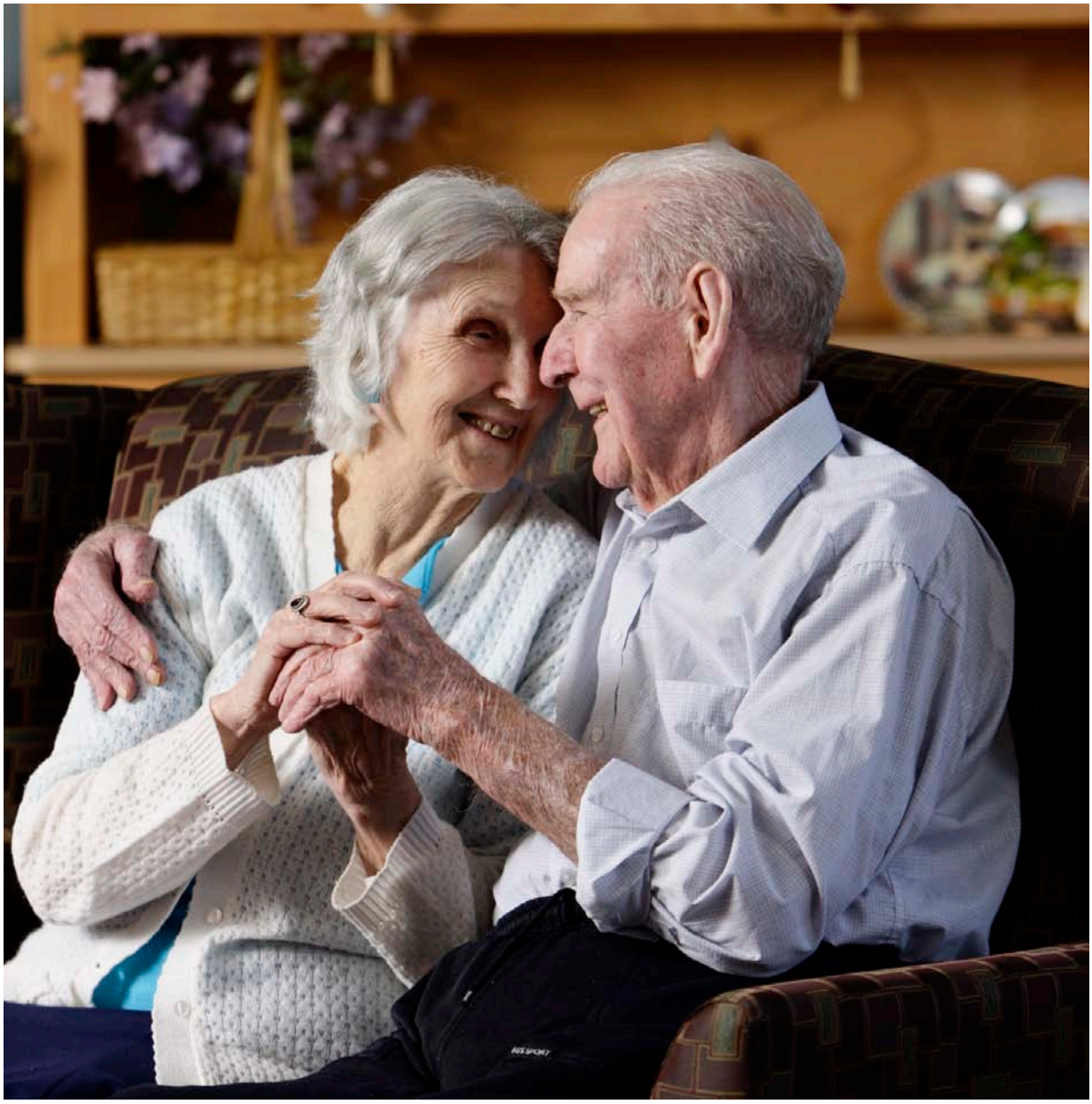
UnitingCare Ageing NSW.ACT
Submission to the Productivity Commission
Public Inquiry into The Care of Older Australians



Inspired Care... Enriching Lives... Together

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UnitingCare Ageing is a Service Group of UnitingCare NSW.ACT which is a member of the UnitingCare Australia Network of aged and community services. This submission is a case study drawing on the experience of UnitingCare Ageing in NSW and ACT in consolidating its services from 52 separate entities to a single unified organisation with a simpler governance structure. It also reflects our experience in introducing a new Service Model with a much greater focus on providing community care to people in the housing setting of their choice.

Executive Summary

This Submission to the Productivity Commission's Public Inquiry on Caring for Older Australians ("the Inquiry") has been prepared by UnitingCare Ageing ("UC Ageing"). With around 14,000 people under care, UC Ageing is the single largest provider of aged care services in New South Wales and the ACT. UnitingCare Ageing is part of the UnitingCare Australia Network which has 12 per cent of Commonwealth allocated aged care places and is the single largest provider of aged care services in Australia.

Over recent years, UC Ageing has undertaken a significant and wide-ranging review of the services it provides. Drawing on six foundation principles that guide our approach, we have developed a new Service Model for aged care that shifts the focus from providing residential care to a wider emphasis on a person's individual experience of ageing and on supporting each person's interaction with aged care services.

Important elements of our Service Model include a separation of accommodation from care, with care being provided in the setting that best suits each person's needs, and an emphasis on wellness and early intervention that can delay or avoid higher acuity. As we have moved to implement our Service Model, we have also undergone far-reaching internal change, including through consolidation of 52 separate local aged care boards into a single unified organisation.

Implementing our Service Model has highlighted the challenges aged care providers face. The care needs of older Australians are changing: responding to those changes requires flexible service delivery, provided in a wide range of venues, in a manner that avoids artificial silos between forms of care, while being financially sustainable and accessible to all. But our aged care system is trapped in rigidities and artificial distinctions, is complex and often opaque, is not financially sustainable and ultimately, does not put older Australians first.

That system relies on the blunt instruments of planning controls and price restrictions to manage the Commonwealth's fiscal risk, but even with those instruments, is unable to ensure that older Australians have access to the services they need at reasonable charges, and that efficient service providers can cover their long term costs. At the same time, it rests on distinctions that are purely regulatory constructs (such as the distinction between high and low care and between conventional high care and extra service) and creates inefficient barriers between the aged care system on the one hand and health care on the other. For UC Ageing, these features of the system impede our ability to provide care, including by making it impossible to finance long term renewal of our accommodation stock. Their wider consequence is to decrease efficiency, while also compromising equity and universality of access.

We believe options for dealing with these issues need to be assessed in terms of the following principles:

- **Equity and universality of access**: the policy framework should ensure all older Australians, regardless of their financial position, life history or place of residence, have access to the care they require to lead satisfying lives in old age, including in terms of promoting well-being, independence and dignity.
- **Efficiency**: the policy framework should ensure resources devoted to the care of older Australians are allocated to the highest value purposes and are used in a way that maximises the community's return on those resources, including by avoiding placing unnecessary burdens on taxpayers.
- **Transparency and simplicity**: the policy framework, the regulations in which it is embodied and the market in which care is provided should be understandable to clients and their families, allow clients and their families to take informed decisions and avoid imposing unnecessary regulatory burdens on care recipients or care providers.
- **Consumer sovereignty**: the policy framework should ensure that to the greatest extent possible, it is the needs and preferences of older Australians that determine what is provided and how it is provided. The demand side of the market needs to be empowered to ensure outcomes meet the preferences and needs of older Australians.
- **Stability, predictability and sustainability**: the policy framework should ensure that all those affected by the system – be they the older Australians it serves, their families or care providers – have a reliable basis on which to plan and take long term decisions.
- **Diversity and innovation**: the policy framework should create scope for diverse, competitive supply, and encourage innovation, including by facilitating cooperation between aged care and other areas of policy affecting older Australians, notably the health and retirement incomes systems.

Given these principles, we submit that the Commission should recommend to the Government:

- A full separation of accommodation from care, and the removal of planning restrictions on the number of places.

- New risk and acuity adjusted payments to be set by the National Hospitals Pricing Authority that ensure financial viability and protect people who are financially disadvantaged.

- Abolition of the distinction between low and high care. Current restrictions on prices charged should be replaced by a lighter-handed form of price control during a transition to open entry, and to be abolished once that transition is complete.

- Greater integration between aged care and health care in terms of workforce planning, funding and payment bases, and full contestability of services such as home care, transition care, rehabilitation and sub-acute care.

- The Commonwealth to manage its fiscal risk by continued and improved means-testing (eliminating artificial differences in co-contribution rates across different types of care services) and by developing and implementing options for all Australians to make adequate provision for financing their care and accommodation needs in old age. The removal of entry barriers and increased competition will also help ensure taxpayers and consumers get value for money.

- Significant emphasis to be placed on expanding the range of housing options available to older Australians, including through more effective subsidies for affordable accommodation for older Australians who are financially disadvantaged, and removal of regulatory constraints that impede the supply of affordable accommodation.

- An improved system for accreditation and quality control, which can be applied to both residential and community care. Rather than being primarily about processes, that system should place greater weight on outcomes for older Australians and should provide older Australians and their families with information that helps them assess the quality of care provided. As part of the system, there should be open disclosure of performance around a set of National outcome measures which can be accessed on a My Aged Care web site. As well as regulatory functions, that system should serve to empower the demand side of the market, bringing greater transparency to consumers about the range of options available.

- A reconsideration of the industrial relations issues created by the Modern Award system for aged care providers and moves to ensure scope for flexible and efficient workplace arrangements.

- Current and prospective skill shortages to be addressed by better workforce planning (including through Health Workforce Australia) and by government facilitating, rather than impeding, access to skills and people overseas when needs cannot reasonably be met locally. Placing aged care on a financially sustainable basis, and allowing it to develop into a more vibrant, competitive and innovative sector, will itself help attract and retain the staff the sector needs.

- Consideration of what needs to be done to facilitate industry consolidation. Consolidation is inevitable as entry restrictions are removed and as economies of scale and scope (for instance, associated with the management information systems required to efficiently provide care across a range of accommodation venues) become more significant. The issue is whether there are barriers to consolidation that government needs to address.

- A commitment to properly funded research, including evaluation, both on aged care needs and service approaches and on the longer term challenges of an ageing society.

We would be happy to assist the Commission in its consideration of these recommendations and more generally, in its Inquiry.

I. Introduction

UC Ageing welcomes this opportunity to respond to the Productivity Commission's ("the Commission") Issues Paper for its Public Inquiry into The Care of Older Australians.

The objective of this submission is to assist the Commission by highlighting UC Ageing's experience with the provision of care to older Australians. UC Ageing is the largest single provider of aged care services in NSW and the ACT and by national standards, is a substantial supplier of residential care, community care and housing services (mostly made up of independent living units). UC Ageing has also developed innovative social justice programs, including services that assist older people to remain healthy and socially connected. Additionally, UC Ageing operates the War Memorial Hospital at Waverley in Sydney, which is a Schedule 3 Geriatric Rehabilitation Hospital. A profile of UC Ageing's activities is set out in Attachment A.

UC Ageing is differentiated by a Service Model developed in 2009. The Service Model, which is presently being implemented, responds to the changing care needs and preferences of older Australians, aligns with our wider social justice objectives, and aims at ensuring the long term financial viability of our services. To this end, we have re-oriented the delivery of care from its traditional emphasis on residential care to a focus on care around the person's needs in a wider range of settings and service options.

We believe that our experience in implementing this Service Model, the challenges we have faced and continue to face in its implementation, combined with the lessons we can draw from those challenges to inform public policy, will be of benefit and assistance to the Commission as it undertakes its Inquiry.

Since 2005, UC Ageing has rationalised its governance. We merged 52 separate local aged care boards into a single unified organisation, with a single service group board for UC Ageing and six regional boards accountable to the UC Ageing Board. We believe our experience in achieving this consolidation also presents the Commission with a case study of what is required to effectively integrate large numbers of smaller-stand alone aged care providers to form an effective operation.

The structure of this submission is as follows:

Part II – **Our Service Model and its Implementation** sets out the major features of the UC Ageing Service Model and relates those features to the broader pressures for change in aged care.

Part III – **The Challenges we face** discusses some of the difficulties we have encountered in implementing and delivering that Service Model as a result of current policy and regulatory settings, highlighting the rigidities and excess costs those settings create.

Part IV – Conclusions and a way forward addresses, against the backdrop described in Parts II and III, some directions for change in public policy and the criteria and objectives we believe the Commission may want to use in considering policy options.

II. Our Service Model and its implementation

In 2009 UnitingCare Ageing introduced a new Service Model to guide the development of our services and to ensure that all people using those services have a consistent experience regardless of where services are provided.

The Service Model provides guidance on the types of services that are to be provided in which communities and to who. Another important role of the Service Model is to guide us in defining our core capabilities while outlining what we do in partnership with others.

That Service Model is based on six foundation principles (discussed in greater detail below) about effective service delivery to older people. The Service Model is also supported by an extensive evidence base which informed its development.

The Service Model was developed in direct response to changes in the external environment, and was particularly directed at responding to changing community expectations and preferences about aged care. It is therefore important to begin by outlining the trends that led us to the Service Model we have adopted.

Future Trends

The trends influencing the future of aged care have been well documented in recent research, including a report by the Productivity Commission.[1] Seen from UnitingCare Ageing's perspective, the most relevant trends include:

- Increasing numbers of people in older age groups – by 2047 the numbers of people aged 85+ (the main users of aged care services) will have increased four-fold.
- Increasing prevalence of dementia and other neurological conditions whose incidence rises with age. Without a cure, the number of people with dementia is predicted to increase from 220,000 in 2007 to 730,000 by 2050.
- Increased longevity and some reduction in morbidity for people (other than for neurodegenerative diseases like Alzheimer's disease), though the extent of the reduction in morbidity remains controversial.
- Greater diversity of the aged population, particularly in regard to cultural and linguistic backgrounds and in regard to numbers of Indigenous people living longer.
- Changing preferences and expectations in the community, and particularly in the baby boomer generation. Surveys indicate that the generations born post-WWII will demand more independence and autonomy than their predecessors and a greater say and choice in their care as they age.
- Diverse trends in income and wealth. While the majority of future aged people are going to be wealthier than the current cohort of older people (largely due to mandatory superannuation and real increases in property values), about a quarter will have low or even no savings or other assets on which to rely. These include single parent families, single people generally, women who have not had access to superannuation, and those people who have never had access to ownership in the property market and remain dependent on rented accommodation.

