ANGLICARE AUSTRALIA

Anglicare Australia's submission to the

Productivity Commission inquiry into Caring for Older Australians

August 2010

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1 Executive Summary

The changing age and health profile of Australia's population is now widely acknowledged. Less evident in this public discussion is the changing expectations of that population, in terms of how we want to live our lives, how we are prepared to care for each other, and how the care and support will be negotiated.

Australia will have a much higher proportion of older people, most of whom will be fairly active and healthy to their eighties; many of whom will have serious chronic health conditions in their later years, including dementia, and require ongoing care and support. The existing health care system is reliant on a diminishing cohort of informal family carers, a highly regulated and a rationed aged care system and an undervalued and largely over worked workforce.

A more appropriate vision for our society is that it looks to provide care for its members though their lives, as they age, but that age is not in itself seen as a medical condition.

Anglicare Australia supports the notion of a continuum of care, where people are entitled to the care they need, and can access it when necessary. Such an approach would necessarily move away from the discrete health and aged care programs that currently govern funding, and the delivery of care towards a socially integrated and more flexible system, with the capacity to respond to individual circumstance.

Older people do not want to be made to fit into programs. Not surprisingly, they would like the care designed to suit their needs. By necessity then, older Australians and the families need to be partners in the design and management of the care they receive. In terms of people's well being, this is where the notion of choice is most useful.

There is a need for systemic change which gives stronger influence and participation in aged care service delivery to service users. This is made more complex by the various dimensions of need, and the different capabilities and circumstances of the people involved. It is a question of resourcing and of engagement. Most particularly it requires an explicit commitment to including all older Australians in the new system of care.

But as the demography makes clear, caring for older Australians will also require changes to our broader social organisation. One of the underlying challenges is factoring that care and support into development. An integrated and flexible approach to care for the growing number of older Australians will need to be supported with investment in community facilities, appropriate affordable housing, transport, intelligent and adaptable buildings. People need to be connected technically and in reality to their community and health supports.

Regional centres, for example, are already becoming aged care centres for the rural and remote populations they serve. It would make sense to invest in these centres now so that the necessary infrastructure and expertise becomes available when it is needed.

Similarly, the development of a universal e-health system and other constructive uses of technology will provide real efficiencies for the health delivery system and can go some way towards supporting ongoing personal and community connections.

There are extensive overlaps between active ageing and the social and economic benefits of social integration too. A part of the change needs to be in how we see older people in our society which in turn depends on reshaping the world of work and culture to take better advantage of what people can offer as they age.

One of the benefits of establishing a more integrated approach to care and support services would be to sew in research and development programs that could draw on the wealth of information and feed back into work practice.

Workforce issues are particularly complex. Good work conditions and staff development helps many age care providers keep the staff while pay equity for nurses, health professionals and other works in the aged care industry would make a real difference in the short term, at a cost. In the long term, both ends of the spectrum need reshaping. Greater health, independence and community connectedness should see older people become partners in their care in the first instance while more funding – through deregulation, insurance or public investment – will need to be found for higher level care. Anglicare Australia affirms its commitment to a system that guarantees equitable access to high quality care no matter what their background or circumstance.

The highly regulated arrangements for the provision of aged care services are in essence misdirected. In order to deliver a continuum of care the focus needs to be on outcomes for the individuals, the carers and their families, not the program outputs. Service providers also need to be able to be more flexible and innovative, able to respond to assessed need rather than working within allocated quotas. The complexity, inconsistency and opacity of the multiple assessment processes are indicative of the problem.

The blending of accreditation and compliance into the one model is also particularly counterproductive and inexplicable. Anglicare Australia supports an independent complaints resolution service.

Finally, in terms of funding, it is inevitable that the proportion of the Australian economy dedicated to caring for older Australians will grow. There needs to be a national conversation about how best to fund it. Anglicare Australia supports the principle that people with considerable wealth or income make an appropriate contribution to their care. Anglicare Australia, through its network members, is also well aware of the circumstances in which many other Australian live, and that they are likely to be in greatest need for care and least able to pay for it themselves. The current funding arrangements work against the most vulnerable people in our society [see Anglicare Australia's submission to ACFI review]. Future arrangements must begin with consideration of needs of those older Australians who are most vulnerable and marginalised, as the plan for an integrated and flexible approach to care will founder if those members of our society remain excluded.

The transition to an integrated and flexible approach to care will need to be very carefully analysed and negotiated. Continuity of care, the financial viability of services, and the need to retain and develop workforce and volunteers all need to be sustained through that process.

There are a number of initiatives, large and small, that would offer immediate benefits to people accessing the current system and be steps towards a more open and flexible approach.

Recommendations for action in the short term

Recommendation 1:

That a streamlined comprehensive assessment process be developed for eligibility for care across all aged care and sub acute programs. This should include:

- **Developing new assessment tools**
- **Developing networks to smooth the pathways between the programs**
- **Building links to referral process particularly in community care.**

Recommendation 2:

That a funding system similar to, or the same as, residential aged care be implemented for community care.

Recommendation 3:

That the categories of "high care" and "low care" be removed and residents be given the care and resources as assessed to meet their needs.

Recommendation 4:

That the Department of Health and Ageing establishes a transparent continual improvement process to address disparities between identified need, actual cost of care, and funding.

Recommendation 5:

That a flexible funding pool is established to be used by care managers when working with special needs groups such as people with a homelessness background, Aboriginal and Torres Straits Islander people, and people from other cultures or with specific needs.

Recommendation 6:

That care costs be separated from accommodation costs in residential aged care.

Recommendation 7:

That accommodation bonds or other capital contribution be introduced for high care residents and the method and size of that contribution be assessed on an individual basis as currently applies for low care.

Recommendation 8

That community based health promotion activity is funded through current programs to support independence and health of people as they age.

Recommendation 9

That case management is factored into community care delivery and its funding.

2 About Anglicare Australia

Anglicare Australia welcomes the opportunity to make this submission to Productivity Commission's inquiry into care for Ageing Australians.

Anglicare Australia is a network of 43 independent organisations joined by values of service, innovation, leadership and the faith that every individual has an intrinsic value. Our services are delivered to one in forty Australians, in partnership with them, the communities in which they live, and other like-minded organisations in those areas. We are in it with those communities for the long term – our services have been around for up to 150 years. Over 12,000 staff and 21,000 volunteers work with over 512,000 vulnerable Australians every year delivering diverse services, in every region of Australia.

Between them, 15 of Anglicare Australia's member organisations provide residential care for 5,282 and care in the community for 12,742 older Australians, employ 7,003 (FTE) aged care professionals and are actively supported by 2,728 volunteers.

Those organisations are Anglican Retirement Villages, Anglicare Canberra and Goulburn, Anglicare NT, Anglicare SA, Anglicare Sydney, Anglicare Tasmania, Anglicare Willochra, Benetas, Brotherhood of St Laurence, Clifton Waters Village, Gippsland Anglican Aged Care, Glenview Community Services Inc, Spiritus, St Johns Anglican Church and St Laurence Community Services.

Anglicare Australia advocates on behalf of the national network's clients. Its primary concern is for people who live with disadvantage, and who are vulnerable and marginalised in Australian society. It advocates for an aged and community care system where everyone, regardless of circumstance or background, has equitable access to the care and services they need, where and when they need them.

This submission represents the views of Anglicare Australia, as the national peak body of the Anglicare network. It has been brought together through the collaboration of a number of the aged care providers in the network. Nonetheless, it may not necessarily represent the views of any individual member organisation in the Anglicare Australia network or of the Anglican Church of Australia.

This submission

This submission includes a brief discussion of the drivers for change in how we care for older Australians, as understood by Anglicare network providers of aged and community care services. It paints a picture of a better integrated and more flexible approach to care and support that we will need in the near future. It concludes with the case for a number of short term initiatives that would address unsatisfactory elements of the current system and double as steps in transition to a better integrated, and more flexible approach.

