Background

The Peninsula Health, Primary Care & Population Health Committee is made up of key service partner representatives to undertake joint planning, service coordination and prioritise primary and community health service strategies in the Frankston and Mornington Peninsula region in Victoria, Australia.

Work undertaken to identify, prioritise and introduce coordinated service strategies focussing on Community and Ambulatory Care initiatives has been widely recognised in promoting and providing quality, innovative, coordinated and personalised health services.

Our membership comprises:

- Frankston City Council
- Frankston Mornington Peninsula Primary Care Partnership
- Mornington Peninsula Shire Council
- Peninsula GP Network
- Peninsula Health (Metropolitan Health Service including integrated acute, aged care, community and mental health services)
- Peninsula Hospice Service
- Peninsula Support Services (Mental Health PDRSS)
- Royal District Nursing Service

A key focus over the past 3 years has been on Diabetes, Respiratory (COPD) and Mental Health (Anxiety & Depression) with many interventions focussing on ageing members of our community.

It is timely for the Productivity Commissions' comprehensive review of the Aged Care service system in Australia. In particular, we support the finding that the current service system is ill equipped to manage the challenges likely in the future. Significant reform is clearly required to respond to changing demands, and the Productivity Commission draft report is a constructive first step in generating the public debate required to effect the required changes to the service system.

We welcome the opportunity to provide a submission to the Commission in response to the draft report "Caring for Older Australians" as a coordinated group of key stakeholders. While our individual agencies may provide more detailed and specific responses, we wanted to highlight some common concerns. This submission responds specifically to the draft recommendations most likely to impact on our collective services and, by extension, consumers of those services in the Peninsula Health catchment area.

Key Considerations

We provide the following dot points of concern for your consideration and have detailed some specific responses to the key draft recommendations below:

- Concern that there appears to be no current synergy between this process and Medicare Locals (as advised by the Commissioner at the MAV Forum 24 Feb 2011) as outlined in the Health reform documentation.
- Proposed reform for "regular transparent recommendations from the new independent regulatory commission on the schedule set of prices and related indexation" and "scheduled prices for aged care should take into account the need to pay competitive wages to nursing and other care staff delivering aged care services" is welcome and needed; this will enable the industry to attract and retain appropriately trained and skilled staff to support our ageing population into the future. Without this, workforce shortages across aged and community care will continue and worsen.
- The proposed reform "scheduled prices for aged care should take into account the costs associated with resources required to support volunteers is welcomed; this will promote volunteering opportunities and make volunteering experiences more productive and enjoyable leading to more volunteering and community participation and healthier communities
- Concerns that "gateway agencies" will be too remote and cover too large an area to adequately assist community members with locally relevant information and access to services
- If only one gateway agency, some community members may not find that gateway; better to have a " no wrong door" approach and enable prospective clients to enter the service system through their most suitable and accessible "door"
- Concerns that "gateway agencies' will compromise the valuable work done in Victoria in recent times around HACC Living at Home assessments and Active Service Model, both of which are impacting positively on HACC clients' capacity to stay living at home safely and independently
- Concerns that "gateway agencies" will undertake telephone assessments which are not an effective means to determining, in conjunction with the community member, the best information or supports that would assist them to maintain and improve their functional capacity, independence, social connectedness and general health/wellbeing
- Client continuity of care is likely to be compromised if approved providers are appointed on a public tender basis, and therefore could potentially change periodically, leading to unnecessary disruption for clients
- The proposed reform to develop building standard designs for residential housing that meet the needs of older people with functional limitations is articulated as being for when "people wish to modify their house"; a far more effective approach would adopt the principles of universal housing design where policy moves towards all

houses being built with a capacity to meet the needs of all residents, regardless of their temporary or permanent functional limitations

