Caring for older Australians

Victorian Government submission to the Productivity Commission

August 2010

State Government Victoria

CARING FOR OLDER AUSTRALIANS

"The meaning or lack of meaning that old age takes in any given society

puts that society to the test".

Simone de Beauvoir

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Executive Summary

Care of older people is much broader than mainstream aged care services; a wide range of factors contribute to the experiences and wellbeing of older Australians.

Into the future, services and support should be organised and delivered in ways that ensure that older people can easily find the *right types* of aged care services in the *right settings* when they need them.

Aged care services have a critical role to play in both meeting the needs of older people and the effective functioning of the broader system of health and aged care services across Australia. While Victoria has done a range of work to improve the experiences of older people within the health and aged care service system, most of the levers for progressing substantive change rest with the Commonwealth Government.

The scale of forecast requirements for aged care services demands fundamental changes in both the underpinning economics of the sector and how the system itself is planned and developed to stimulate the necessary capital investment. Like any market, the "price" paid for aged care services needs to be sufficient to both stimulate capital investment and meet the full, ongoing costs of operating services.

Current regulatory, funding and planning arrangements within the aged care arena also create a fragmented service system that is difficult to navigate, does not actively promote service continuity or, integration, and has limited capacity to respond flexibly to the needs of older Australians and their varying requirements.

Services need to be planned, allocated, funded and managed around optimising the experience for the client.

This will require fundamental changes to many aspects of the service system to put older Australians at the centre and make them active participants in both decisions about and delivery of services. Provision of effective information, support for decision making and capacity to make meaningful choices are fundamental to this.

We need to make it as simple as possible for older Australians to receive the supports they need as their requirements change over time, recognising that in many instances, the relationships they have with both their communities and their current service providers are critical to positive health outcomes and need to be maintained.

The focus of service provision should be on restorative and enabling approaches, that seek to maximise the health and wellbeing of older Australians, and as far as possible, support them to remain at home.

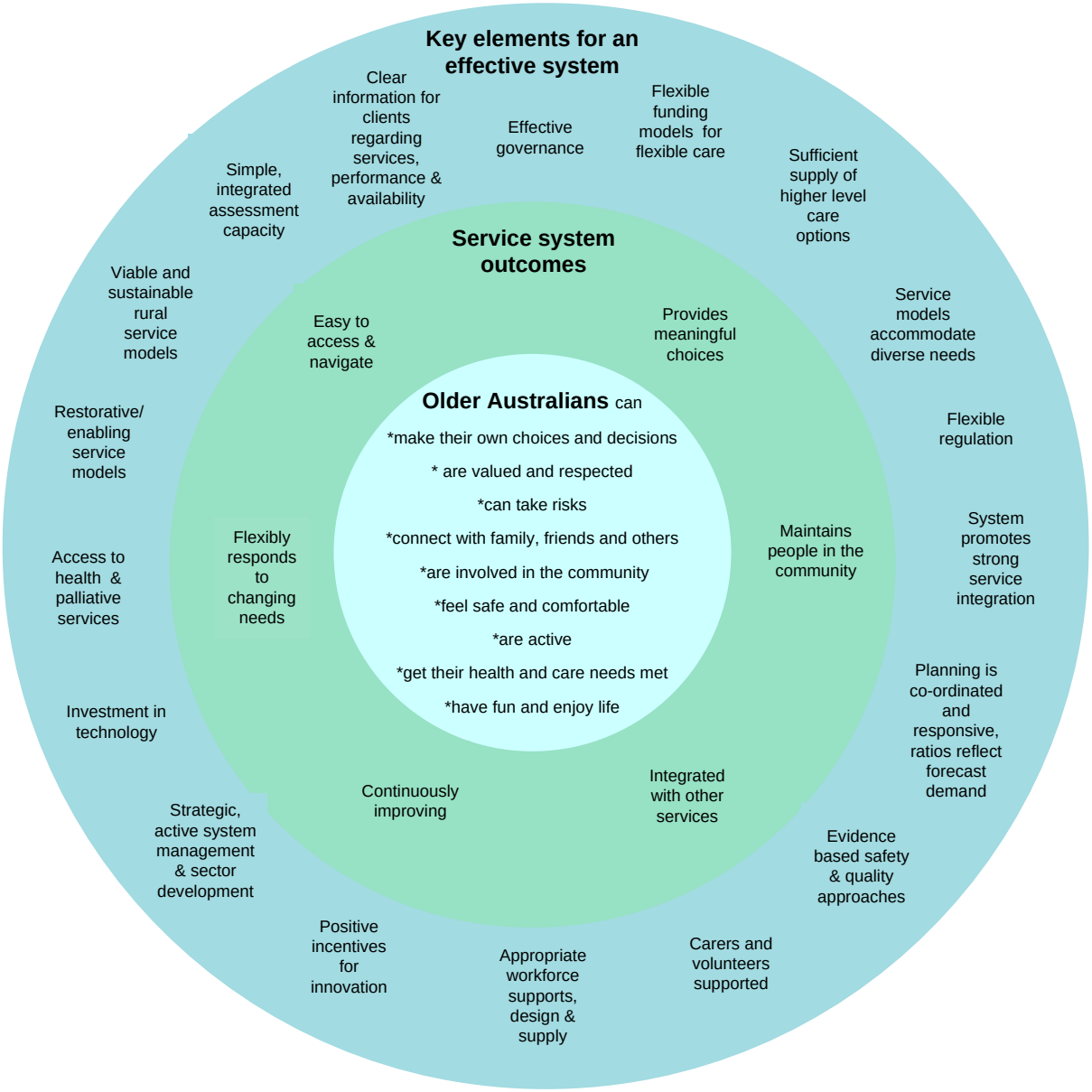
Sustaining local service provision in rural areas is a particular challenge, as is access to services for older people with high level needs.

The 2010 Victorian Government publication *Putting Patients First* emphasises the importance of promoting integrated service delivery and providing sufficient supply of and funding for aged care services to meet future demand.

The Victorian Government believes it has a fundamental role in achieving an integrated and responsive, person centred service system on the ground, to support older people.

Figure 1, overleaf, summarises Victoria's aspirations for older people receiving aged care services, the service system outcomes fundamental to achieving these, and the key elements that will ultimately need to be in place to achieve an effective, sustainable, person-centred service system for older Australians into the future.

Figure 1 Victoria's vision for the future service system for older Australians



Summary of key issues

Part One – Context

Victoria welcomes the Productivity Commission's Inquiry into Caring for Older Australians.

Older Victorians comprise a significant component of our population, and make a rich and valuable contribution to the Victorian community. The Victorian Government plays an active role in the funding and provision of a wide range of services to older Victorians, some of which complement or build upon those provided by the Commonwealth Government.

This submission comprises four main parts:

- Part One outlines Victoria's aspirations for an integrated, responsive service system for older Australians.
- Part Two discusses Victoria's experiences in caring for older people.
- Part Three discusses a range of specific areas where reform to the current aged care system is required to better meet the needs of older people.
- Part Four discusses issues related to some specific accommodation options falling outside the Commonwealth funded aged care system.

Supporting older people

Victoria recognises that as people age they will have different roles to play in society, and different needs to be met. It is also acknowledged that the needs of older people in 2020 will be different from what they are now.

Increases in chronic disease, dementia and level of frailty as people live longer will impact on the broad health and aged care system. At the same time, an increasing number of people will live longer in relatively good health. Thus a focus on maintaining wellness to allow all older people to remain independent for as long as possible is important.

We also need to plan for an increasingly heterogeneous range of needs because our population of older people is diverse, comprising people from culturally and linguistically diverse backgrounds, indigenous people, gay and lesbian older people, people with drug and alcohol dependencies and mental health issues, people living with HIV and homeless and financially disadvantaged older people.

There is a broader community interest in and responsibility for supporting older people with services and helping them plan for their changing needs. Some of these needs they can meet themselves and some need a broader community or government response[1].

Recent Victorian focus group research[2] indicated that older Victorians have a strong desire to remain independent as they age, but revealed that very few were planning for old age. They expressed the view that taking care of themselves was primarily their own responsibility. When self-responsibility for care 'falls short', families and community networks would form the first and critical tier of support. Only after these failed would they turn to the safety net of government support they assumed would be available.[3]

[1] The National Centre for Social and Economic Modelling (NATSEM) work on projecting incomes for the over 65s over the next 15-20 years supports the view that there will remain a substantial role for publicly subsidised services for the 50% of this group who have no income other than the aged pension and very little in the way of assets.

[2] Commissioned by the Department of Planning and Community Development Victoria and conducted by The Open Mind research group, this research explored attitudes towards ageing and perceptions of the government's role.

[3] The Open Mind Research Group (2007) 'Policy development research: Understanding attitudes towards ageing and perceptions of the government's role in relation to ageing', prepared for the Office of Senior Victorians, December 2007.

Older Victorians participating in associated state-wide community consultations[4] said that they wish to remain active and to contribute to society. Maintaining independence and dignity is of the utmost importance, as well as the integrated nature of health and aged care, transport and housing.

Feedback from the Victorian[5] Ministerial Advisory Council of Senior Victorians (MACSV) reinforces the importance of these factors, as well as adopting a broad approach in planning for and supporting the needs of people as they get older. It emphasised that that there are many issues beyond aged care services that are of importance to older people. Addressing factors such as the built environment, age-friendly communities, transport and opportunities for social participation will be essential to improve the quality of life of older people hence their overall health and wellbeing and to create a more socially inclusive and prosperous society for all.

The MACSV also identified the availability of suitable and accessible housing (accompanied by appropriate supports, where necessary) will be critical to meeting the needs of older people.

While some of the issues raised fall outside the purview of the Productivity Commission's current inquiry, this feedback highlights the importance of recognising that there are many inputs to the broad system of services and supports for older people, and that integration where possible is important.

During 2010 the Government will commence implementation of its ten–year plan for building an age-friendly society. *Ageing in Victoria: A plan for an age-friendly society* describes commonsense action to build age-friendly homes, workplaces and communities. The Plan incorporates the Government's *CALD Older Person Action Plan* with strategies for improving delivery of language and other services for our older migrants.

While Victoria's response to population ageing is shared across a range of portfolios and service sectors, the *Ageing in Victoria* plan articulates a single vision for an older society to guide coordinated whole-of-government planning and investment. The Victorian Government will prepare a Status of Seniors report every two years to assess how well it is meeting the three outcome areas of the Plan – good health and wellbeing, age-friendly communities and economic and social participation.

Victoria believes that the work of the Productivity Commission will compliment this, and be important in proposing reforms to the current system that will ensure older Australians can benefit from a simple, integrated and sustainable system into the future.

Aspirations for the care of older Australians

Valuing older people equally is central to the delivery of support and services for older people Victoria recognises that ageing can change some of our capacities, but it does not change our central aspirations. Older people still want to be connected, contributing, and cared for.

A key driver in Victoria's pursuits to promote the continued wellbeing of older people is its commitment to promoting human rights through the incorporation of human rights principles into policy development.

Victoria sees aged care as being underpinned by human rights values. In that context, the Victorian Government has an explicit commitment to respecting the personal autonomy of older people, their choices and providing care without discrimination.

The way in which older people are valued affects our ability to deliver effective services. The desirability of working with older people is affected by how older people are seen in society. The perceived value of that work may also be reflected in how we remunerate that work.

[4] Over 1400 older Victorians and a wide range of organisations contributed to the consultations.

[5] The Ministerial Advisory Council of Senior Victorians was established by the Premier in 2001 to formally enable older people to have a voice about issues affecting their health and wellbeing.

The work that Victoria has done over the last 10 years in developing its health and community care services and systems is based on an understanding that, as they age, people develop chronic health conditions, which can be prevented by healthier choices earlier in life, but once established, and if unmanaged, lead to poor quality of life for the person and substantial and preventable use of scarce and expensive tertiary health care resources[6].

The challenge is to find ways of ensuring that people get an early response to emerging problems they experience, to prevent them from needing to use more intensive and expensive services, and the care and treatment available (including specialist care and treatment) can flex up and down appropriately based on the person's individual needs.

The Victorian Government recognises that no matter where they live, what their background or circumstances, or what their support needs are, older people expect to keep their family and community connections, keep on contributing in the fullest way they can, be supported to take informed and planned risks and to receive the best care possible when independence is curtailed by illness or frailty (DHS, 2009).

As such, the Victorian Government's aspirations for older Victorians receiving aged care services are that they:

- Make their own choices and decisions
- Are valued and respected
- Can take risk,
- Connect with family, friends and others
- Are involved in the community
- Feel safe and comfortable
- Are active
- Get their health and care needs met
- Have fun and enjoy life

To achieve this, services and support should be organised and delivered in ways that ensure that older people can easily find the *right types* of aged care services in the *right settings* when they need them.

Victoria believes that an effective system of services and supports for older Australians should focus on, and be organised around, the needs of older Australians.

Such a system would:

1. Be organised to promote integrated service planning, management and delivery focussed around the needs of older Australians.

2. Focus on ensuring timely and comprehensive assessment, to ensure older Australians avoid spending unnecessary time in hospitals or other settings that may adversely impact their wellbeing.

3. Be easy to navigate, through provision of support and information that allows older Australians to make informed decisions.

4. Promote wellness as far as possible, with service delivery and supports designed to actively assist older Australians maintain their independence and wellbeing.

[6] See http://www.health.vic.gov.au/healthstatus/acsc/index.htm

5. Provide a graduated range of services and supports that older Australians can access flexibly as their needs change over time.

6. Respond to the increasing diversity of our older population, recognising that some older people may need additional supports to access mainstream services and/or require more tailored service responses.

7. Actively promote continuous improvement to improve service safety and quality and promote ongoing innovation and service responsiveness.

8. Resource the necessary infrastructure (capital, workforce, technology) to delivery high quality, responsive care.

The focus of the overall service system would be on best meeting the needs of older Australians, recognising that minimising overlap in service provision, unnecessary hospital admissions and/or extended stays away from home are in their best interests. The service system would also be sufficiently flexible to allow people to step into and out of specialised service systems as their needs change[7].

The vast majority of older Australians would continue to live at home and maintain a key role in managing their own health and support needs, with informal care and preventative health programs contributing to this.

For those needing assistance to maintain their independence within the community, community based care would continue to be at the heart of such an integrated system, with strong linkages to primary care services and a range of other supports that older people may require (such as those delivered by local government).

Whilst acute, sub-acute and residential aged care would retain an important role for older people when they need it, there would be a focus on avoiding unnecessary admissions to (or transfers between) these services.

The overall system would be designed to accommodate the changing nature and level of services that older Australians might require over time[8]. It would be underpinned by an effective assessment function that plays a community triage role and maintains strong connections to services and supports within that locale. Assessment needs to work with older people to identify what they may need, which options would best suit their circumstances, and actively support them through key transitions.

What about choice?

The Productivity Commission's issues paper, Caring for Older Australians, highlights that choice of aged care services is a challenge for an older and increasingly diverse population.