3 Drivers of change

The changing demography, health profiles and expectations of the Australian population are often canvassed in the public domain and are broadly understood. Similarly, the consequences – in terms of the changing shape of the formal and informal workforce, and the likely demands on infrastructure – are now factored into our assumed economic future. The existing age care system is widely acknowledged to be incoherent, inefficient, segmented, over regulated, underfunded, and built upon a pathological approach to aged care.

In the context of this submission, it is useful to briefly explore those factors further, and to look at them together, so as to mark out the ground, and identify some of the parameters, of an integrated and sustainable approach to care for older Australians.

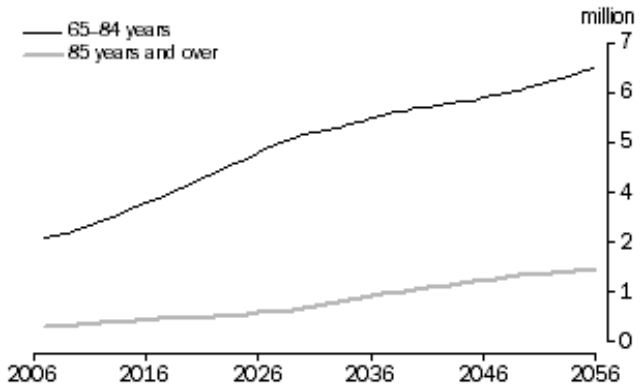
Changing demographic and income trends

Australia's changing demography has a number of facets. Most dramatic will be the boost in the number of our population in the 'old' old age range (i.e., 85 years and on) with a consequent growth in demand for hospital and health services, pharmaceuticals, medical benefits and pensions, individualised care and support services. Also significant will be an increase in the proportion of the 'young' and 'medium' old who might need access to services but will also be more active in their communities.

The Australian Government faces a number of significant separate but related aspects deriving from the growing aged population: the cost of maintaining the Aged Care Pension; the cost of health services that an increasingly ageing population will call upon; and, the cost of providing care in-home or in a residential setting.

The size of the challenge presented by a growing aged population is illustrated in Graph 2. Australia's latest census data shows in 2007 there were 2.4m citizens aged 65-84 years. This number is projected to rise to 6.4m by 2056 representing 21% of Australia's population with an additional 1.7m aged 85+ years - a cohort net increase of 300%. (ABS, March 2009)

Fig1: Projected Australian aged population 2006 - 2056



Data for 2007 is estimated, all other years are projections

Source: Population Projections, Australia, 2006 to 2056

The escalating cost of looking after Australia's ageing demographics has been a constant source of public policy attention since the 2002 *Intergenerational Report* brought it starkly to the attention of governments and the public.

It is these broad national economic and demographic challenges presented by an ageing population that are moving policy makers to look at the application of client driven models of care.

This change of course is the result of reduced fertility, somewhat limited migration and technological advances across a range of human disciplines leading to longer more active lives.

Aged care service provision is struggling to keep up with the rate of social change in terms of expectations, and in providing appropriate services. With increasing age comes an increase in acute, chronic and palliative care needs. These are presently delivered through a combination of informal carer support and a highly regulated, difficult to navigate, inflexible, segmented aged care system.

Our workforce of informal carers (predominately women aged between 55-64 years) is ageing and as a result we are less able to draw on it to provide the types of care these workers delivered in their younger years. This is a significant challenge for the industry if workforce security is to be achieved given the population of those requiring care is about to very dramatically increase.

Many of those still active are now electing to remain in the workforce and seek alternate formal aged care delivery systems to substitute for the care they provided themselves. While many others may not elect to remain in the workforce, the reality for many middle aged women is that their superannuation is not sufficient to support them in a full time caring role and they must remain working and rely on aged care services to be the main care provider for their parents. All of these social trends have led, and will continue to lead, to an increasing reliance on the third sector to provide the necessary services they require.

Workforce

Within the present aged care sector there is a continual struggle to attract and retain registered, endorsed enrolled and enrolled nurses. Heavy reliance on nursing agency staff has resulted, which is not sustainable.

The work force challenges are not limited to nursing staff only, as recruitment and retention of all aged care staff including allied health staff is a significant challenge across the sector.

Known factors can include lower pay rates, low status, the state of the Australian labour market, rundown facilities, the heavy regulatory burden, and limitations to the quality of and variety of care that the sector can provide.

Wealth and expectations

One of the other realities around population is the distribution of wealth. Many of the people who will soon qualify as ageing will have significant assets and resources – property ownership in particular, superannuation, savings and investments – with which to purchase the care of their choice where it is available. Increasing affluence over time will impact through changed expectations about care options, delivery and ongoing life style, including an increased demand for higher end services.

Of course, changes in people's expectations of services are not only linked to increased resources, but also influenced by different life experiences of each generation and societal structures. The past 40 years of economic and social development in Australia has seen a growing expectation of consumer directed services, continuing active participation and an independent social voice.

However the gap between rich and poor is creating an underclass of older people who cannot choose their care. The current aged care system is limiting access for lower income older people. As a consequence they are prematurely entering into publicly funded high and acute care. Additionally, these older people are not always supported to remain connected to their community, and may have diminished confidence and competence in managing and negotiating their own affairs as a result.

Changing health profile of older Australians

There has been a large increase in chronic disease and the burden of chronic disease within the last five years. This has been recognised through the Australian Better Health Initiative and other preventive health programs aimed at people across the age continuum. These programs aim to improve health outcomes.

These programs however, have not captured those Australians currently regarded as ageing. This population group has multiple chronic illnesses and associated disability. This has informed a need to rethink the current patterns of service delivery to include:

- New models of palliative care aimed at chronic illness management; and
- Invigorated community care offerings to embrace Client Directed Care (CDC) and assistive technologies.

There has also been an increase in the numbers of people across the age continuum presenting with a dementia. This is expected to grow further as age expectancy increases, which Access Economics estimated at almost a million by 2050 [Aug 2010.].

A changing model of care

The findings and projections highlighted in the Productivity Commission's (2005) comprehensive report on the economic implications of the nation's ageing population have recently been supported by a report highlighting substantial projected increases in health costs associated with an ageing population (AIHW, 2009). Two subsequent Intergenerational Reports starkly illustrate to politicians and policy makers the urgent need for new care models to address the needs of an ageing population. (Commonwealth of Australia, 2010a; 2007)

The data indicates Australia is not able to accommodate ageing citizens in congregate care facilities. The present number of existing facilities is insufficient to keep pace with the bubble of citizens who will require full-time direct care as a result of ageing. A building program to accommodate the ballooning number has not been amongst successive federal governments' strategies to address this demographic issue.

Governments have consequently looked for alternative care models. The successful introduction of the Community Options pilot initiatives[1] and the subsequent Home and Community Care Program (HACC) through the 1980s were early social policy steps towards moving reliance of aged care away from institutional care facilities towards flexible community-based care which sought to bring about an 'ageing in place' model of care.

This is seeing nursing homes move toward a stronger focus on those aged people with complex (e.g. Alzheimer's or Parkinson disease) or high care needs (i.e. palliative end of the care spectrum) that cannot be addressed in the person's community setting.

How care is provided, and how it is funded, does not yet reflect the changing needs and expectations of our changing community.

[1] These pilots, which originated in the USA, introduced early versions of services designed around individuals; the success of the pilots provided the basis of the introduction of the HACC Program which continue to this day.

4 A vision for more integrated and flexible care and service

In addressing the Inquiry's terms of reference, this submission draws on the insight and experience of Anglicare network organisations that provide community and aged care services. It has, however, proved difficult to frame an integrated, sustainable, vision of care entirely outside of the current medicalised paradigm of rationed aged care services as so much of the analysis has been inevitably informed by reflection on the inadequacy of the current system.

Broader changes to housing design, urban planning, infrastructure investment (including transport) and employment practices underpin the delivery of an integrated and flexible approach to the provision of care. Many of those elements are identified in this submission but not investigated in great depth. Similarly, while the need to revisit our national approach to funding care for older Australians is evident to all, Anglicare Australia has not focussed in great detail on funding models that might support this vision. These are all matters that can be revisited in response to the Commission's draft report.

