Aged Care framework which is accessible to every Australian senior"

Castles and Caring – choose where you live

Separating the provision of accommodation from the provision of care is the first major change required to improve the aged care experience. By distinguishing between the regulations and funding of accommodation and care, the choices become clearer for seniors, meaning they can readily discern where their money goes.

This change is also critical to facilitate further propositions in this submission around consumer-driven care and provider accreditation.

Building Code of Australia (BCA) Options

Currently, residential aged care buildings are the sole development type in Australia to be regulated by legislative requirements additional to the BCA. Neither hospitals nor other highly complex buildings face such a superfluous burden. The Federal aged care certification requirements almost entirely mirror the BCA requirements, creating unnecessary red tape and inefficiencies. In fact, each certification process adds approximately $20,000 and 4-6 weeks to any construction or alteration process[1]. The primary role of certification as a trigger for bed licenses can also be made redundant if a move to provider accreditation is embraced (discussed further under "*Shaping the System – untangling the web*").

As a part of this regulatory amalgamation, the opportunity presents for any development to be classed as "supporting ageing". As such, the requirement of providers to supply ageing-friendly accommodation can be extended to include current self care or retirement village developments. This will ensure the transitions between care levels require minimal disruption to the senior's life, as developments catering for "over 55's" or "retirement lifestyle" would also have to comply with the amended BCA provisions. Once this consistency of regulation is achieved, a rating system akin to the sustainability ratings of buildings can be implemented to clearly communicate the "supportive ageing" status of the development to the potential market of seniors.

[1] IRT Data 2010

Service Delivery Framework

Mirror Housing Supply

The composition of tenancy options in retirement living, across all care levels, in each region should reflect that of the wider housing tenure profile in each region. This would ensure that the supply of affordable housing options for seniors is in-line with the requirements of the community. It is envisaged that these ratios will be set regionally and adjusted after each relevant Census release. For example, the current figures for the Illawarra indicate that 55% of residents are paying off their home, 26% fully own their home, 14% privately rent and 3% are renting from a state or community housing organisation[2] (Further breakdown of this by age would provide a more representative ratio to guide regulations in the Illawarra). This could translate to 3% concession accommodation places, and14% rented with the remainder subject to accommodation charges.

"choices become clearer for seniors"

Person-centered Care

Once care is no longer tied to accommodation seniors are presented with more choices and more control about their ageing journey. This also benefits providers and regulatory bodies as it crystallizes the person's needs as the centre of the aged care experience rather than trying to fit them into pre-determined options.

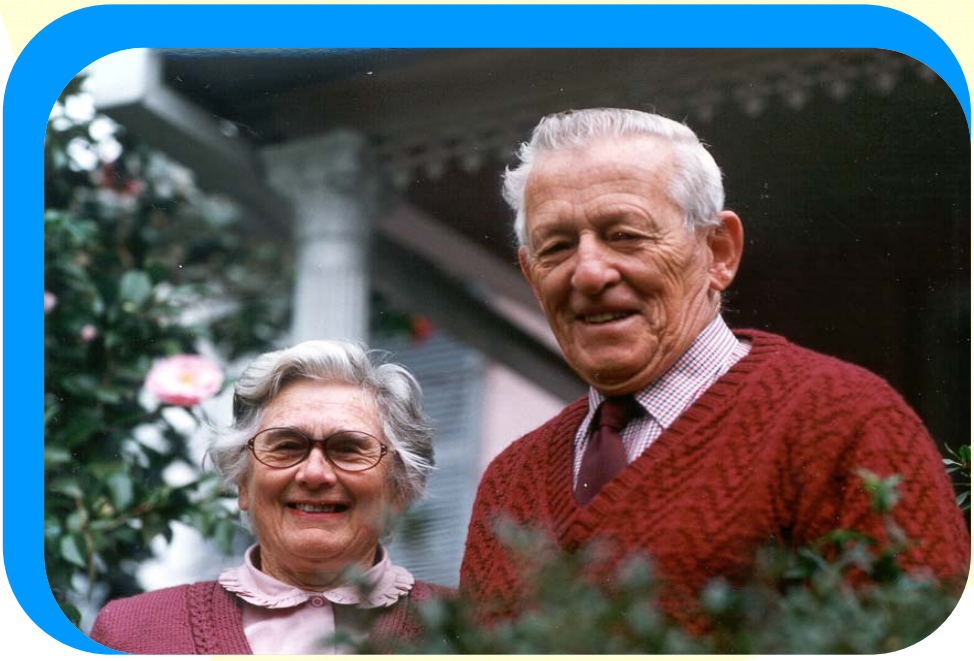
The practicalities of this proposition are discussed further under "*True North – navigating the journey*".

[2] ABS Census 2006

GPs and Geriatricians

Nearly three quarters of aged care facilities report difficulties obtaining GP input at least some of the time for routine tasks, such as reviewing medication charts, prescriptions or general support.[3] The solution for this is not found in the proposed $96 million increase of financial incentives to GPs reporting attendances to residents of aged care[4]. In fact, this doesn't even specify that the attendances must be within a residential facility. A systematic approach ensuring that no Australian senior goes without a GP is required. This could be achieved through the establishment of a Geriatrician network based around regional demographic profiling, meaning the greater the ageing population the higher number of government funded Geriatricians.