[1] Productivity Commission (September 2008) "Trends in Aged Care Services: Some implications". A summary of the Productivity Commission Report and its implications and challenges for aged care providers was considered in the development of the new Service Model. Bruen, Warwick (October 2008) Notes on the Productivity Commission Report: "Trends in aged care services: Some implications. Prepared for the UC Ageing Board meeting October 2008.

The most significant implications arising from these trends appear to be:

1. Residential services will be for people who are much older and who have complex health care needs. The period of care will be characterised by shorter episodic stays, though increased incidence of neurological conditions will lead to a proportion of the resident population experiencing very long stays.

2. As the role of residential care changes, it will be necessary to provide for a wider range of affordable housing options where older people can meet their needs for social interaction and community engagement, while receiving care services when and if they need them.

3. There are opportunities for care services to become more specialised e.g. dementia care; mental health; cultural diversity; palliative care etc.

4. There is a preference for community care. Older Australians will want to continue living in the community for as long as possible, and will value a wider range of housing choices, including living arrangements that involve some degree of congregation but are not as institutionalised as residential care.

5. Consumers will demand a greater role in directing care in the future, and community expectations about quality and service levels will increase.

6. There is an increased focus on healthy ageing and wellness among older people, with very substantial opportunities for such a focus to improve quality of life and reduce and/or postpone the onset of higher level care needs.

7. Population ageing, ever higher levels of female labour force participation, changes in family size and structure and wider social trends (including a possible reduction in the availability of volunteers) will impact adversely on the availability of unpaid carers.

8. At the same time, growing demand for health care will exacerbate competition between the aged care and health care sectors for trained staff, affecting the availability and cost of paid carers.

9. While the reduction in the life expectancy gap between men and women will reduce the average number of years of widowhood experienced by older Australians, it will also result in a situation where there are large numbers of older couples in which both partners require care. This has significant implications for the design of care, and for the type of accommodation venues that are likely to be preferred and required in the future.

10. Affordability will be an issue for a majority of older people with their accumulated assets being their major source of financial contribution to their aged care. Very few, if any, older people who are at the ages where care needs are relevant will be able to draw on income from employment as a way of financing care (or of responding to increases in charges for aged care).

11. The economic implications of an ageing population mean Governments will be seeking alternative funding arrangements with a likely increased emphasis on ‘user pays’ and greater emphasis on efficiency and productivity across the health and aged care system.

Our response

Given these trends, we have sought to define our approach to providing care based on six **foundation principles**. These are:

1. **Client choice and involvement**

   We expect that our clients want to be involved (either directly or indirectly through a carer or advocate) about when they need support and how support is provided, so that they can live with dignity and maximum independence in the accommodation setting of their choice.

2. **Independence and well-being**

   We expect to support older people to be independent and active in older age.

3. **Social justice**

   We operate in accordance with our social justice principles and use our surpluses to support people most in need and to increase our advocacy for social justice and effective public policy.

4. **Social inclusion**

   Through our services and advocacy, we expect to challenge and change the negative stereotypes of older people, so that older people can continue to feel a part of society and are included in all aspects of community life.

5. **Separation of housing and care**

   When older people need support, we work with them and their carers to find the best way to bring housing and services together so that older people continue to have a sense of happiness and well-being.

6. **Recognising the value of carers**

   We understand that for many older people, not having a carer often precipitates the need to enter residential care. We therefore work collaboratively with older people and their carers to facilitate and enable dignity and choice for the older person.

In recognition of these principles, the trends outlined above and the supporting research evidence, we have sought to make our core capability the provision of services across a full continuum of care.

Figure 1 in confidential Attachment B shows the range of services provided across that continuum of care and how these services are targeted to different target groups who seek different outcomes from those services. Figure 1 also provides guidance about how these services might come together in local communities based on having a thorough understanding of community need and of when partnerships might be important in service delivery.

There are levels of support provided across the continuum of care for people from well aged through to frail aged and increasing disability and then to end of life support. The main types of support include:

Supporting Wellness and Healthy Ageing

- healthy lifestyle support and information;
- education and advice on reduction of risks to health and lifestyle;
- assistance with minimizing impact of existing health conditions.

Supporting and Sustaining Independence and Choice

- working in partnership to enhance quality of life;
- providing services that facilitate/enable independence or achievement of individual goals;
- Supporting connections to social networks.

Assistance and Support in Daily Living

- Planned care provided to meet individual needs;
- Enabling quality of life in daily living;
- Supporting lifestyle choice and decisions.

End of Life Support

- Provision of individual palliative care in accordance with the express wishes of the person;
- Working in partnership with the person, family and medical and palliative support teams.

Our Service Model is based on a person's individual experience of ageing and supports each person's journey through the service system. This often commences with a need for information and early intervention support around social inclusion, wellness and career and/or home support.

The Service Model assumes a separation of accommodation from care, with care services being delivered to the person in the accommodation setting of their choice. The representation of the Service Model reflected in Figure 2, confidential Attachment B, demonstrates the application of this principle.

Giving expression to the Service Model

Depending on community need and drawing on a thorough understanding of our competitive position in a community, we seek to provide a full range of services across a range of geographic locations in New South Wales and the ACT.

Our preferred Service Model is to integrate our services in communities, preferably around a well-located community hub which is part of a town centre that provides good access to transport and opportunities for inter-generational contact. In some communities, these services may be located on one site. Community demand, need and good commercial practice, including a thorough understanding of competitor behaviour, always inform how we give expression to our Service Model in local communities.

A central element in our Service Model is that providing services that support wellness and healthy ageing and sustain independence and choice is likely to provide the most appropriate entry point to our services in communities. In other words, we see a focus on early intervention, notably by sustaining wellness, as the starting point for service provision, both because that reflects the preferences of older Australians and because that can ensure care is provided as efficiently as possible.

We provide these services to older people in need of care and support in the communities we serve. How we define an older person will vary depending on the stage of the ageing process: well aged may be from 65; frail aged may be 70+; and end of life may be 85+.

Our **mainstream services** target older people in the second and third income quartiles of older people[2], although the application of this principle is adjusted to suit local market conditions and community need.

At the same time, our **social justice focus** guides us to also target people in the first income quartile, and it is to that group that our social justice activities are directed.

We regard ourselves as having specialised expertise in working with Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds and people who are geographically isolated, as well as older people who are homeless, experiencing financial and social hardship and/or living with mental health issues. Obviously, how this specialisation is applied in communities will always be informed by a thorough understanding of community needs.

Through the War Memorial Hospital at Waverley and a strong partnership with the South Eastern Sydney Illawarra Area Health Service, we have also developed a core capability around providing a range of high quality sub-acute and rehabilitation health services for older people in the environment of a Schedule 3 Geriatric Rehabilitation Hospital.

Application of the principle of social inclusion means that giving expression to our Service Model involves "normalising" a community so that older people have opportunities to engage with inter-generational activities, rather than being in aged segregated settings. While there are potential cost savings from congregated living arrangements, we recognise that there will be an increasing preference, particularly at the lower levels of the care continuum, for accommodation settings that involve an inter-generational mix.

Our core capability is in delivering quality care and we differentiate ourselves from other providers around the following attributes:

- The spiritual and pastoral care services we offer are integrated with our own brand of person-centred care, which we call Inspired Care. This embraces an acceptance of religious and cultural diversity as well as providing for members of the Uniting Church.

[2] The ABS has four income quartiles for classifying the income of the Australian population. The planning for this services model was based on the second and third income quartiles.

- We can use our scale to operate in many communities across NSW and the ACT and because of this we can offer a continuum of services depending on the needs and expectations of our clients.

- The UnitingCare brand is trusted and we are in aged care for the long haul, which means the ownership of our services will always be with the Uniting Church.

- Through the application of the foundation principles of Social Justice and Social Inclusion, we support those in the community who are most vulnerable and disadvantaged.

Where appropriate, and as a means of attracting and retaining good staff and to create age-integrated communities, we invest in affordable key worker housing and provide the opportunity for the inclusion of other community and commercial services in our developments.

Capability Development and our Operating Model

The implementation of our Service Model requires us to develop organisational capability in a number of important areas which have not traditionally been the focus of aged care providers.

These areas for capability development include:

- Clinical assessment for chronic illness and disability;
- Customer focus and improved marketing capability;
- Planning around communities for social inclusion;
- Business development across the service model continuum;
- Business processes that are changing, especially at first contact and intake;
- IT systems, knowledge management and transfer; and
- Housing capability.

Given this need for capability development, our Service Model is supported by a framework for a **Common Operating Model**, which is illustrated in Figure 3, confidential Attachment B. This provides an important link between strategy and execution, so that the operational foundations of our organisation support the strategy and Service Model and ensure consistent application across the whole organisation.

While the Common Operating Model addresses our ongoing activities, and seeks to place them on an efficient and effective basis, we also provide a basis for continuing growth and evolution by investing in **research**, including evaluation.

Examples of our research programs include:

- With the Sax Institute - 45 and Up study;
- With the University of Western Sydney - ADHC funded Transformations of Care study;
- With Newcastle University - evaluation of the Healthy Living for Seniors Program;
- With Alzheimer's Australia NSW – evaluation of the Younger Onset Dementia program; and
- With the University of Wollongong – Measuring outcomes in community care: an exploratory study.

III. The challenges we face

The essence of our Service Model is to shift activity from a traditional emphasis on residential care to an integrated approach that includes residential care but places ever greater weight on care in the community and on providing a wider range of housing options. We believe such a shift best meets the needs of older Australians, responds to a preference for care in non-institutional settings and helps ensure efficiency and financial sustainability in service provision. In this section, we examine a number of challenges we face in implementing our Service Model now and in the years ahead.

In considering these challenges, it is important to start by noting that we will face rising demand for aged care in areas where older people have, and are likely in future to have, relatively modest incomes. Thus, the regions in our service area where the population over 70 is expected to increase most rapidly over the next decade include Western Sydney, the Nepean and South West Sydney. These are areas where there will be substantial numbers of older and very old people with few assets and whose primary or sole income source is the aged pension. This imposes an obvious constraint on their ability to contribute to their care costs.

Our capital expenditure outlays during the last 4 years (including capital expenditure to consolidate our systems) has averaged over $71 million per annum and we expect to outlay over $115 million during the current financial year. This level of expenditure is likely to continue in the short to medium term as we implement our Service Model.

Meeting the care needs of these communities will impose a significant financial burden over time.

While our services are widely dispersed across NSW and the ACT, they are concentrated in more established metropolitan areas of Sydney. This largely reflects the growth of church congregations across Sydney, rather than following any pattern of need. This means we face significant challenges in re-developing our services so that their location better reflects community needs and the pattern of demand growth.

Underpinning the growth in demand is the move of the 'baby boomer' generation to the ages at which care needs increase. Given longer average life expectancy and some trend to a compression of mortality (meaning that the variance in life expectancy at high ages diminishes), we expect that rising numbers of people will require some form of care. **Overall, aged care, which is currently experienced by a relatively small proportion of even the older population, will eventually become a common experience for entire generations.**

Our ability to respond to that shift is hindered by a policy environment that:

A. Does not provide the flexibility required to address differentiated needs;
B. Has fundamental issues of funding adequacy, aggravated by the complex and opaque nature of the funding mechanisms;
C. Makes it difficult to ensure and retain adequate staffing and to secure the best use of human resources; and
D. Does not regulate service quality in a way that best protects the interests of consumers.

We consider each of these in turn.

A. The need for flexibility

As stressed in our Service Model, the care services needed by older Australians are increasingly varied, with that variation occurring across a number of dimensions.

Thus, there is now and has long been variation in the **level** of care required, with higher levels of care needed as a person's ability to undertake activities of daily living declines.

However, in addition to that variation, there is also increasing variation and diversification in the **nature** of the care required, with a focus on wellness and prevention involving a move from care in its most conventional, narrow sense to a wider concept that includes a broad range of interventions that are neither therapeutic nor essentially assistive (in the sense that they are not merely a replacement for activities of daily living that would be carried out by the person). For instance, interventions aimed at supporting social integration of older people into the community can be crucial in supporting good long-term health outcomes and in preventing or postponing entry into residential care, but they are neither therapeutic in themselves nor a substitute for activities of daily living that would be undertaken by the person absent of some degree of impairment.

There is also variation in the **duration** for which care is required, also due to differences in the duration of various kinds of intervention. The demand for respite care is occasional and may be quite intermittent; some forms of wellness support and counselling may be episodic (for instance, in helping adjustment and transition to new situations) whereas others may need to be ongoing (for instance, support with activities that promote good health and some degree of fitness); more conventional forms of care, aimed at filling the gap left by a decline in the ability to undertake activities of daily living, may be for the whole of remaining life. At the same time, ensuring the people to whom we provide care obtain the care they need requires on-going care management, so as to retain contact and assure continuity of involvement and support, even when the care itself is intermittent or episodic.

Finally, and related to these, there is growing variation in the range of **settings** in which it is desirable to provide care. Traditionally, those settings have been the residential aged care facility on the one hand, and the older person's home (typically, the family home) on the other. Though they have played a lesser role in the formal aged care system, there have also been retirement villages and independent living units, variously defined, that have provided accommodation for older people while also offering some degree of assistance to residents.