This articulation of a common vision starts with the description of a continuum of care, in part because the current aged care system is anything but that. It then discusses focussing that care on the 'consumer' – whoever they are – integrating that approach into our wider society, softening the line between care for the aged and preventative health, rethinking the organisation of resources, taking full advantage of technology, ensuring research and development is embedded in the practice investing in workforce development, pursuing an enabling approach to regulation and quality control, and pursuing a public discussion of all funding options.

It will be possible to provide access to care for everyone as they need it only when that care is available as a matter of course, not as a marker of age but rather as a reflection of need.

A continuum of care

The current aged care system often is described as "fragmented" because of the high number of providers. While this fragmentation is real, there is another dimension to the system's fragmentation and this relates to the organisation of service provision determined by government.

Across the continuum of health and well being that an older person (the consumer) may experience, a person potentially needs to negotiate numerous forms of assessment from numerous providers to receive the mix of services they require. It is confusing and it limits the extent to which the consumer can exercise choice.

Specifically, there are significant gaps in current service levels and inbuilt disadvantages of moving between service levels, e.g. HACC/CACP/EACH/EACH-D. Often accessing one service type can limit access to other service type and often geography dictates how and what a consumer can access, depending on funding availability in each area. If funding continues in this way then, arguably a 'postcode lottery' is created with access to services often being dictated by where someone lives.

From a provider's perspective, multiple forms of assessment are currently needed depending on the nature of care to be offered, together with various forms of licensing and approval and numerous models for funding. It is inefficient and places limits on service effectiveness as a client may be passed from one provider to the next to provide the services they need. Or the provider themselves might need to negotiate the range of services.

The complexity of the current system also necessitates a level of dependence on providers and 'the system' by consumers. Few people can navigate their way through the range of

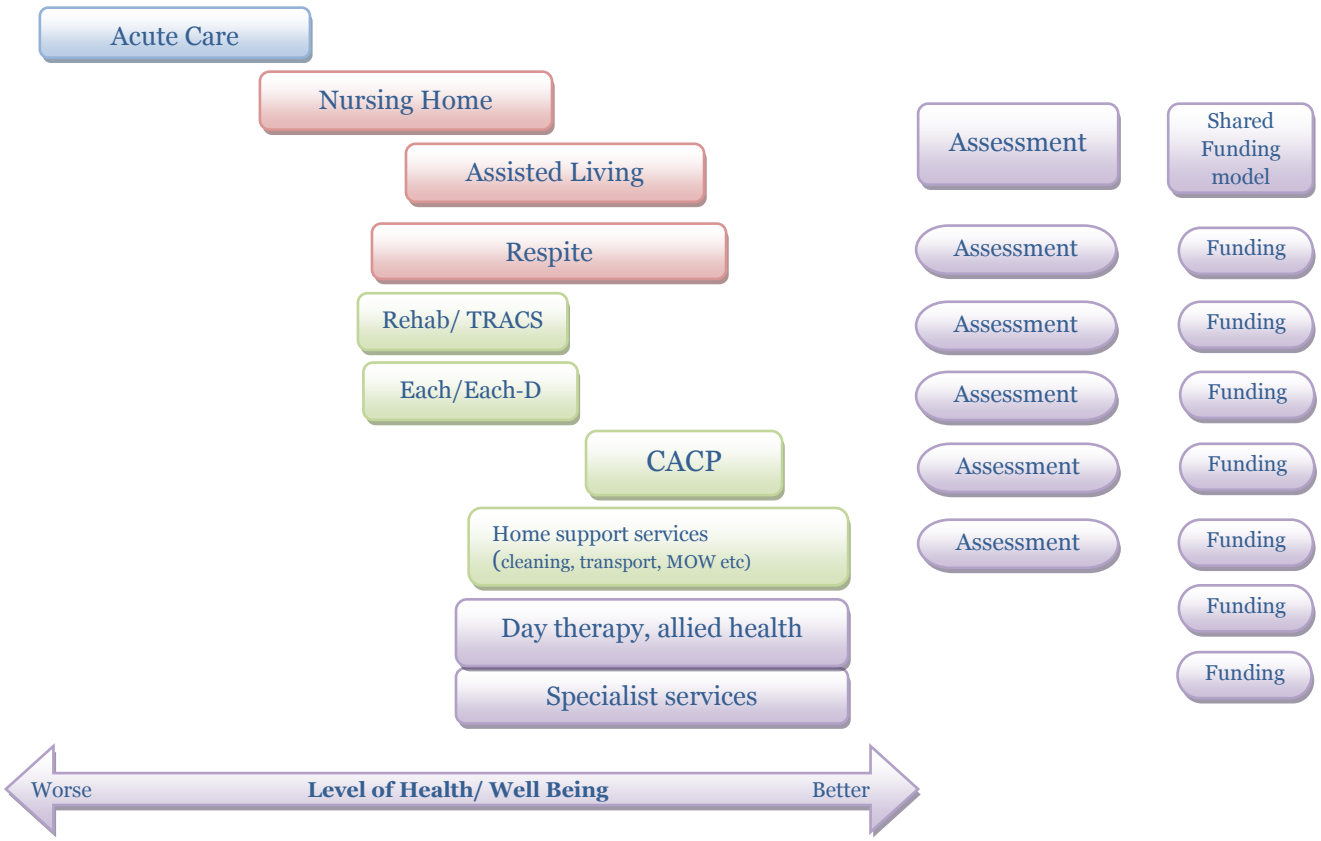
services and options available in the system and so they rely on service providers and government agencies such as ACAT to advise them on what they should do and the services they should access. This, of itself, does not necessarily lead to poor outcomes but it flies in the face of the consumer choice, options and self-determination that governments claim they wish to embed in the system. For consumers to be truly empowered to make the decisions about services which best meets their needs and wishes, the system has to be user friendly and easy to navigate.

An average community aged care provider, which provides a range of contracted services such as those under the following programs CACP, EACH, EACH-D, HACC, NRCP, DVA, VHC and DTC are faced with having to comply with different/multiple:

- Standards; Guidelines
- Quality reporting requirements
- Acquittal and financial reporting requirements/processes
- Statistical reporting processes/forms
- Referral and assessment/review processes
- Software requirements.

This is inefficient, ineffective and unsustainable.

Fig 2: A fragmented system



Anglicare Australia has a vision for a more closely integrated provision of service, where:

Consumers

- Can access all their care and service needs from their provider of choice as their needs change, with minimal disruption to their lives and more control over the service mix

- Are not disadvantaged for improving their self care and becoming less reliant on services and can leave and re-enter the full range of services when they need it
- Have clearly defined expectations of fees and contribution processes