Geriatricians are currently tied to Area Health Services and act as consultants to the health system. This role should be expanded to include consultation with local GPs and aged care providers to ensure all seniors have GP access where it suits their needs. The Regional Geriatrician could be responsible for liaising with doctors who have closed their books, or as a last resort, could provide the services themselves. This mandated role would be further supported by nurse practitioners who have the capacity to operate autonomously within aged care. The entire system would ensure seniors have access to medical services, choice in the delivery of those services and higher overall standards of care received.



[3] A National Health and Hospitals Network: Further Investments in Australia's Health, Australian Federal Govt, 2010
[4] A National Health and Hospitals Network: Further Investments in Australia's Health, Australian Federal Govt, 2010

Service Delivery Framework

Spotlight: Great Danes

The Danish aged care system is underpinned by social policy that, since World War II, has created a welfare state essentially supporting all Danes from 'the cradle to the grave'. Services and benefits are universal and financed through public taxes. Most services are provided free of charge and care services are delivered at municipality level.
Danish ageing policy is based on the idea that the type of housing should not decide the care and other services to which dependent people are entitled. An individual's needs should determine the care given. This care is provided in either the elderly person's own home or in an 'elder home' as they are called.

Denmark merges the delivery of health and social services to the elderly with the aim of overcoming conflicts in professional roles between nurses and social workers and also to provide a more flexible approach to each case. Service coordination includes multidisciplinary teams working across care settings, with service responsibility decentralised to small areas through health centres and common training programs[5].

In-home and residential care is well interfaced, with both forms of care focusing on physical fitness and accommodation kept separate from nursing. In residential facilities nursing care is coordinated through community nursing services, and residents are able to buy additional "food", "laundry" and "domestic" packages. All Danes over the age of 75 are advised of the services on offer, with a district coordinator visiting them at home twice a year. In both instances, the nursing care received is free to the senior.

[5] Korzyk S (2004). Long-Term Workers in Five Countries: Issues and Options. AARP, Washington

Willing and Able – independence and capability

By separating accommodation and care, the health system will be free to focus on optimising the provision of care for all Australian seniors. This would result in an aged care journey that would empower our seniors to be the boss of their ageing journey. Several further suggestions for the operation of this new care framework are outlined below.

> "an aged care journey that would empower our seniors"

No Levels, Just Options

Removing the distinction between levels of care (Self, High, Low, CACP, EACHD, EACHD, etc.), and the caps, funding and regulations associated directly to them, will simplify the process. This would be a user-pays system in which care recipients have assets and income assessed separately, and contribution levels determined accordingly. Special provisions would be available to financially disadvantaged seniors. With consistent minimum standards in place across the spectrum of services, a consumer then has the choice to choose the type, level and location of the services they want according to their individual means, this means the minimum contributions are not automatically set by the senior's needs, but are tied to both the care chosen, and the financial means available to the person. Accessibility to services should be and would be universal and market driven, with assistance to provide equitable access for seniors with lesser financial capacity.

Service Delivery Framework

Rural and Regional Service Provision

Key challenges in the provision of care in isolated locations include: service costs stemming from of time and transport, staffing issues (addressed later in "*Employing Integrity – smart staffing strategies*") and a lack of technology to facilitate connectivity. Possible initiatives include:

- Government subsidising of rural/remote care recipients at a higher rate than their metropolitan peers to cover additional servicing costs;
- Partnership between providers and commercial technology sector to deliver eHealth and Telemedicine efficiencies, either in-home for individual care recipients, or collectively at community service hubs, with groups of seniors sharing the service and cost. This assumes the provision of broadband network services in rural communities is a Government priority;
- Government to cover the upfront building cost of small facilities (either residential aged care or other community structures) in remote areas. Providers can impart their expertise on appropriate design, including the implementation of technological solutions such as SMART housing options to service the wider area;
- Providers can tender to service the facilities, under the higher subsidised rate mentioned above, and also contribute a nominal leasing fee with the option of buying the infrastructure once operations have proved viable.

Parity In Freedoms

The restrictions placed on current residents of aged care communities are at odds with the freedoms enjoyed by those receiving care in their homes. Policy may encourage 'home-like' environments, but it does not encourage 'home-like' rights and choices. Simple restrictions contribute to the negative stigma surrounding aged care and the reluctance of seniors to move into centres despite the potential health and wellbeing benefits. These suppressions include signing out every time you leave a village and not being allowed to have rockmelon or strawberries as fruit options because of the additional regulatory burdens imposed by Food Authority audits. None of these constraints are felt by those receiving in-home care, even when their shopping or food preparation are provided services. The inequity caused by excess regulations should be removed, with more autonomy given to the individual where appropriate..

Spotlight: Purpose Built Communities

Analysis of IRT's customers showed that on average, seniors living in a purpose built residential community require access to both Residential Aged Care (RAC) and Community Services (CS), later in life when compared to their community peers. When accessing RAC the difference is four years, whilst for those accessing CS the difference is two years.

Supporting this is information from Australian Unity's National Wellbeing[6] Index showing that village residents had an average Personal Wellbeing Index score of 80.3, compared to 77.0, among all older respondents.

However, the most recent ABS statistics 90.2%[7] of people over 65 live independently within their own homes. Stimson's pivotal industry research from 2002 also tells us that this is the preference for most Australian seniors.

