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Banksia Villages

Submission to the Productivity Commission Inquiry Into Caring For Older Australians

Ageing is an incremental, highly variable and unique process that requires a response that is incremental, flexible and accessible.

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EXECUTIVE SUMMARY

Retirement and aged care provision is partly a product of its own history. Key features of that history have been identified in this report, along with their ongoing impacts.

PART I – THE AGED CARE ENVIRONMENT

Drivers of Change in Residential Aged Care

Lesson from the 1990s – 1. Models of Residential Aged Care
Hostels had been providing care to residents who qualified for nursing home categories, yet care was being provided using a different (social) model of care and at a lower cost.

Lesson from the 1990s – 2. Institutionalised Behaviour
The more institutionalised the environment, the more institutionalised the behaviour. Or, the more the model of care encourages dependency, the more dependent the recipient becomes.

Lesson from the 1990s – 3. Attitudes of Entitlement
Many recipients and their advocates held the view that there was an entitlement to receive (including the accommodation component), and that 'charitable' services along with government subsidised services were not only for those who could not afford to pay, but were also for those who did not want to pay.

Ongoing Impacts of Key Changes in Residential Aged Care

Ongoing impact of changes during the last 15 years – 1. Capacity for Change
Key stakeholders in retirement and aged care (providers, legislators, some industrial relations peak bodies, and consumers) have demonstrated significant capacity to plan and implement change.

Ongoing impact of changes during the last 15 years – 2. Policy Development
The Commonwealth Government has developed some effective policies (through incentives and disincentives, or carrot and stick) that have helped grow the acceptance of a user pays approach to some aspects of aged care, and have helped empower residential aged care residents to access an above basic level of service where they can afford it.

Ongoing impact of changes during the last 15 years – 3. Political Sensitivity and Community Expectations
Political sensitivity and community expectations drive significant parts of aged care decision making in policy and practice, sometimes constructively.

Ongoing impact of changes during the last 15 years – 4. Capital Funding
Capital funding regimes in residential aged care are inadequate – particularly for those with higher care needs.

Ongoing impact of changes during the last 15 years – 5. Indexation of Recurrent Funding
Indexation of funding regimes in residential aged care are inadequate.

Ongoing impact of changes during the last 15 years – 6. Industrial Change
Some industrial change has occurred, other industrial change has been resisted.

Ongoing impact of changes during the last 15 years – 7. Impact of Technology
Technology has impacted positively on the effectiveness and efficient of service delivery, and has the capacity to deliver much more.

Structural Change in Aged Care Service Delivery – For Profit and Not For Profit Providers

Issue 1 – Differing Strengths of Providers: For profit and not for profit providers bring specific strengths to retirement and aged care, but they only partially counter-balance each other.

Issue 2 – Differing Target Markets: The targeted client, resident mix and service provision in the for profit and not for profit provider groups do not exactly overlap.

Aged Care Supply in a Competitive Market

Issue 3 – Suppliers' Risk: Any refined or new aged care system needs to take into consideration risk as assessed by suppliers.

Residential Aged Care Supply Restriction Versus Choice

Issue 4 – Cross Subsidisation of Aged Care: For many providers, the current level of recurrent funding (subsidised and user pays) in residential aged care is only made tolerable through the impact of cross subsidisation and high occupancy.

Issue 5 – Choice, Occupancy, Risk and Cost: If increased recipient choice results in reduced occupancy, the increased occupancy risk may be priced into the cost of care provision.

Entitlement and Dependency

Issue 6 – A Vision For Retirement and Aged Care: Any refinement or renewal of the retirement and aged care system would be well supported by a vision that in turn drives policy, infrastructure planning and service model design.

Issue 7 – Independence and Entitlement: A vision for retirement and aged care could focus on the right to be independent and the entitlement to support when needed. The support would be flexible with a baseline level funded via subsidy and user afforded contributions. It would have the option of additional user funded accommodation and services, where desired.

PART II – CURRENT ISSUES

Assessment

Issue 8 – Purpose of Assessments: Clear identification of the purpose of assessments is essential.

Issue 9 – Flexible and Holistic Assessments: Assessments for care needs or funding should be flexible and holistic in their application in order to reflect the various ways in which ageing generates needs (mental health, emotional, physical, clinical, behavioural, social and logistic).

Issue 10 – Assessment Criteria: Assessment and re-assessment processes need to be timely, accurate and allocatively efficient.

Issue 11 – External and Provider Assessments: External assessments need to be capable of refinement when providers gather additional data from recipients.

Issue 12 – Staged Implementation of Voucher Systems: Voucher systems may be introduced more effectively if they are initially applied to community care based services and then, once refinements are made, broadened to include the more complicated aspects of residential care.

Issue 13 – Choosing Less Complex Services and Accommodation : Voucher systems may apply more readily to hotel services, assistance with activities of daily living and accommodation.

Issue 14 – Choosing Complex Services: Voucher systems may not apply as readily to clinical and behavioural care where the care is complex and the service provision is difficult to assess without a reasonable level of experience or expertise.

Issue 15 - ACATs: There are strengths and weaknesses in the ACAT system. The expertise of ACATs is a key strength and the extent of untimely access to assessments is a key weakness.

Staffing

Issue 16 - Staff Literacy and Documentation: Literacy support, combined with elimination of unnecessary documentation, will enlarge the aged care workforce pool.

Issue 17 – Cross Cultural Awareness in the Aged Care Workforce: The use of immigration to provide workforce support to aged care requires cultural awareness training.

Issue 18 – Racial Vilification of Aged Care Workers: Specific support is needed for staff in order to address racial vilification that may be directed toward them.

Issue 19 – Refugee Intake and the Aged Care Workforce: Care needs to be taken when linking refugee intake with aged care workforce needs.

Issue 20 – Aged Care Workforce Training: Government initiatives that allow aged care providers and aged care peak bodies to provide training should be encouraged.

Promoting Independence

Issue 21 - Transport: Access, particularly in terms of transport planning, is an essential aspect of effective retirement and aged care.

Suggestion 1 – Cohort Resilience and Transport: In order to encourage the emerging older population to be self helping as a group, there could be refunds of drivers' licence fees in return for hours of volunteer driving (and possibly the passing of regular driving tests). This could also be extended to registration and insurance.

Suggestion 2 - Rehabilitation: Funding rounds or incentives could be provided for organisations that can identify programs that will assist community members to rehabilitate to their most independent level.

Issue 22 – Retirement Living: Government incentives for retirement communities to promote independence at the individual and group level would reinforce a positive and self-sufficient approach to ageing.