[7] For example, there needs to be ability for older people who require residential aged care to access services that can also meet more specialised mental health needs, but as needs change can also transition back to a mainstream residential aged care service.

[8] It is also important that different programs (from different funding sources such as state and commonwealth) targeting the same client cohorts, are flexible enough to support organisations to integrate programs, in order to get the best outcome for clients. There is evidence that 80% of people over 65 years have one or more chronic conditions ranging from those that have little effect on people's day to day lives, to those that are profoundly disabling. Community health initiatives, such as the Diabetes Self Management (DSM) and Early Intervention in Chronic Disease (EIiCD) provide allied health services, care coordination and self-management support to people with a diagnosed disease. Community health services delivering these chronic disease initiatives have the opportunity to ensure HACC eligible clients have access to these chronic disease services. Victoria's view is that this can be supported by policies that align or are complementary. For example embedding self management support into usual practice is a key component of the chronic disease initiatives and requires a significant change in practice. Self management support uses similar approaches to the HACC Active Service Model e.g. client empowerment, problem solving, decision making, goal setting, action planning, and monitoring/ review. Victoria is doing work to ensure that the two policy directions drive improvements within community health that complement each other and is supporting integrated workforce development and service systems improvement.

While there is a paucity of evidence about what sorts of choices people seeking services want to be able to make, the Victorian Government's experience suggests that choice of the setting in which care services are received is the one that most concerns older people. Arguably the most critical decision relates to whether services are provided in home or within residential aged care, and available data suggests that there is significant unmet demand for the former, particularly in relation to higher-level care. Addressing this shortfall, through increasing supply or alternative mechanisms, has the potential to significantly improve outcomes for a range of older Australians.

Older people may currently exercise choice in relation to selecting their service provider, be it a community or residential aged care provider. This exercise of choice however can be limited, due to lack of alternative providers or a complete absence of providers within that location.

Choice can also be limited for people who are assessed as eligible for community packages. These people may be on a waiting list, but being on a waiting list does not guarantee access to a package and people may have no option but to take up the first offer of a package received[9].

In considering options for the future, the question has been raised whether increasing consumer choice in aged care through more market based approaches would lead to better outcomes. Current experience indicates that the current market based approach does not facilitate meaningful choice and can make decision making overly difficult for people seeking services.

This is particularly relevant for community packages, due to the proliferation of service providers with overlapping catchment areas, services that are fragmented and do not adequately interlink as part of a broader service system and a model of service management based on contract administration.

Given the transaction costs and impact for most people entering residential aged care, the relevant point of choice of provider is at the point of entry to the service.

The lack of available public and 'user friendly' information regarding the relative quality and/or suitability of the services delivered by providers further exacerbates the difficulty consumers have in choosing a provider.

Choices available in residential age care or community services are dependent on providers implementing a client centred approach so that residents or service recipients can have meaningful choices about the care and support they receive and the way it is delivered.

Research into health literacy highlights the importance of understanding the extent to which people can make sense of information provided to them in order to exercise informed choice. This work recognises the complexity of information and decision making in relation to health and care options and seeks to put this information in a form that people can understand so that they can make informed decisions about what is best for them.

[9] Victoria has developed regionally based electronic waiting lists managed by ACATs that centralises the record of people recommended for a package with broad prioritisation of need. However, providers only have access to the lists and they instigate an approach to a person seeking a package. The person can refuse an offer of a package but must then wait for to approach them. The power of initiating contact is not with the person seeking services.

Part Two – The Victorian Experience

Victoria's service system for older people differs from most other jurisdictions in some key areas:

- Acute services that are focused on improving care for older people by better tailoring both service delivery and the physical environment, minimising unnecessary emergency department presentations, preventing unnecessary admissions and minimising both the duration of, and functional decline during, hospital stays.

- Victoria has a well developed subacute system, which includes a wide range of programs focused on ensuring older Victorians who require assistance following a hospital admission do so in an environment more appropriate to their need (this may either be through transitional arrangements before they go home, or home based supports).

- The Victorian Home and Community Care (HACC) service system is characterised by strong partnerships with local government and primary care services, as well as public health services. Local government contributes significant resources to HACC delivery in Victoria, with the state government playing an active role through provision of funding, active involvement in service planning and development, and maintenance of key relationships and linkages across the broader system.

- The Victorian public sector has retained a significant role in the provision of residential aged care. Residential aged care services form an important component of many rural public health services, and the public sector also plays a key role in provision of specialist services such as aged persons mental health.

- Assessment in Victoria occurs in distributed locations that are linked by common practice, information about clients shared electronically in a standard form and a shared understanding of how the Aged Care Assessment Teams (ACATs), HACC Assessment Services (HAS), Aged Persons Mental Health Teams and Disability Services do their business. Assessment in the HACC Program has a tertiary prevention, wellness and reablement focus and aims to offer community triage.

These differences have provided the Victorian Government with unique perspectives on what strategies have improved outcomes for older people and where there are opportunities for improvement across the aged care system.

Acute, subacute and primary care services

Victoria's hospitals have a short length of stay for patients, compared with other States and Territories. Victoria also has a higher separation rate than any State or Territory other than the Northern Territory.[10] Older people are significant users of Victorian hospitals (Victorian Government 2010, p 23):

- 15 % of Victorian emergency department presentations are people aged 70 and over

- 35 % of all transfers from an emergency department to an in-patient bed are people aged 70 and over

- Over 40 % of all in-patient bed days are for people aged 70 and over

Victorian Health Services understand that their core business is caring for older people and they have been implementing practices that ensure that older people's overall health and wellbeing do not decline while they are in hospital (DHS, 2003).

[10] ROGS 2010: table 10.6

Over the past two decades, Victoria has developed a range of strategies to divert people from emergency departments unless they require hospital intervention. Many hospitals put resources into developing the capacity to monitor and assess the best response to these peoples needs, other than admission as a patient to a hospital bed. This has also resulted in a program of residential care in-reach for people needing nursing or medical attention in residential aged care services.[11]

An important element of improving care for older people has been Victoria's investment in a well developed subacute system that gives older people opportunities for rehabilitation and longer recovery in either a community or bed based settings, as well as a range of services that facilitate exit from hospitals (Post Acute Care Program) and that prevent people with chronic conditions from needing to present at hospitals (Hospital Admission Risk Program - Chronic Disease Management and Early Intervention in Chronic Disease)[12].

Assessment

In Victoria, both HACC assessment services and Aged Care Assessment Teams (ACATs) play a critical role in ensuring that people get the services they need at the right time and in the right setting for them.

A mix of primarily local councils, and district nursing services have been designated HACC Assessment Services responsible for delivering face to face "living at home" assessments. They are focused on delivering community care triage and mobilising the range of services funded by the HACC Program and other services to address health, support or environmental issues that may prevent people from being able to continue to live independently at home. [13] HACC Assessment Services play an early intervention, tertiary prevention role in Victoria's overall health and aged care system.

By contrast, the majority of ACATs are located in public health services and have strong links to health services. They play an important role in directing traffic for people with more complex care needs, playing a critical role in hospitals' management of patient exit, and ensuring that only those who really need residential aged care or packages of care are recommended for that option[14]. They also manage regional electronic waiting lists for community packages[15] across Victoria.

Victoria's ACATs perform above national averages and regularly exceed state government benchmarks for the time elapsed between referral and assessment[16]. This is important, because ACATs support hospitals in managing the timely discharge of people from their acute episode of care.

HAS and ACATs are networked through subregional assessment alliances based in Primary Care Partnerships which enable those involved in assessing the needs of older people to share good practice and work out their referral and information transmission arrangements.

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[11] Dench McClean Carlson (2009) Residential Aged Care In-Reach Clinical Support Pilot, Program Evaluation

[12] The principles underpinning HARP and EICDM are that people with chronic conditions receive a more effective intervention if it is in a community setting, if they are supported to take simple and effective steps to manage their conditions and if the multiple practitioners involved in their care are coordinated and working to one jointly understood care plan. The steps in many cases are good nutrition, exercise, controlling smoking and alcohol intake and complying with medication regimes, as well as developing confidence in managing the symptoms of their conditions.

[13] They take a restorative and wellness approach to care planning, engaging people to identify their own personal goals. Care plans then break down those goals into achievable steps for the person.

[14] The Aged Care Assessment Program is closely aligned with Victoria's health services with 15 out of 18 ACATs attached to health services mainly in metro Melbourne. The people they assess get priority access to GEM beds, subacute services and rehabilitation as well as geriatrician input. Geriatrician services are partly funded by ACATs and health services either as team members or on a sessional basis.

[15] Community Aged Care Packages (CACPs), Extended Aged Care at Home (EACH) packages and EACH Dementia (EACH-D) packages.

[16] As a proportion of all assessments done, Victorian ACATs do slightly higher than the national average number of assessments in acute settings (not surprising given Vic's higher separation rate). Victorian teams routinely over perform against their State Government set performance measure of an elapsed time of no more than 2.5 days between referral and assessment.

Community based care

There are a variety of community based programs that operate in Victoria, some funded by the State Government, some funded jointly by Local, State and Commonwealth Governments and some funded solely by the Commonwealth.

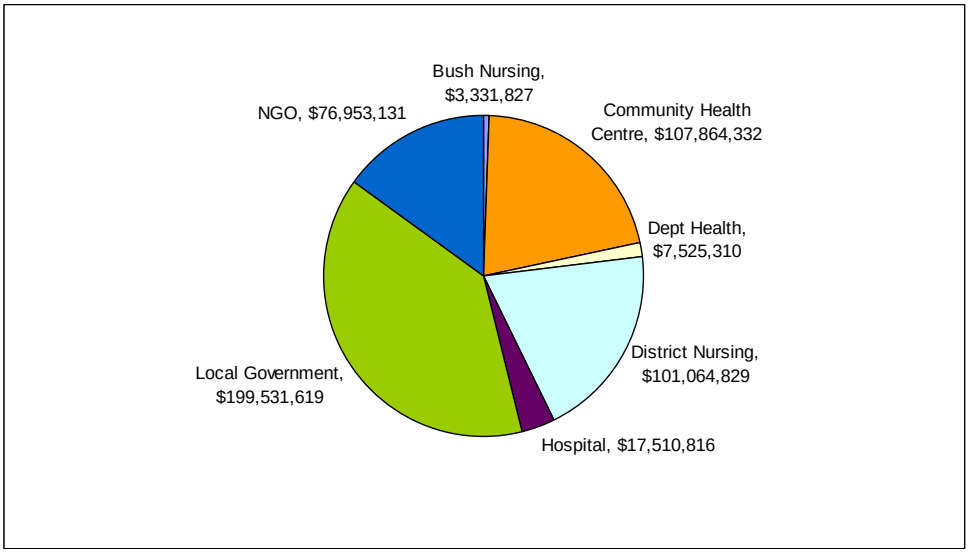
The largest (in terms of funding, hours of service and number of people serviced) is the HACC Program. It provides a comprehensive range of integrated home and community care for clients that facilitates the maintenance of clients in their homes, and avoids premature or inappropriate admission to long term residential care. Services range from social support, help at home and help with showering and dressing to home nursing and allied health services. Victoria's HACC program delivered services to over 260,000 people in 2008-09[17].

HACC service provision has a range of positive outcomes for clients and the efficient functioning of Victoria's overall health and community care service system. In general, clients indicate that the HACC services they receive are the right type and amount (Australian Healthcare Associates, 2008). Most HACC clients ceasing service do so because they no longer need the services in order to stay independent[18].

HACC services also promote timely and supported discharge from hospital, enabling many patients to leave hospital quicker. HACC works in an integrated manner with Post Acute Care to support older people and younger people with disabilities when they are discharged from hospital.

The majority of the resources in the HACC Program are concentrated in local councils, health services, large non government organisations and the Royal District Nursing Service (RDNS). The balance funds are allocated between small not for profit organisations (Figure 2). Large agencies delivering HACC services are also key members of Victoria's Primary Care Partnerships (PCPs)[19] .

Figure 2 Distribution of funds by agency type 2009-10[20]



[17] The HACC Program in Victoria delivers more hours of service than any other State per 1000 of the HACC target population and invests more in home nursing and allied health than any other State. (Steering Committee for the Review of Government Service Provision (2010), *Report on Government Services 2010*, Table 13A.27)

[18] Of those people ceasing to use HACC services, nearly 50% no longer needed the service. Around 17% died, suggesting that many were able to manage at home up to that point with the support of HACC services, Fifteen % (about 8,500) moved into some form of residential care (HACC MDS data).

[19] PCPs are Victoria's platform for coordinating health and human services at a subregional level. Since 2000 Victorian PCPs have worked to improve the coordination of services and care. There are currently 30 PCPs engaging a total of 1200 health and human services organisations. A PCP catchment typically covers two to three local government areas and includes divisions of general practice, local government, district nursing, community health, hospitals and health services as members.

[20] DH administrative data

Local councils are particularly significant as they bring to bear their planning capability in considering the needs of the total populations in their Local Government Area (LGAs) as well as their interests in delivering services. Many local councils are responsible for supporting the needs of their ageing residents across a range of domains, such as land and streetscapes, recreational and social opportunities and health promotion. 76 of 79 local councils in Victoria deliver HACC services. They are often the first contact for most people seeking community support services[21].

Victoria has a distinctive, tri-partite primary health care sector, compared to other states in Australia, with the majority of state-funded primary health care services provided by community health services, which are either independent entities (operating as not-for-profit organisations) or components of larger metropolitan or rural health services. Community health program funding provides allied health, counselling and nursing services and health promotion action, to the most vulnerable groups in the community[22]. These services are integrated with HACC funded services to ensure the delivery of effective multidisciplinary care.

There are good working relationships between services that are funded and managed by the State. Those relationships are not as well developed with solely Commonwealth funded and administered services such as packages[23].

Residential aged care

Unlike other jurisdictions, Victoria has retained a significant role in the public provision of residential aged care. As at 30 June 2010, 194 services (nearly 24 percent of the total number of all Victorian services) provided over 6,400 operational places[24], which represents over 14 % of Commonwealth funded places in this State. Victoria's long standing policy and service provision role in residential aged care was recently reconfirmed in the Victorian Government's *Residential Aged Care Policy 2009*[25].

Public sector services play a significant role in facilitating and maintaining access to residential aged care in small rural communities. Across rural Victoria, 162 Public Sector Residential Aged Care Services (PSRACS) provide 50 % of all high care places. In many rural locations they are the sole provider of residential aged care, and help maintain the critical mass necessary to sustain a range of health services in those communities[26]. The relative strength of public sector providers in small rural communities also means that they may play both a dominant role in service provision and a significant support role to other services in the local area. In some cases close local service relationships have led to formal and informal management arrangements and even to some extent, shared governance.

Public sector provision in Victoria has also helped improve care and access for client groups with specialised care needs. For example, across Victoria public sector facilities offer over 600 places dedicated to specialised Aged Persons Mental Health services for people who cannot be managed in mainstream aged care residential services due to their level of persistent cognitive, emotional or behavioural disturbance.