- The proposal for one level of government to be responsible for aged care is not supported by local government in Victoria, or the COAG agreement that noted the different models currently in operation and the importance of maintaining existing service delivery strengths in Victoria and Western Australia. Victoria has had a long history of service planning, funding and delivery that has resulted in a relatively integrated and equitable distribution of HACC services, as well as providing stability and coordination to clients. Councils have played a significant role in linking seniors to local social recreational and health maintenance services
- A market driven approach is proposed to replace the existing accumulated planning, funding and provision by state/local arrangements based on meeting specified individual needs. Local and state-wide experience suggests that a proliferation of competing providers will actually weaken the capacity to work together cooperatively and effectively.
- It is unclear as to how competition will lead to innovation when both service need and the price for services are fixed. Similarly an open market is unlikely to provide to low density areas or remote areas, or for vulnerable groups that require a more individualised and targeted approach.
- There is no proposed mechanism for how a centrally managed system will relate to local communities and how, without a local/state planning framework, the knowledge of needs and gaps from assessors and providers will inform services development. The model is strong on national uniformity and service continuity issues within aged care but not specific about horizontal integration and pathways with the primary health care, recreational and social services which are important for all seniors.
- That COAG processes be continued to ensure that management of the services delivery functions and pathways between the health and local community support services are maintained and further developed to include:
    - Acknowledgement of state and local government stature role in Victoria in health and wellbeing planning, as well as planning, funding and development of a wide range of preventative health and communities support services - transport, meeting venues, health promotion and maintenance of social programs, as well as the features of age friendly cities and spaces, all designed to support older people at home, over and above aged care services alone
    - That home based assessment continue to be provided, even at early stages of requiring support services, incorporating HACC assessment services experience and knowledge
    - That Active Service Model and restorative approaches continue and that adequate funding is provided to support this.
    - That further work on costing for the service system be developed, including costs for new administrative structures, increased funding levels to meet

current levels of unmet need and processes for protecting access for these with low care needs.
    - That the service types and range to be included in aged care entitlement, be more clearly outlined as well as the processes for ensuring that services can develop to equitably match those entitlement.

- As our population ages and our aged become more complex at the time they present for care, who will choose for those clients who cannot choose for themselves?
- What will happen when a client needs change and their selected provider does not have capacity to meet the changed need?
- The need for investment in evaluation and research is necessary to monitor and further develop changes across the Aged care system.

DRAFT RECOMMENDATION 6.2

The Australian Government should adopt the following principles to guide the funding of aged care:

- ***accommodation and everyday living expenses should be the responsibility of individuals, with a safety net for those of limited means***
- ***health services should attract a universal subsidy, consistent with Australia's public health care funding policies***
- ***individuals should contribute to the cost of their personal care according to their capacity to pay, but should not be exposed to catastrophic costs of care.***

We support the notion of consistent overarching principles to guide the funding of aged care, as well as a safety net for those community members without capacity to contribute to the potentially high cost of their care. We would welcome additional detail as to how standards and costs will be established, with particular reference to support and protection for vulnerable consumers. There is broad understanding that older Australians currently are vulnerable to entering into financial arrangements to support entry into relatively unregulated sectors such as retirement living. It would be unfortunate if this risk were to extend to Aged Care service sectors, particularly with the inclusion of the primary residence in the assets test, potentially leaving older Australians at risk if there are not very clear and accountable support mechanisms to assist them to make appropriate choices to ensure they can support the cost of their care for the duration of their need for care.

A universal subsidy for care is an attractive notion, provided that this is based on the actual cost of care provision, taking into consideration other proposed changes in terms of labour costs. It remains unclear how this would be implemented in practice given the inevitable variation in care needs and hence cost of care.

The one-price approach could lead to 'cherry picking' approach to clients and those with more complex needs being left behind or 'lost in the system'. If the set price does not reflect the true cost of quality service delivery for a customer base in different geographies with different service requirements, it may have the opposite effect to what is intended. Customers may not be faced with a diverse group of quality providers with interesting and exciting service offerings – but a few providers offering the bare minimum.

DRAFT RECOMMENDATION 6.3

The Australian Government should remove regulatory restrictions on the number of community care packages and residential bed licences over a five-year period. It should also remove the distinction between residential high care and low care places.