Assessing the Capital and Recurrent Cost

Issue 23 – Assessing the Capital and Recurrent Cost: Accurate means of calculating the capital and recurrent funding required for ageing and sustainable ways of sourcing that funding are essential for the future of aged care.

Accommodation and Open Competition

Issue 24 – Accommodation and Open Competition: Residential aged care providers need to be confident that they will be able to attract capital to enable refurbishment and upgrading of their buildings.

Ageing With Pre-Existing Mental Health Needs

Issue 25 – Mental Health: Aged care accommodation innovations for those who are ageing with pre-existing mental health needs, such as that commenced by the Sisters of Mercy in Nudgee in Queensland, need to be supported and specifically encouraged through government policy.

Restrictive Workplace Structures

Issue 26 – Residential Aged Care Leadership: We need leadership models in all RAC models of care that service residents needing registered nurse level skills and also allow for a facility's management to be undertaken by:

A Registered Nurse with skills in operataions management (with or without formal qualifications in management) responsible for clinical governance and general management.

OR

A Registered Nurse without skills in operations management who is responsible for clinical governance only, in which –

- the Registered Nurse position is answerable to a general manager, OR
- a general manager is answer to the Registered Nurse position.

Acute Care/Aged Care Interface - Complexity

Issue 27 – Interface Effectiveness and Efficiency: Measures that reduced the complexity of the accessibility, funding and operation of aged care will assist the effectiveness of the acute care/aged care interface.

Acute Care/Aged Care Interface – Communication and the Ageing Process

Suggestion 3 – Electronic Medication Systems: Electronic transfer of records, including medication regimes between acute care and aged care (and pharmacies) would make a significant impact. Noting, however that this will not work if it assumes that the care systems (care planning, medication administration etc) in one of the two sectors will automatically be appropriate for the other sector. A records transfer system that works will need to be compatible with the service delivery systems at both ends.

Ageing and Access to Acute Care

Issue 28 – Access to Acute Care: The extent of services to be provided through aged care services needs to be clearly defined, communicated and funded and the right of the aged to quality acute health care needs to be clearly articulated.

Ageing, Health, Disability – The Differences Matter

Issue 29 – Promotion of Independence: A conscious effort to promote independence, based on the capacity of the ageing, whenever retirement and aged care is discussed, planned or legislated will result in care that meets the needs of the cohort and ultimately costs less.

Issue 30 – A Specific Cohort With Holistic Needs: A conscious effort to identify the holistic needs of ageing people as their own cohort will result in care that more effectively meets the needs of the cohort and avoids counter-productive measures and unnecessary cost.

INTRODUCTION

Background to the Submission

This submission has been compiled by a stand alone retirement village and residential aged care provider, located in a regional location. It reflects the experiences of the organisation and of senior management and executive staff who have been in the sector for up to 20 years, both with the organisation and with other organisations.

Personnel have worked for not for profit providers and consulted to for profit providers. Personnel have expanded existing services, commenced new services and rehabilitated dysfunctional services. They have also been elected to positions within peak bodies. One member of the personnel has undertaken a study tour of Denmark and France. Another has visited aged care facilities in England.

Guiding Principles

Experience in retirement and aged care services has lead to the conclusion that:

- Ageing is an incremental, highly variable and unique process that requires a response that is incremental, flexible and yet simple.

- Each individual and their quality of life can be defined by their capacity and independence as well as their incapacity and need.

- If an ageing population looks solely outside its cohort for support, its needs will not be met. This particularly applies to the upcoming bulge in the ageing population.

Submission by Aged and Community Services Australia and Aged Care Australia

The authors fully endorse the submission made by Aged and Community Services Australia and Aged Care Australia. This submission does not seek to address the matters covered in that submission, but rather provide additional information and suggestions.

Structure of the Submission

The submission is in two parts. The first part highlights essential aspects of the aged care environment that drive the issues most demanding attention. Part II identifies the issues themselves.

PART I – THE AGED CARE ENVIRONMENT

Drivers of Change in Residential Aged Care

Up until the mid 1990s, residential care was distinctly divided into two sectors. Their key features are set out in Table 1.

The system was designed such that residents would move from a hostel to a nursing home as their needs increased. However, in reality, hostel residents transferring to a nursing home would often be classified at higher than the lowest level of care (Category 5). At the time of admission, category 4 and 3 classifications were common and category 2 classifications were not unknown. Sometimes, this was because an event had taken place that had caused the frailty level to rapidly increase (eg a stroke). Often the progression in frailty was smaller, but enough to trigger the transfer. At other times, there was no change in frailty at all, rather the move was triggered by a vacancy occurring in the nursing home, and yet, the higher classifications still occurred at admission.

Historical Key Features of Hostels and Nursing Homes		
	Hostels	Nursing Homes
Original Reason for Existence	Accommodation for those requiring some support (meals, some housekeeping, some socialisation), and/or experiencing housing difficulty	Venue for the provision of ongoing, regular, nursing services that were required on a routine basis
Classification Under the Building Code	Class 3 (the same class as pre-schools amongst others)	Class 9 (the same class as hospitals)
Key staff group	Personal care assistants (now known as personal care workers)	Nurses (AINs, ENs, RNs)
Key union	Health Services Union (and its predecessor) in NSW and the equivalent in other states	ANF
Resident classifications during the early 1990s	Hostel Care Low (least frail), through Personal Care Low, to Personal Care Medium and then to Personal Care High (most frail)	Category 5 (least frail) through to Category 1 (most frail)
Funding stream	Lowest point was Hostel Care Low through to highest point which was Personal Care High	Lowest point was Category 5 (which was higher than Personal Care High) and highest point was Category 1

Conclusions were drawn by policy makers and providers, and they have driven change in residential aged care ever since. There are number of ways of describing those conclusions, of which the following is one:

Lesson from the 1990s – 1. Models of Residential Aged Care
Hostels had been providing care to residents who qualified for nursing home categories, yet care was being provided using a different (social) model of care and at a lower cost.

Lesson from the 1990s – 2. Institutionalised Behaviour
The more institutionalised the environment, the more institutionalised the behaviour. Or, the more the model of care encourages dependency, the more dependent the recipient becomes.

Finally, another phenomenon was apparent to providers:

Lesson from the 1990s – 3. Attitudes of Entitlement
Many recipients and their advocates held the view that there was an entitlement to receive (including the accommodation component), and that 'charitable' services along with government subsidised services were not only for those who could not afford to pay, but were also for those who did not want to pay.