The close link between PSRACS and broader hospital and health service provision improves scale efficiencies across the broader service system and promotes better service integration.

The existence of local governance in Victorian Health Services provides additional local accountability and responsiveness to those with the greatest need. The stable local governance platform on which

[21] A mapping project undertaken as part of the development of Victoria's access point demonstration project showed that most people made first contact with their local council when seeking community support services.

[22] Over the past years, community health services have attracted funding from a broad range of sources (including state and commonwealth government, philanthropic and other) and have become mature organisations that are the platform for the delivery of a range of health and human services (including HACC, disability, mental health, justice, alcohol and drug).

[23] There are however exceptions to this, such as when carer services were initiated by both the Commonwealth and State Governments. In this instance, it was agreed that resources would be channelled through the same platforms in each regions, facilitating more coordinated resource allocation and service delivery.

[24] Two thirds of public sector places are high care, although about half of all Commonwealth funded places are high care.

[25] This policy can be accessed at. http://www.health.vic.gov.au/agedcare/policy/resicare/index.htm

[26] Including acute, general practice and other primary care services.

Victorian public health services are built provides local communities with a high degree of involvement, and a sense of ownership and confidence in the future of local health and aged care services provided. The value of this to local economies and the health status of the local population can not be underestimated.

The active involvement of the public sector in residential aged care provision has also enabled the Victorian Government to develop and roll out of state-wide quality improvement initiatives, such as establishment of quality indicators for public sector residential aged care[27] (an Australian first), and current development of standardised, evidence-based care processes for key clinical risk areas via its Strengthening Care Outcomes for Residents through Evidence (SCORE) initiative.

The Victorian Government is also committed to ensuring there are sufficient numbers of residential aged care places across this state to meet forecast future need. Notwithstanding the Commonwealth Government's responsibilities in this area, Victoria has been progressing strategies to ensure allocated places are developed, are operating without long delays and effectively distributed so that quality residential aged care services are available.

Victoria has taken steps to facilitate such outcomes. For example, it has:

- Progressed a range of reforms to its planning schemes and standards, to help facilitate more timely planning processes for residential aged care developments.
- Fostered partnerships between government and non-government organisations to develop new services to meet needs where the industry is not meeting them alone. Initiatives such as the Aged Care Land Bank encourage the provision of additional high-care-at-entry residential aged care services by providing land to not for profit aged care providers. Assistance is being targeted particularly to areas of significant economic or social disadvantage, including assistance to culturally and linguistically diverse groups.
- Introduced land tax exemptions for the construction phase of residential care facilities and Supported Residential Services, to reduce the cost of developing these facilities and help improve the accessibility and affordability of suitable care and accommodation for Victoria's seniors.
- Advocated on behalf of its community for the Commonwealth Government to allocate sufficient new places to meet this State's forecast needs.

The Victorian Government will continue to explore other opportunities and encourage the Commonwealth Government to do so, recognising that a sufficient supply of operational places is critical to both meeting the needs of older people and maximising the efficiency of our health system.

Other accommodation options

While much of the Productivity Commission's inquiry focuses on Commonwealth Government funded aged care services, many older Australians live in other types of accommodation and/or receive other support services.

Some, such as Supported Residential Services and retirement villages, are subject to state regulation:

- Available data suggests that almost 60 % of people in SRS are aged 70 and over (Social Research Centre, 2009). SRS are private businesses, regulated by the state government, that provide a combination of accommodation and support to a diverse group of Victorians, many of whom are older. At 1 June 2010, there were 178 SRS providing accommodation and support to over 6,000 Victorians who require support with activities of daily living such as showering, personal hygiene, toileting, dressing, meals and medication, as well as physical and emotional support. Residents pay for these services, with fees – and the nature of

[27] For further information on this and other programs referenced here please visit the Victorian Government's Aged Care website at www.health.vic.gov.au/agedcare

services – varying markedly across the sector. Unlike residential aged care, these services do not attract Commonwealth Government subsidies.

- There are also a small proportion of older people live in retirement villages, estimated at 4.5% of persons over age 65[28]. The regulatory system works well with studies demonstrating high satisfaction rates among residents and few complaints being received. Various amendments to the legislation have been made in recent years to address new issues and problems. Retirement villages are well integrated with both community based care and residential aged care. The separate regulation of retirement villages recognises the unique nature of this accommodation, which is distinct from both residential aged care and general housing.

In other instances, older Victorians may access publicly funded services (such as public housing), or private, individual arrangements may exist for the provision of support within individuals' homes.

While this submission will largely focus on services that are currently funded and/or regulated by the Commonwealth Government, Victoria believes it is crucial to recognise this diversity and the advantages it provides, in presenting a wider range of choice enabling different accommodation and support solutions to develop and evolve to meet changing needs.

Meeting the needs of older people with dementia, mental illness or other chronic conditions

People with dementia, mental illness or other chronic conditions, and their unpaid carers, seek flexible innovative services of respite and support to meet their individual needs, and maintain quality of life, health and wellbeing. This implies services appropriate to a person's condition, stage of illness, culture and age. Services need to respond to the differing needs of people with different conditions and at different stages of illness.

The Victorian policy framework *Pathways to the Future, 2006 and Beyond Dementia Framework for Victoria*, and *Implementation Plan* identify several areas for action to support Victorians with dementia and their carers[29]and the Victorian Government has funded a range of service and supports for people with dementia and their carers[30].

Victoria's experiences in this area have highlighted that services and support need to be flexible and able to quickly respond to the changes occurring with the progression of chronic disease, and the changing needs and preferences of individuals[31]. Training and information about long term degenerative conditions such as dementia have also been shown to be important. This can assist carers, especially when offered early in diagnosis, to manage well and cope with the predicted changes ahead.

Aged persons mental health services are also expected to experience increased and sustained demand driven by the ageing population. The challenges include:

- The increased prevalence of depression and anxiety as well as conditions such as dementia.

- The unknown impact of increased usage of alcohol and drug usage on an ageing population

[28] JonesLangLaSalle pp.5-6

[29] These areas are promoting positive ageing and social connectedness, and life planning; education and information, service development and enhancement, and support for people with dementia and their carers, respite and residential accommodation, and transitions to residential aged care, and meeting specific needs.

[30] These include Cognitive Dementia and Memory Services (CDAMS) which are unique to Victoria, providing diagnoses of dementia and information about accessing services and support, and Memory Lane Cafes and café style support services which provide informal occasions for people with dementia and their carers to get together, share their experiences and stories, obtain information about services and support, or simply have a break away from their regular living environment.

[31] For example, people in the early stages of dementia, and younger people with dementia, are more likely to seek one on one support to continue living well at home, and being connected to their local community, or appropriate group support; they are less likely to be comfortable in a group setting of people who are highly confused, and/or have high level personal care needs. People in the later stages of dementia who may need higher levels of care may make greater use of day care or residential respite, giving their carers a break from caring.

- The unknown impact of psychotropic medication on people with serious mental illness into old age

- Responding to the mental health needs of men aged 75 and over who have high rates of suicide

- Identifying mental health problems that might be a consequence of ageing and physical health problems of conditions such as dementia

The Victorian Government's *Because mental health matters: the Victorian Mental Health Reform Strategy 2009-19* represents a commitment to ensure all Victorians have the opportunities they need to maintain good mental health while also supporting those with a mental illness to access high quality, timely care and live successfully in the community.

Prevention, early intervention, recovery and social inclusion lie at the heart of the new agenda. For older people this includes reducing isolation and increasing social inclusion as a means of preventing depression and anxiety. It includes ensuring that there are a range of service options, and preference is given to the least restrictive care and treatment option. It also includes ensuring that mainstream aged care services have capacity to identify emerging or escalating mental health problems and ensure that the right care and treatment is accessed at the right time.

This new mental health strategy embraces the roles of many sectors and services across the community and the whole-of-government, emphasising that mental health is everyone's business. Realising the vision depends on stronger partnerships across sectors to prevent mental health problems from emerging or escalating as well as assisting those affected by mental health problems in a range of settings, including aged care.

A number of reforms are proposed over the life of the strategy which build the capacity to support older people to remain at home or in residential accommodation rather than in acute inpatient services or specialist aged mental health residential beds.

Part Three – Opportunities for aged care reform

Victoria has made significant investments in improving the integration of its health and aged care services to improve outcomes for older people. There are however restrictions on what can be achieved in the absence of national leadership, national investment in enabling infrastructure, funding reforms and a shared view about what needs to be achieved and how to get there. Victoria is committed to improvements in this area, but many of the levers for reform rest with the Commonwealth Government.

Major limitations of the current service system include:

- The array of services for older people are organised around administrative and legislative requirements that are not easily understood by the public.
- This structural feature leads to difficulties in communicating with people about what supports are available and how to get access to them so they can make informed choices about what might best meet their needs, and the potential consequences of those choices.
- There are a variety of services targeting people in the same target group, for example Veterans Home Care and HACC. Many of the programs offer overlapping services and there are some significant gaps. This leads to confusion and frustration for people seeking services.
- Current aged care planning and allocation processes are disjointed and inflexible. They are not delivering sufficient number or an optimal mix of services to meet the needs of older Victorians, nor do they reflect the diversity of our older population.
- Funding models, particularly in community care, are disjointed and inflexible leading to disjointed service delivery on the ground.
- The level of resourcing is not sufficient to meet the costs of operating high care residential aged care beds, associated capital costs or the particular needs of smaller rural services.
- A high level of regulation places a heavy burden on providers and restricts capacity for innovation.
- Service models don't actively promote wellness or restorative approaches.
- The current approach to overall management of the system fails to recognise that a proactive approach to market development is required to deliver effective, integrated service provision, and that strong relationships with providers, local government and other parts of the broader service system are critical to driving effective practice and service delivery.

Many of these problems may be addressed in the short to medium term through policy and funding changes but a different model of program management as well as better long term planning and investment are also required across the sector, based on clear and agreed objectives and priorities. This section explores where there are opportunities to address these limitations and gaps and improve the quality, effectiveness, efficiency and sustainability of the health and aged care system overall.

How should the system look?

Residential care should be adequately funded and reserved for those who cannot be cared for in any other setting. There should be very strong links between residential aged care services and health services and mental health services, without sacrificing a homelike environment, to improve the quality of clinical care for people in those services and avoiding unnecessary admission to acute services.

There should be more diverse housing and accommodation options for people as they age.

The funding for community care should be in one stream and unshackled from the underpinning regulatory and funding links to the residential aged care system. This funding stream needs to incorporate Veterans Home Care as well as HACC, packages and other community care programs funded by both the Commonwealth and State Governments.

Resources should be planned and allocated so that providers can offer services to people as their needs rise or fall without having to change provider unless the person chooses to do so.

Community care should be strongly linked to primary care (including GPs), subacute services, rehabilitation and specialist clinics, supported by the ability to transmit client/patient information securely between agencies involved in a person's care.

The system should be organised around wellness and restorative care principles and practices.

Access to the full suite of community care should be easy and easily identifiable.

Good quality assessment, starting with first contact and initial needs identification should act as community triage, taking a whole of health and aged care system approach to managing people's health and well being on the basis of early intervention and promoting self management and wellness in the community.

Improving planning for services

Key issues - planning

- *The supply of aged care services (especially community and residential high care) needs to be increased.*
- *Planning processes need to be more responsive and flexible to reflect demographic changes and changing client needs, as well as changing sector demands.*
- *Community care planning should use a common method, based on objective data to measure need, for allocating resources.*
- *The service system should be actively managed to promote integrated service delivery and support broad sector development and improvements.*
- *Commonwealth aged care policy and planning should address the increasing diversity of our older population and appropriately resource aged care providers to deliver services that are responsive to diverse needs.*

Increasing supply

A sufficient supply of aged care services is fundamental to meeting the needs of older people and thus ensuring the broader health service system functions as efficiently as possible.

Victoria has long experienced the lowest level of provision of high care residential aged care and has one of the lowest levels of operational places per capita of any state or territory. Data produced in *Putting Patients First* (Victorian Government 2010, pp 24-25) identified significant shortfalls in the number of residential aged care places in Victoria using current planning ratios (See Figure 3, overleaf).

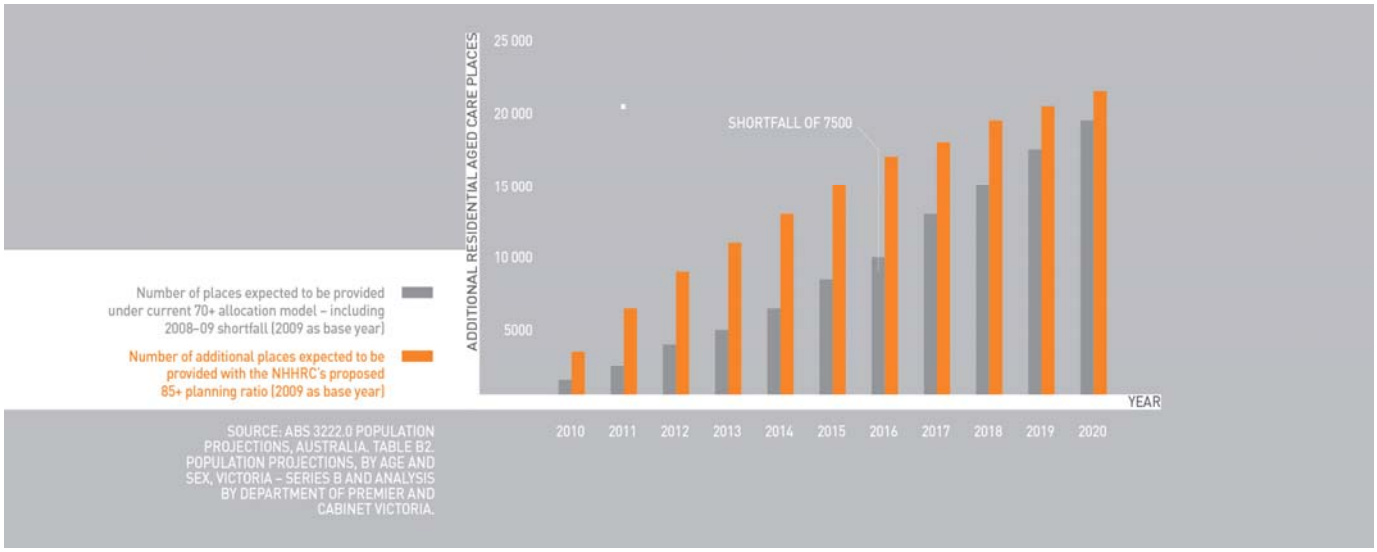
Those planning ratios are, however, not considered to be sufficient to meet future demand over the long term, given the population over 85 is expected to quadruple by 2050. The National Health and Hospitals Reform Commission (2010) recommended a revised planning model that focused on the population aged 85 and over, to keep pace with demand. Victoria supports this planning ratio which, as illustrated in Figure 3, would see a larger number of residential places allocated into the future than would occur with the current planning ratios.