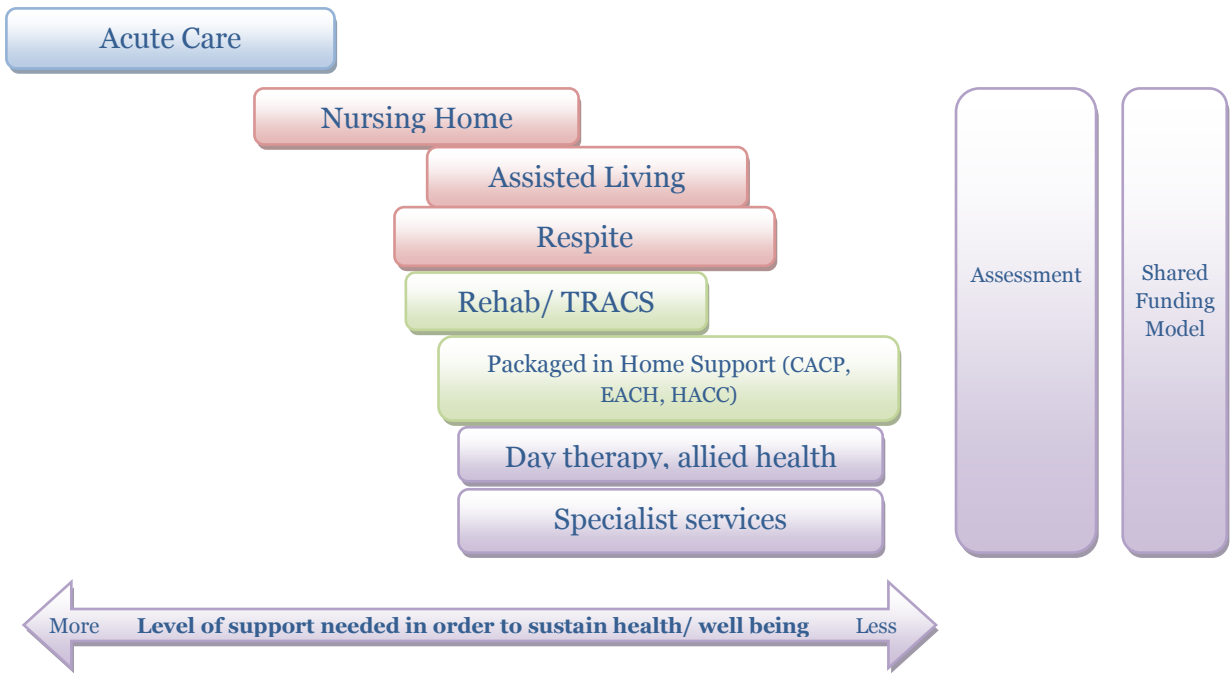
Service providers

- Have the authority to offer a wider mix of services based on one form of approval/licence that covers a spectrum of care types, with one form of assessment that applies across the care continuum and one model of funding that is sufficiently flexible to cover the full spectrum of care offerings
- Can offer elements of care and service that facilitate better connection to and inclusion within their wider community and that can be readily incorporated as they evolve without the need for another approval, funding source and assessment process
- Can respond to the changing needs of their community, switching around the mix of residential, community and social type services as their market demands without having to apply for new forms of funding to do so

The service provision model

- Includes a re-enablement/restorative approach which encourages independence, an increased focus on use of therapy services at all care levels, with specialised services and allied health across all levels of support.

Fig 3 continuum model



Consumer Centric Services

In all aged services the focus must be on older people and their needs, which programs must be designed to meet. Older people do not want to be made to fit into programs, as occurs at present. A responsive system would give older people and their families greater choice of aged care services and greater participation in aged care services planning, delivery and evaluation.

While aged care legislation in Australia now acknowledges the right of individuals to participate in decisions affecting their lives, service development in aged care is presently driven by accreditation processes, and the meeting of standards. This high regulation has ensured that accreditation/standards are at the centre of government focus rather than the actual well-being of the individual consumer/client. There is a need to strengthen the voice of service users and their influence and participation in aged care service delivery.

Studies in the health area have shown that active participation by consumers in decision making in individual care leads to improvements in health outcomes. (Consumer Focus Collaboration (2001) *The evidence supporting consumer participation in health*, Canberra, Commonwealth Department of Health and Aged Care.) For example, in Australia, studies conducted on behalf of Alzheimer's Australia (Tilly and Rees, 2007), Allen Consulting Group (2007), Aged and Community Services Australia (2008), the Brotherhood of St Laurence (Laragy & Naughton, 2008) and Helping Hand (Hardy, 2009) all recommend trialling CDC as an option for care recipients within a universal care program.

Also they show that active consumer participation leads to more accessible and effective health services. A number of documents have been released in the general health and mental health fields providing guidelines, action plans and standards for a more active involvement by service users in the services provided to them.

However aged care is a notable absentee in this area and there is a clear need for the development of national policies, action plans and guidelines to assist aged care service providers to strengthen the participation of clients and residents in decisions affecting all aspects of their care. Client self determination in aged care is limited by the legislative controls, particularly in relation to duty of care. A true consumer centric service would loosen such regulation to better allow for the balance between duty of care and dignity of risk, and so allow aged care providers to support greater self determination in the lives of their clients.

While there is much further to go this area, some initiatives have occurred which are pointing the way for further development of consumer choice and participation. For example the recently announced Consumer Directed Care (CDC) program is a step in the right direction, but it needs to be expanded with an emphasis on building the capacity of older people and their carers to make informed decisions about the care provided, rather than simply being given funds and then asked what they want done with it. The CDC model which has been operational in the disability sector nationally for some years is a sound and empowering model on which aged care could build.

A focus needs to be on marginalised groups who normally have difficulty accessing services, let alone participating in service decision making. Groups such as those from culturally and linguistically diverse backgrounds, those with dementia and those with mental health problems need extra assistance to take on an active role in this area.

Services aimed at such special needs groups such as people who are homeless or at risk of homelessness need to be recognised in their own right. Anglicare South Australia's experience of working with a homeless/at risk of homelessness client group in both residential and community aged care (Ian George Court) has demonstrated the need for services/programs that are focused on that client group; as their needs generally can't be met in mainstream services while evidence suggests that these communities are less likely to access them as well.

Social Integration

Social integration is the result of community wide development as well as specific facilities and services for older people.

Ageing in place is generally seen to be about older people remaining in their own homes and local area so they remain connected to the people and services with which they are familiar.

Social integration, however, should also focus on assisting older people within the community to establish new connections and reconnect people to people/places/activities. Consequently there needs to be a strong integration between place, services and activities. The contribution of older people to the broader community (such as through arts and cultural activities) offers real value to that community, as well obvious dividends in well being for the participants.

Older people need ready access to services in the local community such as shops, social and cultural activities, transport and care and health services.

Housing is likely to remain a significant issue. Housing developments (for an ageing population, for people with disability, and so for everyone) need to follow universal design rules ranging from universal reach principles, wide doorways and being devoid of steps to the inclusion of spaces where friends, family and carers can come to visit and where genuine interactions can take place.

The real challenge, as it is in all aspects of consumer directed choice, is of exclusion.

There are numerous innovations in group and community living emerging for mixed communities and older people to address the issue of exclusion and isolation in old age. Developments incorporating a significant proportion of public and community housing provide but one component of an inclusionary strategy. Agencies with responsibility for planning and building approval will need to look for and embrace new approaches.

There is undoubtedly a critical shortage of social housing right across the country, which the changing demography economy of Australia will accentuate. Requiring development to incorporate a significant proportion of public and community housing, particularly in convenient and accessible locations, is one component of an inclusionary strategy that would address some of that challenge. It would need to be taken up at a local or State level and supported nationally.

There also needs to be a strong link between housing, aged care services and the local community. The campus model is a sustainable model of housing and service delivery that is integrated into the community through community housing, centralised service delivery, supported self care, and usually a community centre that has many conduits to the community (for example, child care, restaurants and services such as a laundry). One organisation in Victoria has recently provided older person's affordable housing, a range of community services, such as hairdressing, a restaurant, a bar and a gymnasium and aged care services all on the one site.

Another key factor in social integration is access to transport. It is a real issue for older people at present. Many aged people with a degree of frailty and mobility difficulties do not have private transport and so rely on public transport to get them to the shops, appointments, to meet with friends and to reach their recreational centres. However public transport is not readily available outside the inner areas of major cities, and older people living in outer areas, in suburban and regional Australia, are often isolated as a result.

All levels of government will need to work with older people and their advocates to develop flexible and affordable systems of community and public transport that meets the needs of the aged population. More generally we need to consider issues of public transport and community design in all new housing developments to ensure that they have appropriate infrastructure planning to accommodate the accessibility issues for older people.

Finally, social integration projects need to be tailor-made, and centred on the individual circumstances of the person. Anglicare-SA's Keeping Connected Program identified the great difference in individuals, and the need for a personal approach to social connection.

Resources

Health and community resources would need to be used in a more collaborative and flexible manner, with medical, aged care and other community facilities collocated, the line between

aged care, community care, the treatment of illness and chronic condition and disability therapy erased, and expertise pooled.

Care services would also be increasingly mobile, with technology supporting experts, such as medical professionals working with – and supervising the work of – a wide range of people.

The challenge and the opportunity of harnessing resources more effectively is especially clear for regional centres which with people from rural and remote locations overwhelmingly moving to the more substantial regional towns and cities. Some variation of the campus model of community and aged care living, with timely investment in infrastructure, could give those centres a framework for economically sustainable care and support networks.