DRAFT RECOMMENDATION 6.4

The Australian Government should remove regulatory restrictions on accommodation payments, including the cap on accommodation charges in high care. It should also abolish the charging of retention amounts on accommodation bonds. The Government should require that those entering residential care have the option of paying for their accommodation costs either as:

- ***a periodic payment for the duration of their stay***
- ***a lump sum (an accommodation bond held for the duration of their stay).***
- ***or some combination of the above.***

To ensure that accommodation payments reflect the cost of supply, and are equally attractive to care recipients and providers, the Australian Government should require that providers offer an accommodation bond that is equivalent to, but no more than, the relevant periodic accommodation charge. Accommodation charges and their bond equivalents should be published by the residential aged care facility.

It is apparent that there is a growing gap between supply of places for community support packages and residential care beds. Removing regulatory restriction has strong potential to assist in increasing supply and is supported in principle. However, the inherent risk is that supply will not necessarily increase equitably; there is the very real possibility of creating oversupply in some areas and continued undersupply in others based on the economic viability of creating infrastructure in particular regions.

There is also a valid concern regarding equity of access in regions with a lower socioeconomic demographic, an issue that is unfortunately relatively over-represented in our catchment. It is noted that the draft report clearly states that the notion of equity does not preclude the range of services (including those over and above the prescribed minimum standard) and standard of physical accommodation being variable in response to the cost of care delivery and demand for services in particular locations. This, taken in concert with the potential perverse incentive to create infrastructure in locations with relatively stronger capacity for capital growth, it is possible that choices will be relatively and inevitably much more limited for those who choose to continue to reside in a socially disadvantaged region or alternatively can only afford services provided in less desirable regions.

This applies in particular to those consumers who may not qualify for supported places by a relatively small margin, and would therefore have very little purchasing power without the inherent protections afforded to those who cannot afford to contribute to the cost of their care at all. Arguably, access to residential care beds in socially disadvantaged regions would also be negatively impacted by the relatively smaller pool of consumers with capacity to pay for a high standard of accommodation or available services. We submit that some level of regulation of supply is essential to mitigate these risks.

The current distinction between high and low care places is becoming increasingly blurred with the rise of ageing in place as well as the lack of agreement between aged care assessment instruments and ACFI. Consequently, the recommendation to remove this distinction has value in recognition that the key distinction is currently financial (i.e.: bond versus accommodation charge) rather than driven by care needs. Again, the success of this recommendation relies on the actual cost of care delivery being correctly set and aligned to the revenue that a provider can expect to generate at all levels of care delivery. At present, the cross subsidisation opportunities provided by the capacity to levy bonds in low care does and must assist providers to defray the cost of providing high care services which are not met by current funding arrangements in many cases.

DRAFT RECOMMENDATION 6.5

To ensure sufficient provision of the approved basic standard of residential aged care accommodation for those with limited financial means, providers should continue to be obliged to make available a proportion of their accommodation to supported residents. The Australian Government should set the level of the obligation on a regional basis. This would not apply to existing providers who are currently not obliged to make accommodation available to supported residents.

Over the first five years, the obligation would be tradable between providers in the same region. After five years, the Australian Government should consider the introduction of a competitive tendering arrangement to cover the ongoing provision of accommodation to supported residents.

DRAFT RECOMMENDATION 6.7

The Australian Government's contribution for the approved basic standard of residential care accommodation for supported residents should reflect the average cost of providing such accommodation and should be set:

- ***on the basis of a two-bed room with shared bathroom***
- ***on a regional basis where there are significant regional cost variations.***

We strongly support universal and transparent protections for those consumers who do not have capacity to contribute to the cost of their care. Current arrangements for the accommodation supplement do not recognise the cost of care provided to concessional or supported residents, encouraging providers to provide care to a specific proportion of supported residents and no more to maximise the revenue benefit to the facility. This to some degree impacts equity of access. The recommendation that subsidies for supported residents reflect the cost of care is welcomed, although actual cost and average cost are different constructs. The gap between the two may mean the difference between financial viability and otherwise for some providers.