Forecast demand growth in Victoria will occur in all regions of the State, but with a greater focus on regional centres and the metropolitan area. Overall, the greatest need for growth will occur in closely settled areas where planning issues and land availability challenges are more likely to arise.

It may be possible for some of this demand to be met by alternative, community based care (such as Extended Aged Care at Home (EACH) packages), but to accommodate this, and maintain the policy objective of keeping older people in their own homes for as long as possible, significant increases in the number of high level community packages allocated will be necessary.

While the Victorian Government is already investing in a range of strategies to facilitate better access to residential aged care, Commonwealth planning and allocation processes for all aged care services need to be reviewed to ensure there will be sufficient supply and an optimal mix that can meet forecast need, recognising both the growing demand for community care and the importance of avoiding unnecessary admission into residential aged care.

Figure 3 Forecast Victorian need for residential aged care places (reproduced from *Putting Patients First*, Victorian Government 2010, p25)



Making planning and allocation processes more responsive

The current processes for planning and allocating residential aged care places and community packages generate a range of restrictions that limit the capacity of the broader aged care system to respond flexibly to the needs of older Australians. For example:

- Residential aged care places are currently allocated through an annual process (the Aged Care Approvals Round, ACAR), with little capacity for places to be allocated outside that process. The Victorian Government is aware of at least one recent circumstance in which a provider was advised that they could not be allocated additional places outside the ACAR process, despite these places being sought for provision of services to a high needs, high priority client group in an under-serviced area. Greater flexibility in allocation processes, at least in circumstances such as these, would seem desirable.

- The current number, mix and distribution of community packages do not align to client need. Past Victorian Government analysis of available data regarding waiting lists for community packages suggests that:

    - The demand for high level packages exceeds their availability in most areas, while in some locations, the supply of lower level packages exceeds current demand.

    - Some local communities, particularly smaller towns that may be some distance from regional centres, struggle to receive access to packages because of an allocation practice that allocates packages to remote providers then does not monitor the delivery of those packages to people in the relevant area.

At the same time, demand for residential aged care places (particularly low care) in some locations has fallen, which means that a number of places are currently not operational. The Victorian Government has sought to at least partially remedy gaps in community package provision (particularly in rural Victoria) by seeking to convert non-operational residential places to community packages in areas of identified need. Rigidities in Commonwealth processes have prevented such conversions occurring in most instances.

Planning also needs to make stronger linkages between related services. As *Putting Patients First* (Victorian Government 2010, p21) notes, "primary care should be closely linked to acute health, community and aged services. However nationally there is limited coordination between these sectors in setting priorities".

All community care program planning (including Veterans Home Care administered by the Department of Veterans Affairs) should use a common method for allocating resources based on need for services per capita of the target population, clearly defined, as estimated by objective sources of data such as the Census and the Survey of Age Disability and Carers (ABS).

Current allocation process for community packages also pose practical limitations which mean it is not easy for clients to readily determine what their options are. Overlapping catchments, delivery of packages in some communities by organisations based outside those areas, and the lack of delivery of packages into some outlying communities all generate practical difficulties for older people seeking to secure community packages. This fragmentation also can limit the ability of other parts of the service system to work with those providers to achieve positive outcomes for their shared clients.

Limitations of current purchasing arrangements

The current practice of both the Department of Health and Ageing and the Department of Veterans Affairs involves market-based procurement processes in which services are retendered every 3 to 5 years.

This has injected instability into the service provision platform in Victoria[32], and has also impacted on the overall service system and its development. In Victoria's experience, strong relationships with service providers are essential to achieve service integration, promote service improvements and support sector wide practice change.

While Victoria has assumed this role in relation to the HACC and Aged Care Assessment Programs as well as its own funded services, there is a need for a similar role to be played across both residential aged care and packaged care to achieve integrated, efficient and effective service delivery for older Australians.

Responding to diverse needs

An increasingly diverse cohort of older people are seeking aged care services, comprising people from culturally and linguistically diverse backgrounds, Indigenous people, gay and lesbian older people, people with drug and alcohol dependencies and mental health issues, people living with HIV, and homeless and financially disadvantaged older people.

At the same time, increases in chronic disease, dementia and level of dependency amongst recipients of aged care services are likely to impact on the nature and intensity of services required in at least some parts of the broad aged care system.

While all older people may face a number of challenges as they age, these challenges can be significantly magnified if an older person's needs cannot be adequately addressed by current service planning, funding and delivery models.

The Victorian Government has a range of work underway to address issues of particular concern to diverse groups (see Attachment B). To be responsive to all older Australians, however, Commonwealth aged care policy and planning must also address the increasing diversity of our older population and appropriately resource aged care providers to deliver responsive services to an increasingly diverse population.

The aim is to treat all people with equity, fairness, and respect.

[32] With rural councils replaced by other service providers in some instances, significantly undermining the viability of those councils service delivery capacity.

Improving funding models

Key issues - funding

- *The scale of forecast requirements for aged care services demands fundamental changes in both the underpinning economics of the sector and how the system itself is planned and developed to stimulate the necessary capital investment.*
- *Funding for aged care needs to be sufficient to sustain service delivery and meet ongoing infrastructure requirements.*
- *More sustainable funding models for rural services that provide greater certainty are required.*
- *Major providers of community care need to be resourced to deliver care to people from low to high levels of service need.*
- *Management by the State of a consolidated funding stream for community care would maximise system integration on the ground and maximise the opportunities for keeping people as well as possible in their own homes.*
- *The Commonwealth's role should be establishing the financing and broad policy framework for these services.*

Improving the economics of aged care

Debate about the adequacy of funding has focused on residential aged care and the inadequacy of both recurrent funding to meet care costs and capital funding streams to fund high quality physical environments and facilitate future expansion.

Putting Patients First (Victorian Government 2010, p24) summarises the issue as follows:

> *The Commonwealth is responsible for funding and regulation of residential aged care which has been left short of funds for far too long. The Aged Care Association of Australia made it clear in 2009 that it considered the aged industry to be in crisis – a crisis that is being ignored. The Association warned the industry is effectively going broke, with 44 per cent of providers running at a loss.*

Aged care services have a critical role to play in both meeting the needs of older people and the effective functioning of the broader system of health and aged care services across Australia.

As previously discussed, the forecast level of growth in residential aged care services required to meet demand is substantial. Victorian figures suggest that by 2021, an additional 21,000 places will be required. Assuming that the average facility size was 90 beds, this would require a new residential aged care service to be completed on average every 2-3 weeks between now and 2021 to meet that need.

Like any market, the "price" paid for aged care services needs to be sufficient to both stimulate capital investment and meet the full, ongoing costs of operating services. Given the scale of forecast demand for aged care services, changes are required in both the underpinning economics of the sector and how it is planned and managed.

Victoria has direct experience of how the current economics of residential aged care is mitigating against much needed investment in this sector. For example, in some instances Victoria has been unable to attract a suitable not for profit provider to develop residential aged care on specific sites offered via its Land Bank initiative, despite offering heavily subsidised land for that purpose.

The fall in private investment in development of new residential aged care services (especially since late 2008) suggests that the underpinning economics of the sector are flawed . This must be addressed to create the necessary incentives for investment in this sector into the future.

Concerns have also been expressed about the adequacy of allowed revenue increases (indexation of subsidies and allowable charges). These have demonstrably not kept pace with cost increases, with the Commonwealth Government allocating 1.7 % indexation for 2010-11 across both residential aged care and HACC. As the current system fully regulates revenues, the only means of sustaining the system has been through increasing efficiencies and there is limited capacity to do so, given the labour intensive nature of aged care services. More sustainable funding models that meet the full costs of developing, delivering and maintaining these services are required.

There are also historic anomalies in Commonwealth Government funding for residential aged care that need to be addressed. A prime example of this is the Adjusted Subsidy Reduction, whereby the funding applied to residents that are in a state or territory government operated RACS is reduced "as recognition of an ongoing State Government responsibility for the capital upgrading and maintenance of nursing home buildings" (Department of Health and Ageing, 2005). It is indexed annually and represents a reduction of approximately 9% of the daily high care subsidy. In 2010, this represented approximately $13.8 million across Victorian public sector residential aged care services[33]. While the 2004 Commonwealth publication 'Review of Pricing Arrangements in Residential Aged Care' ('the Hogan Review') recommended that the ASR be abolished, this has yet to be fully implemented by the Commonwealth Government.

Ensuring sustainable rural residential aged care services

Rural aged care services play an important role in not just in meeting the needs of older Australians in their local communities, but in contributing to the sustainability of other health services and the local economy of those communities.

These services are often a significant part of local employment and economic activity, and can be the difference between a local community retaining a general practitioner and/or other key services. The Victorian public sector experience has shown that local provision of aged care can also promote more integrated service delivery, which has a range of benefits for both service recipients and wider service efficiency.

While there is no clear, evidence based consensus regarding the optimal or efficient size and configuration of RACS, industry trends during the past decade have consistently been towards aggregation and growth in facility size. According to AIHW (2008) the number of facilities with 40 or fewer beds has decreased from 53% to 37% between 1998 and 2007. This trend has been premised not only on growth to meet increased demand, but on the pursuit of higher efficiency through increased facility size, and Commonwealth policy over the past decade has promoted industry rationalisation and growth in facility size to this end.

Growth and achievement of economies of scale may not, however, be an option available to small rural providers. Many rural services are small and may have limited catchment areas[34]. There is often limited capacity to achieve economies of scale, and the impact of a small number of unoccupied beds can be significant.

These factors suggest that further consideration of the funding model and operational arrangements for smaller residential aged care services, particularly those in locations where they are the sole providers, is urgently required[35]. Alternatives such as block funding approaches that fund on the number of operational places rather than funding for occupied days (as currently occurs) require

[33] To avoid Victorian public sector services being disadvantaged, the Victorian Government currently covers this shortfall, to PSRACS high care beds that were operational prior to 1997.

[34] For example, some 80% of rural Victorian public sector residential aged care services have 40 or fewer beds, with population projections and changing care preferences by eligible care recipients, indicating no significant need for growth in the foreseeable future.

[35] The Commonwealth Government currently provides additional "Viability funding" to rural services; however available information increasingly suggests that current funding models and levels are not sufficient to sustain local services in some rural communities. For example, there have been a number of instances where small rural residential aged care services have experienced significant viability issues that have either led to closure or amalgamation with existing services. In addition, preliminary analysis of industry conditions in smaller rural communities suggests that a significant number of them are experiencing viability concerns.

serious consideration, as these have the potential to provider greater funding certainty and potentially reduce administrative burden.

Such a model, however, needs to provide sufficient funding to fully meet the needs of residential aged care recipients, and also meet associated capital and other costs. While the Commonwealth Government established multipurpose services (MPS) several years ago, Victoria believes that current cash out rates, the way in which these are typically now applied[36] and their exclusion from access to various funds available to other residential aged care providers[37] makes the current MPS model an unviable alternative to achieve sustainable small rural aged care providers. It could, however become a viable alternative if the funding approach adopted provided greater revenue for providers that allowed them to meet their operating and capital obligations, as well as the increased costs that arise when local demand for services increase.

More flexible community care funding leading to more flexible community care

The HACC program in Victoria allocates its funding to agencies with targets set around the mix and volume of services provided (for example, an agency might have a target of delivering 50,000 hours of domestic assistance and 10,000 hours of personal care). The target does not specify the number of clients, or what proportion of clients should get both domestic assistance and personal care. As the HACC program is a price by volume purchaser of services, it also specifies a standard unit price (e.g. $30 per hour for domestic assistance and $40 per hour for personal care).

By contrast, packages (CACPs, EACH and Linkages) allocate their funds as a number of care packages at a single average value (around $13,000), and provider targets will be set in terms of the number of packages delivered. The target does not specify the quantity or mix of service types that should make up a package or the number of clients (although generally one package is thought of as one place).

It is open to package providers to adjust up or down the value of the services provided to a recipient, based on the person's assessed needs, as long as they can operate within their overall budgets. This flexibility is however limited by both the gap between the value of CACPs and EACH packages, and the limited number of EACH packages available[38].

The current restrictions on the mix of services available in the different Commonwealth-funded community care packages are also problematic, because as people need higher levels of support, they may not be able to access these through their existing provider and/or a package. Furthermore, the requirement for security of tenure of a package operates against the reality that peoples' needs fluctuate over time. These restrictions import perverse incentives into people's choice of type of service[39].

Major providers of community care need to be able to deliver the full range of community care from low levels to high care for people with complex needs. They need to have the flexibility to tailor the mix, quantity, either up or down and duration of services to an individual's situation, so should retain discretion about resources allocated at the level of clients[40].

[36] While earlier conversions applied to all beds, more recent practice has been to only cash out the number of beds that are occupied at the time of conversion. This means that the service in question does not have resource flexibility to accommodate any increase in demand.

[37] To date, this has included exclusion from some capital funding and one off funding for information technology.

[38] In practice, rigidities have also been imported by agencies on the basis of what it is convenient to deliver. This has been complicated in Victoria by a prevailing use of a brokerage model of delivery where package providers directly provide case management but subcontract out direct service delivery to other agencies, which can incur significant transaction costs, (reducing the proportion of the package available for actual service provision).

[39] For example, the level of service a person can expect to get from a CACP can be less compared with retaining their existing HACC services, and the contribution they are expected to make can be more. If a person moves from HACC to CACP, they may be required to change providers, as many HACC providers have not been able to gain access to CACPs via current allocation processes.

[40] This approach is consistent with that sought under agreed COAG health reform initiatives where the delivery of health services will be delegated to the local level, where individual needs are best met.

A community aged care system focused on assisting people to maintain their wellbeing and function would provide progressive resourcing in response to increasing needs with provision for coordination for those with more complex needs and case management for the few with that need. Only when people experienced a high degree of cognitive and/or physical dependence would they have the need to have the comprehensive accommodation and care services that we associate with residential aged care today.

One way of achieving this might be to consolidate all community care funding into one stream, making it possible for current HACC providers and packaged care providers to reconfigure their service provision so they can offer basic supports to people with low level needs and higher level care to people with more complex care needs. Another approach might be for the Commonwealth and the Victorian Governments to agree to allocate funds from the HACC Program and packages to make it possible for major providers to deliver services across the range of care needs.

A necessary feature for any reformed funding model, for both planning and accountability purposes, is a client based data collection reported by service providers that includes client demographic characteristics and the hours of service delivered. Service providers should report this data quarterly.

In Victoria, management of consolidated community care funding stream by the State would maximise system integration on the ground and keep people as well and as independent as possible, in their own homes.

Improving service accessibility

Key issues - improving service accessibility

- *A "one stop shop" entry point needs to be able to direct people making contact with it to the most appropriate service for their needs, rather than simply responding to the presenting issue.*
- *Investment in face to face assessment is important to maximise opportunities for wellness and reablement approaches to service provision.*
- *There is an opportunity to rationalise HACC and ACAT assessment in community settings, but not at the expense of the responsiveness required by hospitals in seeking the best option for older people when they are discharged.*
- *Better information about available services is essential if older Australians are to make more informed choices about the services and supports they receive.*

Creating simpler entry points to the system

Services and support need to be organised and delivered in ways that ensure that older people can easily find the right types of aged care services in the right settings when they need them. There are reports that older people and their families find the current system difficult to access and/or navigate.