We believe the range of options will continue to expand, and will include both *non-residential settings*, such as day centres for older people, as well as a wider range of *assisted accommodation*, much of it not specific to older people, for instance aimed at providing affordable housing to financially disadvantaged older Australians, as well as key worker housing. Currently, the non-traditional venues in which we provide services include Men's Sheds, two Centres for Healthy Ageing and various approaches to Day Care Centres.

Our experience at the War Memorial Hospital with various rehabilitation and sub-acute services delivered in a health care setting, is that increasingly residential aged care settings will also become appropriate alternatives in which older people are able to receive sub-acute and post acute services. This is an important focus for reform because in our experience, the health system has not generally recognised the part aged care can perform in this area.

Obviously, any particular person served may require a package of care assembled from the 'menu' of options outlined above. The package that is provided should seek to reflect the needs and preferences of that person as effectively and efficiently as possible. This includes catering for mobility across the spectrum of care needs outlined above, recognising that a person's requirements can evolve in complex ways.

Adapting to these increasingly varied and variable needs will demand a new degree of flexibility from aged care providers. That flexibility must be based on operating processes and systems that can manage, track and monitor ongoing shifts in the package of service required by each person served, including for the purposes of ensuring people actually receive the services they need, ensuring also that staff can intervene as needed to update the services supplied and ensuring appropriate financial control.
Developing and implementing such operating processes and systems is a substantial challenge, but is indispensable to good business practice.

Since 2007, our investment in IT infrastructure and business improvement projects has averaged over $6.3 million per annum. Much of this expenditure creates a platform for operation as a single organisation. Expenditure in this current financial year is expected to exceed $15million.

However, as well as challenging aged care providers, the need for flexibility creates major challenges to current policy and regulatory arrangements. These arrangements reflect a number of distinctions and demarcations that, in our experience, reduce the ability of aged care providers to respond to changing needs both for the older population as a whole and at an individual level. Six major sources of rigidity are especially relevant.

First, while the expansion in the number of community care packages is welcome, care and accommodation remain largely bundled in our current aged care arrangements, most obviously so in the residential care system. This makes it more difficult to shift resources from residential care settings to community settings, even when doing so would improve the quality of the service provided, enhance an older person's satisfaction, and allow efficiencies in the form of avoided costs.

Second, within residential care, the distinction between low and high care is largely obsolete, as most people entering residential care now, and even more so in future, are already at relatively high care levels. Today, over 70 percent of operating expenses in residential care are in high care, with the industry trend being for that share to rise over time. Moreover, the relevant distinction for funding purposes is obviously in the precise level and mix of care a person requires, and those variations, which are complex and diverse, are not easily reconciled with a rigid segmentation between low care on the one hand and high care on the other. It is therefore difficult to understand what purpose is served by that segmentation, which hinders the reallocation of resources in line with changes in patterns of demand. The retention of a distinction between high and low care in residential care appears to exist only for purposes of determining how people pay for the capital side of residential care.

Third and related, controls over the number of places through the planning system make the industry structure more rigid and less responsive than it could otherwise be. While we understand that the purpose of those controls is to manage the Commonwealth's fiscal risk, it is questionable whether they are an efficient way of doing so. Among other things, these controls can create barriers to entry by new providers (or to expansion by existing providers), which is likely to increase costs and reduce choice in the long run. In any event, the formula for these planning ratios (currently at 113 places/1000 people 70+) does not support patterns of demand or the age profile of people receiving care.

Moreover, the planning system seems to combine functions of resource planning, resource allocation and supply control. The manner in which it does so may have been sensible in the context of a primary orientation to residential care, with its bundling of accommodation and care. However, it is difficult to see how it could continue to serve as the primary instrument for those functions in an environment where the Commonwealth has responsibility for the full spectrum of funding instruments, including HACC.

Fourth, the current structure of funding for community care is based on a sharp demarcation between levels of acuity, with HACC, CACP and EACH essentially targeting different levels of need. Moreover, there is a very substantial funding gap separating these, and especially between CACP and EACH. In contrast, a person's needs tend to lie along more of a continuum. The result can be to create ranges of needs that are not, or not properly, covered by the system, placing the burden on the service provider to devise solutions that adjust service levels in line with a person's needs and ensure some degree of continuity of care.

Fifth, a person's need for care is assessed using different assessment tools depending on the care setting. Among other effects, this produces a cultural effect among staff and people entering care (and their carers) which reinforces the view that receiving care in a residential care facility is somehow very different to care delivered in other accommodation settings. This reduces flexibility, not least by creating a culture in which staff who work in residential care may not willingly work in community care and vice versa. These attitudes and beliefs do little to reinforce the view that an older person's care needs should be no different whether they receive that care in a residential setting or in their own home.

Different approaches to assessment also impede flexibility in encouraging and enabling people to receive care in different settings. The notion that someone goes home from residential care should be enabled both practically and culturally by having common approaches to the assessment of care needs regardless of the care setting. Further anomalies occur around assessment where Aged Care Assessment Teams ("ACATs") use a different assessment tool to that used by aged care providers in residential and community care. This can have significant impacts on funding.

Sixth, there are issues that arise from the boundaries between aged care on the one hand and the health system on the other. In essence, the aged care system provides a number of services related to chronic disability in older people, as well as addressing a wider range of needs of older Australians (for instance, supporting social integration and assisting in the supply of accommodation to older Australians who are financially disadvantaged). There is therefore inevitably a significant degree of overlap with the health system, as the repeated concerns about 'cost shifting' between aged care on the one hand and hospitals on the other have served to highlight.

However, these systems have different 'gate-keepers', with ACAT assessments serving as the primary controller of access to aged care, while health services are generally available on a 'walk in' basis. Moreover, the administrative and bureaucratic structures within which these services are provided differ, and the degree to which they are coordinated is very uneven. The result is that interventions that could be efficiently carried out in an aged care setting – for instance, for rehabilitation – are often carried out at what seems to be far higher cost in the health system.

The political focus has been on the acute side of health care, with an emphasis on reducing hospital waiting times especially for emergencies. However, these waiting times are rarely considered against the waiting times for older people needing to leave hospital for an alternative care setting. We contend that by making better use of the capability and infrastructure of aged care providers, hospital admissions for large numbers of older people could be avoided in the first place. Unfortunately, this important contribution of aged care providers to the health reform agenda has not received the consideration it deserves.

Thus, as the operator both of over 80 residential aged care facilities spread across NSW and the ACT and of the War Memorial Hospital, we believe we could achieve substantial efficiencies by reallocating resources between these systems without in any way compromising quality of care. That is very difficult, if not impossible, to achieve in the current 'silos', which restrict the movement of clients and resources across these systems.

Our experience is that these 'silos' are reflected in strong cultural divides which usually align with staff's perceptions of whether they work in the "health" system or in "aged care" (which is perceived as a variety of social work). These perceptions are reinforced by different industrial agreements, including rates of pay, as well as differences in practice, all contributing to "health" models of service provision costing more than "social" models.

We were recently able to demonstrate this to the Minister for Ageing the Hon. Justine Elliott when she visited the War Memorial Hospital where, among other services, we operate a Geriatric Flying Squad. That facility provides a sub-acute hospital avoidance service to older people, along with residential and community based transitional care services. While this has been made possible by the Schedule 3 hospital status afforded to the War Memorial Hospital through the NSW Health Services Act 1997, there is no practical reason why these same services could not operate from any of our 80 or so residential services, especially the more recent ones.

We can well understand how each of the distinctions, demarcations and segmentations discussed above has developed. As with any set of arrangements, the policy and regulatory framework for aged care has largely evolved incrementally over time, and as that process played itself out, the desire to retain control over public spending has resulted in the attempt to limit the scope of each new element that has been added. However, while the objective of expenditure control is quite proper, the overall outcome is to create rigidities that are now unnecessary and costly both in financial and social terms. As the need for service flexibility rises, removing what are increasingly artificial boundaries will become crucial.

B. Funding

Questions of funding adequacy have been a constant source of controversy in the aged care sector in recent years. In our view, there are two sets of issues here. The first relates to the level of payments, be it in terms of Commonwealth contributions or of payments by people receiving care services. The second relates to the structure of those payments.

The level of payments

Discussions of the level of payments have concentrated on residential care, though there are also issues with respect to care in the community.

While our Service Model recognises and endorses the growing importance of providing care in the community, residential care is likely to remain a crucial component in the aged care continuum.

In effect, residential care can be the most effective way of providing high level care, as it allows that care to be supplied in an accommodation setting that is optimised to the supply of that care, and where economies of scale and density can be achieved including in terms of ensuring adequate, continuous, staffing and supervision. The rising incidence of dementia, as well as of chronic conditions such as diabetes that are characterised by risks of progressive deterioration and multiple co-morbidities, mean that access to high quality residential care will continue to be important in the years to come, albeit in different designs and configurations which enable it to become more homelike.

That care will be supplied in a setting where there is no sharp distinction between what has been until now referred to as 'low' and 'high' care respectively. While care needs will continue to differ substantially among clients, and while residential care will typically cater for higher levels of disability, there will also remain a substantial need for lower acuity forms of residential care, including for purposes of respite and rehabilitation.

Increasingly, we believe aged care services delivered in residential care settings will also be funded through different funding sources depending on the desired outcomes specified for that funding (for example, rehabilitation services could be funded by a State Area Health Service or Local Health Network). A move to a single level of funding has the potential to facilitate this evolution, provided the services required are properly coordinated.

The continued importance of residential care poses a particular challenge to UC Ageing as our residential housing stock is relatively old and requires replacement on a significant scale. Funding that replacement, or at the very least extensive refurbishment, will require significant capital raising. In that sense, UC Ageing has to confront the issue of whether current and prospective income levels will be sufficient to recover long run costs, including the costs of construction or refurbishment.

Our experience in operating a large number of residential aged care facilities is that their financial performance varies (Refer confidential Attachment C). While we are achieving organisationally set targets around budget performance overall, it is our expectation that variation will continue. This variation reflects a range of factors that include:

- the age and configuration of the facility (newer facilities cost more to operate);
- the acuity of the residents (older low care facilities cost less to operate than newer high care facilities);

- where the facility is located (it is more difficult to staff facilities in areas where housing costs are higher and where it is generally difficult to recruit staff due either to remoteness or the economic and demographic structure of the population in that community, e.g. Canberra); and

- staff capability and leadership (this is an ongoing challenge given the structure of the aged care workforce and the funding base which limits the ability of aged care providers to offer comparable wages to those paid in the health sector).

But while the level of long run costs differs among localities, there is little doubt that costs are very high relative to current and prospective payment levels. It is true that some moves in the direction of greater income adequacy have occurred in recent years, with ACFI providing somewhat higher payments, relative to costs, at high levels of acuity. However, those improvements are by no means sufficient to permit long-term capital costs to be covered.

This is especially so if the benchmark is set in terms of the costs of constructing single bed rooms, rather than a shared ward standard. While it can be viable at current levels of provider income to refurbish existing four bed wards, so long as they remain four bed wards, the reality is that market demand is now heavily oriented to single bed rooms and will be so even more in future. A supplier providing four bed wards would find it difficult or impossible to obtain high occupancy levels, especially from non-supported residents, and hence would be unable to spread common costs over a sufficient base of demand.

The issues this raises from an operational perspective are all the more acute as we believe construction costs are likely to rise further, as a result of planning constraints, greater competition for land, greater competition for the skilled labour involved in construction, and mandated increases in the quality of accommodation (notably associated with Commonwealth building certification).

As a result, the question of whether revenues are adequate to cover long run costs needs to be assessed against a base-line of rising costs. This applies for the cost of construction as well as operating costs associated with delivering care, including health and allied health services, hotel services, facility management and transport.

The unsurprising result of payments being less than costs has been under-allocation of places in recent Aged Care Approval Rounds ("ACAR"). From UC Ageing's point of view, the difficulties involved in ensuring the financial viability of residential facilities have led us to emphasise community care, noting, however, that residential care remains important if the care needs of older Australians are to be met.

Our current planning for development of a site in Canberra reflects the difficulties that providers now face. Our evidenced based description of how aged care will be shaped in the future is drawing us to design alternative buildings and structures to enable care to be delivered in a different and more flexible way. However, the current funding model and regulatory environment is focusing the design back to congregate type settings.

For example, we estimate it will cost approximately $20k to convert a functional, universally designed Independent living unit into a certifiable dwelling for residential aged care. This additional cost is not recognised or supported by current funding arrangements. Also, the current operational funding model (subsidy and care recipient contribution) does not support the provision of residential aged care in a disparate environment.

New buildings will have a life of over 30 years and must be designed and built to address future trends, not a current convenience.

The options for addressing this situation are relatively limited: increased payments must come from government, from clients, or both. Moreover, it needs to be recognised that there are limits on the extent to which many care recipients, especially those in disadvantaged areas, can contribute significantly to care and accommodation costs, particularly for the very long duration stays that will account for a greater share of resident-days as the prevalence of dementia rises. Looking out 10 to 20 years, there is therefore a very significant financing need that is currently unmet. But unless it is met, the residential stock will inevitably decline (or at the very best fail to increase), just as the demand for residential care is rising.

All that said, it is important to note that issues of funding adequacy are not limited to the accommodation aspect of residential care. The regulated daily fee in residential care – to offset services such as meals, cleaning and utilities – is set at 84 percent of the single pension. At best, this covers a rather basic standard of living; moreover, the extent of the cost coverage it provides is under stress, notably as labour costs and utility charges rise. Given the obvious difficulties involved in increasing that fee as a proportion of the pension, and absent supplementation from another income source, it is obviously important that there is a margin in the ACFI payments to help cover hotel service costs. Here too, inadequate indexation arrangements are compromising the long term viability of supply, especially if that supply is to meet community standards.

There are also significant issues in community care. In our experience, the number of hours we can provide for the typical CACP package has declined significantly in recent years, as the costs of providing domiciliary care continue to rise. As for EACH, while the packages come closer to being fully compensatory, rising costs against poor indexation arrangements will threaten the number of hours we can provide in the future. Given indexation arrangements that bear no relation to the cost increases the sector experiences, it seems only a matter of time before issues of funding adequacy also come to the forefront in community care.