Ongoing Impacts of Key Changes in Residential Aged Care

The major ongoing impacts of key changes in residential aged care are set out in Table 2. There are many other changes that have occurred (eg building certification, prudential requirements), however Table 2 lists those that are the most critical in terms of future impact.

Ongoing impacts of changes during the last 15 years have been grouped below.

Ongoing impact of changes during the last 15 years – 1. Capacity for Change: Key stakeholders in retirement and aged care (providers, legislators, some industrial relations peak bodies, and consumers) have demonstrated significant capacity to plan and implement change.

Ongoing impact of changes during the last 15 years – 2. Policy Development: The Commonwealth Government has developed some effective policies (through incentives and disincentives, or carrot and stick) that have helped grow the acceptance of a user pays approach to some aspects of aged care, and have helped empower residential aged care residents to access an above basic level of service where they can afford it.

Ongoing impact of changes during the last 15 years – 3. Political Sensitivity and Community Expectations: Political sensitivity and community expectations drive significant parts of aged care decision making in policy and practice, sometimes constructively.

Ongoing impact of changes during the last 15 years – 4. Capital Funding: Capital funding regimes in residential aged care are inadequate – particularly for those with higher care needs.

Ongoing impact of changes during the last 15 years – 5. Indexation of Recurrent Funding: Indexation of funding regimes in residential aged care are inadequate.

Ongoing impact of changes during the last 15 years – 6. Industrial Change: Some industrial change has occurred, other industrial change has been resisted.

Ongoing impact of changes during the last 15 years – 7. Impact of Technology: Technology has impacted positively on the effectiveness and efficient of service delivery, and has the capacity to deliver much more.

Structural Change in Aged Care Service Delivery – For Profit and Not for Profit Providers

The past decade has seen an increase in the number of for profit community and residential aged providers. The two basic provider types (for profit and not for profit) have some distinct strengths and weaknesses. They are listed in Table 3. They only partially counter-balance each other.

Issue 1 – Differing Strengths of Providers: For profit and not for profit providers bring specific strengths to retirement and aged care, but they only partially counter-balance each other.

Issue 2 – Differing Target Markets: The targeted client, resident mix and service provision in the for profit and not for profit provider groups do not exactly overlap.

Aged Care Supply in a Competitive Market

Competitive markets are premised on sellers not **declining to sell** for any reason other than price. In aged care 'sellers' will also decline to sell for other reasons (usually incapacity to meet a care recipient's needs), particularly given that the 'sale' is not a discrete once off or repeated event: It involves continuous 'sales', from which (legislatively) the 'seller' cannot easily extract themselves.

Markets also require the buyers and sellers to both have information. In aged care, information that is withheld from 'sellers' can include behaviours, (eg life histories of violence by care recipients), mental health conditions, and clinical conditions (eg penicillin resistant bacterial infections).

Inevitably, risk management strategies (often informal) apply. In each case, aged care providers identify whether they can meet their legislative responsibility with regard to each care recipient's needs, staff safety and other care recipients' safety. Consideration includes mindfulness of punitive measures that will apply corporately and individually if responsibilities are not met. Occasionally, and increasingly rarely, such considerations are overwhelmed by organisational vision and mission.

Issue 3 – Suppliers' Risk: Any refined or new aged care system needs to take into consideration risk as assessed by suppliers.

Table 2: Ongoing Positive and Negative Impacts of Key Changes in Residential Aged Care	
Positives	**Negatives**
Change 1: *The* Aged Care Act 1997 *provided* ***one funding system*** *for all residential aged care facilities, reinforcing a single RAC system.*	
Impact: Residents stayed longer in low care RACs. The low care RACs received the funding that matched the residents, including high care residents.	**Impact:** The full extent of care being provided in low care RACs became apparent and costly. Validation processes (where DoHA verified the funding claims) became bogged down in pedantry with the apparent aim subsidy recovery. They were time consuming and ruinous of the relationship between DoHA and providers. The problem was exacerbated by the nature of the RCS funding tool.
Change 2: *The* Aged Care Act 1997 *was amended removing the extension of accommodation bond funding to all RACs. It was replaced by an* ***inadequate capital regime for high level RACs.*** *Also,* ***government assessments of the capital cost of providing residential aged care did not include all costs (eg land costs).*** *Consequently, accommodation charges in high care were calculated at too low a level, as was the government subsidy for those who were unable to pay an accommodation charge or an accommodation bond.*	
Impact: 1. Extra service high level places have become more accepted, initially by for profit providers and then by not for profit providers (many of whom have been able to overcome their own resistance to charging those who can afford to pay).	**Impact:** 2. The process of achieving a streamlined residential aged care system was undermined by the distinction in capital funding between high and low care places and its impact on provider options and resident choice. 3. Planned high level places have been deferred indefinitely. 4. High level places that have been provided are often of a minimum standard (eg the proportion of bedrooms and bathrooms that are shared). 5. Providers operating across the continuum have cross subsidised, including – - using returns from self care unit activities (particularly as these have increased with the real estate booms and providers' preparedness to increase 'prices' for those who can afford to pay) to cross-subsidise high care RAC capital requirements. - providers with older self care unit sites (often originally government subsidised) have redeveloped them (and they now house fewer people) or sold them in order to fund high care RAC places.

Table 2: Ongoing Positive and Negative Impacts of Key Changes in Residential Aged Care	
Positives	**Negatives**
Change 3: *The **recurrent funding indexation system** was reviewed in order to achieve coalescence across the states and territories and to apply a new annual indexation system.*	
	Impact: The subsidy became inadequate. Supplements (eg the conditional adjustment payment), partially offset the shortfall. The ACFI funding tool saw a partial catch up effect take place, but the indexation issue remains.
Change 4: *The Commonwealth Government has taken action to place the **assessment of people's capacity to pay** into its own systems.*	
Impact: Disclosure to Centrelink is much more accurate than disclosure to a RAC provider.	
Change 5: *The Commonwealth Government has **exempted accommodation bond and equivalent amounts from asset and income assessments** involved in income tested fee liability and pension entitlement calculations.*	
Impact: Residents and their families have become more accepting of accommodation bonds.	
Change 6: *A new **building code classification to cover all residential aged care buildings** was introduced. It took a long time and care had to be taken to ensure that it was not predicated on specific staffing regimes.*	
Impact: From 2003 most if not all new RACs buildings able to accommodate a broad range of frailties.	
Change 7: *Employer representatives (in NSW and elsewhere) sought to establish awards that enabled personal care workers and assistants in nursing to **multi-skill across caring, cleaning and food preparation**. The negotiations with the care workers' union succeeded. The negotiations with the ANF did not.*	