The Commonwealth Government has announced that it will be moving to "one stop shops" that can provide both information and assessment services to improve service access and system navigation.

The Victorian experience to date[41] suggests that a single point of entry would be a positive addition to the service system.

However, Victoria would be concerned if a single entry point simply acted as a funnel into funded services rather than taking an active triage role. An entry point needs to be able to direct people to the most appropriate service for their needs, rather than simply responding to the presenting issue[42].

[41] Victoria is currently trialling an access point model, Direct2Care (D2C), as a result of a COAG agreement in 2006 that access to HACC would be simplified. This is an access point for people who do not know where to go who are seeking information and access to services and focuses not just on assessing eligibility for services, but also providing information and advice about the range of services available in the system to assist older Australians to make more informed choices about their options. There is no requirement for people to go through D2C to get access to a service. While it is a sign posted information, assessment and advice point, it is not the only one, and many people have continued to make their first point of contact with their local council.

Victoria believes there would be value in routing all initial inquiries through a central point so that a consistent approach to initial needs identification, screening and eligibility testing can be applied, with subsequent referral to the right response to meet the person's needs in the community.

The data set and framework underpinning these processes should be nationally consistent. It should, however, be noted that while the processes may be consistent, the architecture of the entry points, the arrangements between entry points and surrounding service providers and the service responses will not be, given the differences in service systems, service profiles and resource bases between each State and Territory.

Implementation of single entry points would also make it clear where there are bottlenecks for service provision and whether resources are matched to what people actually need, assuming there is a client level data collection that enables everyone to see the range of services each client (de-identified) is receiving post assessment.

Issues to be resolved include:

- The geographic coverage of single points of entry (i.e., one per region or one per State);
- The relationship between a single entry point and the surrounding services;
- The governance arrangements for one stop shops: the State sees itself as having an important role as system manager for the overall health and community care system;
- The percentage of people seeking services referred for face to face assessment (see below);
- The scope of a single entry point – is this just for 'aged care' services or does it encompass services older people may need and want to use; can it include community mental health services and disability services; and
- The information management and communication and technology requirements to ensure that client information can be shared between agencies with a role in providing health care and support for the person.

Strengthening assessment

Victoria believes that community care assessment has an important community triage role to play. Such a role involves early intervention to resolve developing problems experienced by an older person seeking services, tertiary prevention such as identifying reablement and restorative opportunities and ensuring that people get the assistance that responds to their needs, which may be different to their presenting issue. [43]

Our view, informed by substantial consultation with service providers across the State over several years, is that face to face assessment is important to achieve these goals for a significant proportion of people seeking services, and the best way of ensuring that they get the right service, at the right time and in the right place, contributing to allocative efficiency in the overall health and aged care system[44].

[42] For example, a request for meals on wheels can mask mobility or cognitive issues, that if identified and directly addressed before they become a crisis, would have positive outcomes for both the person and the health and aged care systems. This may not be an aged care service; it may be memory clinic, a continence clinic, a seniors' walking group or the local chess club. Achieving this outcome is dependant on investing in skilled staff for the entry point.

[43] Victoria has designated 99 agencies across the State as HACC Assessment Services. Their role is to deliver Living At Home Assessments for people who are seeking HACC services. A Living At Home Assessment is focused on capitalising on restorative and reablement opportunities for the person and simple changes that can be made to the person's environment (their home) and the equipment they use that will enable them to continue to undertake the activities of daily living themselves, to the extent this is possible. HACC Assessment Services need to have routine access to Allied Health professionals to assist in developing care plans.

[44] http://www.health.vic.gov.au/hacc/assessment.htm

Relying solely on telephone assessment would limit opportunities to actively managing demand for community care and other services, and also restrict capacity to focus on wellness and restorative care, both of which may ultimately result in increased demand for services across the broader health and aged care system.

There is an opportunity to rationalise the role of HACC Assessment Services and ACATs in undertaking assessments of people in the community. However, this cannot be at the expense of the responsiveness required by hospitals when patients need an assessment to determine whether transition care, residential care or community care is the right response for them when their discharge from hospital is being planned.

Assessment is a continuous practice that needs to be based on good quality information about a person that can be shared between practitioners and service providers involved in the person's care. A key enabler is an electronic health and care record that can be securely transmitted around the service system so that health professionals and other service providers are not solely dependent on the person's memory for crucial health and care information.

There is an opportunity to build on the work that Victoria's Primary Care Partnership Strategy has been undertaking over the last 10 years to improve service coordination through more consistent client information management and transmission, including the use of information standards for recording and transmitting referral and care planning information and standardised information systems for electronic referral, in a partnership environment.

Assessment practice is also important. Victoria is currently implementing an assessment framework in the HACC Program that aims to set up a community triage service ensuring that people get the right interventions at the right time to address their underlying needs in a way that promotes their improved wellness and independence.[45] People who access an assessment service may continue to have a high level of disability due to chronic illness but this approach aims to move toward one of tertiary prevention that assists them to adapt to their level of disability and reduces its impact on their day to day lives.

Improving service models

Key issues – improving service models

- *Promoting wellness should be a fundamental objective of the service system.*
- *Substantive changes to current services will be required to actively maximise physical and wellbeing of all older Australians.*
- *More flexible community care models that allow older Australians to access a graduated range of services as their needs change are required.*

Promoting wellness & restorative care

As *Putting Patients First* notes, "Victoria supports a much stronger investment in keeping people well and out of hospital" (Victorian Government 2010, p 19). As such, promoting best possible health for all older people should be a fundamental objective of the service system. Experience to date in Victoria highlight the substantial benefits that can flow from such approaches for older people, service providers, and the broader community

To actively pursue this goal, however, there would need to be a greater emphasis on promoting wellness and reablement[46] in all aged care services. Such a service system would focus on supporting

[45] http://www.health.vic.gov.au/hacc/assessment.htm

[46] 'Wellness' refers to a state of optimal physical and mental health, especially when maintained by health promoting activities, and is consistent with the WHO active ageing framework in that both aim to keep older adults engaged in life for as long as possible. Taking this approach to community care delivery involves focusing on whole of system support for clients' independence by changing the way that all people involved in service delivery work with people receiving services. Reablement refers to short term targeted interventions pitched at tertiary prevention for people who already have a well established level of

older Australians to obtain and maintain the best possible physical and mental health they can[47], regardless of whether a person is living in their own home or in residential care.

For example, the 'traditional' approach to HACC has been to provide services to substitute for what people cannot do for themselves. Victoria is actively pursuing a restorative approach which seeks to improve people's function. The Active Service Model (ASM) is aimed at mobilising the range of HACC services to help people regain (or retain) their independence[48].

Conceptually, the ASM completely recasts the old distinction between levels of care[49], asserting that a proper mix of assessment and individualised goal-setting is appropriate at any level of client need. The task for the service provider is to put together a care plan for each individual. Services are varied in content, financial value and time span (e.g. a single payment for household equipment plus short-term occupational therapy (OT) to restore confidence with housework, or some weeks of personal care with a rehabilitative plan to regain independence with bathing and mobility, or individualised support for a person to re-engage with the kinds of social or recreational activities they formerly enjoyed).

The success of this model depends on several factors: good assessment, individualised goal-setting, active feedback from care providers to the care coordinator or case manager, and inbuilt review of the care plan based on the direct evidence from workers. The model also depends on:

- Systems and structural change right across the pathway (e.g. message at intake, strength based assessment tools, goal based care planning, flexible rostering for service intervention);

- Training and ongoing support of staff to operate within a changed paradigm and during the transition to change; and

- Building on other related initiatives that share a similar approach (such as chronic disease management).

Work in the United Kingdom, New Zealand and Western Australia has already established that short term reablement interventions are able to increase people's independence and reduce ongoing reliance on formal services. Reablement pilot projects over the next couple of years will test how short-term interventions might work in the Victorian context.

System reforms to create incentives to drive such approaches and support the necessary long term practice change would help progress this important system change, which has the potential not just to improve the wellbeing of older Australians but also to drive greater service sustainability and efficiency.

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disability or frailty as a result of age, chronic disease or both. Generally, these interventions are low cost and low intensity (Victorian Government Department of Human Services (2008A) ,p5).

[47] The needs of older people change over time. Increasing age, co-morbid conditions and dementia can significantly increase the vulnerability of older people to clinical harm. Therefore, a 'wellness' approach for this group of older people that focuses on minimizing functional decline and providing appropriate timely health and palliative care is of paramount importance.

[48] The ASM is a capacity-building model, where interventions focus on the restoration of function (e.g. learning how to manage the housework or self care after a health setback) rather than simply providing an ongoing substitution for the person's incapacity. Central to this approach is enabling the client to be more actively involved in goal-setting – that is, setting goals for the intervention that are meaningful to the person, rather than clinical goals. Evidence indicates that adopting such strategies can make a positive difference to the quality of life for older people, improving well being and morale for the older person, and reducing the number of hospital admissions and delaying need for permanent residential care. Other Victorian work such as Well for Life and Count Us In! have also focused on improving overall wellness of older Victorians in a range of settings including residential aged care, with an emphasis on promoting physical nutrition, exercise and social inclusion.

[49] Previously, it has often been assumed that a client could be supported for months or years with basic home care services and then, after an assessment, would progress to a high-level package of care as they became frailer and more disabled. The third stage would be entry to residential aged care.

Access to a broader range of supports

Residential aged care services need to be funded and supported to universally adopt the notions and practices that allow a person to experience living and dying in a home like environment within a congregate setting[50].

The Commonwealth makes available funds for residential aged care to purchase palliative care however the uptake of palliative care services by residential aged care services does not correspond with the expected need for palliative care of this group of clients. It is understood that current funding and administrative processes create barriers to accessing services in such circumstances. Considering alternative approaches, such as funding that supports the capacity for palliative care services to provide in-reach into residential aged care services, may address this issue.

There are other potential areas where improvements to current arrangements may improve access to timely palliative care services for older Australians, should they need them, including:

- Increased flexibility of care packages, review of the exclusion criteria for packages, and review of shared care arrangements
- Promoting and improving links between palliative care services, divisions of general practice and residential and community aged care services.

The use of Advance Care Planning in residential aged care services and the community sector is also patchy. It is not currently specified in key documentation such as the specified care and services and the accreditation framework. Including such references in key documentation may promote the consistent use of and support for advance care plans in aged care services including home and residential services.

Regulation and continuous improvement

Key issues – regulation and continuous improvement

- *The current regulation of aged care should be reviewed to identify where alternative approaches can remove unnecessary burden without compromising safeguards.*
- *The current system requires mechanisms beyond regulated standards for driving safe high quality care and improvement.*
- *A system that encourages transparency and learning from adverse events and system errors could promote sector wide quality improvement and more effective risk management.*
- *An increased focus on governance and leadership is required to drive high quality aged care services.*
- *Investing in data and systems is essential if clinical governance is to be improved across aged care services. Investment in linked up sector wide systems and science in relation to safety quality for older people.*
- *Establishment of a patient safety centre for aged care should be considered to foster improved practice and minimise potential harm.*

In the aged care sector, regulation is used to both protect the wellbeing of older people receiving services and set a wide range of parameters relating to the operation and resourcing of aged care services. Residential aged care in particular is subject to a high level of regulation with detailed and extensive requirements set out in statute and supporting documentation.

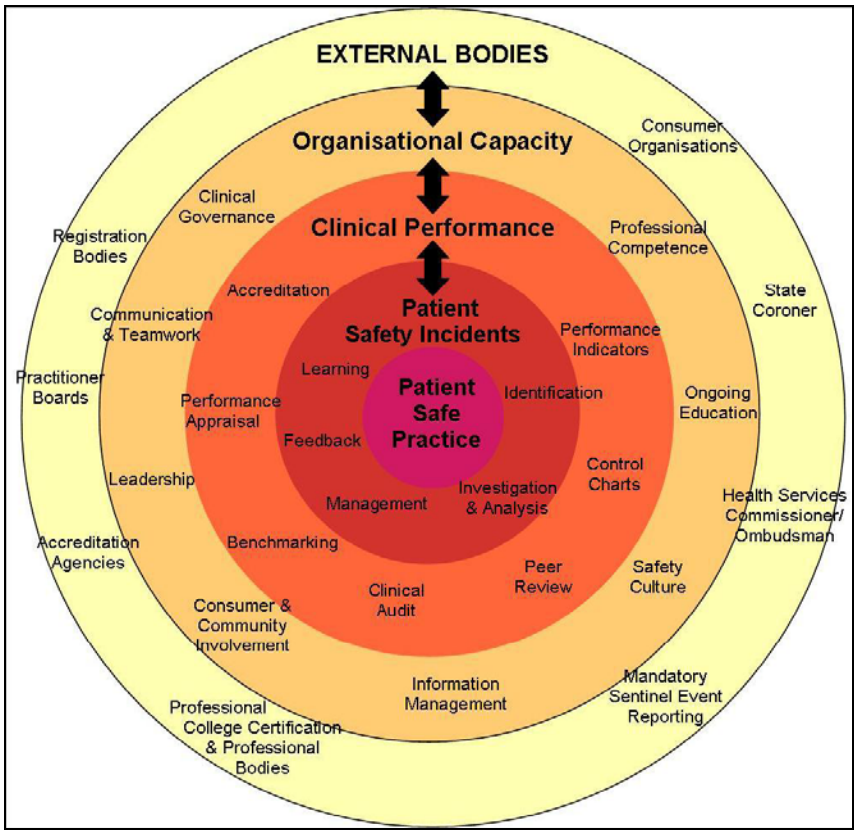
Effective protections for vulnerable older people are essential to an effective regulatory scheme for the aged care system. There are however associated costs with the current regulatory scheme: complex regulatory schemes can be difficult to understand and navigate, compliance with complex regulation

[50] Creating environments geared to older people's individual needs and preferences for living, with a focus on people with cognitive impairment. Australian and international knowledge and resources exist for the industry to use, including tools such as the Dementia Friendly Environments work developed by the Victorian Government.

generates significant administrative burden, and the strong emphasis on meeting regulated standards (and the punitive responses for a failure to do so) can generate a risk adverse environment which in effect stifles potential innovations and can limit scope for continuous quality improvement.

The Australian Commission on Safety and Quality in Healthcare has identified a wide range of internal and external elements (of which accreditation and standards are two of the many mechanisms that are required to drive a systems approach to safe high quality care (Figure 4, below). The experience of acute care suggests that fundamental shifts in culture, accompanied by a sophisticated range of organisational changes and evidence, would be required to achieve ongoing quality improvements in client care across aged care services[51].