It is of concern that the proposed level of accommodation upon which this cost may be based represents a diminution of the level of accommodation currently provided within some health network facilities, where there is a preponderance of single rooms with en suite in both low and high care.

Social justice demands that the basic standard of accommodation and care is consistent for both supported residents and those with capacity to pay a co-contribution; it is unlikely that shared accommodation would be the choice of those with capacity to pay hence the inherent potential for a socially inequitable approach to aged care is created. In pragmatic terms, existing facilities required to accept supported residents (where the standard of accommodation is currently single rooms) face a choice between capital expenditure to create shared rooms to be consistent with the rate at which they can expect to be funded, or provide a standard of accommodation that exceeds the standard upon which the funding for that place is based and internally subsidise the gap between cost and revenue. Either option carries significant issues for the provider.

DRAFT RECOMMENDATION 6.10

The Australian Government should set a lifetime stop-loss limit comprising the care recipients' co-contributions towards the cost of government-subsidised aged care services (excluding accommodation and everyday living expenses). Once the limit has been reached, no further care recipients' co-contributions would be required for those services.

With a stop-loss limit in place, the Australian Government should exclude aged care costs from the net medical expenses tax offset.

DRAFT RECOMMENDATION 6.11

The proposed Australian Aged Care Regulation Commission (draft recommendation 12.1) should make transparent recommendations to the Australian Government on the scheduled set of prices for care services and the required level of indexation, the lifetime stop-loss limit, and the price for the approved basic standard of residential care accommodation. The Commission should monitor and report on the cost of care, basic accommodation and the stop-loss limit.

Given the known potential for lifetime care costs to become very high, it is reasonable to propose a limit on the expenditure any one individual can be required to make via co-contributions for care. It would be useful to review and articulate the relationship between disability services and aged care in this context, in light of the reality that a growing number of aged care service recipients are younger people. A lifetime limit has potential to bias providers towards accepting older consumers who are unlikely to reach the limit for co-contribution in their lifetime, limiting access for younger consumers requiring care who already face difficulty in accessing appropriate care, particularly residential options. Further articulation of the proposed funding arrangements for those consumers who reach the stop-loss limit within their lifetime would be useful, as a subsidy reflecting the cost of care at that point may serve to mitigate the incentive outlined above.

It is noted that a comprehensive benchmarking process is proposed for the purpose of establishing the true cost of care. It is noted that industry input is anticipated as forming part of the planning for this benchmarking process. This is a welcome inclusion given that an accurate understanding of the true cost of care is fundamental to the success of any reform of the aged care service system. Any benchmarking exercise must take into consideration differing staffing profiles between public and private sector residential care facilities, regional differences, and inherent differences in terms of the market being served (e.g. aged person's mental health facilities present different care and cost challenges than generic facilities).

DRAFT RECOMMENDATION 8.1

The Australian Government should establish an Australian Seniors Gateway Agency to provide information, assessment, care coordination and carer referral services. The Gateway would deliver services via a regional structure.

- ***A platform within the Gateway would provide information on healthy ageing, social inclusion and participation, age-friendly accommodation, and also information on the availability, quality and costs of care services from approved providers, and how to access those services.***
- ***Assessments of the needs of older people would be undertaken for their potential entitlement to approved care services, with the level of assessment resourcing varying according to anticipated need.***

- ***An aged care needs assessment instrument would be used to conduct assessments and an individual's entitlement to basic support, personal care and specialised care, and carer support. Assessments of financial capacity to make care co-contributions toward the cost of the services would also be arranged.***
- ***Initial care coordination services would be provided, where appropriate, as part of the Gateway. If required, case management would be provided in the community or in residential aged care facilities by an individual's provider of choice.***

The Gateway would be established as a separate agency under the Financial Management and Accountability Act 1997.