Table 2: Ongoing Positive and Negative Impacts of Key Changes in Residential Aged Care	
Positives	**Negatives**
Impact: Care workers became employees of choice (including in high care facilities). The 'hostel model' (social model) of care was reinforced, and made more efficient, and its growth into higher frailty care was underpinned industrially.	**Impact:** The AIN positions were phased out and replaced by care workers in many high care (nursing homes). A siege mentality with regard to the traditional, clinical based models of care was reinforced. An opportunity to formally involve nursing representatives in the processes aimed at ensuring high quality clinical care was provided within the evolving hostel/social model of care did not arise. (Providers have addressed this at the service organisation and site level where the rigour of accreditation also applies.)
Change 8: *The New South Wales Government repealed the Nursing Homes Act in deference to the enhanced coverage by the Commonwealth. However, and despite the extensive quality assurance provisions in the* Aged Care Act 1997*, it also amended the public health act to retain the **Director of Nursing position that emanates from the history of the hospital sector**. The Director of Nursing position applies to facilities that are nursing homes prior to the* Aged Care Act 1997 *or have high care places under the* Aged Care Act 1997.	
	Impact: Providers are averse to applying for high care places. (In order to provide high care, they apply for low care places, allow residents to age in place, provide their clinical care as required by the residents' needs and the quality assurance processes (including 24 hour registered nurse coverage where required), and are free to appoint managers into the managing role in facilities where appropriate.
Change 9: *The qualifications of EN with Medication Endorsement and **Cert IV with Medication Endorsement** were created**.***	
Impact: There was an increase the staffing options in all RACs: These staff were able to fulfill much of the medication role previously delivered by RNs.	
Change 10: *Advances in medication technology enabled **medication packaging systems** that allowed lower qualified staff to administer residents' routine medications. Facilities that utilise Registered Nurses for the administration component of their medication regime can only use the single dose versions (one pill per section).*	

Table 2: Ongoing Positive and Negative Impacts of Key Changes in Residential Aged Care Positives	Negatives
Impact: 1. Medication systems, protocols and safety procedures have been developed in many facilities that allow the use of this multi-dose system, improving efficiency and re-designing the role of the registered nurse.	**Impact:** 2. As an activity emanating from the hospital sector, controlling the medication trolley has been a core activity for many Registered Nurse shifts and there are many control issues involved in some change management situations. **3.** Some accreditation assessors struggled to assess the new systems on their merits.
Change 11: *Advances in technology have enabled the* ***possibility of communication between doctors' software, pharmacists dispensing and facility administration systems.***	
	Impact: The software in doctors' surgeries assumes the traditional single dose administration system, dramatically reducing the usefulness of the linkage to facilities using multi-dose administration systems.
Change 12: *The* ***Commonwealth Government funded several rounds of training*** *that enabled providers to ensure that staff – particularly personal care workers – achieved certificate level qualifications.*	
Impact: The numbers of qualified personal care workers increased.	
Change 13: Accreditation was introduced to residential aged care via the **Aged Care Act 1997.**	
Impact: **1.** Quality assurance processes have enhanced the delivery and quality of care. In particular,,they have embedded continuous improvement as a philosophy and culture.	**Impact:** 2. Accreditation has links with the complaints management process that do not always work smoothly and the current interactivity undermines the credibility of both. 3. Care has been needed to ensure that assessment is always one of quality assurance and not of principles and practices from assessors' previous workplaces and personal preferred practices. **4.** There remain double ups with other government bodies, and this is wasteful and demoralising.

Table 3: Strengths and Weakness of the Not For Profit and For Profit Sectors

Sector	Strengths	Weaknesses
For Profit	**Cost Management** Rigour in cost management **Result:** In combination with the provision of information through sector benchmarks - cost management within aged care (particularly around consumables) is very tight	**Cost Management** Views cost management as a central/investor management function and internally 'outsources' care service delivery to traditional nursing structures, and tends to assume that quality assurance systems will also replace the need for leadership and management on site. **Result:** Innovative care models (particularly those that explore alternatives staff structures and roles for nurses) tend not to be developed, leadership at the service site reduced, and issues not captured by quality assurance tend not to be resourced (at least not in the first instance).
	Motivation Is motivated by profit. **Result:** Tends to be more responsive to residents needs and wants as a way of generating custom.	**Motivation** Is motivated by profit. **Result:** Tends towards cherry picking with regard to concessional and assisted ratios and special needs groups, regardless of need.
	User Pays Preparedness to charge for services in excess of the basic requirements prescribed under the Aged Care Act 1997. **Result:** The concept of a basic standard with services and buildings in excess of that standard being funded by users has become much more widely accepted across the entire aged care sector and the community.	

Table 3: Strengths and Weakness of the Not For Profit and For Profit Sectors		
Sector	**Strengths**	**Weaknesses**
For profit (cont.)	**Client Responsiveness/Customer Service** New members of the for profit sector, especially those providing extra service places have a tendency to embrace and instil customer service principles. **Result:** There have been some shifts in staff attitudes towards residents (moves away from paternalism), and residents are presented with more choices regarding additional services (for which they are charged).	
Not For Profit	**Impact of Vision** Through their vision, they tend to be motivated by a commitment to residents' well being as an end in itself. **Result:** Innovative models of care are attempted. The multi-skilling of aged care staff (particularly personal care workers) has improved the tailoring of services to residents needs and wants and has delivered efficiency. **Result:** Providers embrace those who may otherwise not be offered a place within residential aged care due to concerns about risk or financial return. Eg The Sisters of Mercy in Nudgee in Queensland are providing RAC care to those who are ageing with significant mental health impairment, with no additional funding to support the additional resources required. Eg not for profit providers are more likely to exceed concessional and assisted resident requirements where there is a need.	**Impact of Vision** Through their vision, they tend to have a commitment to residents' well being as an end in itself. **Result:** Care cultures can still be paternalistic with ingrained cultures that focus on operational imperatives and traditional (acute health care system, based) power models, with decision making that is removed from residents. **Result:** Income generation and cost control have not had as high a priority as in the for profit sector, at times leading to inefficiency and a reluctance to pursue legitimate income from users. This has been strongly countered over the last decade through the impact of sector benchmarking that in turn has been influenced by the for profit sector, the scarcity of income and the action by the Department of Health and Ageing (see following sections).