Our experience in delivering community care services varies across locations. For example, the costs involved in delivering community care to people living in remote communities like Broken Hill and Menindee and in other parts of Far Western, North Western NSW and some remote coastal communities are very different from those in inner Sydney. This difference is driven by travel costs and time and the availability of sufficient appropriately qualified carers. Without access to higher payments in high cost areas, there is inevitably pressure for the level of service provided to adjust.

In short, the current level of funding impedes, where it does not entirely prevent, providers from responding to the social and demographic pressures that are increasing demand.

We have previously joined with other providers in engaging Access Economics to prepare the following reports:

- Economic Evaluation of Capital Financing of High Care, March 2009; and
- Submission to the Review of the Conditional Adjustment Payment, August 2008.

Our wages expense, representing over 65% of total organisational expense, increased by 3% with effect from 1 July 2010. Other costs are expected to rise in line with CPI, with utilities expected to increase by over 10%.

The main findings of those reports, available to you upon request, retain their overall validity today. Indeed, in relation to indexation, providers are even worse off than in August 2008 following the announcement of the indexation factor of 1.7% which applies from 1 July 2010. With the annual all groups Consumer Price Index currently at 3.1%, the resulting funding shortfall represents over $3 million for our organisation. The impact over time from this shortfall will inevitably force us to review the services we provide.

The structure of payments

While public commentary has focussed on the level of payments, we believe there are also serious issues with respect to the structure of payments.

That structure is marked by very considerable complexity associated with a multiplicity of pay points, i.e. of individual elements for which specific payments are to be made. Additional complexities arise from the controls over pricing, which are then compounded, from the point of view of the care recipient, by the interactions between the rules regulating co-payments for aged care and the tests for eligibility for social benefits, notably the aged pension. The result is a structure that is opaque, if not incomprehensible, to users, and that produces any number of discontinuities and unintended consequences. At the same time, the complexity imposes significant compliance costs on suppliers, who have to keep track of a large number and variety of separate payments. Last but not least, there are some services – for instance, those associated with wellness and social integration – for which payments are simply not available.

It is clear that many of these complexities have developed as a result of the attempt to control fiscal risk while nonetheless adjusting payments to meet emerging needs. Other complexities have then been added by the price controls, which evolved as a way of protecting consumers from price gouging in a market where the planning system creates a degree of artificial scarcity. But while these goals (of protecting consumers from price gouging and limiting fiscal risk) are commendable, the current structure is a very blunt and costly instrument with which to pursue them. For instance, the goal of protecting consumers from localised market power is best advanced by removing barriers to entry, and allowing competitive supply to develop, rather than through price controls, provided appropriate measures are in place to protect disadvantaged people. Of course, fiscal risk is best managed by ensuring subsidies are targeted to disadvantaged people, while putting in place a long run framework in which those people who can afford to pay for services do so – a theme to which we return below.

As well as not being ideally suited to achieve its goals, the current structure of prices and of price controls creates other distortions. In particular, the prohibition on bonds in high care creates an incentive to favour entry into low care, or to in other ways cross-subsidise high care from low care (most notably through ‘ageing in place’). This, however, makes the long-term financial viability of high care dependent on the flow of entries into low care, which is both inefficient (as it skews the structure of supply) and likely to be unsustainable (as the ratio of low care to high care demand falls).

The restriction on bonds in ordinary high care also creates what amounts to a price umbrella for extra service (which is allowed to charge entry bonds), as it makes it more attractive to provide extra service places than it would be in a less regulated market.

UC Ageing has not participated in the extra service funding places available. This has been a deliberate policy decision we have taken possibly to our own financial detriment. However, we have done so because we believe current Government policy around extra service places is flawed. It is a policy which creates an illusion of two classes of care, where some people are paying more for higher standards of care even if that is in areas like hotel services and the quality of the built environment. Inevitably, this system works to create perceptions of two classes of residents that should be segregated. Because we believe strongly in social justice and social inclusion, our philosophy around service provision is to try as best we can to reflect the normal social mix of any community in our care settings. We further observe that there are restrictions on the number of extra service places available and that these tend to be located in higher income areas.

That said, we are not opposed to service differentiation. It is a fact of life that older people's access to resources varies, and that some people will value, and have the means to pay for, a higher standard of hotel services. But the growth of extra services is not primarily a market response to differentiated patterns of demand, as would occur in a less regulated market; rather, it is a response to an artificial restriction on supply, and one that is both inefficient and inequitable.

In effect, it could be argued that a significant share of the growth in extra service merely reflects the regulatory distortion associated with the fact that bonds are allowed in extra service but not in other forms of high care. Given that other prices are controlled to levels that do not cover long run costs, the result is to suppress supply in ordinary high care. This, in turn, has two effects. First, it tends to reduce quality in ordinary high care (relative to the level of quality that would be chosen in an undistorted market), as it limits the ability and incentive of suppliers to upgrade their facilities. Second, it leads to some degree of rationing of demand, as the number of places does not keep up with growth in need. The extra service sector then responds to, and benefits from, those developments.

This is inefficient, first because extra service may expand even when the least cost expansion would be in ordinary high care, and second, because the resulting relative quality levels provided are unlikely to best match the pattern of demand. It is also inequitable, because it forces the less well-off to put up with rationing and a degree of service degradation, while the better-off can both jump the queue and do so to better quality service.

Additional distortions arise as the interaction with the pension means test makes it attractive for residents to trade-off higher entry bonds against lower daily fees. This creates opaque, poorly targeted transfers between taxpayers (who bear the costs of increased pension entitlements that result from higher bond payments) and providers of care (who benefit from the reduced price elasticity of demand with respect to entry bonds). While this also occurs in low care, the consequences are especially perverse in high care, where it creates a degree of taxpayer subsidy of extra service places (as only extra service providers can charge bonds, and hence benefit from the transfer).

It is difficult to believe that any of these outcomes would be intended or desirable.

There are additional issues that arise in community care. As we have noted, there is a substantial gap between CACP and EACH payments. This makes it difficult to incrementally scale up domiciliary service provision as acuity rises, likely precipitating some unnecessary entry into residential care. It would be preferable if the payment scheme for community care involved a range of acuity levels, allowing a smoother increase in service levels as needs evolved.

Moreover, differences in co-payments between CACP on the one hand and HACC on the other can distort care recipients' choices. Co-payments are lower under HACC, so HACC may be preferred, even when a package would better address the care recipient's needs.

The gap between CACP ($36.05 per day) and EACH ($120.50 per day) is $84.45. Further distortions occur when compared with Transitional Aged Care Packages. Rates for some of these programs are set by a local Area Health Service as $344 per day for services in a residential setting and $210 per day for services in a community setting.

C. Human resources

UC Ageing has over 6,000 employees and over 2,100 volunteers.

86% are women
23% are casual employees
62% are part-time employees

Aged care is highly labour intensive, with the primary inputs being people and physical structures (i.e. buildings). While the growing importance of information technology is affecting the pattern of outlays, IT expenditures too are likely to primarily involve new kinds of labour costs once adequate systems are in place. Overall, industry surveys show wages typically amount to some 70 percent of operating income, and that is likely to remain the case. Moreover, it hardly needs to be said that attracting, retaining and appropriately managing high calibre, dedicated staff is key to delivering the quality and consistency of care older Australians can legitimately expect.

45% of staff have English as a second language

42% are either casual or work less than 2 full shifts a week.

As a charitable organisation, we can benefit by attracting and retaining staff who are motivated by and committed to our social mission and broader values. Moreover, those broader values shape our approach to staffing issues, and hence provide our people with confidence that they will be treated with respect and encouraged and assisted to make the best use of their capabilities. Our charitable purpose, in other words, underpins not only the assurance we can provide to the people we serve, but also the environment and set of expectations that can be held by our staff. This is an important aspect of non-profit organisations such as UC Ageing.

That said, it is obvious that we must compete in the labour market for skills and people. Moreover, how we contract in that labour market must respect broader constraints arising from the industrial relations system. There is therefore a complex interplay of staffing needs, labour market realities and industrial relations constraints.

In navigating that complex interplay, difficulties arise from differences in funding available to aged care on the one hand and to the health system on the other. Simply put, from the point of view of aged care providers, it is unsustainable for health care funding to increase at a rate that allows it to bid all forms of health professionals away from other uses, while funding for aged care remains hindered by inadequate indexation of public payments and restrictions over client co-payments.

The resulting problems are likely to become more acute in the years ahead, for three reasons.

First, political pressures to deliver better outcomes in the health system – especially around indicators such as waiting times in emergency treatment and for elective surgery – will further increase the health care system's demand for staff, aggravating existing shortages of trained professionals. Although there are plans for expanding supply through increased training programs (and incentives for staff to remain in the sector), as well as (limited) scope to address some of the issues under current migration arrangements, these are not likely to be sufficient to materially alter the supply/demand balance over the next decade.

Second, with responsibility for setting funding for health care (and notably hospitals) shifting to an independent authority that will determine case-mix payments, hospitals are likely to receive payments that will make them even more competitive in the labour market. Moreover, public hospitals are less constrained by long run breakeven requirements than aged care providers. As a result, even if the case-mix payments were not fully compensatory, it is likely that the political pressures on hospitals to meet performance indicators such as those mentioned above would lead them to nonetheless compete aggressively for staff. In contrast, funding for aged care is subject to the constraints we have discussed.

Third, low birth rates are translating into slower growth in the labour force, while rising levels of education are expanding the range of choices available to labour force entrants. Over the course of the next two decades, these factors are likely to reduce the availability of staff for some of the less skilled tasks that are an important factor in the supply of personal services. Combined with declining availability of informal carers and volunteers, this will accentuate the labour availability problems faced by aged care providers and translate into rising costs.

These difficulties have already seen a trend in the sector to substitute away from highly skilled nursing staff. Some of that shift may reflect the achievement of real efficiencies and a more person–centred, homelike, approach to care, i.e. better utilisation of existing resources, as well as recognition that people prefer to receive care in their home. However, there must come a point where the process reaches the limits set by the needs to provide consistent, high quality, service. There is also a risk that any scope for savings in that respect will be limited by regulatory requirements mandating particular staffing ratios, regardless of the adequacy of income streams to support those mandated staffing ratios.

Difficulties in terms of staff availability are then compounded by the constraints the industrial relations system imposes on efficient contracting with staff. From our point of view, it is desirable to have an enterprise award that provides flexibility and avoids artificial demarcations in the use of our human resources. This requires an integrated approach across the range of our operations.

While the transition to the new Modern Award system could consolidate some of our existing award and agreement structure, an organisation with a broad service profile such as UC Ageing will still be required to operate under the coverage and scope of a significant number of Modern Awards to effectively cover all current and emerging job classifications.

This new industrial framework therefore still presents a degree of complexity similar to current multiple-award structures. One alternative is the development of a single enterprise arrangement; while this would allow for a single industrial framework we would then be responsible for the development, maintenance and parity of this agreement. Furthermore, the relevant Modern Awards still maintain an implicit division of Residential and Community Care workforces, notional references to coverage in the Modern Aged Care Award notwithstanding. The changing nature of the aged care industry with the focus on person-centred care, the provision of client-based services across the continuum of care, and the ever-increasing focus on community and home-based service provision are not adequately reflected in the new Modern Award system, in terms of classification structures and award provisions.

As a result, any organisation which intends to manage delivery of aged care across the continuum will either have to contend with a cumbersome and outdated industrial framework, or design and/or negotiate a significantly different Enterprise Based Agreement structure. Either option imposes a range of additional costs and burdens for an aged care provider.

Moreover, UC Ageing is opposed to the setting of staff-to-care recipient ratios for registered staff because we believe this is simplistic and will simply drive up costs in aged care. We understand the desire by some organisations to entrench the role of registered nurses in aged care: and there is certainly a place for Registered Nurses in aged care. There is, however, also a need to respond to changing work practices. Increasingly, the role of the Registered Nurse, along with other categories of Nursing Professionals (such as Nurse practitioners and Clinical Nurse Consultants), is to provide highly professional evidence-based clinical assessment, advice and mentoring to care workers around the care needs of the people we serve.

Our view is that the assessed care needs of the people we serve should drive the composition of the staff provided. We are about to embark on a cost of care study which will look at the assessed care needs of people across our 80 residential services and arrive at some standard rosters to align with those profiles of care need.

While we appreciate and support the need to give priority to local employment, the reality is that the workforce shortages we face in aged care will not be met solely by local strategies. Our proposed partnership with a Training College in the Philippines would have enabled us to directly recruit a limited number of Assistants in Nursing for training and then offer them career pathways to becoming (over two years) permanent residents - if that outcome was supported by them and the Government. As detailed in the accompanying text box, these assistants would have helped us address immediate situations where older Australians need additional care: however, the government has made our ability to address this need conditional on "stronger Union endorsement". We believe the legitimate concerns of our workforce and its unions can be addressed without compromising on care needs.

Overall, given the demographic trends, the long term requirements of the aged care sector should be given increasing weight in the planning of the health labour force. While the recent health reforms do provide for better labour force planning, the reality is that that planning remains centred on the health system. Along with differences in access to funding, and with rigidities arising from the award system, this threatens the ability of aged care providers to meet their staffing needs and to ensure the best use of human resources.

We have had a recent negative experience with the Commonwealth Government (across three departments, with resulting difficulties of coordination), which has hindered our ability to enter into a Labour Agreement with a Training College in the Philippines. That Agreement would have enabled us to recruit a limited number of semi-skilled Nursing Assistants into our services to meet acute workforce shortages in specified locations. This application, we believe, was the first to be approached in aged care. We made the application with the advice of an immigration lawyer in 2008 on the basis of extensive research and supporting evidence. Three Government departments needed to support the application – the Department of Immigration and Ethnic Affairs, The Department of Education, Employment and Workplace Relations, and the Department of Health and Ageing. Union and industry endorsement was also required. After two years, we remain "in limbo" with no resolution and a recent request from Government that if we wish to proceed, we will need to submit another application and obtain "stronger Union endorsement".