There is clearly a tension here where seniors prefer to live in their own homes, even at the expense of their wellbeing and health.

Michael & Frances Trumph are examples of a healthy, independent ageing couple happy living in their purpose-built environment of Kangara Waters, a newly opened IRT facility located in Canberra's north.

The couple say the lessons learnt from their experience with their own parents' final, frail years – helped them decide they didn't want to burden their only-child with big decisions and wanted to be in control of their own ageing options.

The Trumphs bought a villa in an environment which offers care and support either within an in-home environment or in the co-located residential care unit with shared facilities such as heated pools, a gym, café and community centre.

"We only looked at options that offered support and progression, where we were guaranteed care for the rest of our lives," Mr Trumph, 75, says.

"We've never looked back. There's so much to do if you want to but you don't have to do anything. I still play tennis and do weights twice a week and swim daily here. We've made many friends since we came here. We have happy hour and do trips to the coast in the Kangara bus."

Mr Trumph said making the decision earlier supported the couple to re-establish in a new community, with residents aged in their 80s finding it harder to adjust due to their more limited physical capabilities.

[6] http://www.australianageingagenda.com.au/2010/05/17/article/Village-residents-have-greater-wellbeing/WNDLSGGBRI
[7] ABS figures in Stimson, R.J. 2002. The Retirement Village Industry Australia

Service Delivery Framework

True North – navigating the journey

Consumer-driven care is at the crux of our proposed reforms. Essentially the eligible senior requiring care is given the discretion to choose their care delivery mode. Consumer-driven care encourages autonomy, promoting the senior as an equal partner of their care and independence. The staffing, funding and costs incurred all relate not just to the individual's care needs, but also their individual choices.

No Caps or Per Capita Bed Licenses

In order to ensure all persons requiring aged care are able to receive services the current caps on bed licenses, community packages and extra services need to be abolished. The ratios (eg 2.5% of over 70s require a Community Care package) and geographies (ie ACAR Regions) underlying current supply models are arbitrary rather than evidence based. They encourage city-centered care provision rather than services where seniors are located[8]. The end result is seniors living in areas such as the NSW Central Coast or Brisbane North face supply that is concentrated around the coastal centres, while caps on community places and bed licenses often result in seniors moving to a more expensive area, away from their family and support networks. Abolishing caps and bed limits will allow the market to meet demand wherever the senior desires to live.

One Stop Shops

Under the National Health and Hospitals reforms, the Federal Government has committed $32 million to create a network of one stop shops to be a first and central point of contact for people needing information and access to aged care[9]. We applaud this initiative and seek to further highlight how it can assist in the context of our proposals. Rather than becoming assessment centres we see a role in offering information, referrals and coordination of seniors' service requirements. As well as this, the shops could also provide standardised training for assessors, be a community touch point for people looking to work within aged care and act as a marketing arm to promote the sector generally.

[8] IRT LGA Analysis Data 2010

[9] A National Health and Hospitals Network: Further Investments in Australia's Health, Australian Federal Govt, 2010

Case Manager

It is recommended that a case management approach is mandated as a part of the accreditation process. Once a provider has been chosen, a designated representative works in partnership with the senior to generate a holistic wellness plan and maintains periodic contact with the senior throughout their experience. A wellness plan would encompass all aspects of health, personal care and activity needs. Part of the case manager's role may include brokering required services outside the provider's scope of operations, for example lawn mowing or transport, however the provider maintains responsibility for the senior's overall wellbeing, unless the senior decides to move to another organisation.

> "consumer-driven care is at the crux of our proposed reforms"

Facilitate Collaboration

The current ad hoc nature of collaborations between services such as disability, mental health, housing and others, is driven by the constraints of the service provider and the limitations of allied health providers rather than by the needs of the ageing person. This results in duplication of in-home care infrastructure, the shifting of responsibilities, the compartmentalising of service provision, and the relegation of the seniors needs to a lower priority. Compounding this are the funding inequities around the provision of identical services (refer the Palliative Care Example under "*Summing Up For Seniors – resourcing options"*). Seniors are subjected to unnecessary repetitive and onerous processes as a result of this disconnect between services and the overarching deficit model of aged care. The case management approach outlined above elevates the needs of the older person above the system. Further regulatory changes to enhance collaboration are discussed later under "*Shaping the System – untangling the web*".

Service Delivery Framework

Remove Inefficiencies

The duplication of current service infrastructures is debilitating to providers, expensive for government and confusing for seniors. For example, in-home care is regulated, funded and reported under numerous bureaucracies – HACC, VHC, CACP, etc. Whilst the aims of consumer protection are valiant, the senior's desires are lost within the myriad of administrative perspectives. The system should be such that being an Australian senior is recognised first, and then other special needs or considerations of particular groups are taken into account e.g. being a veteran, homeless or having a disability. This would ensure that all Australian seniors are provided seamless transitions across all services.

Spotlight: Red Tape Transport

Jean Weston and Eve Jones share much in common at Peakhurst Retirement Village, where they both moved to "Age in Place" in their independent living units more than 10 years ago.

At 87, Mrs Weston attended a local Stroke Support Group to tap into the unique services it provides, including social outings and group networks. In a similar way, Mrs Jones, 94, participated in a shopping group and social outings with another organisation. Both women made a contribution to these HACC funded services to maintain their ties to the community and receive necessary support.