Residential Aged Care Supply Restriction Versus Choice

Residential aged care has become so tight in its operational funding that there is an enormous pressure to achieve very high levels of occupancy in order to cover fixed costs. In this context, given not only employment covenant requirements, but also the need to attract and retain staff, ensure roster coverage (24 hours per day, 365 days per year) and ensure staff skill and qualification coverage in the roster, staffing effectively becomes a fixed cost (benchmarked at 60% to 70% of recurrent income at 98% occupancy), along with other fixed costs.

Limiting the supply of residential aged care places has historically supported fuller occupancy. The introduction of more readily available choice and the lifting of supply restriction will, in likelihood, lead to lower occupancy, and there is already some evidence of this in the aged care sector as supply restriction has lifted with the increase in government allocated places. Suppliers face a higher occupancy risk than previously.

Markets price risk into the required return. If costs are already constrained, and the pricing of labour is under pressure to increase, surely increased return then requires increased pricing.

Issue 4: For many providers, the current level of recurrent funding (subsidised and user pays) in residential aged care is only made tolerable through the impact of cross subsidisation and high occupancy.

Issue 5: If increased recipient choice results in reduced occupancy, the increased occupancy risk may be priced into the cost of care provision.

Entitlement and Dependency

Ageing is an incremental process, requiring incremental support. Models of care that assume high frailty and dependency, encourage high frailty and dependency.

In Denmark, when a resident is assessed as requiring residential care, they are assessed for their capacity to continue to care for themselves, as well as for their needs that require support from others. For instance, if they enter residential care and they can still contribute to the cleaning of their rooms, then there is an expectation that they will do so.

In France, the retirement and low (hostel) levels of care are effectively rolled into one, and residents are far more used to assisting one another to live independently.

In Denmark pedestrian and cycle ways allow the population to walk and ride (daily) well into their 80s, keeping them fitter and healthier. The infrastructure impacts on behaviour and health.

In the Netherlands, the ‘use it or lose it’ philosophy underpins the ‘Apartments for Life’ system that is now being attempted by the Benevolent Society in Sydney.

In Australia, there is an aversion to paying and a tendency towards entitlement – particularly to services that are funded by others, and even a sense of entitlement to being dependent. One of the fundamentals that may assist to address the issue of the affordability of care for the ageing is to

address the attractiveness of independency, primarily by promoting the benefits, facilitating the opportunities, and providing incentives to be independent. Some suggestions are made in Part II.

Issue 6 – A Vision for Retirement and Aged Care: Any refinement or renewal of the retirement and aged care system would be well supported by a vision that in turn drives policy, infrastructure planning and service model design.

Issue 7 – Independence and Entitlement: A vision for retirement and aged care could focus on the right to be independent and the entitlement to support when needed. The support would be flexible with a baseline level funded via subsidy and user afforded contributions. It would have the option of additional user funded accommodation and services, where desired.

PART II – CURRENT ISSUES

Assessment

Effective and efficient assessment is essential. The characteristics of an effective and efficient assessment process are:

- unambiguous purpose,
- clear identification of holistic needs, and
- resourced and performed by people who are appropriately skilled.

Unambiguous Purpose

Assessment systems often get asked to do too much – identify care need, decide funding, and attempts are even made to prescribe service provider's staffing via recipient assessment processes (although this is usually rigorously protested by providers, not least because assessment levels are too crude in their structures to be meaningful to the finely tuned staffing allocation processes and because ensuring appropriate staffing is embraced in quality assurance processes).

Clear Identification of Holistic Needs

The assessment identifies the needs for the recipient's use and for providers' purposes. Providers need to ensure that they can meet the recipient's needs. They need to know:

- any diagnoses and their associated prognoses,
- capacity of the care recipient to care for themselves and the projected path of that capacity, and
- the incapacity of the care recipient to care for themselves.

Needs may range across the mental health, emotional, physical, clinical, behavioural, social and logistic.

Externally assessed needs usually differ from the needs as assessed by a service provider. The degree of difference can be significant. The reasons for this are:

- the provider will spend more time with the recipient,
- the recipient will change behaviour outside the intensity of a formal assessment process, and
- the recipient may have been having a good (or bad) day when being assessed.

Assessment systems need to allow for this variance to be addressed, particularly where the assessment is linked to funding. The voucher option outlined below addresses this issue. It allows for the concept that the areas where the most differences between assessment and ongoing care provision arise lie in the higher/clinical and behavioural/dementia care areas.

Voucher Systems and Informed Choice

Recipients and their advocates would find themselves able to adequately differentiate between the extent and quality of both community and residential care with regard to:

- hotel services (as currently prescribed in the *Aged Care Act 1997*),
- assistance with activities of daily living (ADLs - also as currently prescribed in the *Aged Care Act 1997*), and
- accommodation,

rendering a voucher system workable in these areas.

However, with regard to:

- clinical care, and
- behavioural (usually dementia) care

significant experience and knowledge is needed in order to completely assess the skill and competency of providers. The care involved is complicated and technical and goes well beyond the normal consumer assessment skills and knowledge.

Changing Care Needs

Recipients' needs change over time, and assessments will need to be renewed, where access to additional funding is needed.

In this regard, externally provided assessments have been shown to be highly variable in their timeliness. Delays deny providers the funding they need in order to provide care (but they provide the care anyway – they just don't get the funds).

Assessments by providers are timely, however, providers do have a conflict of interest given the funding involved. A check mechanism would be needed.

Resources and Skills

Assessments need to be provided in a timely manner, and need to be as accurate and detailed as the needs of recipients and providers dictate, no more and no less. Too little information leads to ill informed choice and decision making by recipients and providers. Too much information requires excessive resourcing and compromises the timing and availability of the assessment, to the detriment of recipients and providers. The assessment system needs to be:

- readily accessible,
- flexible to accommodate the variety of ways in which people age,
- accurate, and
- complete, but only to the extent required for choice and decision making.

Assessments for funding, if funding is to be assessment based, need to have the same characteristics as assessments for care, and they also need to:

- accurately determine appropriate funding, and
- be allocatively efficient.

The capacity for assessment and classification tools to fulfil both the care needs criteria and the funding criteria without becoming unwieldy and resource consuming is unproven. For instance, in the case of residential aged care, there were significant problems with the Resident Classification Scale (RCS) and the long term value of the Aged Care Funding Instrument (ACFI) is still being established.