D. Quality regulation

A final factor that hinders our ability to respond to the changing needs of older Australians is the current system of quality regulation.

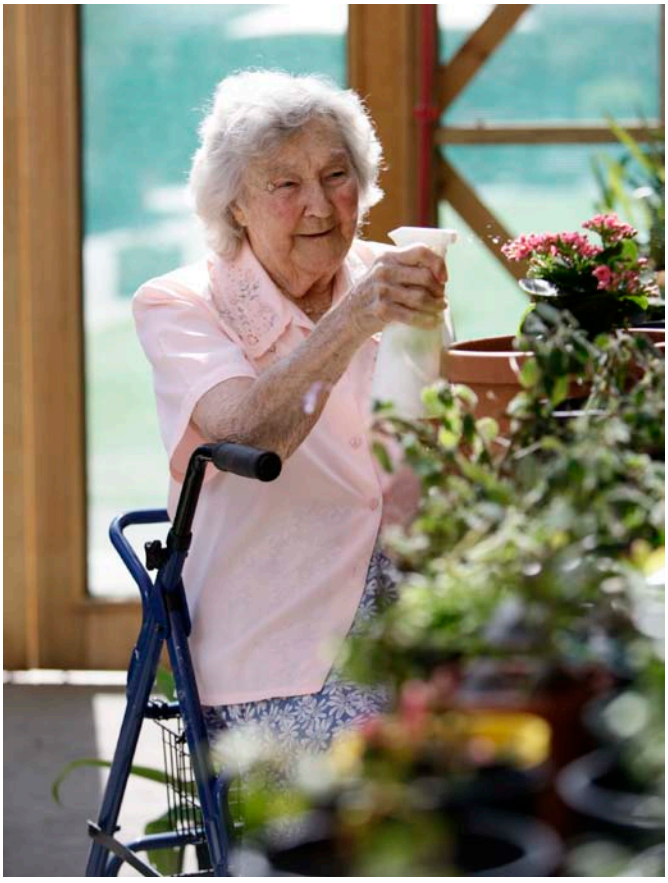
UC Ageing is fully committed to providing the highest level of service quality. Our commitment to the safety and wellbeing of clients is fundamental to every aspect of the operating model we have sought to implement. And we recognise that the condition of many care recipients makes it imperative that there be effective processes that can protect those care recipients' interests, including through adequate regulation. This is not an area where short cuts are acceptable, much less desirable.

However, quality regulation, as it has developed in the sector, has been more heavily focussed on inputs rather than outputs, most obviously in residential care. In residential aged care, there are elaborate, costly processes for accreditation, along with spot checks and inspections, and very time-consuming, mandatory, processes for managing complaints, with little scope to vary the process in line with the likely severity of the incident. While the accreditation process does mandate interviews with clients, audit reports generally refer only simply and broadly to interview findings, with little being done to systematically measure outcomes, including in terms of client satisfaction levels, or to make outcome-oriented measures available to the public. (Included as Attachment D is our July 2009 response to the May 2009 discussion paper "Review of the accreditation process for residential aged care homes", which provides greater detail on the accreditation process.)

There are different systems for quality assurance in community care, with those systems differing as between Commonwealth and State governments. The accreditation systems for community hospitals, for supported accommodation and for retirement villages then differ again.

All of these factors translate into significant costs: what can be very large amounts of staff time are devoted to processes that seem to have scant benefits. As in other industries, there is also the risk of engendering a 'tick the box' culture that values compliance with process rules above responding to client needs. There is a danger, much emphasised in the international literature, of transforming aged care centres into hospitals, where the need to ensure process integrity dominates over the desire of clients to retain independence and the capacity to take decisions. Such an approach will inevitably clash with the preferences and expectations of the baby boomer generations.

Looking to the future, an increased emphasis on community care would sit more naturally with a different approach to quality regulation. To begin with, a move to consumer directed care – managed by the client and/or by an advocate on behalf of the client – can in itself provide a significant degree of quality assurance. In a competitive market for care provision, community care recipients (or their advocates and counsellors) are likely to be able to monitor quality and 'vote with their feet'.



Moreover, as care moves to a greater variety of accommodation settings, it is difficult to see how current regulation, which is very much shaped by the residential care environment, could migrate with it, nor would such a move be desirable. Rather, attempts at transferring the current framework into such wider settings are likely to make those settings unviable, both by inflating building costs and by forcing poor use of staff time. As a result, a different approach is required.

IV. Conclusions and a way forward

Overall, UC Ageing is committed to a Service Model that, in our view, best responds to the needs and expectations of older Australians. Implementing that Service Model has required a shift from an emphasis on providing residential care to a far wider approach, that stresses goals of wellness, prevention, social integration and independence, and seeks to promote those goals by intervening in a broad range of settings.

Achieving the full potential of this Service Model requires great flexibility in the services provided and in the settings in which those services are provided. It also requires flexibility in the use of resources and most notably of our people's time and skills. And of course it requires adequate funding that can be deployed in line with client needs while ensuring long term financial viability.

These elements are not now in place. Policy and regulation create silos that impede the efficient use of resources and limit responsiveness to client needs. In addition, funding levels are inadequate and will compromise the ability to provide services, most obviously to the financially disadvantaged. There are also serious problems with long term availability of skills and people, while industrial relations constraints impede efficient management of human resources and regulation focuses on inputs and processes rather than on needs and outcomes, imposing unnecessary costs and undesirable rigidities.

We therefore now turn to considering policy options in each of these areas

In considering policy options for dealing with the issues we have identified, we believe the Commission should rely on the following criteria, accepting that they involve some degree of overlap:

- **Equity and universality of access**: the policy framework should ensure all older Australians, regardless of their financial position, life history or place of residence, have access to the care they require to lead satisfying lives in old age, including in terms of promoting well-being, independence and dignity.
- **Efficiency**: the policy framework should ensure resources devoted to the care of older Australians are allocated to the highest value purposes and are used in a way that maximises the community's return on those resources, including by avoiding placing unnecessary burdens on taxpayers.
- **Transparency and simplicity**: the policy framework, the regulations in which it is embodied and the market in which care is provided should be understandable to clients and their families, allow clients and their families to take informed decisions and avoid imposing unnecessary regulatory burdens on care recipients or care providers.
- **Consumer sovereignty**: the policy framework should ensure that to the greatest extent possible, it is the needs and preferences of older Australians that determine what is provided and how it is provided. The demand side of the market needs to be empowered to ensure outcomes meet the preferences and needs of older Australians.
- **Stability, predictability and sustainability**: the policy framework should ensure that all those affected by the system – be they the older Australians it serves, their families or care providers – have a reliable basis on which to plan and take long term decisions.
- **Diversity and innovation**: the policy framework should create scope for diverse, competitive supply, and encourage innovation, including by facilitating cooperation between aged care and other areas of policy affecting older Australians, notably the health and retirement incomes systems.

It is with these criteria in mind that we now discuss each of the following:

- Allowing consumer choice;
- Placing funding on a sustainable basis;
- Expanding the range of accommodation options;
- A consumer-focussed quality framework;
- Ensuring coordination with the health system;
- Meeting labour force needs;
- Facilitating industry restructuring; and
- Supporting continued development through research and evaluation.

A. Allowing consumer choice

There are two fundamental impediments to consumer choice in the current aged system. The first is the rationing of places; the second is de facto bundling of accommodation and care. These are, in our view, inefficient, inequitable and ultimately, unsustainable.

These impediments spring in part from the history of the aged care system, which developed with a strong focus on residential care. As the Commonwealth assumed the funding responsibility for aged care, it maintained that focus, and then imposed rationing both as a resource allocation tool and as a means of managing fiscal risk. The consequence is a system that seriously distorts outcomes.

It skews the structure of supply, both between community care and residential care, and among forms of care in each category (for instance, between low care, conventional high care and extra service). Moreover, with limited places, it is by no means obvious that those who obtain care are those who value or benefit from it most highly. And even if those who need care obtain it, they may not do so in the setting they prefer: for instance, the limitation on the number of community care packages to 22% of places means that older people who might prefer to continue receiving care at home (or in a congregate setting that is less institutionalised than residential care), can be forced to move into residential care as their condition deteriorates.

The overall outcome is then inequitable, in that the affluent can purchase domiciliary care for themselves, thus fulfilling their preference for care provided in a community setting; that option is not open to the financially disadvantaged, who may therefore have little alternative to residential care – and even then, will usually not be able to access what places there are in extra service.

We believe these features of the system to be not only undesirable but also unsustainable. Older people will make up a steadily larger share of the electorate in the years ahead: By 2020, voters 65 and over will account for a fifth of the voting population; that share is expected to increase to a quarter by the end of that decade. It is difficult to believe that the current system could persist at a time when an ever greater share of older Australians will require some form of care.

Rather, the sensible approach is to begin now to transition to arrangements that are more efficient, more equitable and financially sustainable. The key elements in this respect are to:

- Make funding for care dependent on a person's assessed care needs, irrespective of the accommodation setting;

- Allow people to choose the accommodation setting in which that care, and the associated funding, is received; and

- For those people who are unable to make that decision, there should be provision for the appointment of independent advocates removing the bureaucracy and time involved in seeking more formal guardianship.

Such a move to neutrality in the choice of accommodation venue would require a parallel move to a single classification of care across a continuum from low care to very high care. This classification should support client outcomes to:

- Promote wellness and Healthy Ageing;
- Support and sustain healthy choice;
- Provide assistance and support for Activities of Daily Living; and
- Provide end-of-life support.

This common assessment tool should be agreed to and consistently used by aged care providers to provide the evidence base to support assessed care needs.

B. Placing funding on a sustainable basis

It will not be possible to provide older Australians with the care they require and can legitimately expect unless aged care funding is placed on a sustainable basis. This requires comprehensive reform of funding instruments, along with the development of mechanisms that facilitate provision, by those who can afford to do so, for their eventual care needs. We start by considering the issues associated with the reform of current funding instruments and then discuss the mechanisms that may be required to ensure the sustainability of aged care funding.

Reforming existing instruments

As a general matter, it would be desirable to move towards funding instruments that are simpler and more transparent than those currently in place.

First, as we have noted above, the current **distinction between low care and high care** as a way of differentiating pricing policy is increasingly difficult to justify. The flashpoint in this respect has been the issue of whether high care providers should be able to charge bonds. In reality, however, the policy issue is not with the charging or otherwise of bonds; rather, it is about the appropriate degree of control over the prices that can be charged to people receiving care. At the moment, all charges in ordinary high care are regulated; in contrast, in low care and extra service, charges are regulated with the exception of bonds (which are only lightly regulated through the constraint on the share of assets that a bond can represent). The ability in low care and extra service to thus charge bonds to some extent nullifies the other price controls, making it unclear what function those other price controls are intended to play.

It would seem more sensible to relax the price controls, so long as consumers could be protected from market power. In other words, the current price controls in all forms of care could be eased, in parallel with removing the constraints on the number of places. As an interim step, we would recommend allowing the charging of bonds in high care, though it may be that those bonds should be subject to some form of price surveillance (for instance, a cap on revenue from user co-payments relative to the rate of inflation) . If such surveillance were to be imposed, it should apply on a non-discriminatory basis to all forms of residential care, including extra service. (There are a number of other issues involved in ensuring adequate accommodation is available to older Australians; these are dealt with further below.)

Second, as regards **care payments**, there is merit in moving towards an acuity and risk-adjusted capitation system, assessed on the basis of the population served by the provider. In such a system, payments would depend on the assessed care needs of the population served by the provider. At low levels of acuity, this could involve a simple per capita amount, determined on a basis that allows not only for the provision of care as traditionally defined, but also for programs aimed at promoting wellness and thereby postponing, avoiding or mitigating increases in acuity over time. At higher levels of acuity, some greater degree of differentiation in payments may be required, for instance so as to recognise the care costs of particularly high cost conditions.

Overall, the scheme would amount to a simplified version of case-mix, with per capita payments for low acuity combined with additional payments for specific services required in higher acuity cases. These payments would be independent of the accommodation setting in which care was being provided. The new National Hospitals Pricing Authority would seem best-placed to determine the level of these payments. It could be directed to set these payments on the same basis as it used for determining required payments for hospitals; this would facilitate efficient competition in the supply of those services where the aged care and health sectors overlapped.

Under such a scheme, the current HACC, CACP and EACH would be replaced by acuity-graded payments, with payments for community care being no different, for each level of acuity, from those for residential care settings. However, until such a scheme is put in place, we would recommend retaining HACC (which under the recent health reform agreements, will become a Commonwealth-funded program in all States excepting Victoria and Western Australia) as a separate program, not least because it is currently the only program that supports early and healthy aging interventions. That said, we believe it important to introduce greater flexibility and greater contestability into HACC. Currently, for example, a high share of HACC funding goes directly to the Home Care Service of NSW and to NSW Health. There is no reason why that funding would not be contestable by all appropriately qualified providers.

As regards who should be responsible for determining the use of payments, we can see great merit in Consumer Directed Care as an expression of consumer sovereignty, a way of ensuring value for money and an empowerment of older Australians. There are, however, some important transition issues associated with Consumer Directed Care. Unfortunately, under current funding restrictions, which mean that payments do not properly reflect care costs, maximising the care provided requires some pooling of the income from packages, both at any point in time and over time. This pooling allows a provider some flexibility to vary the service provided in line with the changing needs of recipients, allocating a few more hours to those with high needs and a few less hours to those whose immediate needs are lower.

However, the effect of Consumer Directed Care would be to reduce the scope for that pooling, as each recipient will naturally want to take up, in each period, the amount he or she has available. As a result, until care payments are appropriately compensatory and set by an independent agency, caution needs to be exercised in moving towards Consumer Directed Care.