The social resources that build up through this campus approach could also pick up some of the load in care and support that is born at present by voluntary family carers.

Healthy and Active Ageing

Different levels of Government, in conjunction with health providers, have developed many public awareness programs for older people to maintain their health and fitness. Programs on diets, physical activities and social interactions have all figured in these promotions, and these need to continue. However a major barrier to healthy and active ageing is the widely held belief that the impending huge growth in the aged population will have a negative impact on services such as health care, and the overall economy. In essence this increase in the number of older people in Australia is regarded as a future burden on our society with a declining portion of the population in the workforce and a greater demand on publicly funded services, especially health. The positive contribution made by our older people to our society, such as through volunteer work, is often overlooked and rarely mentioned.

One of our member organisations, Benetas, in partnership with Deakin University, recently released a report *Respect in an Ageing Society* which discussed the findings of a research project on this area. These findings indicate a general societal view that old people are unproductive, lack ambition post retirement and are fragile. This ageist viewpoint is reinforced by the media where older people are often portrayed as forgetful, lacking physical co-ordination, in poor health and quite senile.

It is also reinforced by existing aged care practice, where the structures and services encourage dependence of clients on services. The care models do not make it easy to work on an empowerment/enabling approach to supporting people. In residential care, for example, the time constraints and the risks of a client falling often means that wheel chairs are used rather than assisting the client to walk to the dining room.

It is clear that a range of strategies need to be undertaken to counteract the ageist viewpoint that is so prevalent in our society and to raise the status of older people: from initiatives such as an active media campaign, similar to the Aged and Community Services Australia's current *Can't do it without you* social media campaign, to further develop and expand the government's policy approach to *Active Ageing* for Home and Community Care services into other areas of aged care.

Rather than a burden on our society, older people are making a significant contribution to our nation's social and economic well-being, which needs to be acknowledged and celebrated.

e-Health Systems and Technology

An important feature of a model aged care service is an e-Health system, such as that currently being developed by the Commonwealth Government, which would allow the electronic transfer of health information of individuals across health and aged care services. This would assist in overcoming many of the problems that occur at present with loss of

information when a resident is transferred by a hospital back to a residential aged care facility.

Of course appropriate information in the context of aged care the e-Health system would include more than strictly health information, as person's care needs are greatly impacted on by social /family/cultural issues.

Also many other types of electronic technologies are in use or being developed which would greatly enhance the quality of life of older people, at some cost. These can be put into two generic groups – Assistive Technologies (AT) and Information and Communication Technologies (ICT).

In general AT can provide:

- Behaviour monitoring tools that consist of sensors and warning systems that can be used to alert care givers as to the movements of the carer recipient.
- Smart home tools can manipulate the home environment, such as automatically turning stoves and lighting on and off, or scheduling heating to come on and off.
- Telehealth tools focus explicitly on the older person's health and illness issues and include sensors to monitor falls, and tools to exchange data on the older person's health to a health professional, such as blood pressure or diabetes measurements.

Where available, ICT can greatly benefit older people by keeping them connected to family and their communities of interest, thereby helping their social inclusion, Such ICT tools include email, the internet, chat rooms and discussion groups, webcams such as Skype and on-line computer games played with others.

Research and Development

Improved practice in service delivery and development of new services need a strong evidence base and comes through rigorous research and evaluation. There is a certain amount of research occurring with the care of older people, however much of it is focused on physical health and clinical care. While this type of research needs to continue, there also needs to be a greater emphasis on research which looks at the whole area of the well-being of older people and their quality of life. Older people may receive the best practice medical and clinical care yet have little life satisfaction.

Most people receiving aged care services are not sick and we need to research the merits of the current medical model before investing further in it. The "Australia's Welfare 2009" report (AIHW, 2009) analysis of DOHA ACCMS database as at October 2008, records that only 13.5% of all Aged Care Funding Instrument (ACFI) defined high care residents in residential aged care facilities across Australia are identified as having a level of dependence based on "complex health care" needs. According to DOHA's own data and based on the assessments made by aged care providers, aged care needs to be much more than clinical or health care. In caring for older people services have to take into account the needs of the whole person, physical, emotional, psychological, social and spiritual. To assist service providers in this work research has to be undertaken to provide the evidence for best practice in enhancing the quality of life of older people.

In research on older people, service providers need to be involved so that they can impart their knowledge to inform the research and in turn improve their services as a result of the research. Many Not-for-Profit Organisations in aged care have made substantial financial investments into research and advocacy activities, and this funding usually comes from their own internal resources including donations. However to really develop research into key systemic issues, appropriate government funding involvement is required and a research funding stream for service providers and researchers ought to be established as a priority.

In addition to the actual research, there needs to be a focus on the transfer of the knowledge gained from research findings to service delivery providers and consumers. It seems that

quite a large amount of research is being undertaken by tertiary institutions and others, but the knowledge gained from the results of this research is not being disseminated in a fashion that is readily available to the aged care sector and consumers.

While research findings are made accessible through web sites, journal articles and conference presentations, they are often put in an academic framework where the language and conceptual emphasis make it difficult for service providers to convert the results to care practices. The service model being proposed by Anglicare Australia would have providers play a leading role in research and make research findings readily available in user friendly language and format, for practical application.

Workforce

Current research data indicates that the aged care industry, and many other Australian industries, will face reduced workforce growth in the next ten years. The workforce profile of aged care services reflects a predominance of workers aged over 45. This, combined with the projected increase in demand for more complex aged care that will require greater skill mix from staff, points to the need to build a self driving and sustainable workforce and strong and attractive employer brands. In that context, a number of aged care organisations are already taking initiatives such as:

- Investing in traineeships
- Investing in scholarships to assist with fees, materials, travel and accommodation for staff learning and development
- Sponsoring award programs
- Staff referral and reward programs
- Policies and procedures that support and encourage women's leadership, workforce participation and work/life balance including parental leave and flexible work hours
- Additional leave purchasing schemes
- Staying connected programs for staff on parental and carers leave
- Paying above award wages to all staff
- Providing maximum roster flexibility for shift workers
- Operating on site affordable child care for staff, particularly rostered staff who work outside the hours of mainstream child care services

With over 80% of the permanent and casual workforce in aged care being female and over 60% of staff working part-time, family friendly work practices have to be widely adopted to retain valuable staff.

A major obstacle in aged care recruiting of trained nurses remains the large difference between salaries paid by the acute health sector and the aged care industry. In some states the acute health sector pays up to 20% more than aged care, which is not funded to match this large difference. If aged care is to continue to recruit much needed skilled nurses and allied health staff then funding will need to be made available, or funding structures changed, in order to narrow this gap.

Alternatively, if government is not prepared or able to increase funding to meet the real cost of a skilled workforce in the aged care sector, it will need to remove many of the restrictions on aged care providers' capacity to charge a range of fees for service. Most providers cater to a broad range of clients, both residential and community, and if allowed to charge on a capacity to pay basis, those with higher incomes could provide an income stream to providers to subsidise the services available to those less able to pay.

Governments frequently say that this will lead to a 'two tiered aged care sector' and that such a model is unacceptable. We have so called two tiered childcare, education, hospital and health care sectors all of which are supported and funded by governments of all persuasions. The rationale for starving aged care of both funding and a fee income stream limits the aged care sector's capacity to attract and retain the numbers and skill mix in our workforce we require.

Regulation and quality control

There is a need to change the current, highly regulated arrangements for the provision of aged care services if we are to meet future consumer demands and expectations, especially in relation to choice, responsiveness and flexibility.

In recognition that the majority of older people want to stay in their own homes for as long as is feasibly possible with the support of community care, service providers must be allowed to be more flexible and innovative in their service modelling for choice and flexibility to really be exercised by consumers.

Only when funding is based on assessed need rather than allocated quotas, will choice in relation to service type be a reality.

As providers, we must be able to look at ourselves beyond the realms of accreditation and being funded to provide service, to that of a provider who is governed by a suite of care, quality of life and user feedback indicators, where we enable consumers and their families and carers to make informed choices about where and what they access.