Figure 4 Health care safety system (Australian Commission on Safety and Quality in Healthcare, 2006)



Achieving consistently safe high quality care for older people receiving aged care services would require similar approaches tailored to accommodate sector-specific internal and external drivers. While some of this work could build on existing initiatives and structures within the aged care service system, moving quality systems beyond minimum standards established through regulation to achieving safe high quality care would require new, integrated work across a range of areas.

Fundamental to any such transformation would be a change in culture and a system that encourages transparency and learning from adverse events and system errors to promote sector wide quality improvement. An increased focus on effective clinical governance[52] would be required to drive such

51 Historically, such advances in quality improvement in health have been triggered by evidence (such as the Quality in Australian Healthcare Study), which highlighted significant risks and adverse events impacting on client wellbeing many of which were avoidable, and improvements in service quality and safety have been achieved over extended periods of time. Subsequently, the acute care sector has moved through a number of stages to achieve safe high quality care and its quality systems now are under pinned by greater transparency, governance, risk management, measurement and improvement of care with increased understanding of achieving safe high quality care in a complex and high risk environment.

52 The Victorian clinical governance policy framework defines clinical governance in the Victorian health service context, as "the system by which the governing body, managers, clinicians and staff share responsibility and accountability for the quality of

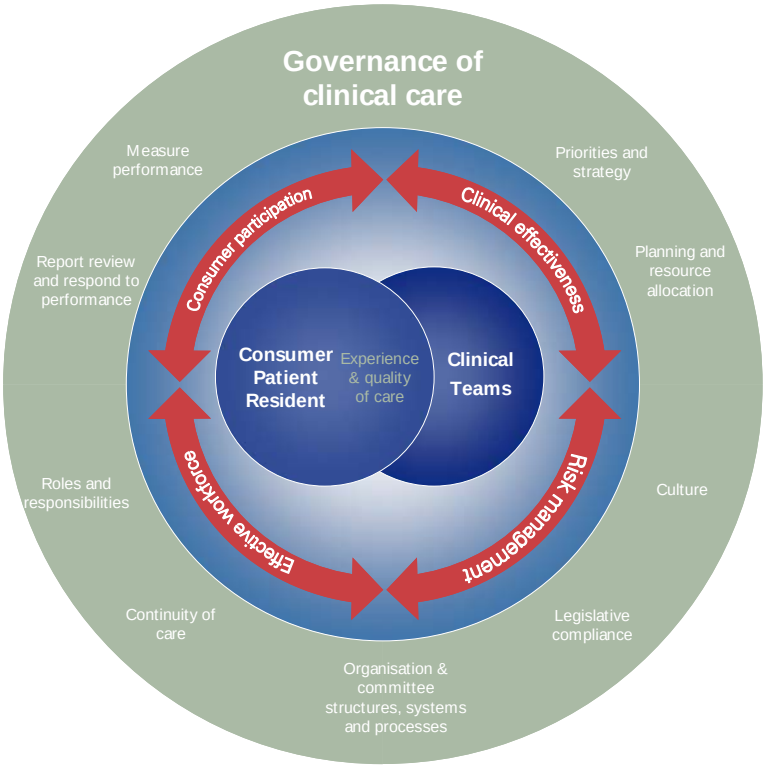
change, underpinned by robust data and systems. Significant changes in the way current aged care service provision is regulated and monitored would also be necessary, to create the necessary environment in which such changes could occur.

Inherent in the approach adopted by health care is the establishment of patient safety centres nationally and internationally. These centres promote approaches that maximise best practice and minimise patient harm through an evidence base[53]. Establishing a similar entity to promote safety and quality in aged care could deliver a range of benefits for older Australians and requires serious consideration.

While the traditional focus of clinical governance work has been on acute services, improving clinical governance in aged care is equally important, where increasing age, co-morbid conditions and dementia can significantly increase the vulnerability of older people to clinical harm. This inherent vulnerability of older people reinforces the need for organisations with responsibilities for the care of older people to treat the governance of care with the rigor that is at least equal to that commonly associated with the governance of finances, OH&S, plant, equipment and other corporate governance responsibilities.

The Victorian clinical governance policy framework depicted in Figure 5 (overleaf) provides an example of a clinical governance approach that is directly relevant to aged care provision. The Victorian Government's Aged Care Beyond Compliance strategy has progressed work on a number of fronts to support PSRACS to improve service capacity and drive robust systems for clinical governance in these services.

Figure 5 Components of the Victorian clinical governance framework



care, continuously improving, minimizing risks, and fostering an environment of excellence in care for consumers/patients/residents".

[53] See, for example, the NHMRC designated Centre for Research Excellent in Patient safety – website http://www.crepatientsafety.org.au/

Strengthening the workforce

Key issues – strengthening the workforce

- *Work in aged care must be valued equally with other work in the health and community sectors. Strategies need to be adopted to promote the importance of working with older people, reflecting renewed perceptions of their value in society.*
- *It is essential that workforce planning for the community and residential aged care is based on information about the age structure of these groups.*
- *New workforce strategies will need to be developed and resourced to meet the changing needs of both the aged care workforce and its clients, and system incentives will be required to support such changes.*
- *Expanding utilisation of the vocational educational training (VET) sector may make a valuable contribution to addressing current and emerging aged care workforce challenges.*

Like all service provision, having access to the right people with the right skills at the right time is crucial. Victoria agrees with the key future workforce challenges as outlined in the Productivity Commissions issues paper.

There are, however, a number of additional workforce challenges that require consideration. These include the:

- Impacts of an ageing workforce, and implications of other workforce demographics
- Challenges of attracting and retaining a suitable workforce to care for older Australians
- Provision of model/s of care that are responsive to the needs of older people
- Optimal use of existing skills in the workforce

While these are challenges common to most human services sectors, they are particularly pronounced within the aged care workforce. There are a range of areas where there is potential to address some of these challenges and secure an effective, future workforce to care for older Australians.

Retaining existing staff

The effects of workforce ageing are more pronounced in community and residential aged care than many other sectors. Data from the Australian Bureau of Statistics (2006) identified that 58% of the residential aged care workforce is over 45 years of age compared to 38% across the general workforce (over 70% Victorian workforce census respondents were over age of 45). Similarly, Martin and King (2007) identified that the community based workforce has an older age structure than the residential one.

At the same time, increases in chronic disease, dementia and level of dependency amongst recipients of aged care services are likely to impact on the nature and intensity of services required in at least some parts of the broad aged care system.

To deliver the necessary services and retain the expertise and dedication of existing staff as they age, some services may need to make a range of changes to accommodate the specific needs of older workers[54]. This could, for example, involve changes to the resources and equipment available to support safe and effective work practices, the mix of staff skills required[55], work practices and/or professional development opportunities.

[54] This may, for example, involve changing the nature of employment arrangements (to provide greater flexibility), redesigning tasks and how they are delivered (for example, through greater use of assistive technology), and/or considering how the specific health needs of individual workers may be best accommodated.

[55] Taking into account the environment within which that care is being provided and the needs of those clients

Attracting new staff

While much can be done to retain the existing workforce, there is also a need to attract new staff into the sector to meet changing demands.

Working in community and residential aged care is often accompanied by a range of negative images and perceptions, despite it offering a breadth of career opportunities. Strategies to counter this and attract a broader range of people into caring for the aged will be critical to meeting future demand[56].

An active Commonwealth Government campaign against ageism which promotes the positive aspects working of aged care should form an important element of any such work.

Articulating and promoting the career path available within aged care has the potential to assist in promoting the sector as a more attractive career option and can begin as early secondary school. For example, in rural Victoria, secondary school students have obtained experience in aged care, and have been offered the opportunity to undertake a Certificate III in Health Services Assistance through the VET sector. The VET sector in particular has the potential to offer a range of training options that can be tailored to changing care needs and/or targeted to address particular workforce shortages.

Support could be also provided to investigate opportunities for the development of partnerships between acute facilities and aged care organisations (community and residential) to promote inclusion of care of the aged into graduate programs, for medical, nursing or allied health graduates and support sharing of scare skills and resources across services. This would strengthen the relationships between the sectors, promote more integrated care for older Australians and also provide opportunities for graduate exposure to aged care.

Building staff skills to meet evolving needs of clients

In planning and supporting development of the workforce of the future, the needs of older Australians should determine both the skills and attributes that will be required of that workforce. The workforce skills to meet these diverse needs will be required to support the varying levels of dependence of older people who live in the community and residential aged care. This will range from people who are relatively independent to those with high levels of dependency due to complex care needs.

For many older Australians, such services will focus on wellness, enablement and/or social connectedness. Victorian Government initiatives such as *Well for Life*, *Count Us In!* and the HACC Active Service Model have highlighted that the skills and knowledge required to effectively provide such services may differ from those typically included in traditional health and community services qualifications. In addition to illustrating the need to consider a wider range of skills and knowledge than those traditionally associated with care of the aged, these initiatives have also demonstrated that incorporating such approaches into models of care can positively impact on both resident quality of life and staff job satisfaction.

At the same time, the increasingly complex needs of some older people in residential aged care and HACC services may require additional clinical expertise in certain services. Recent Victorian initiatives such as the Residential Aged Care In-reach service have highlighted some potential gaps in current clinical capacity in some services, in particular gaps in availability of clinical skills and resources and stock required to provide more specialised services. High turnover of staff was also identified as a factor that made maintenance of skills and knowledge difficult in some services.

Examples such as this reinforce the need for upskilling, ongoing education and professional development along the lines of those outlined in the Productivity Commission's discussion paper.

[56] These strategies in particular will need to target younger people, men, mature workers, people from culturally and linguistically diverse backgrounds and those interested in pursing a career in aged care including those who are changing careers. The strategies will need to articulate how best these people can be supported to pursue a career in aged care. The mechanisms to achieve this will involve developing and articulating explicit foundation training models that would lead to multiple career pathways in aged care and the vocational and tertiary qualifications achieved.

Exploring alternative workforce models

A mix of staff currently works within the sector, and the roles played by nurses are particularly important. To retain staff and promote best possible service provision, it is critical that best use be made of the skills of those staff, and that there is an appropriate match between what residents need and the skills, knowledge and aptitudes of the staff providing them.

In thinking about and planning for the future service system, there is an opportunity to think differently about the way teams are constructed and focus on skill sets. Existing staff will continue to be fundamental to service provision, however in some circumstances, different ways of using existing experience and/or changes to models of care to accommodate new kinds of workers at a wide range of levels (from support staff to highly trained nurses) may have the potential to better meet resident needs whilst improving staff satisfaction.

This might, for example, involve nurses undertaking more complex clinical work (with the necessary supports and training), supported by other staff. Such an approach has a range of benefits for both:

- Residents, who can receive timely access to the kinds of more complex or specialised services they might require within their homes
- The staff themselves, who are able to make use of and maintain their skills

Broader systemic incentives would be required to support changing models of care, including changes to current funding processes and instruments.

For example, in residential aged care providers are required to respond appropriately to complex or specialised resident care needs, often these are of an intermittent or short term nature. The current ACFI funding process does not recognise or support the intermittent complex care needs of clients such as those required during an acute illnesses, or during the transition period from palliative to end of life care.

Often these conditions result in residents being transferred to acute facilities. If there were appropriate systemic incentives, staff could be supported to up skill to have the necessary skills and knowledge to enable them to respond to short term but often complex changes in resident needs. This would result in timely, responsive complex care being provided by appropriately skilled staff within the residential care setting; thus avoiding costly and often emotionally traumatic transfers to hospital and unnecessary use of acute hospital beds.

Investing in information technology and assistive technologies

Key issues – investing in technology

- *Electronic client information systems have the potential to enhance service provision and need to be underpinned by training, practice change management and staff support.*
- *Investment in assistive technologies supports a wellness promoting model of care.*
- *Access to assistive technologies through aged care programs is variable and inconsistent.*
- *The majority of older Victorians are accessing assistive technologies through other sources such as Victoria's aids and equipment program.*

ICT

The services within scope of this submission are information rich. That information is essential to the quality and safety of the care and support of the people using the services. At present it is either hoarded or squandered in a less than systemically purposeful way.

An important objective for the system must be to electronically record, store and transmit client information, to take the onus off the person to remember his or her medical history and drug regime. The availability of this capability can over time lead to better use of available resources (such as

through telemedicine), significant reduction in duplicated procedures as well as reduced polypharmacy and avoidable adverse events.

Information and communication technology are essential collateral areas of investment when planning for the implementation of an electronic health record.

As noted above, Victoria has gone some way in moving in this direction; however critical infrastructure, such as a national e-referral hub and robust electronic platforms that use open source systems and a national broad band network, is missing for the benefits of this approach to be fully realised.

Victoria's experience is that implementing end to end electronic client/patient information recording, storage and transmission must be accompanied by substantial training, practice change management and staff support over the implementation period, or it will fail to fully deliver the benefits envisaged.

Assistive technologies

The South Carolina Assistive Technology Program defines assistive technology as "any device, system or design, whether acquired commercially or off the shelf, modified or customised, that allows an individual to perform a task that they would otherwise be unable to do, or increases the ease and safety with which a task can be performed"[57].

Such technology is a key component of supporting older Australians to remain living in community. The probability of having a severe or profound disability increases dramatically with age:

- By the age of 65 to 69 it has increased to one in ten reporting a severe or profound core-activity limitation.

- By the age of 85 or more, one in two people report a severe or profound core-activity limitation.

A recent report by the Australian Academy of Technological Sciences and Engineering (2010) noted that "emerging innovative technologies offer the prospect of enhanced security, safety, diagnosis, treatment and physical assistance to improve the quality of life" for older people, both at home and in residential aged care. The report found that use of smart technologies within individual's homes could assist with ageing in place and delay or even prevent admission to residential aged care.

Assistive technologies range from the decidedly low tech (light weight vacuum cleaners and mops, no scrub bathroom cleaners and simple devices that act as extensions of a person's hands that enable them to wash and dress themselves without other assistance) to the high tech (e.g. remote vital signs, health and movement monitoring).

There is clearly a role for low tech interventions in the context of a wellness promoting approach that encourages people to continue to do for themselves, rather than have things done for them.

These types of devices merge into what are traditionally regarded as 'aids and equipment', which for older people are generally low tech low cost items such as commodes and shower chairs (although there is an increasing demand for motorised sit-on scooters).

While investment in assistive technologies supports a wellness promoting model of care, access to these through aged care programs is variable and inconsistent, and the majority of older Victorians are accessing assistive technologies through other sources such as Victoria's aids and equipment program. Improving access to such technologies via aged care programs could deliver significant benefits, particularly if this included a focus on timely availability for older people on low incomes.

[57] South Carolina Assistive Technology Program website, http://www.sc.edu/scatp/what.htm.

There are other issues regarding such technologies that also require further consideration, such as the suitability of current prescribing arrangements.

There is a lot of interest in high tech interventions such as remote monitoring of health and movement. They need to be trialled in practice in Australia to understand their impact on people's overall health status and their quality of life as well as the systemic links that need to be in place for them to work effectively. Personal Alerts supplied through a Victorian Government program, Personal Alerts Victoria, are a very popular lower tech version of these technologies, providing people who are on their own at home and their families with confidence that help is at hand in the event of misadventure.