Third, there needs to be consistency across funding instruments in the determination of **recipient co-contributions**. In particular, the basis for such co-contributions should be the same across care venues, removing the distortions that currently affect, for example, the choices older Australians may make as between packages and HACC.

Means-testing of government payments is required to ensure the fiscal sustainability of the social safety net and thereby ensure universal access. That said, the extent of the means-testing needs to be reasonable, and to keep co-contributions to affordable levels, i.e. to levels which do not prevent older people from receiving the care they need. This is especially important as liquidity constraints can prevent older Australians from accessing resources they are deemed to have available. The fact of the matter is that recipient contributions to care costs have been rising very rapidly in recent years. It would be desirable to have clearer guidelines, and greater transparency generally, in respect of policy and implementation in this area. Better monitoring of the outcomes of those co-contributions, aimed at systematically assessing the impacts of co-contributions on access to care, would also be desirable.

Fourth, **indexation** of payments needs to be cost-reflective. There is no doubt that indexation based on Commonwealth Own Purpose Outlays (COPO) is unsatisfactory, and merely serves to reduce funding in real terms. An appropriate cost of service index ought to be developed that is specific to aged care and used for indexation purposes.[3] If the Commonwealth wants to offset cost changes by a productivity dividend, it should separately justify the quantum of the claimed scope for productivity improvement, rather than arbitrarily reduce payments in real terms. Again, the role of determining the reasonable path of charges over time, as well as their initial level and structure, should be placed in an independent entity, presumably the National Hospitals Pricing Authority, with all the safeguards that will apply to that Authority's decisions in respect of hospitals also applying to its decisions about aged care.

Managing fiscal risk

The changes suggested above are likely to involve an increase in charges over time. At the same time, the volumes of care provided are also likely to be rising substantially: in part because of demographics, and in part as the separation of accommodation from care, and the resulting increased availability of community care places, leads to greater take-up. It is easy to see that this could materially increase the burden on Commonwealth spending.

It is not the purpose of this submission to address this issue in detail. However, the point that is worth making is that there are a range of ways in which the resulting fiscal challenge could be managed. These range from some form of mandatory pre-savings scheme through to various types of insurance, along the lines of the competitive social insurance model, Medicare Select, proposed by the National Health and Hospitals Reform Commission.

[3] Obviously, for services provided both by the health care system and the aged care sector, a common indexation base should be used.

In practice, an efficient approach is likely to involve some mix of options, such as a pre-savings scheme for low level care needs (such as home help) along with insurance against less predictable and potentially catastrophic long duration, very high cost, outcomes (such as dementia). Means testing would then ensure that those who had used these options to accumulate the income required to meet their own care costs would do so, reducing the burden on taxpayers.

By implementing options such as these, the Commonwealth could manage its fiscal exposure far more efficiently than through rationing. It could also build on to these options effective means of protecting universal access, for example, by ensuring that the financially disadvantaged receive income transfers that allow them to participate on an equitable basis in any pre-saving or social insurance mechanism.

The policy lesson, in other words, is that rationing is not required to meet the Commonwealth's understandable goal of managing the burden on taxpayers associated with long term trends in the requirement for care. Rather, this objective is better met by explicitly recognising the need to make provision now for care needs in the future. While transitioning to such arrangements will inevitably take time, the sooner a start to the process can be made, the lower the eventual burden will be.

C. Expanding the range of accommodation options

The changes outlined above will in themselves address many of the distortions that currently impede the allocation of capital to residential care. However, it is also important to address other issues that prevent older Australians from having access to the full range of housing options they require.

In considering these issues, it is important to be mindful of two trends.

First, while the next two to three decades will see very substantial increases in demand for aged care in all of its forms, the bulge of demand associated with the aging of the baby boomers will eventually play itself out, and the absolute size of the older population will stabilise. There is also the possibility that a cure will be found for dementia, at least in its less severe forms, reducing the demand for institutionalised care. Given that the building stock has a life of fifty years or more, it is important to ensure that it has the flexibility to cope with changes such as these.

Second, there is likely to be a strong preference among older Australians for accommodation settings that are less institutionalised and age segregated than conventional residential care. The alternative to that setting, however, should not be solely the family home, which is often poorly adapted to the needs older Australians have, including the need for social integration. For many older Australians, living in the family home creates a risk of social isolation, including because of poor access to public transport, while also impeding timely and cost-effective delivery of care.

There is consequently a significant opportunity to develop accommodation options that allow the efficiencies in care provision associated with congregation, but provide a more home-like environment than conventional residential care, cater for a more diverse population (including, importantly, in terms of age brackets) than do retirement villages, and are flexible in their range of uses. As well as better meeting the preferences of older Australians, such an approach is also likely to be more efficient in managing the demand risks noted above.

To this end, it is important to remove policy and regulatory obstacles to flexibility in the development of new housing options. An important obstacle exists in the form of current building certification requirements around 9C buildings, which make it difficult to develop residential care facilities that offer domestic scale houses and apartments. A comprehensive review of these requirements would be warranted.

At the same time, it is also important to note that there are significant populations that, without adequate government funding, will not have access to the accommodation they need in old age. These include long term renters, who may have little security of tenure and be in housing stock very poorly suited for conditions such as frailty and vision impairment, the homeless, who often also suffer from mental illness and may be highly vulnerable to psycho-geriatric conditions, indigenous Australians, and people in remote communities.

In the past, government provided incentives for new accommodation options to be developed, for instance by funding the construction of independent living units in the 1970s. Since then, programs have been more episodic and there has been little continuous attention paid to ensuring the adequacy of the housing stock. There is a requirement for a more integrated approach that would be coordinated with other housing-related funding programs, notably NRAS.

We believe NRAS could make an important contribution to expanding older Australians' housing options, especially targeting the needs of disadvantaged groups. However, the scheme's effectiveness is compromised by the limited amount of the incentive it provides, its 10 year ownership assumption and the functioning of the Commonwealth/State shared arrangements. These features make it difficult to develop housing options under the scheme that will cover their cost of capital. Reforming these features of NRAS would be warranted; together with portability of the accommodation component of aged care payments, this would help reduce the shortfall in housing availability.

Finally, retirement villages are a significant accommodation option for older Australians. The trends we have outlined above, including the emerging preference of older people for a mixed demographic setting, could challenge conventional approaches to retirement villages in the years ahead. Nonetheless, this option has a role to play, and it should not be impeded from competing by unnecessary regulatory constraints. Greater consistency of approach between the States and Territories could help in this respect; whether achieving that greater consistency requires a transfer of regulatory powers to the Commonwealth is worth considering, noting that there can also be some value in diversity of approach.

D. A consumer-focussed quality framework

We have noted above our concern that the current quality framework is geared to inputs rather than outcomes, and does not provide a consistent and consumer-oriented approach to ensuring quality in aged care. That said, the current system, administered by the Aged Care Standards and Accreditation Agency, has to be seen against the backdrop of the need, at the time of its introduction, for urgent and effective action to raise service standards. Viewed in that perspective, we believe the system has served consumers and providers well. Today, however, most providers are fully accredited and thankfully, sanctions are rare. It is therefore timely to reconsider the arrangements, with the goal of increasing their focus on consumer outcomes.

Such a reconsideration is all the more merited given just how onerous the current quality system is for providers. The activity around reportable assaults is also very significant and it is questionable whether that activity serves its purpose of improving safety outcomes for consumers. Moreover, compliance burdens are increased by the fact that there is a different quality system for community care and residential care. As well as increasing the load on providers' management processes, this difference impedes simplification of the care system for consumers. We would be happy to provide the Commission with information on our direct experience in each of these respects.

As noted above, we have recently expressed our views on how the quality system in aged care should be developed. The document setting out those views is attached to this Submission. In summary, our recommendations are as follows:

- We believe that a new approach to quality should evolve where providers receive four years of accreditation which remains in place as long as there are no breaches.
- The Commonwealth should develop a scorecard of performance measures including outcome measures against which all providers should be held accountable.
- Performance on these measures should be available for consumers both on the DoHA website (or a My Aged Care site) and on the provider's website.
- These measures should include measures around customer satisfaction; staff satisfaction/engagement; care performance; key performance indicators expressed in terms of dollar outlays (e.g. care cost to revenue); and safety outcomes.
- Benchmarking providers on these standard KPI's should also be encouraged, though that may take some time to make fully operational.
- Should providers wish to include other information that differentiates their service delivery then that should also be included, so that consumers and their advocates can make informed choices about where they want care delivered and from whom.
- Clearly this approach to quality would always need to be underpinned by a solid consumer protection framework with clear avenues for consumers and their advocates to pursue in the event they believe there is evidence of poor practice and sub-standard care.

E. Ensuring coordination with the health system

Coordination with the health system will be crucially important in the years ahead. To begin with, such coordination is critical to securing good outcomes for older Australians, both by ensuring care is provided where it best suits their needs and by minimising the risk of care needs 'falling between the cracks'. At the same time, coordination is needed to ensure the additional funding devoted to health is used most efficiently, including in appropriate prevention programs.

However, while it is easy to see the importance of coordination, achieving it has been and likely will remain a challenge. The fact that the health care system is about to experience significant structural change in its governance arrangements makes that challenge all the greater, as relatively little thought appears to have been given to how aged care will relate to the new arrangements.

However, we believe there are notable positives to the changes that have been agreed. For example, a move towards integrated Commonwealth/State funding for health has the potential to also facilitate better allocation of resources between the health system and aged care. Equally, a move to case-mix funding for public hospitals could be a basis for allowing care needs that could be met more efficiently in the aged care sector to be met in that sector, i.e. a move toward greater contestability of the funding provided to the hospital system.

However, the mechanisms needed to achieve these benefits are not in place, nor has their design and implementation figured significantly in the public discussion. As a result, there is little clarity as to specifically how the aged care system is to interact with the proposed local hospital and primary care networks.

Without wishing to pre-empt the discussion that needs to occur, we believe the mechanisms ultimately developed should facilitate the allocation of care tasks to the level of care that can provide the required care most efficiently, i.e. at greatest net benefit to the community, taking account of the benefit to the recipient and the cost to the funding source. One area where the current arrangements fail in this respect is transitional care.

Thus, we are confident that UC Ageing (through its services at War Memorial Hospital) can demonstrate that it is a more efficient provider of transitional aged care services than traditional health providers where those services are costed on a medical model. Unfortunately, how and whether aged care providers are considered as realistic alternatives to provide transitional and other sub-acute care services depends on the attitude of the Area Health Service (in NSW) to the service delivery. In most cases, Area Health Services believe these services are better provided through formal health services. This belief ought to be open to market-testing, through portability of the case mix payments for transition care delivered by aged care providers in a range of care settings.

Similar issues about portability, and ensuring care is delivered where it can be provided most efficiently, apply to Hospital in the Home services. New South Wales has a very under-developed approach to Hospital in the Home programs compared to other states (especially Victoria). Given the size and capacity of many aged and community care providers in delivering a wide range of community care services to people in their homes, there should be opportunities to implement and evaluate how aged care providers can be involved in these programs. There is a precedent in Silver Chain in Western Australia which delivers substantial Hospital in the Home services through its community care services across metropolitan Perth. Again, this is an area where greater portability of payments between the aged care and health care systems could achieve substantial efficiencies.

For that portability to occur, there needs to be greater consistency in the payment structures between the health system on the one hand and aged care on the other. Here two trends currently at play in the health system are relevant: the move to capitation payments for chronic conditions, notably diabetes; and the move to case-mix payments for hospital services. As we have noted above, there is potential to use both of these payment structures in aged care, with capitation for lower level care and case-mix for higher acuity, more complex needs and for episodic interventions.

That said, we would not want to understate the issues that would need to be addressed in moving aged care payments on to such a basis. Thus, capitation payments can impose substantial risks on care recipients and providers, and could be particularly challenging for smaller providers (who could not pool the relevant risks across a large served population). Great care also needs to be taken to ensure there is proper risk equalisation in any capitation scheme, in other words, that the capitation payment appropriately reflects the care needs of the care recipient (and evolves with those care needs over time). As for case-mix, there are difficult issues about how it will cater for fixed costs, i.e. the basis on which the payments will be set. What is important is to ensure that as these issues are considered in the health care system, their potential relevance to aged care is fully taken into account, with the goal of providing for the greatest degree of contestability in service provision between the health care system on the one hand and aged care on the other.

There is also a significant need to ensure better coordination of labour force planning as between the health system and aged care. This ought to be an important part of the mandate and responsibilities of Health Workforce Australia, providing an opportunity for a more comprehensive and systematic approach than has been adopted to date.

Last but not least, ensuring care recipients can better navigate as between the aged care and health care systems will require progress in electronic information transfer between and within these systems. UC Ageing is very supportive of electronic health records and we are actively engaged with NeHTA to ensure that our care management systems are NeHTA compliant. But there is still a long way to go in respect of health informatics, and it is essential that the aged care and health care sectors work together in moving the application of IT in these sectors forward.

We have recently been involved in selecting a new community care system able to provide information on care needs around the person in a range of care settings across our Service Model continuum. That experience has shown us that this market is grossly under-developed and could benefit from some industry incentives by Government, including recognition of the development costs involved.

F. Meeting labour force needs

We have canvassed above many of the issues associated with ensuring aged care can meet its labour force needs going forward. Five points are worth emphasising.

First, it is difficult to attract and retain sufficient appropriately qualified staff into aged care when the wage differentials with health care are so great. Moreover, the substantially increased funding being made available for health care has the potential to seriously exacerbate this problem in the future.

Second, the issue of the ability of aged care to provide competitive remuneration will become even more important to the quality of outcomes in aged care as the content of aged care services changes. Those changes will demand an increased role for, and an increased contribution by, more highly trained staff. Enabling the employment of more allied health professionals and Nurse Practitioners will be needed to allow aged care providers to support older people more effectively and efficiently either in their homes or in other care settings thus avoiding entry into hospital. At the same time, and no less importantly, future aged care must be in a position to attract and retain highly qualified professional, managerial and administrative staff if it is to be run more efficiently than it has been run in the past. The fact that the technology used in aged care is advancing so rapidly makes this all the more challenging, as competition for technologically skilled staff is intense.