As the neighbours began to experience more age-related health issues their needs led to an ACAT assessment that resulted in them each receiving a Community Aged Care Package. Despite their ageing, both Mrs Weston and Mrs Jones maintained a positive, active lifestyle, looking forward to their regular outings.

Both the women were then shocked to be told they would no longer be "allowed" to access the HACC-provided services, all because of the tick of a different box which they thought would provide them with more support for their increased needs. This was unfortunate as the services they received were unique to HACC and unable to be replicated by their community care provider, IRT.

"I just don't understand how they can take services away from me as I age?" Mrs Weston said.

Luckily IRT's community ethos has meant that the provider has covered the majority cost of the HACC charges for the now non-eligible service. In doing so, IRT are paying well beyond the actual total care costs for both these women.

Funding and Regulatory Arrangements

Summing up for Seniors – resourcing options

The current Aged Care Funding Instrument (ACFI) is annually indexed in such a way as to fund failures. Existing formulas are inherently flawed as they are designed to fall short of CPI and annual wage increases. Amendments are required urgently, with adjustments to existing formulas and the introduction of new initiatives to ensure the sector is adequately supported. Australia requires a healthy and growing aged care sector, and providers need to have financially viable services in order to leverage into the new and more diverse services that will be demanded in coming years.

Accommodation – User Pays With Flexibility

Contributions should be paid by all people receiving care where they are in a position to do so. A means-tested scale could provide the minimum amount, with families allowed the flexibility to "top up" or contribute additional funds for a higher accommodation standard. For seniors with less financial capacity the mirroring of housing tenure proposed earlier will provide affordable options.

Care – User Pays and Concessional Places

The current pilot of Consumer Directed Care in Community Care Packages is suggested to be expanded to apply to all care recipients. This would allow for a means-tested contribution, not dissimilar to the current system, as well as giving the individual control around the allocation of their care budget. Those who are unable to afford the care level they require should not be neglected, with current concessional placement ratios and ACFI supplements increased to reflect the true cost of care. For example, current subsidies sit between $20.16 and $26.88 per concessional place, where the cost for care (excluding operating costs) is between $41 and $119[10] (There is also potential to extend the percentage of concessional places, as care contributions would be received across all levels.) Inequities are also evident between Government support of Hospitals compared with Aged Care providers (please see *DRG - Palliative Care Example*). The average support payment received to maintain the care of an older person in hospital is estimated to be about $700 per day, compared to about $110 per day in residential care.[11]

[10] Stewart Brown June 2009
[11] A National Health and Hospitals Network: Further Investments in Australia's Health, Australian Federal Govt, 2010

Funding and Regulatory Arrangements

Insurance Options

Approximately a quarter of Australians over 55 access in-home or residential aged care.[12] This means it would be grossly unfair to burden the general population with a non-refundable levy along the lines of the current superannuation set up. An alternative would be to work with the insurance industry to establish a form of seniors' cover whereby lifelong contributions are able to be claimed at the aged required. This again gives individuals the choice to prepare financially for their own future care.

> "it is about recognising opportunities for development & innovation"

Reward Investment in Seniors

Several ideas regarding the shift away from a deficit rewards structure are suggested below:

- ATO concessions – the major role that community based and not-for-profit providers play in both aged care and social housing should be recognised.
- Accreditation bonus – under the provider-based accreditation proposal outlined below, continuous high performance in accreditation assessments should be rewarded with a financial bonus, possibly administered via the CAP indexation, or through reprieves in the assessment schedule.
- Innovation Fund – it is strongly recommended that the Department of Health and Ageing formalise a marketing and projects team to administer an innovation fund directed at aged care operations. The recent Deloitte survey found that over 80% of providers run less than six facilities each, a situation that is unlikely to change in the future.[13] An innovation fund would allow for formal and consistent support to initiatives created by innovative operators that have the potential to benefit the industry.

[12] ABS 2006 Census and The Grand Plan

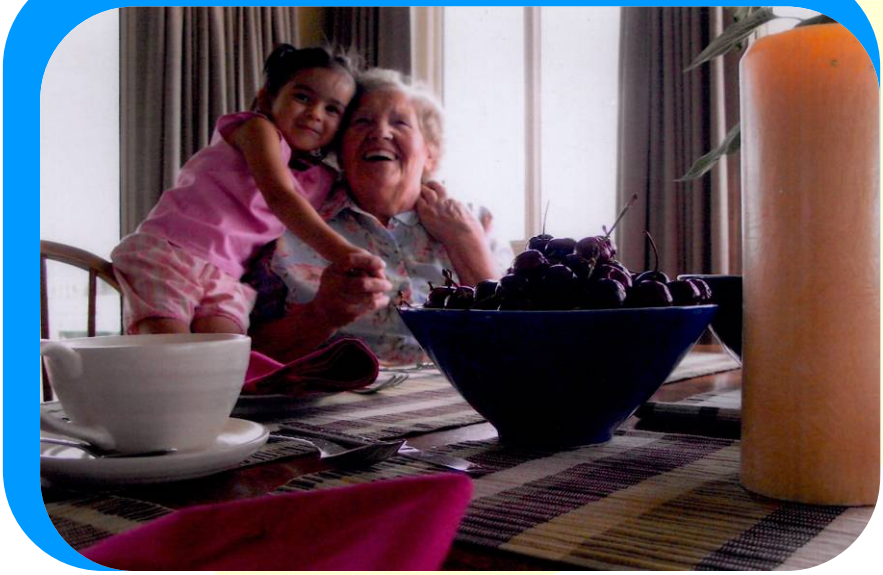
[13] Deloitte Annual survey into the Australian Aged Care Industry 2010

Funding Support

With the removal of distinctions between levels of care, both in residential and community settings, the options between in-home or facility based care should incur no extra care cost for the senior – bearing in mind accommodation charges are proposed to be managed separately.