Current consistency, fairness and eligibility in the assessment processes vary, often according to program parameters rather than on the basis of consistent assessment processes. Multiple assessments often constitute a significant component of a consumer's journey through service provision as the spectrum of disease changes and as well as being time consuming and unnecessary for clients, it is also resource intensive for providers and costly for funders. It is imperative, therefore, that the assessment process for older Australians is reviewed against best practice international evidence and models and that a single assessment framework is determined that can be used across multiple spectrums of provision which can be taken with the client from provider to provider.

e-Health developments need to be considered against a backdrop of a single assessment process for older Australians, but also with the option of a single consumer health record that is transferable from provider to provider to complement the process. There are many international models of practice against which developments can be influenced and a strong evidence base to support that when consumers own and carry their record, they are less likely to lose it.

A focus on wellness and illness prevention can only be achieved if the lens for delivering community and aged care is challenged. Current community funding, often output based rather than outcome focused, drives activity (based on volume rather than on need) and consequently can miss the purpose for which it is intended. A strong body of evidence supports the need to incorporate wellness management into chronic disease management programs to achieve a model where consumers, families and carers work as participants in their care. To achieve this, a shift in working with consumers as care enablers, rather than care receivers, needs to occur and responsibilities of both parties must be reflected in the contractual arrangements with the people we serve.

Service providers should be able to submit common minimum data statistics, using standardised reporting tools with the cost of the regulatory burden on organisations being factored in to funding agreements to complement this process.

The current residential aged care accreditation process is resource intensive and organisations receive no specific funding stream to support it. Staff time and energy is arguably diverted away from direct client care and activity in an effort to maintain an ever increasing amount of paperwork in order to evidence the systems and processes that support safe and effective care

delivery to residents, from the time of application for accreditation through to dealing with scheduled and unannounced visits. The amount of time and attention spend on the current process is disproportionate to the perceived, positive quality outcomes; and works against the intention driving up standards and improve client care across residential facilities.

A truly universal system would include a range of national validated tools that are appropriate for assessing people from CALD and Indigenous backgrounds.

It would also align assessment tools, such as ACAT with those used to generate care subsidies. That would simplify the system and maximise the opportunity for services to focus on care rather than documuenting applications and assessment.

As well as people from CALD and indigenous populations requiring specialist assessments and interventions, the special needs of consumers from rural, remote, isolated and country areas must not be overlooked. Under the current system, funding allocations are based upon a one size fits all scale, overlooking the pressures placed on delivering services in hard to reach areas. Many Anglicare providers have clients living in hard to reach areas who have to travel long distances to access appointments.

Complaints Investigation Scheme

Arguably across the sector, there is a perception that regulation dictates provision and thus providers have become risk averse to trying new models or to taking on new risks.

The current complaints investigation procedure could be viewed as having a negative impact upon provision because of the rigidity in application. Under the current system, there is little scope for conciliation and encouragement to resolve an issue and so a full review of regulatory requirements is indicated to challenge the existing rigid model, but to also reduce the multiple agencies that providers have to respond to if a complaint or allegation is made. Under the current regime, if a complaint is made an aged care facility can expect a visit from The Accreditation Agency, DoHA and CIS. As CIS is currently funded by DoHA, little objectivity is arguably brought into the investigation process and little differentiation is made between the investigation process for investigating minor or major allegations. Unless an independent autonomous body takes on the role of investigation, a fair and equitable system will not be achieved.

Accreditation

Under the current system, it appears that accreditation and compliance has become blended into one model and there is only one approved provider to scrutinise the process of accreditation and for this the Government funds itself. The market needs to be open to competition and the role and function of accreditation bodies really needs to be explored. Providers would welcome a choice in their accreditor. Competition would increase standards and open to accreditation standards to contestability.

Poor operators create a fear factor with consumers and consumers must be given the power to speak out and publicly rate what they experience. They must be provided with mechanisms to be heard and their voices should impact heavily upon the regulation or deregulation of a facility. Providers must be held to account for the quality of the service that they deliver and to achieve this, the compliance systems must be reviewed and streamlined to reduce duplication and the consumer voice must be seen as a powerful indicator of a facility's fitness for purpose or not.

Anglicare therefore recommends a revised approach to complaints management and investigation, with an emphasis on complaint resolution through processes such as conciliation at a local level. We also recommend that compliance, complaint management and ongoing quality monitoring be separated.

The existing Consumer Investigation Service needs to be re-established as an Independent, accessible and enabling complaints resolution service.

Funding

Any formula for future funding needs to ensure that the most vulnerable people in our society can and do access the care that they need, and that is appropriate to them. That includes Indigenous Australians, people from culturally and linguistically diverse backgrounds, people who have experienced homelessness, who live with substance issues, and those who have mental ill health and personality issues.

All the work that Anglicare agencies do with people who are excluded or on the margin of our society points to the value of flexible individual engagement and support.

Wherever the funding comes from for aged care at the higher level, if we are to connect with the special groups of at risk older people, then that engagement will need to be adequately resourced.

Anglicare SA's experience currently in providing services to these special needs group in the community and residential care (e.g. Ian George Court) is that the cost of indirect service provision (case management) is significantly higher than the funding covers.

There is a convincing, international evidence-base to support case management for special needs groups that economically makes absolute sense. Presently funding for case management is the exception. It is left to the discretion of the provider to provide such a model of care without being fully funded to deliver. Client satisfaction levels are reportedly higher within case management models and yet the cost of provision can be viewed as prohibitive to funders, making case management extremely rare within some communities of significant need.

One of the underlying issues that would need to be tackled in setting up a sustainable system is the growing gap between funding formulae and the real cost of care. Viability is a growing issue for many providers as annual increases in funding do not reflect growing health and care costs. That includes increasing wages and the cost of providing specific treatment and support. Industry submissions will go into these aspects of the current system in accurate detail.

The fact that the existing system is so heavily prescribed, limited and regulated compounds the problem. In its submission to the Department of Health and Ageing review of the Aged Care Funding Instrument (ACFI) earlier this year, Anglicare Australia found that ACFI neither covers the care that residents need nor adequately funds those services it covers and that it specifically works against ensuring appropriate care is available for those who are most vulnerable. An accepted process of setting a fair cost on care, however it is funded, is a necessary stepping stone towards a sustainable system.

Anglicare Australia hasn't yet formed a specific view on the general funding of aged care into the future. The argument for some kind of insurance scheme is attractive and we would be interested in seeing some detailed modelling on how it would work in practice.

Similarly, a strong argument can be made that aged care is a public good, and should be funded as such from the public purse. That argument is hard to sustain, however, if those in our community who have accumulated substantial personal wealth do not contribute at an appropriate level.

It would appear that a call for people to accept a higher tax regime in order to ensure the well being of older Australians, now or in the future, is unlikely to fall on fertile ground at present. On the other hand, there is no doubt that as time goes by many more older Australians will be able to pay for the care and services that they want themselves, and would be prepared to do so.

There may be a wider range off options to fund the necessary capital investment. Australia's very substantial superannuation funds – which have not generated high returns – might well be put to good use in building the aged and community care facilities we will need in the near future.

Anglicare Australia is interested in seeing what kind of hybrid models emerge over the next few months, before we make a further response following the release of the Commission's draft report.

5 Short Term /Transition

Under the auspices of the current Government's compact with the Not for Profit Sector, and under the Coalition's election commitment to set up a formal agreement with aged care consumers and providers, details of major reform to the delivery of care for aging Australians would be developed in partnership with sector.

Transition will need to be very carefully analysed and negotiated, as there are ongoing issues of continuity of care, the financial viability of services, and the need to retain and develop the workforce and volunteers.

There are however a number of initiatives, large and small that could be of immediate benefit to the aged care system and the people that depend on it, and be steps in transition towards a more open and flexible approach.