Telemedicine offers the possibility of gaining access to specialist expertise for rural and remote communities, but it is not ubiquitous at this time because the ICT infrastructure is not uniformly in place to support it.

Supporting carers and volunteers

Key issues – carers and volunteers

- *Flexible and practical support, respite and resources need to be provided to meet individual needs as they change over time.*
- *Volunteers provide an important role in meeting the needs of older Australians, and opportunities for volunteering need to be flexible to maximise participation of volunteers into the future.*

People in care relationships

It is well understood that carers play a critical role in enabling people to remain at home if they have significant levels of disability. It is also well understood, given the changing profile of the population, the more geographically dispersed location of family members and women's increased workforce participation, that the amount of time and effort available for caring for people with significant levels of disability is likely to be less into the future than it is currently. This is the case regardless of the age of the person cared for.

There is an important policy question lurking in there which demands further investigation. That is, does less availability of time and effort for caring mean that family members do not want the role of carer? This question can be answered empirically. If the answer is that family members want to fit their caring role into their other obligations to work and children but lack the time to physically deliver care on a day to day basis, what is a reasonable response from governments given an overriding interest in encouraging workforce participation for economic and other reasons into the future?

A 2009 Commonwealth Parliamentary Inquiry into better support for carers, *Who cares…?,* identified, on an anecdotal basis, the profound physical, emotional and financial effects providing care has on carers and their families. Carers indicated they want choices for themselves and the people they care for, and that needs of carers and those they care for, are inextricably bound. With a shift from institutional care to care in the community, there is increased reliance on unpaid care of family and friends. In the absence of adequate support, the report considers carers are in crisis. Pressures on systems of support for carers have been building over decades and are projected to increase.

Victorian experience supports those findings. The Victorian framework for supporting unpaid carers focuses on both sides of the care relationship, acknowledging that supporting one person in a care relationship should result in supporting others in that relationship, and the relationship as a whole. *A Victorian charter supporting people in care relationships* and the state framework *Recognising and supporting care relationships* promote the following in program delivery, funding and service provision:

- Recognition, respect and support of all people in care relationships, whether carer or care recipient; and
- Participation of carers and care recipients in care planning and delivery, and in quality improvement and assurance processes.

The charter and framework are supported by the action plan *Recognising and supporting care relationships for older Victorians*. The plan acknowledges care relationships are dynamic and diverse, changing over time, and that the needs of individuals in care relationships may differ. The care dimension of a relationship is only one of many dimensions of the relationship between those people. They are also husband and wife, parents etc.

Services need to be flexible and innovative, to respond to diversity, different needs and change in care relationships. Flexible and practical support, respite and resources need to be provided to meet individual needs as they change over time; such needs include grief and loss, access to support groups and support during key transition points in care relationships.

Research suggests most older people prefer to live in their own homes for as long as possible. The research of Langeland and Wahl (2009) indicates services of support and social integration need to enhance people's self-esteem in participating in mutual partnership responsibilities in care. Furthermore, social integration, identified as meaningful relationships and fellowship with others where people share common interests and concerns, needs to be a feature of services supporting older people. Support and respite services are needed that:

- Promote health, wellbeing and quality of life
- Are beneficial to people in care relationships
- Are of acceptable quality to carers
- Respect people in care relationships
- Have a willingness to care.

Other identified features of desired services include:

- Knowledgeable and supportive health professionals and workers able to identify people's needs;
- Social services that support social networks, for example through an integrated approach across health and social service funders and providers;
- Information accessible when needed and offered by health professionals, for example in primary care;
- Coordinated holistic whole systems approach across disciplines, responsive to changing needs over time;
- Supportive carer networks for carers to engage with as they choose; and
- Acknowledgement and appropriate support of the broader environment of family, friends and neighbours.

There is a multiplicity of social support and respite options available, funded through a range of Commonwealth and State programs, many of which are aimed at overlapping target populations. As the 'Who Cares…' report noted, the proliferation of different programs has not made access easier, it has made it more difficult.

It is not clear that the service offerings available respond to the preferences of the people seeking them or that they are flexible enough to respond to the different types of relationship people have. For example, respite for one couple could be the freedom to spend time together without having to worry about the incidents of care, for another it could be going fishing.

Volunteers

Many services, both residential and community based, rely on assistance from volunteers. This is the case particularly for services such as meals on wheels, social support through friendly visiting services for isolated people and transport (to medical appointments or to do their shopping).

Residential care services rely on volunteers to support lifestyle and leisure activities, provide companionship to isolated residents, and assist residents with meals.

Overall rates of volunteering in Victoria remain high and consistent with national levels. However, underlying changes are presenting challenges for many organisations that rely on volunteers. The key features of the evolving volunteer landscape are (Victorian Government Department of Planning and Community Development, 2009):

- People are increasingly time poor and are not becoming involved in community organisations in the same way as previous generations,
- People want to volunteer and make a difference, but many cannot find suitable opportunities,
- As the population ages, there will be increasing demand for services that volunteer based organisations provide, and
- Many volunteer based organisations are not yet responding to the need to adapt to the changing volunteer landscape.

While the percentage of adults volunteering in Victoria has risen, the average number of hours volunteered per person has been in decline. In 2001 people aged over 65 made up 13% of the Victorian population (ABS, 2006). By 2031 this age cohort will be almost 23% of Victorians. In 2006 the highest rate of volunteering was among those aged 35 to 44. Those aged 75 and over volunteer much less as they age.

A number of factors may impact on the availability of people who have traditionally provided support as volunteers:

- Increasing numbers of people aged over 60 in employment
- Responsibility for caring for grandchildren
- Limited flexibility in the volunteering opportunities available

We are aware of the analysis the Commission has done on trends in volunteering in its report on *Economic Implications of an Ageing Australia* (Productivity Commission 2005), projecting a doubling of the number of volunteers aged 65 and over, over the next 40 years. We note that the majority of this age group work voluntarily for community and welfare organisations, including services for older people.

Part Four - Beyond the Commonwealth's aged care system – issues & opportunities

While much of the Productivity Commission's inquiry focuses on Commonwealth Government funded aged care services, many older Australians live in other types of accommodation and/or receive support services that fall outside the Commonwealth funded and regulated system. In Victoria some, such as retirement villages[58] and supported residential services, are subject to state regulation. Others, such as public housing and low cost accommodation support programs like the Community Connections program, receive state funding. In other instances, private, individual arrangements may exist for the provision of support within individuals' homes.

Victoria believes there are significant benefits to such diversity, which provides older Australians with a wider range of choice, and enables models to develop and evolve to meet changing needs. It also recognises that not all aspects of the broader system require extensive government involvement and that many people can, and will, assume a key role in managing their own health.

This section explores some of the issues specific to retirement villages and older people in public housing.

Retirement villages

Key issues – retirement villages

- *Current arrangements for retirement villages work well and provide an appropriate level of flexibility.*

The Productivity Commission's issues paper made specific reference to retirement villages, and raised questions regarding whether current regulation of retirement villages was appropriate.

Older people are not a homogenous group; as individuals they differ from one another just as much as younger people. These differences include housing choices. There is a growing trend for older people to move into retirement villages but it would be a mistake to assume that the majority do – or ever will.

Across Australia, the vast majority of older people (aged 55 and over) live in owner-occupied separate houses (AHURI May 2010); for people over the age of 80, 76% live in homes that are owned outright (Gibson, 2010 p10). The remaining minority lives in a variety of accommodation settings including private rental, public rental, with family (more than one in 10 older people in their eighties and nineties share a dwelling with their adult children (Gibson 2010 p6)), retirement-specific accommodation and residential aged care.

Retirement-specific accommodation (excluding residential aged care) is a diverse and evolving area. A recent report by the Australian Housing and Urban Research Institute (AHURI) identified 18 possible types (categorised according to type of provider, nature of the physical structure of accommodation and whether service provision is by the accommodation provider or external) (AHURI, January 2010).

Nationally, the population living in retirement villages was estimated at 127,808 in 2006 based on census figures (AHURI January 2010, p 32), and at 160,000 in 2010 (Productivity Commission, 2010).

[58] In Victoria, only a small proportion of older people live in retirement villages, estimated at 4.5% of persons over age 65 (JonesLangLaSalle, 2008). The regulatory system works well with studies demonstrating high satisfaction rates among residents and few complaints being received. Various amendments to the legislation have been made in recent years to address new issues and problems. Retirement villages are well integrated with both community based care and resident aged care. The separate regulation of retirement villages recognises the unique nature of this accommodation, which is distinct from both residential aged care and general housing.

	No. of units[59]	Penetration rate >65 years of age[60]
Queensland	20,400	approx.5.5%
Victoria	22,950	approx.4.5%
Western Australia	12,700	approx. 7%
South Australia	13,950	approx. 8%
NSW	33,900	approx. 5%

In Victoria, the retirement village industry is approximately 30% commercial operators and 70% not-for-profit operators. In commercial villages, units are predominantly owner-occupied or long term lease/license residents with a significant amount required to be paid to enter the village. In not-for-profit villages, it is not always necessary to pay to enter the village, or the amount may be heavily discounted. Not-for-profit retirement villages contribute to providing affordable housing for low-income older persons (AHURI 2004, 2004a).

Regulation of retirement villages

There are significant differences in retirement village regulation across Australia. These differences reflect the different historical trajectories of the industry, physical geographies, community expectations and housing and tax policies across the states and territories.

Current Victorian regulation of the retirement village industry is primarily by the *Retirement Villages Act 1986* administered by Consumer Affairs Victoria. This provides protection for retirement village residents' investments and a broad framework to regulate relationships between residents and village owners and managers. The *Retirement Villages Act* has protections for residents that involve the *Transfer of Land Act 1958*. It would be difficult to transfer retirement village regulation to the Commonwealth and preserve consumer protection entitlements without transferring the retirement village land and jurisdiction over the land to the Commonwealth, which would pose serious constitutional obstacles.

The 2002-04 review of the *Retirement Villages Act* found that the current regulatory regime enables new and emerging problems to be addressed. Importantly, Victorian solutions can be tailored to Victorian problems. The Victorian Government has regular engagement with retirement village stakeholders through many different forums which allow the most appropriate responses to be developed. The Victorian Government considers that residents, village owners and managers are in the best position to make decisions about their own retirement villages. It is only natural that disagreements arise between retirement village operators/managers and residents at times due to differences in the nature of their interests. The *Retirement Villages Act* enables these differences to be navigated without prescriptive regulation which can increase costs and stifle competition and innovation. Prescriptive legislation is unsuited to a context where models are as diverse as retirement villages.

Differences in retirement village regulation across Australia do not seem to be an issue for residents. There is no evidence of significant movement of retirement village residents to retirement villages in other jurisdictions. Retirement villages in different states and territories are essentially separate markets. Consumers are more likely to compare retirement villages and residential parks within states rather than between retirement villages across Australia. Nevertheless, there is merit in states/territories learning from others' experiences. There is regular officer level contact between the Australian states and also New Zealand. Problems can be addressed through inter-state cooperation: for example, the current project to harmonise regulations between Victoria and NSW relating to pre-contractual disclosure, the terms that must be included in the contract, the terms that must be excluded from the contract, implied terms and the condition report.

[59] Property Council of Australia

[60] JonesLangLaSalle (2008, pp.5-6)

Overall, there is no evidence of systemic problems in the retirement village industry. A number of studies have found high levels of satisfaction among retirement village residents and that they consider it has improved their quality of life. Since 2005, complaints to Consumer Affairs Victoria about retirement villages have not exceeded 79 per year despite significant community advertising campaigns and community education activities and initiatives to inform potential and actual residents about their rights. Furthermore, the significant majority of these complaints are resolved through Consumer Affairs Victoria's conciliation service.

Retirement villages and community based care

The large majority of older Australians would prefer to receive services that allow them to remain in their own homes as long as possible. Retirement villages are simply one of the housing options in which community based care is provided. According to AHURI (January 2010, p 126) "For many years there have been no impediments to the provision of HACC services and CACP and EACH packages to residents of retirement villages", which suggests that the current interface between retirement villages and community based care works well.

Some retirement villages, typically not-for-profits, are HACC or community package providers. Access to these publicly funded community care programs by residents is through assessment processes, as per older persons in the general community. Other retirement villages (who are not community based care providers) assist residents to access such community based care, and in other villages it is up to the resident him/herself to pursue (as is the case for older persons living in the community).

Publicly funded community based care comes with the associated regulation and protections of the enabling legislation and associated programs. There is currently no *specific* government regulation of privately funded community care services. These services are regulated by general consumer protection legislation (*Fair Trading Act 1999 (Victoria)*, *Trade Practices Act 1974)* and professional regulations (nursing, doctors, allied health etc). Consequently, there is currently a consistency in the regulation and protections for all older people receiving community based care, regardless of their accommodation.

Retirement villages and residential aged care

Just as a proportion of older people live in retirement villages, a proportion of people moving into residential aged care will come from retirement villages. This means there is a gateway from retirement villages to aged care, just as there is a gateway from the wider society to aged care.

Co-location of retirement villages and residential aged care is relatively common in Victoria. In Victoria in 2005, about 30% of retirement villages were co-located with a residential aged care facility. Victoria amended the *Retirement Villages Act* in 2005 to remove regulatory duplication in co-located facilities, yet retain the protections of the retirement village and aged care regulatory frameworks for the respective residents.

From a resident's perspective, research by the Retirement Village Association found that one of the top three reasons for moving into a retirement village is that "if health starts to decline there are benefits to living in a supported environment and the transition into higher level care is easier" (The Senior, January 2010, p 21).

The *Retirement Villages Act was* also amended in 2005 to make it easier for non-owner residents to obtain their exit entitlements where they are going into residential aged care and are required to pay a bond. These residents are now able to obtain their exit entitlements within 6 months. Previously there was no regulation of when exit entitlements were to be paid, with some residents having to wait 8 years.

Retirement villages – future directions

In the absence of evidence of regulatory or financial problems intrinsic to retirement villages, an alternative to the present regulation framework is not warranted. The movement of some people from

retirement villages to residential aged care does not justify the creation of a national regulatory framework.

The Victorian Government considers that retirement villages make an important contribution to housing older people in the community. It is a unique sector with important differences from both general housing and residential aged care. The current regulatory model is appropriate and effective. When the need has arisen in the past, the existing framework has been reviewed and amended to address new issues and new circumstances. There is no reason to think that it would not be similarly adaptable in the future.

Housing challenges for older Australians

Key issues – housing

- *Meeting the housing and support needs of older people at risk of homelessness will require joint effort between the State and Commonwealth Governments.*

The *National Housing Supply Council Report 2010* identifies that the ageing of the population will have significant impacts on the housing sector, as the proportion of older households is projected to grow from 19 % to 28 % of all households over the next 20 years.