Aged Care Assessment Teams

As providers, we have noted that ACATs:

* are usually skilled assessors with a wide range of clinical and service provision knowledge, and access to all the requisite skill and knowledge in one person is efficient,

* are often not available to meet demand, limiting recipients access to service and providers access to funding,

* are vulnerable to suspicion of corruption if providers conclude that one provider is being favoured over another in terms of encouragement of recipients to access a particular provider.

Issue 8 – Purpose of Assessments: Clear identification of the purpose of assessments is essential.

Issue 9 – Flexible and Holistic Assessments: Assessments for care needs or funding should be flexible and holistic in their application in order to reflect the various ways in which ageing generates needs (mental health, emotional, physical, clinical, behavioural, social and logistic).

Issue 10 – Assessment Criteria: Assessment and re-assessment processes need to be timely, accurate and allocatively efficient.

Issue 11 – External and Provider Assessments: External assessments need to be capable of refinement when providers gather additional data from recipients.

Issue 12 – Staged Implementation of Voucher Systems: Voucher systems may be introduced more effectively if they are initially applied to community care based services and then, once refinements are made, broadened to include the more complicated aspects of residential care.

Issue 13 – Choosing Less Complex Services and Accommodation: Voucher systems may apply more readily to hotel services, assistance with activities of daily living and accommodation.

Issue 14 – Choosing Complex Services: Voucher systems may not apply as readily to clinical and behavioural care where the care is complex and the service provision is difficult to assess without a reasonable level of experience or expertise.

Issue 15 - ACATs: There are strengths and weaknesses in the ACAT system. The expertise of ACATs is a key strength and the extent of untimely access to assessments is a key weakness.

Staffing

Literacy problems are not uncommon, nor surprising, given the pay levels currently applicable to aged care. Their impact is exacerbated by the extensive documentation requirements in aged care. There are some high quality carers in the sector, who also have poor to very poor literacy. Current funding does not allow for training in this area by employers.

With regard to the capacity of immigration to impact on workforce needs:

- Cultural awareness of other NESB cultures and ESB cultures will be needed for NESB staff.
- Staff of Asian and African appearance tend to experience heightened levels of racial discrimination and vilification from care recipients (some of it is quite unpleasant and nasty).
- Hearing loss is common in those who are ageing, and if a staff member cannot speak clearly in a manner that can be understood by the particular recipient group, they cannot provide quality care.

A number of the above issues can be addressed with education, training, support for good management and leadership. However, the impact of these issues and the resources required to address them needs to be recognised.

There is the at times espoused view that refugee intake should be increased as (with the aid of a readily obtainable Cert III in Aged Care) it would help address the staffing shortfalls in aged care. It is noted that the community is often informed that refugees are often in need of emotional and mental health support. The frail aged are certainly often in need of significant emotional support and can also require mental health support. The needs of these two groups do not cancel each other out. This is not to say that there may not be excellent potential aged carers amongst those seeking refuge. However, the notion that the vulnerability and need of both these groups makes them an automatic fit for each other can only arise from a failed understanding of the complex needs of both.

Providers are identifying that staff who have qualified using Cert III and Cert IV training in aged care through training organisations that are not also active in the aged care sectors as providers, are often in need of significant on the job training and education.

Issue 16 – Staff Literacy and Documentation: Literacy support, combined with elimination of unnecessary documentation, will enlarge the aged care workforce pool.

Issue 17 – Cross Cultural Awareness in the Aged Care Workforce: The use of immigration to provide workforce support to aged care requires cultural awareness training.

Issue 18 – Racial Vilification of Aged Care Workers: Specific support is needed for staff in order to address racial vilification that may be directed toward them.

Issue 19 - Refugee Intake and the Aged Care Workforce: Care needs to be taken when linking refugee intake with aged care workforce needs.

Issue 20 – Aged Care Workforce Training: Government initiatives that allow aged care providers and aged care peak bodies to provide training should be encouraged.

Promoting Independence

Transport

Access issues, particularly transport access, are identified in most health service plans, NSW Local Government Social Plans, and by aged care providers (particularly rural and regional). Two factors are increasing the importance of transport:

1. The growing emphasis on remaining in the home for as long as possible enhances the need for transport to services.

2. Growing specialisation of health services, with an associated requirement for population catchment critical mass in order to warrant provision of a service centre means that older people will travel increasing distances to services.

Issue 21 - Transport: Access, particularly in terms of transport planning, is an essential aspect of effective retirement and aged care.

Suggestion 1 – Cohort Resilience and Transport: In order to encourage the emerging older population to be self helping as a group, there could be refunds of drivers' licence fees in return for hours of volunteer driving (and possibly the passing of regular driving tests). This could also be extended to registration and insurance.

Rehabilitation

In Denmark, an aged care provider has set up an adaptable kitchen for use by any member of the community who has suffered an acute episode (such as a stroke or a hip replacement). Community members are able to access the kitchen as they determine the changes that will work best in their own home to allow them to remain as independent in their own home despite the recent changes to their health.

Suggestion 2 - Rehabilitation: Funding rounds or incentives could be provided for organisations that can identify programs that will assist community members to rehabilitate to their most independent level.

Retirement Living

There is a diversity of product now available in retirement living that ranges from the gated community/lifestyle choice through to the charitable model that originally accessed government capital funding. The culture within retirement living groups varies widely, and includes villages where residents organise levels of support between themselves eg volunteering to drive the village bus. Historically, many of these villages have been very active with Auxiliary's and social clubs, and the expressed desire by residents to participate in some, aspects of village life. Although the language (eg Auxiliary) is old fashioned, the capacity for self support will remain. The issue becomes one of incentive.

Issue 22 – Retirement Living: Government incentives for retirement communities to promote independence at the individual and group level would reinforce a positive and self-sufficient approach to ageing

Assessing the Capital and Recurrent Cost

Inadequacies with the current methods of calculating the capital cost of residential aged care and indexing the recurrent funding of residential aged care are highlighted in Part I. This matter has also been addressed by other submissions.

Identifying an adequate method of calculation and a sustainable way of funding these two items would not only address the issue of funding, but it would also reduce other counter-productive outcomes, eg by:

- taking some pressure off recurrent subsidy validation processes, and
- ensuring that the financial capacity of other activities (eg self care unit operations) to continue to renew and develop is not undermined due to cross subsidisation of RACs.

Issue 23 – Assessing the Capital and Recurrent Cost: Accurate means of calculating the capital and recurrent funding required for ageing and sustainable ways of sourcing that funding are essential for the future of aged care.

Accommodation and Open Competition

There is a high level of speculation about the concept of vouchers and open competition in aged care, particularly with regard to the specialised and expensive nature of residential aged care building provision.