They include:

1. A single assessment process with choice of assessor
2. Single funding stream for residential and community care
3. Accurate assessment of the cost of care
4. A flexible funding pool for special needs groups
5. Separating care and accommodation in term of regulation, cost and funding
6. Introduce bonds and/or other mechanisms for high care residents to make a capital contribution to residential care
7. Funding health promotion activity
8. Incorporating case management cost in program funding

Single Assessment Process

The move to put aged care and acute and sub-acute health services under one government body is a welcome initiative. However, these services still receive separate funding and have their own information systems as well as assessments, care/treatment plans and discharge procedures. They operate in silos and making connections between them is often difficult and complex. As a result older people have to fit into the different service systems rather than services being provided to meet the individual needs of older people.

There needs to be a much closer relationship between these services so that a service user is provided with a continuum of care across a seamless service system. For example older people ready to leave hospital need a service which includes residential or community aged care, rehabilitation, primary care and allied health. Transitional care packages are a step in the right direction but they don't necessarily lead to a breaking down of the service silos.

The National Health and Hospital Reform Commission recognised the issues around segregated services and made a number of recommendations to integrate service delivery. These recommendations include:

- The widespread establishment of Comprehensive Primary Health Care Centres and Services
- The development and introduction of streamlined, consistent assessment for eligibility for care across all aged care programs.
- A more flexible range of care subsidies for people receiving community care packages, determined in a way that is compatible with care subsidies for residential care.

- Flexible funding arrangements are required to reconfigure health service delivery to achieve the best outcomes for the community.

The Commission in its report made clear that it believed the implementation of these recommendations would assist in keeping people from being inappropriately admitted to hospital or being kept in hospital when they are eligible to be discharged.

Building on these recommendations, a comprehensive assessment process could be developed to expand the current ACAT assessment to include assessment for rehabilitation services, palliative care, transition care and other allied health services. Such an assessment could be undertaken by a team composed of aged care and sub-acute care professionals, and an integrated assessment form could be developed and tested. Built into this would be the ability for re-assessment process to be more flexible and incorporate existing service providers input.

The next reform that would need to occur is to align the care subsidies and user payments right across residential and community aged care and all sub-acute care services. This would entail separating care from accommodation costs in residential aged care. Older people would then be given greater scope to choose for themselves between using their care subsidies for residential or community aged care, and choosing their sub-acute care provider and services.

Additional processes for defining and establishing fee waiver/reduction in community aged care would need to be made clear, consistent and solidified.

Clearly this a major reform, but it is one that all stakeholders in the sector are calling for.

A cross discipline team with appropriate representatives from government, service providers and external "experts" could be established to plan the process, with a view to developing a draft assessment document for testing in the first instance.

These partnerships have the potential to involve all of the above programs and provide opportunities to develop systems to smooth the pathways between the services and develop new policies and programs.

Benefits would include real financial savings as the better integration of services would ensure older people were not trapped in hospitals, but would leave as appropriate with the services they require provided in home and community settings. Hospital discharge planning for elective/planned admissions could occur in primary care, as soon as the patient is admitted for all acute episodes. Inappropriate admissions back into hospital could be minimised.

Planning and communication across these systems would help link funding for care according to older people's assessed needs rather than as dictated by a service planning system.

Recommendation 1:

That a streamlined comprehensive assessment process be developed for eligibility for care across all aged care and sub acute programs. This should include:

- **Developing new assessment tools;**
- **Developing networks to smooth the pathways between the programs**
- **Building links to referral process particularly in community care.**

Single funding stream for residential and community aged care

Inflexible Community Packages

A major problem at present in the community services area is the large gap between the CACP subsidy ($36.05 per day) and the EACH subsidy ($120.50 per day) which creates an inflexible system where people with quite high needs, but not assessed as needing EACH subsidies, can only receive the same services as those with low care needs. This is at odds with the gradational system used in residential care where there are four funding categories under low care.

An example of the impact this is having on service users is highlighted by the following case study.

Case Study

J is a 78 year old woman who lives alone in an independent living unit. J worked as a psychotherapist, she is a writer and has performed on stage. She had a CVA 6years ago and has significant expressive dysphagia, confusion and short term memory loss. J experiences significant frustration with her word finding difficulties and her independence is compromised by her memory loss and problems arising from her accessing the community independently. J's family has been involved but this has reduced in recent months.

J was assessed as eligible for a CACP and is currently receiving the maximum her CACP budget will allow – fortnightly home care and weekly shopping assistance. J has attended a writing group for many years but is unable to attend any longer because of her inability to use public transport safely. She attends a weekly dinner at the retirement village but J does not attend any other group and has few other supports. J rarely leaves her home

J has been offered a vacancy in a weekly local therapeutic activity group but is unable to meet the cost of attendance and transport and the cost will not fit within the CACP. The CACP is unable to fund the cost of transport to her writing group. J does not require the level of support provided by an EACH package but is not having her needs met by a CACP and consequently is at real risk of social isolation

In a similar vein there is a real need for clients on the EACH program to have access to a higher level of funding on a par with the highest level of funding for high care in a residential setting which is currently $162.89 per day compared to the EACH subsidy of $120.50 per day.

An example of the impact this is having on service users is illustrated by the following vignette

Case Study

Mrs G resides in her family home in with her husband/primary carer. Mrs G has a diagnosis of Alzheimer's disease and Lewy Bodies dementia (parkinsonian symptoms). Mrs G sustained a fall in February 2010 and fractured her right hip requiring hospitalisation for several weeks. Mrs G's needs are classified as high due her cognitive impairment. Mrs G was offered an EACH package which the family accepted, as it was their firm belief that Mrs G would be happier at home in her familiar environment.

The case manager undertook a meeting with the client, her husband, daughter and staff of the nursing home, where Mrs G was receiving respite services, to discuss the range of services required to enable Mrs G to return home. Two weeks after assessment and discussion, Mrs G was able to return home with an extensive range of support services for herself and her husband. Benetas EACH package commenced at an exceptionally high level to enable the client to settle at home. Personal care was provided for seven days per week am and pm, domestic assistance once per week and once weekly respite shift to enable husband to attend social needs and their shopping needs. The case manager arranged for an occupational therapist to review and recommend appropriate equipment which was then purchased/ hired, and training arranged for carers to enable them to attend to their duties as per OH&S guidelines. This equipment was assessed and was placed in the home within one day of the OT visit.

Staff required training in the use of the hoist lift to be able to attend to the client. Prior to client being at home she was not communicating verbally and was quite restless. However since returning home her wellbeing has vastly improved, and her family is relieved that Mrs G's wish of remaining at home has been met.. This has also improved the family's well being, and reduced the stress levels of all concerned.

The cost of providing this high level of care and extra resources is well above the current EACH funding and these extra costs have been met by the service provider. These extra costings average around $165 per week.

The above examples show there is a clear need to bring in a funding system for community care that is similar to, or the same as, residential aged care funding. Community care clients should be funded for their individual care needs, as occurs for residential aged care, rather than and not lumped into one single funding category; and where they can move between different care level/funding as their situations improve. In other words, service provision that allow peaks and troughs of funding dependant on need.

Recommendation 2:

That a funding system similar to, or the same as, residential aged care be implement for community care.

High/Low Care Distinction

People coming into aged care should receive the services appropriate their needs and to artificially create certain domains on the ACFI which put a person into "high care" makes no sense. More and more older people are ageing in place in residential aged care facilities, and

low care facilities operating pre-1997, which meet the building codes, are accepting an increasing number of high care. When residents classified as "low care" have increased needs, and their ACFI score increases to a stage where they pass the mysterious barrier to "high care", all of a sudden a whole range of resources have to be provided to them at the cost of the facility. However, if a resident needs these resources, but cannot pay for them, providers are required to ensure residents receive these resources to meet their duty of care. So why have this barrier?

Also real difficulties arise when ACAT assesses a person as low care, but the provider's assessment has them as high care. The provider has to get another ACAT assessment, which could take a great deal of time, and there is no guarantee that the ACAT will change its assessment. This means a high level of service and care is being given to a resident but the subsidy does not recognise this care because of this labelling of "low care". If there were just the ACFI domains with "high care' or "low care" labelling then subsidies would reflect the care being given.