The Report further states that projections of underlying demand indicate that there will be pressures on both private and public rental markets to meet the needs of older renter households. As lone and couple only older households grow in number they may increasingly seek smaller dwellings. Additional housing will be needed to support independent living and existing homes may need to be retrofitted. Other challenges remain to ensure that there are sufficient options for older households to age in their own home or alternative appropriate accommodation.

COAG has charged the Ministerial Council for Federal Financial Relations with responsibility for increasing the supply of affordable housing. This work will include addressing demand from high needs groups such as older persons.

A growing number of Victorians are experiencing homelessness in their later years. The circumstances of these older people can vary considerably. Some become homeless for the first time in their lives as a result of factors such as financial troubles or the death of a partner. Others have experienced a lifetime of homelessness requiring specialist care and housing. The undersupply of affordable and suitable housing and an ageing population will impact on the number of older people in the rental market experiencing housing difficulties. In this environment, many Australians may turn to accommodation options that may not be appropriate.

With an ageing population, it will be important that there is sufficient support available to enable older people to remain in social housing and other housing tenures. It will also be important to consider current and emerging trends and different models of assistance that meet the needs and preferences of older people.

The Victorian Government has committed to releasing a new Homelessness Strategy, and is exploring alternative approaches to addressing these challenges. The Commonwealth Department of Health and Ageing also has a key role to play, and the Victorian Government will be seeking to actively engage it in both planning and development of strategies to meet these growing needs.

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Attachment A: Key components of the Victorian system

For more information on any of these programs, please visit the Victorian Government's Aged Care website at www.health.vic.gov.au/agedcare

Aged care assessment service	
Aged care assessment services have a broad role in the Victorian health service system and are an important mechanism for keeping people out of hospital.	Two main services undertake client assessment for aged care in Victoria: Aged Care Assessment Teams: 18 organisations, 15 of which are located in health services and 3 in community health centres; HACC Assessment Services (HAS): comprise 100 organisations, including 70 local governments, the RDNS and several community health services and NGOs.
Home and Community Care	
The Home and Community Care (HACC) program supports frail older people, younger people with disabilities and their carers to continue to live independently at home for as long as possible.	Provided by some 467 agencies. Victoria has the highest number of people receiving HACC services of any State or Territory, and the highest number of hours of service delivered per 1000 population over 70 years of age.
Community support programs	
Personal Alert Victoria	A personal monitoring service providing 24 hour contact to assist frail older people and people with disabilities who live in their own homes and are isolated and vulnerable.
Support for Carers	Funds 43 agencies to provide a range of support and respite services for carers of older people, people with a disability and people with a mental illness.
Dementia Services	Includes funding to Alzheimer's Australia Vic for the Support and Links Program, as well as for education, training, counselling, information and support services, and for the Support for Carers of People with Dementia program.
Victorian Eyecare Services	Provides subsidised spectacles and eyecare services for people on low incomes.
Health promotion & preventive health	
Well for Life	Aims to improve the health and wellbeing of frail older people in aged care settings by improving nutrition and increasing levels of physical activity.
Falls Prevention	Preventing falls and minimising fear of falling are key components of *Well for Life* and *Making a Move*, a falls prevention initiative targeting HACC clients aged 65 years and older diagnosed at risk of falls. The Sub-acute Ambulatory Services program funds falls and mobility clinics and rehabilitation services.
Cancer screening	All Victorians, including older Victorians, have access to screening for breast, cervical and bowel cancers.

Vitamin D deficiency	The Victorian Government is undertaking a number of activities to address this issue, including targeting older people living in residential aged care services.
Sub acute and continuing care	
Geriatric Evaluation and Management (GEM)	Provides an inpatient service that addresses the complex care issues associated with ageing, cognitive dysfunction, chronic illness or loss of functional ability.
Hospital Admission Risk Program (HARP)	Supports people with chronic disease and complex needs who frequently use or are at imminent risk of hospitalisation. HARP provides specialist medical care and care coordination in the community/ambulatory setting through an integrated response of hospital and community services.
Hospital in the Home (HITH)	Provision of hospital care in the comfort of a person's own home. Patients receive the same treatment that they would have received had they been in a hospital bed and remain under the care of their treating doctor in the hospital. HITH also provides health care to people in residential aged care, enabling them to avoid unnecessary admissions to hospital.
Residential Aged Care In-Reach	A strategy aimed at providing access to clinical assessment and treatment from health services into residential aged care services, especially after hours.
Transition Care Program	Operates at the interface between the hospital, community and residential care, available to older people who have completed their hospital episode of care and require more time and support in a non-hospital environment to complete their recuperative process, optimise their functional capacity and finalise and access their longer term care arrangements.
Post Acute Care	Provides and coordinates short-term, community-based supports to assist people to recuperate in the community, including residential care settings. The program aims to assist people discharged from a public hospital.
Subacute Ambulatory Care Services	A statewide network that provides centre based and home based rehabilitation services as well as a number of specialist clinics providing diagnosis and management of a range of age relevant clinical conditions such as dementia and memory, falls and mobility and continence.
Other services that support older people	
Diabetes Self Management (DSM) & Early Intervention in Chronic Disease (EIiCD)	Early intervention strategies focussing on the most effective ways to keep people as healthy as possible for as long as possible and avoid preventable hospital admissions. Includes multidisciplinary service delivery, care coordination and self-management support.
Palliative care	Provided by an integrated and designated service system funded to provide specialist interdisciplinary palliative care in a range of settings, including inpatient, consultancy, community and statewide services. Community palliative care services provide specialist end of life to care to people in their own homes (including residential aged care services) who would otherwise be admitted to a hospital for this care. There are 39 community palliative care services, 32 are in rural regions.
Victorian Aids and Equipment Program	Provides people with a permanent or long-term disability with subsidised aids, equipment, vehicle, and home modifications. It facilitates

	community participation and supports families and carers in their role.
Public sector residential aged care services	
Victoria is the only state or territory in Australia with a significant role in the provision of public sector residential aged care services (PSRACS)	There are 194 PSRACS or nearly 24 % of the total number of all Victorian services. Of these, 162 are in rural areas and most are run by a health service, usually associated with a country hospital.
Supported residential services	
Supported Residential Services (SRS) are privately owned facilities that are regulated by the Victorian Government.	Some 178 SRS provide an additional accommodation option for older people in Victoria, particularly those who need assistance with some activities of daily living and can no longer live alone or choose not to do so. The Supporting Accommodation for Vulnerable Victorians Initiative improves the viability of eligible services and the quality of life of residents living in pension level SRS.
Low cost accommodation support	
Community Connections program (CCP)	Uses an assertive outreach model to proactively find, engage, assess, and link people into the services they need. There are currently 16 CCP services located across Victoria.
Housing Support for the Aged Program (HSAP)	Supports people 50 years and over with complex needs and a history of homelessness to maintain long-term public housing and improve their health and wellbeing. There are currently 13 HSAP services in Victoria.
Older Persons High Rise Support Program	Provides monitoring and support to tenants of 11 older persons high-rise public housing estates in the inner suburbs of Melbourne.
Housing assistance	
Housing and Community Building Housing Assistance for Older Victorians	The Victorian Government recognises that affordable and appropriate housing is fundamental to the health and wellbeing of older Victorians. Housing and Community Building (HCB) provides a range of housing assistance programs to Victorians, including older people. Assistance includes the provision of social housing through direct tenure public housing and community-managed social housing; financial assistance to people in the private rental sector; homelessness assistance; and home ownership assistance.
Increasing Social Housing and Homelessness Support	Housing affordability is an issue for the Commonwealth as well as state governments. The *National Affordable Housing Agreement* which commenced in 2009 will provide approximately $1.3 billion for Victoria over five years for social housing and homelessness. It is an historic first step toward achieving common goals to improve affordable housing supply and reduce homelessness. The National Partnership Agreement on Homelessness identifies support services and accommodation to assist older people who are homeless or at risk of homelessness as a priority. In addition, $6 billion has been earmarked nationally for social housing as part of the *Nation Building and Jobs Plan*. This translates to nearly $1.266 billion for Victoria to build over 5000 homes for lower income households and to refurbish existing social housing for low income Victorians, including older persons. The Commonwealth and state governments are also working together through the National Partnership on Homelessness to reduce the incidence and impact of homelessness.

Social housing and Homelessness	A significant proportion of public housing is allocated to older people. Nearly 40 percent of people in public housing are aged over 55. Movable units are also provided to low income Victorians. The movable units are specifically designed to allow eligible older or disabled people to live independently while remaining in close proximity to families or friends. A range of community-managed housing options provide affordable accommodation for a wide range of groups, including older persons. These programs are managed by registered housing agencies, including housing associations and community-based organisations. Social Housing Advocacy and Support Program provides support for public housing tenants, including older tenants to maintain stable tenancies. The Transitional Housing Management Program provides transitional housing, information and referral services and support to people in crisis as a result of homelessness. The Homelessness Support Program assists people with a history of homelessness or insecure housing through a range of services such as supported accommodation, links to health, education and outreach support.
Accessible housing features	To assist older social housing tenants, HCB constructs accessible and adaptable housing where practicable which caters for the needs of older tenants and people with disabilities. HCB also modifies public housing properties to assist older tenants to live as independently as possible in the community. Eligible seniors and people with a disability who are private homeowners or tenants can also apply for government assistance for property modifications through the *Home Renovations Loan Scheme* and the *Aids and Equipment Program.*
Private rental assistance	Under the Bond Loan scheme, National Rental Affordability scheme and the Housing Establishment Fund, assistance is available to low income Victorians, including older people, who are in private rental housing, or seeking accommodation in this sector.
Mortgage relief	The Mortgage Relief Scheme offers eligible Victorian homeowners, including older homeowners, short-term, interest-free loans of up to $15,000 to assist with mortgage repayments during times of financial stress.

Attachment B: Planning for Diversity

A wide range of work has been undertaken to identify issues for specific groups of older people within the community:

Meeting the diverse needs of people in the HACC target group

There has traditionally been a focus of targeting of community care resources to improving access to services for a range of defined 'special needs groups'. Victoria believes that there are problems with this approach to addressing disadvantage in that the language of 'special needs' is archaic; the approach silos disadvantage; it assumes that there is a finite list of people who have difficulty in accessing services; and it focuses solely on access and does not deal with broader issues of providing appropriate service responses to meet the diversity of the population eligible to receive the services.

In Victoria, the HACC Program is moving from an approach that focussed on separately targeting access issues for special needs groups to a broader strategy that encompasses the diversity of the Victorian community, and acknowledges that barriers to accessing services are experienced by many groups who are marginalised or disadvantaged. Ensuring that organisations plan and provide their services in a way that treats all people with equity, fairness and respect is core business.

Planning for diversity is about making sure we plan for the needs of all people. Diversity planning encourages us to recognise the commonality between people as well as recognising and responding to what is different and to understand that there is difference within groups. Standardised or formulaic service provision does not respond to these differences - and the real risk is that the quality of client outcomes is diminished.

Diversity Planning will not diminish the substantial work and resources allocated to improving services for people from CALD backgrounds and Aboriginal communities

Meeting the Needs of Older People from CALD Backgrounds

Migrants make up a large and increasing share of Victoria's older population. By 2011, Victoria is projected to have the most diverse older population of any state or territory in Australia, when nearly one in three people or 30.8% of the population aged 65 years and over will be from a CALD background.

Meeting the needs of older people from CALD backgrounds has long been a focus of the HACC program in Victoria:

In 1997 the Victorian Government initiated the *Cultural Planning Strategy* to help Victorians from CALD backgrounds gain access to culturally appropriate services.

From 2004 to 2008, the Victorian Government funded the *Culturally Equitable Gateways Strategy* which resourced ethno-specific agencies to work in partnership with local councils to facilitate access to services for people from CALD backgrounds. That Strategy resulted in trialling the role of supported access workers in 8 large ethno-specific agencies.

The evaluations of both the Cultural Planning and CEG strategies highlighted the variety of approaches undertaken by HACC services to improve access and appropriateness of services for Victorians from CALD backgrounds.

The Victorian Government recognises that access to language services is critical to the provision of culturally responsive aged care services. Many migrants who are now moving into older age had little opportunity to learn English due to work and family responsibilities and the challenges of living in a new country. Furthermore, older migrants who were once proficient in English may revert to their primary language as they age, often as a result of dementia. The ageing of the CALD population is therefore increasing the demand for interpreting and translating services.

The Victorian Government spends over $20.9 million annually on interpreters and translators to ensure language support is available in the services most used by older people, such as those funded by the HACC Program.

In addition to these initiatives, all Victorian public sector health services, including public sector residential aged care services (PSRACS), are required to submit cultural diversity plans to ensure they are meeting the needs of their CALD clients.

Other residential aged care initiatives include the *Count Us In!* social inclusion initiative, which aims to promote and facilitate community inclusion, good health and quality of life for older people living in PSRACS, specifically targeting older people from CALD backgrounds.

Meeting the needs of Older Indigenous People

Within the context of HACC Diversity Planning, the Victorian Government is explores ways to ensure that Aboriginal communities have access to culturally appropriate HACC services through our *Strengthening HACC in Aboriginal Communities strategy*.

This strategy aims to increase access to a range of services for HACC eligible Aboriginal people by developing good working relationships between ACCOs and mainstream services; strengthening the response from 'generic' HACC providers to Aboriginal communities; and supporting sustainable service delivery of HACC services by Aboriginal organisations to Aboriginal communities.

Gay, lesbian, bisexual, transgender and intersex (GLBTI) older people

The Victorian Government recognises that the needs of gay, lesbian, bisexual, transgender and intersex (GLBTI) older people often go unrecognised - and therefore unmet - in aged care, particularly in residential aged care.

Highlighting this, a recent Curtin University Study found nearly 90 % of aged-care providers who participated in the first Australian survey into their attitudes to GLBTI people said there were none in their facility, and failed to understand that older GLBTI people may be afraid to reveal their sexuality. More than two-thirds of providers did not think that GLBTI residents had special needs and while most facilities had an established discrimination complaints process it usually did not reference sexuality.

Under the current Commonwealth framework, GLBTI older people are not recognised as a 'special needs group'.

Aged care services can struggle to support the sexuality of heterosexual clients, and often fail to recognise non-heterosexual sexualities, making it harder to respect the sexual orientation or gender identity of each resident and protect them from discrimination. This can mean that clients do not feel comfortable or safe to come out, or talk about their needs. This may have a range of impacts from limited sexual and gender identity expression to social isolation that, in turn, can have negative consequences on emotional and physical wellbeing.

Recognising this, the Victorian Ministerial Advisory Committee on GLBTI health and wellbeing published *Well Proud: a guide to gay, lesbian, bisexual, transgender and intersex inclusive practice for health and human services (2009)* (www.health.vic.gov.au/glbtimac). It includes recommendations for specific health care settings to support the needs of older GLBTI people, including those in residential aged care.

Following on from this, the Victorian Government also funded Gay and Lesbian Health Victoria to develop *Well Proud: An Audit of inclusive practice for aged care services, 2010* (in development – due July 2010) - a tool to assess how inclusive aged care services are of GLBTI clients.