Providers currently require high levels of occupancy in order to address capital viability. Older facilities are able to continue to achieve occupancy due to the ceiling on supply, saving funds from bonds and accommodation charges to then resource refurbishment. Providers are concerned about

how to ensure that ageing buildings will achieve sufficient occupancy to ensure that funds can be saved for refurbishment.

Issue 24 – Accommodation and Open Competition: Residential aged care providers need to be confident that they will be able to attract capital to enable refurbishment and upgrading of their buildings.

Ageing With Pre-Existing Mental Health Needs

With the de-institutionalisation of mental health care during the 1980s, the prevalence of mental health care needs amongst the ageing population living in the general community is starting to require specific attention from the aged care sector.

Issue 25 – Mental Health: Aged care accommodation innovations for those who are ageing with pre-existing mental health needs, such as that commenced by the Sisters of Mercy in Nudgee in Queensland, need to be supported and specifically encouraged through government policy.

Restrictive Workplace Structures

Defining the Workforce Needs

A residential aged care facility is not purely a care servicing environment. It is the residents' home, with all the relationship and communal living issues inherent in a group environment, requiring a specific skill set from the management and staff. The care that is provided is also diverse, ranging from spiritual care to the physical environment to clinical care to emotional care to support for leisure and interests. This is reflected in the Accreditation Standards. Currently, there are 44 standards, 17 of which are health and personal care standards, 7 more have some linkages with registered nurse competencies, and the rest are management, lifestyle and environment standards.

RAC Leadership

RAC leadership requires both clinical governance skills and qualifications, and general management skills and leadership. Typical nursing qualifications (see curriculum for Charles Sturt University – Bachelor of Nursing) address clinical care. The National Competency Standards for the Registered Nurse address professional practice, analysis, care co-ordination and collaborative and therapeutic practice.

When placed in a position in which they do not have training or sufficient experience, people mismanage, obfuscate, or reject the premise for the need for the activity for which they do not have the skills or education. Where an organisation is also legislatively required to have an RN in a position as controlling as the traditionally perceived Director of Nursing role, and the individual

concerned does not have general management skills (including financial management skills), ineffective management then follows.

Legislative Requirements

The *Public Health Act* in NSW requires a 'Director of Nursing' for RACs with high level care places (as allocated in the *Aged Care Act* or places that existed in what were previously licenced nursing homes). The problems with this are:

- The requirement is for the individual to be a registered nurse with 5 years' experience and to have two years' experience in administration in a nursing unit manager (NUM) or more senior position. This requirement is arbitrary, and is no guarantee of the general management skills needed to be in a position as controlling as that of the Director of Nursing as it has been traditionally implemented, or that of a role that includes the general management of a residential aged care facility as it is increasingly being defined.

- The requirement is for the position to be responsible for care of the residents, but the act does not define 'care'. It is capable of a range of interpretations from the narrow (all clinical care) through to the broad (all activity that impacts on residents, including resource allocation, lifestyle support and maintenance).

- Facilities that were previously known as hostels, and places that have been allocated as 'low care' under the *Aged Care Act 1997*, are frequently occupied by residents who have been assessed as in need of high care. There needs are being met by a team of personnel with the same qualifications and experience (including care workers and registered nurses) that provide care in the places captured by the *Public Health Act*. The care is being assessed via the accreditation standards and is no more or less subject to complaint or non-compliance. The care levels may, on average, be slightly less, but they are still high level care.

Issue 26 – Residential Aged Care Leadership: We need leadership models in all RAC models of care that service residents needing registered nurse level skills and also allow for a facility's management to be undertaken by:

A Registered Nurse with skills in operataions management (with or without formal qualifications in management) responsible for clinical governance and general management.

OR

A Registered Nurse without skills in operations management who is responsible for clinical governance only, in which –

- **the Registered Nurse position is answerable to a general manager, OR**
- **a general manager is answer to the Registered Nurse position.**

Legislation needs to support this principle, not impede it. From a quality of care perspective, the accreditation standards are able to support this flexibility, as evidenced in the Australian Capital Territory. Additional legislation is not needed at the state level. If it is to remain at the state level,

then it needs to provide the flexibility whilst ensuring both clinical governance and managerial effectiveness (as per the options outlined above). In addition, this approach will ensure a larger possible workforce rather than a smaller one from which residential aged care will be able to draw its clinical governance and general management.

Acute Care/Aged Care Interface - Complexity

The movement of staff between the two sectors tends to be from acute care to aged care. (The anecdotal reasons for this have been that aged care has been perceived as being less demanding. Feedback over recent years has been that those who have made the change to aged care have found that the work is just as demanding, and more so where behavioural care is required.)

The aged care sector is incredibly complex, with multiple provider and funding bodies. It's confusing enough when you work in it. Personnel in the acute care sector don't have the time, even when they have the willingness, to gain an effective understanding of the retirement and aged care sector.

As a consequence of these two factors, there is a very low level of knowledge within acute care with regard to how the aged care sector works. This impedes the capacity of the two sectors to interact effectively, and it impedes the capacity of acute care personnel to guide their patients as to the most appropriate transitional and ongoing care options.

Issue 27 – Interface Effectiveness and Efficiency: Measures that reduced the complexity of the accessibility, funding and operation of aged care will assist the effectiveness of the acute care/aged care interface.

Acute Care/Aged Care Interface – Communication and the Ageing Process

As older people can often have more than one ongoing chronic health issue, it is difficult for emergency department personnel to determine which aspects of a patient's presentation are ongoing and which have triggered the admission, unless they have reliable communication. Similarly, aged care providers have complained for years about the poor level of information that accompanies residents when they are discharged from hospital – particularly where medications are concerned.

Care is compromised by these problems, and this is so common it is almost accepted as inevitable, if not normal. Rebound admissions to acute care occur as a consequence.

Suggestion 3 – Electronic Medication Systems: Electronic transfer of records, including medication regimes between acute care and aged care (and pharmacies) would make a significant impact. Noting, however that this will not work if it assumes that the care systems (care planning, medication administration etc) in one of the two sectors will automatically be appropriate for the other sector. A records transfer system that works will need to be compatible with the service delivery systems at both ends.

Ageing and Access to Acute Care

Ageing people need access to quality acute health care, as do people of all ages. The notion that hospital beds can be freed by providing sufficient aged care services and support is only true to a point. The difference in the types of services offered by the two sectors are exemplified by the differences in their bed day costs and funding levels (even once other contributing factors, such as differing wage levels, are factored into the calculation). Caution needs to be taken when assessing the extent of acute care utilisation that can be defrayed by creating more aged care services, and even extending the type of service that they provide.