It is recognised that removing the categories of high care and low care would mean all residents would be treated the same financially, so that all residents with the financial means would be expected to pay an accommodation bond. But again this seems very fair as all are treated equally financially irrespective of their care needs.

Recommendation 3:

That the categories of "high care" and "low care" be removed and residents be given the care and resources as assessed to meet their needs.

Assessing the costs of care

One of the vital ingredients in an adequate system of care is a continually accurate assessment of the cost of the care that a person is entitled to. In its submission to the ACFI review, Anglicare Australia pointed to the risk of a fear of escalating demand leading to a *cost containment approach which factors in inadequate funding for the care provided and/or inadequate care itself. Anglicare Australia strongly supports the call from NACA (National Aged Care Alliance), among others, for a full review of the cost of care across the sector.*

One powerful intermediate step would be to conduct a rigorous and independent cost of care study in order to inform the design and structure of a whole of society approach to the care for older Australians. It may also serve as an interim measure, in that adequate funding for occasions of care might provide an important boost for morale in the workforce and across the sector.

Recommendation 4:

That the Department of Health and Ageing establishes a transparent continual improvement process to address disparities between identified need, actual cost of care, and funding.

Flexible funding for special needs groups

Prior to providing services to people with special needs, such as those with a homelessness background or people from Aboriginal and Torres Strait Islanders (ATSI) groups, a great deal of time has to be spent developing a rapport and building trust. In most cases these people do not have a history of positive engagement with mainstream services and they are reluctant to be involved in programs such as Community Aged Care. Consequently, after receiving the referral, care managers have to arrange a number of meetings with the prospective clients to introduce themselves, talk about the program and try to develop a relationship of trust.

These pre-service delivery meetings usually occur where the prospective client feels safest and this could be on the street, in a park or in a crisis centre, and it can take up to five or six meetings or longer before the prospective client agrees to receive the service. At present there is no funding for this important pre-service work, and given the special needs of this group this type of engagement is essential to bring the person onto the program. If a person from these special needs groups is provided with services before this trust is established then inevitably the person will drop out of the program.

This work of building trust should be regarded as an integral part of service delivery and needs funding. A flexible funding pool could be established for care managers to use in these special circumstances where lengthy assessments are required.

Recommendation 5:

That a flexible funding pool is established to be used by care managers when working with special needs groups such as people with a homelessness background, Aboriginal and Torres Straits Islander people, and people from other culture or with specific needs.

Separating Care and Accommodation Costs

One way of assisting service providers to meet the escalating costs of operating residential aged care facilities is to unbundle care and accommodation costs. This would also remove a large barrier between community care and residential care and enable aged care to operate as a seamless service system with people moving easily between different services.

People should meet their own accommodation and living costs as they do throughout their lives. People with low incomes living in the community are eligible for a range of subsidised housing as well as Government concessions and rental assistance. People who can afford it, and who live in the community, meet all their own accommodation and living expenses.

It is difficult to understand why this alters when a person enters residential aged care. Surely it would be simpler, easier and more equitable for people to meet their accommodation and living costs irrespective of their particular care needs. For people who require residential care and are unable to meet these costs then Government should pay on their behalf. This payment needs to be in line with the payments made by people with financial means so that there is equity of access.

The costs for all types of care services could then be subsidised by the Government as currently occurs with Medicare, with each individual undergoing a financial assessment to determine the level of payment they can afford over and above the Government subsidy.

By separating accommodation and care costs individuals can contribute to the overall costs in a more equitable way, with those with the financial means making a more meaningful contribution.

This reform would also streamline the delivery of services and make the whole aged care system much easier to navigate for clients, residents and their families.

Recommendation 6:

That care costs be separated from accommodation costs in residential aged care.

Capital Funding

Numerous reviews over the past few years, including the Hogan Report and the National Health and Hospitals Reform Commission, have recommended that accommodation bonds be permitted for people entering residential high care.

The current situation whereby an accommodation charge is all that is available to service providers to meet high care capital costs is untenable and is a major factor in the decline in building works planned by approved providers (Department of Health and Ageing; Report on the Operation of the Aged Care Act 1997 – 1 July 2008 to 30 June 2009 (2010) 49). This situation is also causing our members to think carefully about planning any new facilities for high care residents.

There is a large shortfall between the return on an accommodation bond and the return on an accommodation charge. It has been reported (ACAA; Health Reform – the Aged Care Chapter, July 2010, 9) that the estimated annual difference between an average accommodation bond and an accommodation charge is about $12, 846 per resident. Also the same paper states that this annual shortfall for an average 100 bed facility with 70 high care residents equates to $899,220 or the funding required to construct 3.5 new residential care beds each year.

Accommodation payments should be based upon each resident's ability to pay what they can afford, and this should apply irrespective of their care needs. The initial justification for the accommodation charge seems to have been based upon the need to preserve the family home, but if this is the case why did it apply only to those with high care needs? When residents pay an accommodation bond they lose only the interest and a small administrative fee. The bulk of the estate remains intact.

All residents of aged care facilities should be subjected to the same financial requirements regarding accommodation payments, and the differing financial requirements of high and low care should be removed so that all residents are liable to make a capital contribution, depending upon their financial situation.

Recommendation 7:

That accommodation bonds or other capital contribution be introduced for high care residents and the method and size of that contribution be assessed on an individual basis as currently applies for low care.

Funding independence

An example of the 'dependence' model of service funding which currently exists is particularly evident in NRCP funded services. One AA service provides respite for carers of aged family members. The service operates six days per week and is very cost effective. One woman who was the full time live-in carer of her elderly mother began using the service. Her mother enjoyed the clubs and friendships available at the respite service so much that she chose to attend most days. The daughter observed her mother's health and well being improving to a level she had not believed possible. Her mother became so well and enjoyed her respite so much, that the daughter returned to part time work while her mother was in respite. After several more months, the daughter returned to full time work and her mother moved into a unit in a retirement village and continued to attend the respite service every day. Her mother was now living independently and the daughter had returned to full time employment.

This positive and life affirming development meant that neither the daughter nor her mother were now eligible for the NRCP day centre as the daughter no longer qualified as a 'carer.' If the service had complied with its funding requirements in this case, the mother's and daughter's lives would have irrevocably and sadly returned to their previous situation, which

was unacceptable to both. Good services will often turn peoples' lives around: aged people should not be forced by funding models to be denied the very service which supports their independence.

Recommendation 8

That community based health promotion activity is funded through current programs to support independence and health of people as they age

Case management

Aged care delivery systems derive resources from a complex suite of funding sources. These sources come from local, state/territory and federal funds. Often these funds are shared responsibilities between government sectors and the not for profit sector.

This is frustrating and those in need can easily fall through the cracks. Services lurch from one funding cycle to the next unsure if there are more resources available for worthwhile projects. The clients in receipt of these services may, without a lot of notice, find themselves without vital support to keep them functional in their own place.

There is no inherent flexibility available to many service providers. This means many older people are locked into a number of services that are not coordinated or case managed.

Case Study

Marjorie has recently sustained a fractured femur. After a period in the local acute hospital she was waiting for a transition care bed to support her further rehabilitation and make it possible for her to go home. Marjorie spent 6 weeks in transition care and then went home with a battery of different services in place. Marjorie had meals on wheels, the wound nurse, visits to her local GP, visits to the hospital clinic, visits to the hospital physiotherapist, visits to the local pathology collection centre, visits to her local pharmacist and community transport.

What Marjorie did not have was a case manager and she struggled to self coordinate these priorities.

Marjorie talked to the community transport person who recommended and Anglicare Life Centre. After her initial contact, the community coordinator made a visit to Marjorie. Marjorie joined a local community life group and the coordinator became her case manager.

For Marjorie this meant one care plan that wrapped up all her needs with a case manager, less travelling around and use of community transport, More time for recovery and rehabilitation, the establishment of enhanced social networks, access to all of Anglicare's community services and Better use of resources.

This case management though is unfunded. It is made possible through community generosity. Given the age demography of the donor base it is expected that this source of funding will atrophy over the next few years.

Recommendation 9

That case management is factored into community care delivery and its funding.

END