In order to achieve this, the indexed user-pays system should be applied at the customer end, with government support to ensure the operational cost differences are minimized for providers, thus ensuring a balanced supply range of options in the market. Economic modelling around the cost disparities is suggested, with the aims of clearly indentifying economies of scale advantages for residential care and requirements for the highly demanded in-home care so they can be funded appropriately.

A further and crucial change to the ACFI model is to widen its scope and introduce equity between the 64 funding categories. For example a “High” rating in behavioural needs is only $30.25, compared with $91.47 in Activities of Daily Living & $56.11 in Complex Health Care. The reality is that often high behavioural needs require major resources and this funding does not compensate for this care. It also does not compensate for growing areas of need such as dementia, Alzheimer’s disease and other behavioural diagnoses. At present there is a clear fiscal incentive for providers to care for those with physical difficulties ahead of those with behavioural or mental difficulties. This could also be overcome by changing the ACFI model to centre around diagnostic related groups.



Funding and Regulatory Arrangements

Spotlight: DRGs – Palliative Care

Diagnostic Related Groups (DRGs) are a patient classification system that provide a clinically meaningful way of relating the types of patients treated in a hospital by their diagnosis with the resources required by the hospital to treat the person[14].

Australia's DRGs and their associated cost weights have been developed in the context of advances in medical technology, and the increasing pressures placed on the health system as a result of an ageing population and growing health workforce (labour) costs. In response to these developments, health financing policy has been continually concerned about finding ways to improve efficiencies in the way in which resources are applied.

The use of casemix measures has been actively pursued as a way of dealing with the challenges confronting hospital management and financing. DRGs have represented a significant breakthrough by enabling hospital inpatient episodes to be classified as units of hospital output.

Essentially, they allow for hospital performance to be measured through linking the characteristics of patients treated (outputs) with the resources consumed in producing them (inputs).

Clarence Smith, 75, was in and out of Milton Hospital for two years to receive treatment for his lung cancer until his condition worsened and he was transferred to the palliative care unit at Berry Hospital. Whilst under their care, Berry Hospital received $793 per day to subsidise Clarence's care[15].

Visiting him became a challenge for wife Eileen as she didn't drive, but friends and family gave her lifts so she could spend every possible moment with her husband of 52 years.

It was a relief all round when Clarence was assessed by the Aged Care Assessment Team as being eligible to be transferred back to the palliative care unit at Sarah Claydon Village, a short distance from the family home.

Clarence was visited by his palliative care specialist every three weeks and his doctor every other day. Care staff trained with palliative training and a registered nurse provided daily pain relief, emotional assistance and end-stage support for Clarence, Eileen and their family. He died three months later, surrounded by his family.

Despite Clarence receiving the care he needed irrespective of location, the government funding received for his care in the residential facility was only $188.06 per day[16]- less than a quarter of the funding the hospital received for similar end-of-life care.

[14] http://www.health.gov.au/internet/main/publishing.nsf/Content/AR-DRG-Version_6.0
[15] NSW Health Episode Funding Policy 2008-09, SNAP adjustment for palliative care
[16] http://www.health.gov.au/internet/main/publishing.nsf/Content/New+Funding+Model+for+Residential+Aged+Care-1

Shaping the system – untangling the web

Aged care is unnecessarily complicated for seniors. Simplification is the straightest path to assuring older people that they will have access to the care they need, without compromising their independence. Providers need to be granted the authority to administer aged care efficiently. The sector agrees that a complete review of accreditation, regulation and assessment is required, as evidenced by this inquiry.

Accredit the Provider

The accreditation process should change to accredit an Approved Provider, rather than each village, facility and service. This would focus the regulatory process to an integrated model encompassing residential, community and independent living.

It is suggested there be a single accreditation body to assess all providers. Ongoing random auditing could be developed to support this model, with core mandatory criteria across all streams; e.g. the rights of residents, protection of residents, health and social care needs, quality of life, staffing, the care environment and management and governance.

The accreditation body needs to develop a national set of quality indicators to be reviewed as part of their "risk management approach", as measured against industry-agreed standards. This approach recognises that risk is not always about "what can go wrong", but that it is also about recognising opportunities for development and innovation of an organisation based on overarching principles such as openness and transparency, outcomes focused, person-centeredness and evidence based practice.

This approach would inform the accreditation body on where resources are required to audit systems far more effectively than knee-jerk reactions to newspaper exposes. Despite having a much narrower focus, WorkCoverNSW has made inroads in developing an aged care specific OH&S risk assessment tool[17], while international models such as the Irish National Quality Standards (illustrated below) can be considered for more overarching insight into developing an industry tool.