Issue 28 – Access to Acute Care: The extent of services to be provided through aged care services needs to be clearly defined, communicated and funded and the right of the aged to quality acute health care needs to be clearly articulated.

Ageing, Health, Disability – The Differences Matter

Ageing, healing the sick, and living with a disability have similarities. The support and care provided in those sectors can be shared across the sectors and lead to improvements. However, the similarities often overshadow key differences. This leads to assumptions about incapacity that in turn lead to one or more of:

- over provision (encouraging dependence and/or demeaning ageing people),
- under provision (increasing risk), and
- wasteful provision (increasing cost).

It is all done with the best of intent, but it is based on erroneous assumptions.

Example 1: Adaptable Housing and Hot Water

The Australian adaptable housing standard (AAHS) was drafted for those with disabilities. When reviewing the NSW State Environment Planning Policy 5 (SEPP5), a decision was taken to attach the (AAHS) to the SEPP5 requirements for retirement villages. The AAHS called for thermostatic mixing valves (TMVs) to be used on hot water supply. TMVs have traditionally been used in nursing homes in order to restrain hot water temperatures to a maximum of around 45°C to prevent scalding of residents. At the time of the change to the SEPP5, tempering valves had come into being and were being implemented in the general community. Their maximum setting is around 65°C. They are cheaper to install and maintain.

A decision was taken that retirees should have the same protection as nursing home residents, and the requirement for TMVs was embedded in the AAHS and hence the SEPP5.

The problem was that retirees are more independent and many do their own washing up. The 45°C hot water was found to be too cold, so they would boil a jug and transfer the boiling 100°C water to the sink. In the effort to protect retirees, there was a blindness to their level of independence, and the end result was a higher risk of injury.

Even when they understood the problem, local councils were not able to approve an engineered solution as they are often able to do under the Building Code of Australia, because it was a SEPP5 requirement.

Eventually, the requirements were changed, but there remain in existence self care units that were built during this time that still have TMVs.

Example 2: Toilets for the Disabled and the Ageing

Toilet design for the disabled is premised upon a user who is wheelchair bound, and has the upper body strength to transfer themselves, usually sideways. Disabled toilet design positions grab rails and toilet height in accordance with this incapacity (the paraplegia) and capacity (the upper body strength).

When people age, the body changes in many ways and weakness increases across the entire body. There is significant person to person variation in the type and of weakness. Good toilet access involves a flexible mixture of symmetrical rail support and portable aids. It is also subtle when incorporated into retirement living as retirees do not wish to view themselves as incapacitated prior to becoming frail. For instance, often this subtlety involves reinforcing walls cavities to allow for later installation of grab rails.

There is a tendency to apply disabled toilet standards to retirement and aged care building requirements for all residents, not just ageing residents who are also disabled (again via state planning legislation and national codes, eg the building code). This is done with a view to providing optimum support to residents, based on what works for the disabled.

The capacity to provide an engineered (alternative) solution, varies with the legislation and from provider to provider and local council to local council. It can be easier in rural and regional environments where provider organisations are well known to council personnel and there is a greater openness to consideration of alternative solutions.

Example 3: The Resident Classification Scale – the RCS

The RCS was the funding tool in residential aged care for a decade. It was a tool that was compiled with a large influence (in fact dominating influence) from clinical (acute) care, as assessed by personnel working at the registered nurse (degree equivalent) level and higher, along with post graduate and senior level researchers.

After pilot studies were completed, much of its implementation (in terms of fulfilment of documentation requirements) was undertaken by Cert III and Cert IV level staff, because they are the main care providers in residential aged care. The subtlety of the tool's requirements were often in excess of their documentation skills, which had to be developed to the extent that they could be, not in order to provide better care, but in order to better meet the requirements of the funding tool. Even then, specialist resources had to be added in order to ensure some resilience within the validation process, a process that became increasingly pedantic due to the clinical and complicated nature of the RCS.

Also, the RCS was applied not only to residents who had clinical needs, but also those with significant behavioural needs (particularly with the rising levels of dementia). However, the dominance of clinical care provision within the RCS generated undervaluing of behavioural care. For example, time spent

showering a resident once a day was recognised, whilst time spent repeatedly diverting and redirecting a resident with dementia throughout the day was often only partly recognised at best.

Finally, its clinical nature meant that the RCS recognised the time (and hence funding requirement) taken by providing care, but did not recognise the time (and hence funding requirement) taken by encouraging independence. For example, time spent physically assisting a resident to undertake a task or indeed doing it for them, was recognised. Time spent encouraging and facilitating a resident to do as much of the task as possible for themselves, was not. In order to obtain funding, providers had to constantly highlight the residents' dependence. There were even those who were tempted to encourage it.

Example 4: The Aged Care Funding Instrument (ACFI)

There is a question in the ACFI that asks residents if they can remember four individuals and why there were famous. The question is aimed assessing the acuity of the resident's long term memory, of particular relevance in dementia care. At piloting, the four names were Adolf Hitler, Charlie Chaplin, Joseph Stalin and Captain Cook.

At piloting, feedback was given that the question was in appropriate given the impact of World War II on residents, particularly those with dementia, and it should be replaced. The response was that it was the only scientifically validated question that was free of copyright charges that provided this assessment. (There was no response to the suggestion of generating another tool.) Provider feedback on two occasions was that if the question could not be replaced, as it should be, at least Winston Churchill could replace Adolf Hitler. The tool in practice reflects that change.

Subsequent review, as reported by the Aged and Community Services Association of NSW and ACT at its June 2008 state conferences was that of all the questions in the ACFI, this was the one where staff were showing a significant level of refusal to ask the question of a number of residents, because they knew it would upset those residents. So, funding was missed.

In summary, a tool that fulfilled the scientific, clinical and cost of use requirements was implemented despite its negative impact on the people to whom care was being provided. It took the care level staff to give priority to the care of residents. It is worth noting that, from a cost of care perspective, it is the content of long term memory, rather than whether it exists or not, that generates the need for care resources.

Issue 29 – Promotion of Independence: A conscious effort to promote independence, based on the capacity of the ageing, whenever retirement and aged care is discussed, planned or legislated will result in care that meets the needs of the cohort and ultimately costs less.

Issue 30 – A Specific Cohort With Holistic Needs: A conscious effort to identify the holistic needs of ageing people as their own cohort will result in care that more effectively meets the needs of the cohort and avoids counter-productive measures and unnecessary cost.