Third, it is impossible to address this issue without placing funding on a comparable basis as between the aged care and health care systems. Ultimately, what is required is that where the aged care system can provide a service efficiently, it can access a level of funding that reflects those efficient costs, and can do so to no less an extent that can the health care system. Moreover, the funding available to aged care needs to reflect the costs it can allow the health care system to avoid, thus aligning the incentives for cost-avoidance with the scope to deliver that cost-avoidance.

Fourth, while aged care will require a very substantial absolute increase in the number of trained and highly trained staff, it will also remain reliant on large numbers of staff with lower skill levels, including some who are in the course of training. There needs to be a frank discussion about how those needs for less skilled and unskilled staff will be met in the future, including the role of the immigration program.

Fifth, the industrial relations system needs to support rather than impede flexibility and productivity growth. We have noted our concerns about the Modern Award system as it applies to our operations; here too, there needs to be a frank discussion about how those difficulties are best addressed.

We have noted the scope for Health Workforce Australia to play an important role in addressing labour force planning issues. However, these issues cannot be sensibly considered outside of the economic context that shapes them. As a result, it will be important for the Commission to provide the aged care sector, and entities such as Health Workforce Australia, with guidance as to an economic framework that can allow the industry's workforce needs to be better met in the years ahead.

G. Facilitating industry restructuring

Since the Hogan Report, considerable attention has been paid to the need to increase productivity in aged care. One aspect of achieving that goal must be to deal with an industry structure that remains highly fragmented and has many operators that appear to be well-below minimum efficient scale.

The issue of the future of these operators, and of the long term structure of the sector, is likely to come more sharply into focus as:

- Liberalisation of entry increases competitive pressures in the sector, with a deregulated market emerging in which consumers choose where, how and from who they receive their care;
- Changes in the aged care service delivery model, which will be imposed by those competitive pressures, will require substantial investments by providers in new information management systems, in IT systems generally and in building workforce capability and leadership; and
- Issues of renewal of the building stock also come into play, likely made all the more acute by some decline in demand for low care.

From our direct experience in integrating 52 separate aged care entities into one, it is difficult to see how stand-alone service providers will have the scale required to provide the range of services needed and to undertake the investments that will be demanded by a less regulated market. Rather, significant consolidation may and likely needs to occur. As well as allowing the sector to more fully achieve economies of scale and scope, that consolidation could make the service system somewhat simpler for people to navigate, for instance in terms of conveniently accessing the full range of aged care services.

The key role for government in this respect should be to define a policy framework in which that industry restructuring can occur. This requires both a more open, competitive environment and stable policy settings that can allow operators to assess their future and determine strategies accordingly. That said, government has supported industry re-structuring programs in other industries; it would be appropriate to consider whether such facilitated restructuring would be warranted in the case of aged care.

H. Supporting continued development through research and evaluation

Australia will not have the aged care system it needs without systematic investment in research and evaluation. Currently, research in aged and community care tends to be very fragmented and is largely driven by the research interests of academics. While curiosity-driven academic research has an obvious role to play, it needs to be supplemented by systematic research and evaluation that can inform care delivery and help shape public policy. Research is also needed to provide the tools the sector will need to manage future care needs.

For example, we note that providing care in the future will require greater coordination between and within care providers as the range of venues in which care is provided increases. Electronic care management systems will be crucial to achieving that coordination. However, government should not underestimate the cost developing and implementing these systems will impose, both on individual providers and on the sector as a whole.

We have already indicated from our experience that there is currently no electronic care management system available in Australia (i.e. adapted to the Australian health and aged care system) able to support the organisation of care services around the person in the accommodation setting of their choice. Developing such a system is merely one example of the kind of task that could usefully be assisted by a systematic research program.

To this end, consideration should be given to having a dedicated aged and community care category in the ARC/NHMRC research programs with funding priorities linked to the achievement of national priorities in Ageing. Consideration could also be given to having a separate research program devoted to Ageing (i.e. going beyond health and aged care into areas such as social engagement and participation, financing options, housing and new models of care etc), assessing and reviewing its implications for Australia's future and the best ways of meeting the challenges it creates. The most recent inter-generational report highlights the importance of the issues associated with population ageing, and future inter-generational reports could draw on research done under such a program.

I. Going forward

The Commission's Inquiry has the potential to be of great significance. Few issues are as complex or as important as the challenge population aging creates for our provision of social and health services. This is not an area where there are easy answers; but the sooner sustainable policies are put in place, the better we will be able to manage the challenges population ageing creates. Those policies will require substantial change relative to the current policy and regulatory framework: our own experience shows how difficult achieving such change can be.

We trust our submission is useful for the Commission's inquiry into Australia's aged care arrangements and would welcome requests for further information or discussion from Commission members or staff.

Attachment A

Summary Service Profile

Service Type	Number	Narrative
Residential	5,319	5,319 residential places in almost 80 locations. 60% of the places are located in the Sydney Metropolitan area with the balance across rural NSW and ACT. Our newest developments are currently under construction at Nambucca Heads, Port Macquarie and Shellharbour. This will increase our total number to in excess of 5,600 places.
Packaged CACP	1,561	1561 CACP packages across NSW and ACT. Approximately 50% of the services are provided in non- metropolitan areas.
Packaged EACH/EACHD	349	349 EACH and EACHD packages across NSW and ACT. Approximately 50% of the services are provided in non-metropolitan areas
Community Other	3,452	We operate a significant range of other Community Care Services including ACHA programs; NRCP (Day Programs and Respite); HACC (Social Support, Respite and Centre Based Day Care); Veterans Service (Nursing and Homecare); Mens Sheds and other private services. These services are spread throughout NSW and the ACT depending on service need.
Independent Living Units	2,439	We operate a wide range of ILU villages across NSW and the ACT with the size ranging from our smallest village of 4 units to our largest of 114 units. Of our total number, over 25% are occupied by people from a financially disadvantaged background.

Attachment B Confidential – This attachment has been removed intentionally due to confidentiality.

Attachment C – Confidential – This attachment has been removed intentionally due to confidentiality.

Attachment D - July 2009 response to the May 2009 discussion paper "Review of the accreditation process for residential aged care homes"

Response to the Department of Health and Ageing's May 2009 discussion paper –

Review of the accreditation process for residential aged care homes

UnitingCare Ageing NSW.ACT - July 2009

Background

UnitingCare Ageing NSW.ACT, a service group of UnitingCare NSW.ACT is the single largest provider of aged care services in New South Wales and the Australian Capital Territory with around 14,000 people in our care. UnitingCare Ageing offers care in a range of settings including the residential setting, community care, retirement living, day centres, respite care and private nursing services.

UnitingCare Ageing's residential services [including the services supplied by Wesley Mission] include over 90 residential facilities as home to approximately 6000 people. We cater for low, high care and specialised needs and focus particularly on the provision of care to those who are disadvantaged, vulnerable and isolated. We employ almost 6000 staff who work in our services which are spread across the state and ACT. Our staff are supported by approximately 1500 volunteers.

We seek to provide positive lifestyle choices for people with services delivered in a Christian context characterized by love and compassion for all. The organisation has a tailored person centred model of care which was collaboratively developed. The model, INSPIRED CARE, focuses on relationships between people and reflects UnitingCare Ageing's mission, vision and values.

UnitingCare Ageing NSW.ACT is committed to the provision of high quality care across the continuum of aged care services. As such we are completely committed to a system that ensures that all people receive the care they need in the environment most suited to them. Also that any regulatory system provides assurance for the community that those services providing care do so in a cost effective, diligent manner and caring manner.

We propose that the following attributes are essential to a sustainable accreditation system.

- Resident focus. The person receiving care, and their quality of experience, must be the focus of any system. The expected outcomes of the Accreditation Standards are largely resident outcome focused. It is critical to ensure that all auditing processes are also resident focused, as well as the decision making and reporting systems.

- Transparency. Processes and findings must be open and transparent and conducted in a collaborative manner.

- Reliability and Accuracy. The industry and community have a reasonable expectation that any assessments conducted using the Accreditation Standards are conducted reliably and result in consistent findings. A related expectation is that findings will be correct and accurately reflect the care and outcomes delivered by a home. That includes the appropriate sampling and reporting techniques.

- Value for money. Accreditation costs for approved providers are high, both in terms of the fee for accreditation and the on site costs of preparation of applications and site visits. It is imperative that any system of accreditation delivers outcomes and improvements consummate with the costs involved.

- Effective. The accreditation system must deliver improved outcomes for residents, representatives and approved providers. It must identify areas for service improvement and monitor progress towards improvement goals. Where required, the system must articulate any required corrective action.

- Fit for purpose. Any accreditation system should be matched to the environment and outcomes of the industry that it aims to accredit. As such, a program should evolve and develop as its target audience evolves and develops. It should also be flexible and adaptable to suit the range of service providers and outcomes demonstrated in the industry.

Response to review questions for consideration

1. Self assessment

a. *Should approved providers have to apply for re-accreditation or should the accreditation body conduct a rolling program of accreditation audits, which ensures that each home is reassessed prior to their current period of accreditation running out (without the need for the approved provider to put in an application)? What are the advantages/disadvantages of the two approaches?*

UnitingCare Ageing comment

Providers should not have to reapply for accreditation. Accreditation should remain in place unless and until it is revoked.

- As the industry enters its fourth round of accreditation results indicate that standards of care are generally excellent – 98.4% of providers are compliant with the Accreditation Standards and as at 30th June 2008 92.3% of homes were accredited for three years.[1]

- The accreditation period and process should be redesigned to better fit the existing compliance ratio.

- Such redesign could include routine and regular visits to homes e.g., annual visits with one such visit in a three or four year cycle being a full accreditation audit.
    - Where an audit is undertaken they could proceed without the significant application process currently undertaken.
    - In a well performing home other visits in the cycle (e.g., annual visits) would be smaller support visits.
    - If and where non-compliance is identified the Agency may apply discretion regarding the conduct of more than one audit in the cycle to determine status of accreditation.

b. *Should the provision of detailed self-assessment data continue to be a requirement of any application process? If so, why?*

[1] Annual Review of Regulatory Burdens on Businesses. Productivity Commission Draft report 26/6/09

UnitingCare Ageing comment

No. UnitingCare Ageing supports the suggestion to reduce or eliminate the application. Approved providers acknowledge their responsibility to assess and evaluate care delivery.

- The preparation of the current self assessment (a substantial document) is onerous, and after four rounds of accreditation, is repetitive.

- Value extracted from the self assessment document for the Approved provider and the accreditation team is not equal to the effort required to prepare it and to review it.

- It is apparent that quality assessors vary in their use of the self assessment document and overall the value to the audit appears limited.

- It is recognised that the positive aspects of self assessment (such as the opportunities for self reflection and evaluation) should be retained. Home's would still conduct a regular self-assessment, as part of their quality management system, but not as part of any application and not necessarily in the current format which is widely recognised as onerous. There would need to be a mechanism to ensure the veracity of the home's internal self assessment process.

- One mechanism to ensure veracity is that any self assessment begins with, and is underpinned by, good and meaningful information. If self assessments were a considered review, including the use of meaningful outcome and output data, appropriate analysis and improvement then they would be immensely valuable and would streamline any site audit activity. This sort of information as part of the home's routine evaluation and improvement processes would:
    - demonstrate that the home's self assessment process is in place
    - readily demonstrate areas and outcomes that have been improved
    - identify and target aspects for planned improvement

- Removal of the application as a requirement also eliminates the need for a desk audit.
    - The term 'desk audit' is a misnomer as assessors have no ability to verify information at that stage.
    - The Agency's statistics show minimal decisions not to proceed to site audit.
    - This indicates that the step has little auditing value. It is a planning activity.

c. *Would the removal of the requirement to provide self-assessment data on application create a more stressful accreditation site audit? If so, how might this be avoided?*

UnitingCare Ageing comment

No, providing the home has conducted a self assessment as part of its ongoing quality management system.

- The initial part of any site audit is a familiarization with the home, its systems and processes, and its major achievements and results. This is conducted currently, with a self assessment application process in place. In the absence of an application/self-assessment the audit process would not change but would rely more heavily on this initial orientation and the home's own self assessment materials.

- The audit process would be further enhanced if the self assessment conducted by the home used good measurement and information concerned with resident outcome (see point above).

- The current value of the information provided in the self assessment to the assessors and the audit process is predominantly one of planning and direction.

- The site audit process demands that assessors gather and triangulate (verify from various sources) all information provided in the application during the course of an audit. As the audit develops the value of the initial self assessment document to the site audit process and decision making diminishes. This assumes that the self assessment document is of a high standard which is not universally accepted.

2. Use of electronic information

a) What problems, if any, have approved providers /services experienced in respect of accreditation audits and electronic records?
b) What are the current barriers to assessment teams utilising electronic records and how might these be overcome?

UnitingCare Ageing comment

This is largely a matter of assessor training. Part of good audit practice is to work flexibly with and adapt to the home's own information management systems. There should be no need for assessors to take copies of any documents that are electronically available.

3. Nomination of a member of the assessment team

a) Should approved providers continue to be able to nominate a quality assessor as a member of the assessment team that will be conducting the site audit on their aged care home?
b) If yes, Why? How does this improve the assessment process? How can issues of perceived conflict of interest be managed?

UnitingCare Ageing comment

There is no substantial issue with the ability of one assessor to be nominated and appointed.

- Each audit team has a minimum of two assessors and the audit findings and report ought to be a team consensus.

- The continuation of the ability to nominate assessors shows a collaborative, open and inclusive approach to the accreditation function.

- Continuity of one assessor does have some benefits for instance the ability to fully appreciate improvements, changes etc that have occurred.

- In the case of larger providers with multiple sites process are needed to ensure that the appointment of a particular nominated assessor has reasonable limitations to avoid any over familiarisation and potential bias.