[17] http://www.agedcareohs.info/pages/ohs_manage/risk_assesment_tools.html

Funding and Regulatory Arrangements

Remove ACAT

The current ACAT process imposes unnecessary time burdens and duplication of bureaucracy. Under a provider-based accreditation system, the Aged Care Assessment Team will not be required to assess individual seniors prior to their receipt of services, as this would be done by qualified assessors employed by providers and monitored as part of their overall accreditation and validation framework. As provider-based employees they will be responsible for ongoing assessments of seniors' changing needs, a task made manageable by the introduction of eHealth identifiers, accessible by all of the senior's health advocates, assuming permission is granted.

This shift in responsibility will alleviate lengthy delays and reduce mistakes that frustrate both consumers and providers. It will also unravel complicated funding adjustments as the seniors' needs change. Furthermore, it will eradicate duplication of resources for government, allied health providers and aged care providers. This means seniors will no longer face multiple assessments in order to receive care.

Complaints Process

It is acknowledged that an external complaints mechanism is required, however currently there is no obligation from a consumer perspective to raise an issue with an Approved Provider before contacting the Complaint Investigation Scheme (CIS).

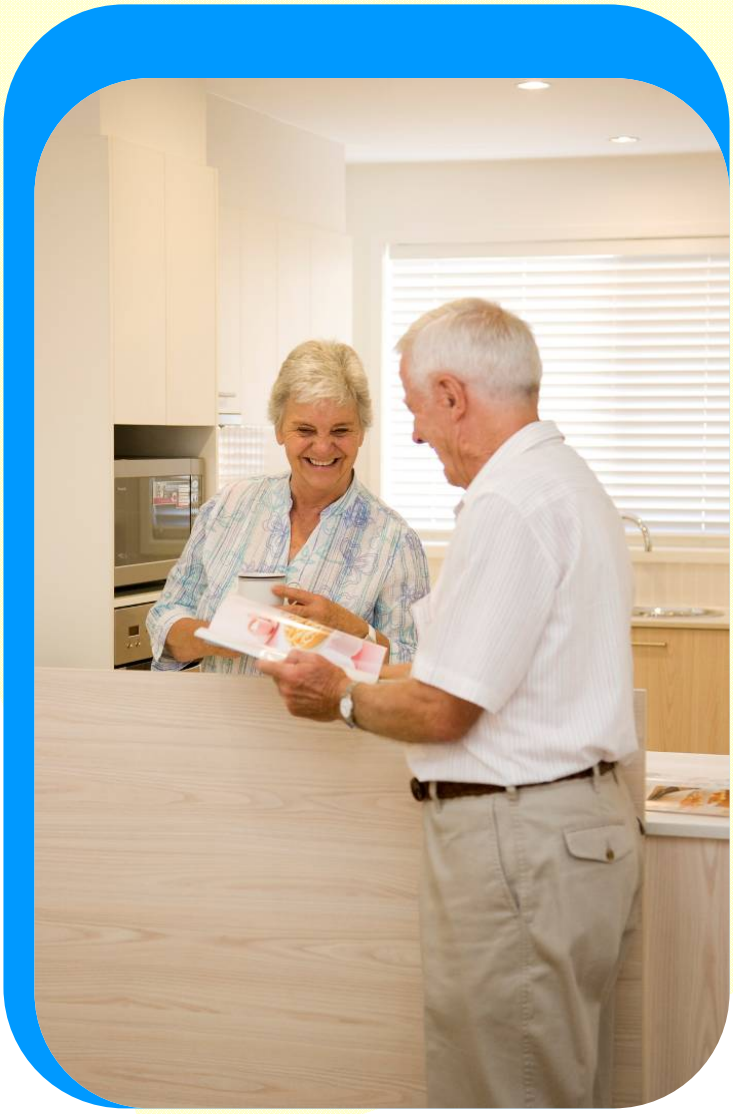
It is understood that the nature of some complaints by consumers may cause them to feel uncomfortable in raising the issue with the management of a facility. However, for cases where there is not a perceived risk to health, safety or wellbeing, an Approved Provider should have an opportunity to respond to the matter before an investigation commences, and the complainant should be advised that they need to contact the management first.

The role of the CIS in these cases should be one of mediation, rather than commencing with the assumption that the Approved Provider needs to demonstrate no fault in the case.

The process of closing out a complaint referred to the CIS can take more than 6 months due to the delays in the internal processes of the CIS. By having a right of reply for providers the volume of incidents handled by CIS will be reduced, and when reaching CIS, complaints will have already begun a review process at the provider level, thus expediting solutions.

User-Friendly

As referred to under "*Castles and Caring – choose where you live*", the current regulatory environment is confusing to seniors and doesn't allow providers to be focused on the care needs. Current regulations are written around the provider and their obligations, they don't explicitly address doctors or other services brought into aged care. Nor should it. The focus should be on an individual's capability to make an informed decision. For example, NSW food regulations prohibiting fruit such as rockmelon and strawberries are absurd, but can be of great consequence. It denigrates seniors' right to make their own decisions when in residential care. Regulations need to enhance a senior's autonomy and should monitor a provider's ability to do this.



Spotlight: The Irish Model

In Ireland[18], National Quality Standards for have been developed by the Health Information and Quality Authority (the Authority). They set out the expectations of quality, safe service for an older person living in a residential care setting. For service providers, these Standards provide a road map of continuous improvement to support the continued development and provision of person-centred, accountable care.

The National Quality Standards for Residential Care Settings for Older People have been developed based on legislation, standards in other jurisdictions, research findings and best practice. The approach to their development was informed by the following principles:

- Openness and transparency, to ensure that the general public is informed of the development of standards and the decision-making process
- A focus on outcomes, to ensure that the implementation of standards will result in real, meaningful and tangible improvements in services
- Person-centeredness, to ensure that all stakeholders, including service users and those who deliver health and social services, are involved in the development of standards
- Evidence-based practice, to ensure that the standards are underpinned by up to date, peer reviewed national and international research

There are 32 Standards divided into seven sections, which are made up of standard statements and criteria.

The Standards are grouped into seven sections to reflect the dimensions of a quality service. Thus, there are sections on the rights of older people, on protection, health and social care needs, quality of life, staffing, the care environment and management and governance.

In addition, the proposed Standards include supplementary criteria that apply to units that specialise in the care of people with dementia.

[18] National Quality Standards for Residential Care Settings for Older People in Ireland 17 February 2009

Employing Integrity – smart staffing strategies

The aged care sector is currently undersold and underwhelmed in attracting and retaining staff. This is perpetuated by sensationalised media coverage. The unglamorous image is exacerbated by potentially confronting workplace experiences, particularly when new to the sector, a perceived lack of career path and comparatively poor rates of pay.

> "the intense personal nature of caring for a senior fosters strong relationship development"

Attracting staff

Many initiatives have been trialled by providers in their ongoing attempts to attract suitable staff to the sector, including expensive and time consuming overseas recruitment drives. Providers need Government support to attract more workers to aged care. A typical provider has a workforce that is predominantly female, aged 40+[19]. Thus the challenge facing the sector is in attracting younger people and more males. Suggestions include:

- Equal Opportunity recruitment exceptions to target male workers,
- School education pathways (VET and community service placements)
- The recently announced aged care scholarships for nursing students are a great initiative[20], however they are limited in their appeal. We propose applying a reduction to any HELP debt accumulated under every course when a graduate is employed in the aged care sector.
- Government supported national marketing campaign around career options within the sector (eg Australian Defence Force campaigns).
- Sharing casual and specialised staff between hospitals, private health providers and other aged care services. This could be facilitated through the proposed one-stop shops, and may take the form of exchange programs or staff pooling.
- Enhance career pathways by providing the option to undertake career entry and development rotations that promote a comprehensive industry experience. These rotations should be recognised through a formal certificate system.

[19] IRT Data 2010
[20] http://www.australianageingagenda.com.au/2010/07/13/article/Aged-care-scholarships-for-nursing-students/ISWXKOEMCZ

Future Workforce Requirements

Retention, Learning & Development

Regulations around job roles should be more flexible to enable the deconstruction of responsibilities. This will free key staff, such as RNs, to concentrate on priority tasks within the hours in which they wish to work. Where possible, regulations should be directed at the provider rather than burdening front line staff. For example, instituting clinical governance minimum standards, providing flexibility to the staff skills mix that is being supplied, rather than a blanket requirement for an RN to be on site at all times.

Reviewing the way in which key roles are regulated will provide many benefits. Employees making decisions beyond their skill level would be minimised, versatility of hours worked would be built into positions and staff could undertake extended job training to integrate variety into their current role.

The intense personal nature of caring for a senior fosters strong relationship development. This is an integral reward for sector employees. Recognising and leveraging this as per the case manager approach outlined earlier will help to retain staff. A further initiative to leverage this career fulfillment could include be to consider expanding current trainee incentives to all aged care employees. This would allow for short up-skilling workshops that enable staff to provide increased and expanded care services for the senior, enhancing their wellbeing beyond essential care provision. For example, leisure activities or interest areas.

Remuneration

We recognise that there are discrepancies between responsibilities and pay awards for nurses and care workers in general. Most providers are not in a financial position to offer higher wages as they already constitute up to 70% of operational costs[21]. As a heavily regulated industry this is exacerbated for the aged care sector by a flawed funding mechanism used to calculate recurrent Federal funding, which is designed to leave aged care workers worse off than general wage earners[22].

Rather than simply asking for more money, the endemic issues around remuneration need to be addressed. Suggestions focus on tax concessions to benefit aged care employees directly, such as:

- Annual rebates for aged care specific job roles
- Access to Defence Forces-like benefits around housing loans interest rate reductions
- Increase and broaden salary sacrifice options to include expenses e.g. health insurance
- Allow for payment of employment-enabling services such as childcare from pre-tax incomes.

[21] Stuart Brown June 2009

[22] The Aged Care Industry Council Federal Budget Submission 2010-2011, January 2010

Rural & Regional Specific

As identified in the issues paper, providers face particular challenges in staffing rural and regional operations. These include attracting and retaining skilled staff, costs of relocation, social isolation issues, extended responsibilities due to fewer staff, and a lack of local career development pathways. Whilst the bulk of these issues are operational, Government can support efforts of providers and Local Governments that facilitate community integration for area newcomers.