4. Skills of quality assessors

a) Should the accreditation body have the flexibility to contract 'expert members', who are not quality assessors, to participate on an assessment team? If not, why not?
b) If yes, what sort of 'expert members' might be used and what safeguards, if any, would need to be put in place to maintain the integrity of the assessment process?

UnitingCare Ageing comment

No, not under the current accreditation system and standards. The flexibility to contract advice in the area of mental health may be one exception.

c) *Should it be a legislative requirement for assessment teams conducting visits to high care facilities, or to low care facilities with a significant number of high care residents, to include a quality assessor who is a registered nurse?*

UnitingCare Ageing comment

The focus of the accreditation audit is compliance with the Accreditation Standards and is not a clinical care review or clinical peer review.

- Clinical care is one of four standards and there is no requirement for registered nurse experts as there is no requirement for experts such as engineers, management consultants, HR professionals, leisure and lifestyle experts.
- Resident outcomes are the focus of the audit, not clinical decision making and choices.
- Assessors may review how the home ensures that its clinical care is reviewed but it is not the assessors' role to conduct such a clinical review.
- Skills required by assessors are strong auditing skills and relationship management and reasoning skills.
- It is useful to have a registered nurse as part of the team as it is useful to have assessors with other professional skills and qualifications.

5. Announced site audits

a) Should accreditation site audits be unannounced?

UnitingCare Ageing comment

Audits should be announced.

- An audit by its very nature does require access to many staff at all levels and this occurs best when planned for.
- The current system already includes unannounced support contact visits to each home. Additional unannounced visits, especially audits, are not required.
- Additional unannounced regular visits may place an unreasonable burden on the homes and staff. It also signals a lack of trust in the industry and increases the culture of 'inspection'. The Agency has developed a more collaborative and supportive culture since 1997 which benefits the industry.
- Exceptions where unannounced visits may be appropriate would be in the case of consistent and significant under performance by a home or homes which are the subject of significant complaints investigations.

b) If not, why not? How can the public perception that announced site audits provide the assessment team with an inaccurate picture of a home's general performance be addressed?

UnitingCare Ageing comment

The current system has extensive mechanisms in place to enable teams to arrive at an accurate picture of the home's performance.

- The Agency's accreditation program including the comprehensive training and registration requirements of assessors provides robust argument that the announced audit processes are robust.

- Included in the current system are unannounced support contacts. In 2007-2008 the Agency conducted 4731 support contacts across Australia of which 3056 were unannounced. 87 review audits were conducted of which 49 were unannounced.[2]

c) *What strategies might the accreditation body use to encourage input to the accreditation site audit from residents and their representatives?*
d) *What strategies might the accreditation body use to encourage input to the accreditation site audit from residents and their representatives?*

UnitingCare Ageing comment

An enhanced mechanism to ensure adequate resident feedback would be supported.

- In the absence of robust mechanisms to gather, interpret and respond to resident feedback there is a tendency for assessors to focus on administrative and documentation concerns as de facto evidence of resident outcomes.

- However the accreditation process does currently mandate interview of at least 10% of residents.

- Many of the expected outcomes of the Accreditation Standards are concerned directly with outcomes for residents (27/44 expected outcomes) so by their very nature demand resident viewpoint as part of the information gathering and analysis.

- Accurate and adequate resident feedback should be gathered as a central aspect of the audit process and teams' process for recommendations about compliance. But there is little available evidence to establish how well that process (ensuring adequate and meaningful resident viewpoint) is carried out, documented and reported.

- As yet there is no fool proof mechanism to report in detail, or to comment fully, on resident outcomes. Audit reports generally refer only simply and broadly to resident/representative interview findings. The lack of a requirement for detailed resident feedback in the report may drive scant attention to resident interview, and quality of interview, during site audit and support contact visits.

- An additional focus on site audit planning to identify relevant special needs groups in the home such as cultural and linguistically diverse groups, war veterans and so on would be important to ensure a relevant sample from these groups is involved in the on site interviews.

- Assessor training targeted at quality interview techniques would improve resident consultation.

- Reporting requirements of detailed resident interview findings would drive improved interview processes.

[2] Annual Review of Regulatory Burdens on Businesses. Productivity Commission Draft report 26/6/09

Suggestions in the paper of assessors running annual resident focus groups are fraught and are **NOT** supported.

- Community consultation is a specialist capability that is not the subject of the Agency's recruitment criteria for assessors nor is it the subject of their professional development activities or competency assessment.

- It is a more reasonable expectation that the homes themselves would conduct or contract such activities as part of their management activities.

e) *Should a home be able to nominate some 'black-out' days, during which the accreditation body will try to avoid scheduling a site audit? If not, why not?*

UnitingCare Ageing comment

Yes.

6. Consumer focus

a) *Does the current accreditation process allow for appropriate levels of consumer input? If not, why not? How might this be improved?*

UnitingCare Ageing comment

The accreditation process does currently mandate interview of 10% of residents – that is the current process does **allow** for adequate input. See above.

- Additional training and capability development for quality assessors on high impact/quality interviewing would benefit the process.

- Also, interviewing residents and representatives as part of a lead in to an audit (the first activity of the audit) may also help focus auditing activities. This would ensure that the feedback aspect of the audit is a central and driving part of the activities.

- Changing the reporting format to highlight resident feedback would also drive different auditing activity and behaviour. At the moment there is no requirement to report in detail, or to comment fully, on resident outcomes. The report template could include a dedicated section for detailed and comprehensive resident feedback.

It **must be noted** that gathering feedback from relatives outside of or after the audit process is not feasible.

- Resident/representative feedback is a central feature of an audit process and can lead or shape the audit depending on results.

- The resident interviews, staff interviews, observations, document review all form parts of a complete auditing process and together lead to the audit findings and recommendation.

- It would be poor practice to separate one part of information gathering from the others and completely incorrect to add in further information once the team was off site and unable to corroborate and follow up any information arising from interviews held after the team had left the home.

b) *Should there be a minimum target set for consultations with residents and/or their representatives during visits to a home by the accreditation body? If so, what would be an appropriate number or percentage?*

UnitingCare Ageing comment

The quality of interview and reporting on resident outcomes is critical rather than the percentage of residents interviewed.

- 10% is an appropriate sample provided the interviews are conducted appropriately and covering a broad range of topics in sufficient detail.

- Appropriate sampling is also critical to gain feedback from any significant groups of residents.

c) *Should assessment teams seek to attend homes out of normal business hours? Would this increase opportunities for consultation with relatives/representatives?*

UnitingCare Ageing comment

Attending out of hours may prove beneficial in limited circumstances e.g., visiting after hours or on Sunday to conduct relative interviews only.

- It would be crucial to ensure that weekend or after hours care activities were not interrupted by any additional work load.
- Clear guidelines would be necessary to ensure staff were not directly involved in any significant audit activities during these out of hour periods.

7. Communication with residents about serious non-compliance

a) *Should approved providers be required to organise a meeting with residents and their representatives to discuss incidences of non-compliance?*

UnitingCare Ageing comment

Providers should not be required to convene residents' meetings to discuss all incidences of non compliance. Many instances of non-compliance are easily corrected and would not pose serious risk or compromise outcomes for residents.

Homes use discretion and relationship management regarding whether to conduct meetings. This would be based on their record of active involvement of residents and families and the nature and extent of non compliance.

8. Confidentiality of sources

a) Does the lack of confidentiality for staff act as a barrier to them providing frank information to the accreditation body?

UnitingCare Ageing comment

It is recognised that lack of confidentiality can act as a barrier however it is evident that on occasions disgruntled staff incorrectly use anonymous complaint systems as a form of industrial action. The accreditation process is not the forum for potential cases of grievance management nor are the assessors trained to act in response to grievances.

b) Should the confidentiality protections provided in the Aged Care Principles for residents or their representatives be extended to all persons who provide information to the accreditation body?

UnitingCare Ageing comment

See above. In the case of any confidential feedback assessors currently need to triangulate information and demonstrate the veracity of all interview results; positive and negative. This would remain critical.

9. Monitoring failures

a) Is the current accreditation and monitoring regime for residential aged care homes effective in identifying deficiencies in care, safety and quality? If not, why not?

UnitingCare Ageing comment

The current process can be improved. There is little objective evidence that the current process does not effectively identify deficiencies.

b) If the accreditation and monitoring regime was to be enhanced, what approaches should be adopted?

UnitingCare Ageing comment

In terms of consistency in identifying deficiencies the greatest improvements would be made by enhancing the current processes rather than increasing the number of accreditation processes.

- Assessor skills are critical to the identification of deficiencies and consistency of findings. The following initiatives may enhance consistency.
  - Additional training which targets assessment and determination of compliance with consistency testing between assessors
  - Appointment of only experienced assessors as team leaders
  - Training and support for assessors in the early and confident identification of non-compliance
  - Annual competency assessment for assessors focused on determination of compliance and non compliance.

The suggestion in the discussion paper of an annual review audit for all homes is **not supported**.

- The demands on the approved provider and staff would be unjustified.
- The Agency could not support the required number of quality assessors.
- Increasing the number and depth of contacts would be the least effective avenue of improving audit effectiveness and consistency (see above).
- Random sampling of homes (as suggested in the discussion paper) is a less invasive and more effective technique however the home bears the burden of the Agency's processes to ensure consistency and effectiveness.
- Targeting homes considered at risk for more regular review audits is the most desirable approach. Care would be needed though to ensure that the objectives of such increased visits are clear.

c) Should homes be required to collect and report against a minimum data set?

UnitingCare Ageing comment

A minimum data set is a good starting point for evaluating quality of care and Approved Providers do have systems of collecting such data.

- Review of such data is used by some assessors as an opening step of audit.
- Such review could be useful as a required auditing step.
- This does require homes to have adequate systems for data collection and monitoring.
- Selection of the indicators would require careful consideration and piloting.
- The collection and availability of such indicators could be required though the publication of such data should not be required because of confounders and cohort variations across homes.

10. Reconsideration, review rights and offences

a) Should decisions only be appealable to the Administrative Appeals Tribunal if they have already been subject to reconsideration by the accreditation body?
b) Should the accreditation body be able to undertake 'own motion' reconsideration of decisions in certain circumstances?

UnitingCare Ageing comment

Yes, the accreditation body should be able to undertake 'own motion' reconsideration of decisions.

- This provides a fair and transparent procedure of appeal and reconsideration.
- The current approach of the Administrative Appeals Tribunal is prohibitively costly and only applies to those decisions where a penalty applies such as potential sanctions.

11. Reporting of accreditation decisions

a) *Is the current way in which audit reports and decisions are published adequate? If not, why not?*
b) *Should audit reports and decisions of the accreditation body that are subject to reconsideration or review be made publicly available prior to the finalisation of the review process? If not, why not?*
c) *Should approved providers be required to provide residents and carers with access to reports and decisions of the accreditation body?*

UnitingCare Ageing comment

The format of published reports has been streamlined over time and this has resulted in reports that are now generally bland and inappropriately similar.

- The detail and quality of reports currently published are generally not helpful to the approved provider as they fail to adequately describe the findings and do not enable a clear understanding of any identified deficiencies and required corrective actions.

- The reasons for the decision maker's findings are also inadequately described and do not inform planned corrective action.

- The current practice of publishing both the audit report of the assessment team and the Agency's decision is confusing when the Agency's decision differs from that of the assessment team's recommendations.

12. Distinction between various types of visits

a) *Are the current distinctions between different types of visits conducted by the accreditation body appropriate? If so, why? If not, why not?*

UnitingCare Ageing comment

The differences in current types of visits are clear to the approved providers and the industry though the distinction would be less clear to those not closely involved (residents and representatives, others).

The distinction in processes and intent of each visit is also currently clear in the current system.

- The scope of review audits and accreditation audits is the same i.e., covering the 44 expected outcomes of the Accreditation Standards.

- The scope of support contacts is smaller and more focused and provides a small window into the maintenance and improvement of the home's systems.

In the case of a system of permanent accreditation the visits could be conducted in a rolling fashion and include one annual visit to each home with discretion concerning what the visit will involve for example:

- In a well performing home three out of say four annual visits are support contacts and one visit in the four year cycle would be a full accreditation audit (review of performance in the 44 expected outcomes of the Accreditation Standards).

- In a home where significant non-compliance and/or risk is identified the visits could continue to be full accreditation audits if required to ensure improvement in compliance.

- Shorter support contacts are used to monitor changes and improvements in all homes.

- The system would be fit for purpose and flexible to allow focus of auditing attention in homes where there is significant deficiency.

13. Provision of industry education by the accreditation body

a) Is it problematic for the accreditation body to provide education to industry?
b) If not, why not? What are the benefits of the current approach?
c) If yes, what are some alternate models for providing education to industry?
d) Does there need to be another source of advice for industry, besides the accreditation body, about issues in respect of accreditation and improving performance? If so, what would be an appropriate source for such advice?

UnitingCare Ageing comment

It is appropriate for the Agency to provide education to the industry. The education programs run by the Agency are of a high standard, tailored to the assessment requirements and are well utilised. Education is available in both face to face and self-paced learning packages.
Peak bodies, associations and others also currently offer education and support which are well utilised.

14. Period of accreditation

a) Should there be a maximum period of accreditation specified in the legislation?
b) Should homes that have sustained compliance with the Accreditation Standards over a number of years be rewarded with a longer period of accreditation?
c) *Are there other means of rewarding good performance?*

UnitingCare Ageing comment

It is suggested that accreditation remain in place unless and until revoked.

- The frequency of support contacts or visits would be planned relative to the determined sustainability of compliance.

- As previously noted results indicate that standards of care are generally excellent – 98.4% of providers are compliant with the Accreditation Standards and as at 30th June 2008 92.3% of homes were accredited for three years.[3]

- The accreditation period and process should be redesigned to better fit the existing compliance ratio.

[3] Annual Review of Regulatory Burdens on Businesses. Productivity Commission Draft report 26/6/09