As learning and development opportunities are fewer and more complex in regional areas, it is suggested a subsidised blended learning system be implemented, such as live streaming of training courses. Assistance with the investment in physical set up and maintenance requirements is needed, whilst program development and implementation can be done by providers.

The current Rural Preferential Recruitment program developed in 2006 by the Institute of Medical Education and Training has proven successful in attracting rural physician staff.[23] A similar Government-led initiative for aged care employees should be investigated.

[23] http://www.archi.net.au/e-library/workforce/staffing/rpr-program

Future Workforce Requirements

Spotlight: Recruitment

Dalmeny Village has always struggled to attract Registered Nursing staff to join its staffing ranks, despite the picturesque location of the seaside town, located 70km south of Batemans Bay. It's not that there isn't people wanting a "sea-change", but Dalmeny is remote and finding jobs for RN's partners is always a challenge, whilst single people often find the local social life a little dull.

Village manager Meredith Brownstone decided to employ a different tactic to attract RNs earlier this year, deliberately targeting new graduates via on-line advertising and offering them a $1500 relocation bonus in return for a 12 month commitment to the aged care village. From six enquiries, Meredith received four applications for the two roles.

Employed was single women Aimee Cook, 22, a recent Newcastle University graduate, and Ling "Lynne" Chan, 24, a Wollongong University graduate who was a full-fee paying student from China. Both women had their accommodation paid for three weeks before they found fully furnished one-bedroom units at Dalmeny.

Meredith has provided both recruits with a three month orientation period, unusual in aged care, which included a full month rotating through the different facets of the village, before being "buddied" with experienced RNs. The manager doubts the women will stay beyond their 12-month commitment as there is little to do in the town and not much coordination for social opportunities, but she holds out hope they'll settle and call Dalmeny home.

It wouldn't be the first time there's been a success story – last year Meredith corresponded by email with an Australian nurse who married a Spaniard and was looking to relocate with their young family. Kelly and her family moved to Dalmeny, integrating well into the local community through their primary school aged children, with husband Pedro picking up casual work at local cafes and the aged care village.

"I do whatever I can to attract staff to the village – I need care staff who are going to build relationships with our residents and hopefully make this town their home," Meredith said.

Transitional Arrangements

Transition starts with a decision to create one national aged care framework, followed by the establishment of clear policy which directs the integration of services. From this comes the accreditation of providers and a standardised regulatory structure across all aged services in Australia, including implementing reforms to the funding models that support the industry.

This standard national framework would encourage specific innovations such as those outlined above. While implementing these reforms, a service integrated housing model should be promoted as this provides seniors with a supportive, independent living environment.

Transitions to both the national integrated service model, and a national service integrated housing model can commence immediately upon acknowledgment and agreement by stakeholders, followed by the distribution of draft policy for discussion.

Elimination of duplicated regulations and bureaucracies will unfold with the creation of the national integrated aged services framework. There must be due sensitivity to the staging of the transition to ensure the integrity of consumer protections and service standards. Additionally, the focus and promotion should be on the evolution of consumer choice and direction as a key theme in the new framework.

Specific innovations such as the elimination of high and low levels in aged care can be phased in over a 12 – 24 month period to allow for adjustments by service providers and government agencies. Simultaneously, the broadening of the user-pay accommodation contribution can be phased in upon amendments to existing legislation to allow for these changes.

Concurrently, a schedule for the establishment of a federal marketing and projects team dedicated to aged care. Their priorities would be to create a promotional campaign to attract staff to the sector, implement the Rural Preferential Recruitment program and establish the recommended innovation pool.

"every Australian senior should have access to suitable accommodation, and the choice of where, and how they receive any services they require"

Transition key milestones:

- Establish and communicate the new framework
- Establish specific timeframe, stages and phases for each of the accepted innovations
- Ensure this is an agreed schedule between stakeholders for the implementation
- Engage and inform industry providers – clarify implications and responsibilities
- Establish standard principles and charter of rights and responsibilities for all aged services across Australia
- Implement reforms to funding mechanisms
- Legislate for one controlling body under the Commonwealth Government
- Standardise regulations
- Profile and promote Consumer Choice as overarching principle for service or accommodation provision
- Establish regulation and principles ensuring equity and access for all seniors
- Establish a federal marketing and projects team to implement the recommended workforce attraction and retention strategies.

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Australia – Ageing Well

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Employing Integrity – smart staffing strategies	
Introduce initiatives to attract staff to the sector: • Invest in a national aged care marketing campaign • Provide EO exemptions to target male recruits • Expand school education pathways nationally e.g. VET in NSW • Reduce HELP debt for graduates of any course that attain aged care employment • Facilitate staff sharing between all health service providers • Establish cross-sector career rotations with formal recognition	25
Provide minimum standards to allow flexibility in skills mix	26
Expand current trainee incentives to all aged care employees.	26
Provide tax concessions for aged care sector employees: • Annual rebates for aged care specific job roles • Access to Defence Forces-like benefits around housing loans interest rate reductions • Increase and broaden salary sacrifice options to include expenses e.g. health insurance • Allow for payment of employment-enabling services such as childcare from pre-tax incomes.	26
Address rural and regional specific challenges by: • Facilitating community integration programs through Local Government support • Assist providers to set up and maintain technological learning initiatives • Introduce “rural preferential recruitment” program for aged care employees	27