The current aged care service system is widely acknowledged to be complex and difficult to navigate, with multiple arbitrary divisions based on funding streams. In this context, a central agency charged with assisting older Australians and their carers to navigate the system and access information has potential to be a very valuable addition. The current lack of national consistency in Aged Care assessments is problematic. In addition, the ACFI is not referenced by or taken into account within the current assessment framework, giving rise to anomalous outcomes for providers who may have a low care assessment for a resident, who is then assessed as high care via ACFI.

Considerable work has already occurred in our catchment to address these and other issues within the systemic constraints that undoubtedly exist. Given this, and the large number of aged care services that exist both within and external to health services, it would be essential for those providers to contribute to configuration of the proposed Gateway.

Whilst some aged care assessment services approach aged care assessment as a needs based process; this is by no means universally the case, with many assessments being based around eligibility for services. Any alternative assessment mechanism would, in our view, benefit from being needs focussed, and the draft report seems to indicate that this is what is intended. This to a large degree relies on streamlined funding mechanisms and eligibility criteria, such that a package of services can be tailored to individual requirements for care irrespective of funding streams.

It is noted that there is national evidence discussed within the report with respect to long, and in many cases excessive, waiting times for assessment services. We submit that this is not universally the Victorian experience where a relatively robust sub-acute network supports Aged Care and waiting times are significantly less across the board than those quoted. In fact, Peninsula Health ACAS consistently meets the Department of Health and Ageing KPIs with respect to waiting time for assessment.

It is apparent that the level of knowledge and skill required to manage an Aged Care referral, intake, and assessment process is extensive. What initially appears to be a straightforward referral for a specific need can rapidly evolve into a much more complex process, requiring a broad range of responses, including direct admission to an inpatient service. In addition, the assessor not only requires a high level of clinical decision making skill, but a robust knowledge of the financial implications of any care

plan arising from the assessment given this is often the key concern of consumers. Complicating the issue still further is that 25% of all aged care assessments in the Peninsula ACAS catchment occur while the individual is still in an acute hospital. This raises some questions about the efficacy and responsiveness of the proposed two staged assessment process.

At a pragmatic level, attraction and retention of suitably skilled and qualified staff for the current assessment model is an ongoing issue for most if not all providers. This needs to be considered in planning for any alternative model that is likely to be if anything more complex given the intent is to assess for need across the entire service system. The need for highly skilled staff within that model, inclusive of robust medical and other specialist assessment availability to support good assessment, and the ongoing training requirements for those staff are significant and must be considered as an integral part of the Gateway proposal.

In essence, the Gateway proposal has much in common with many of the discussions occurring within health services and local regions with respect to single points of access and "no wrong door" approaches. Any regionally based process will require significant input from providers from all sectors of the aged care service system to be successfully implemented. The key point of emphasis in the Gateway proposal that extends on current discussion relates to information and education provision to consumers; this issue appears unlikely to be resolved at a regional level and requires a national approach to achieve lasting change.

It would be useful to have additional clarity with regard to the relationship between the proposed Gateway and current Medicare Local proposals, as well as existing co-ordinated care networks, which in many instances work very well.

DRAFT RECOMMENDATION 8.2

The Australian Government should replace the current system of discrete care packages with a single integrated, and flexible, system of care provision. This would deliver care services currently provided under Home and Community Care, Commonwealth funded care packages and the care component of residential aged care services.

The Australian Government should approve a range of care services to individuals on an entitlement basis, based on assessed need. Individuals should be given an option to choose an approved provider or providers.

The Australian Government would set the scheduled price of each service.

To support these revised arrangements, Australian governments should fund an expanded system of aged care consumer advocacy services.

One of the key frustrations of service providers and consumers alike is the difficulty in putting together a package of care that meets consumer needs. The current service systems funding and eligibility criteria is without question complex to navigate, given the existing siloed funding arrangements. The notion of a more flexible approach to service delivery has significant merit and has potential to make an enormous difference to the capacity to effectively support consumers. To some extent this does already occur within some integrtaed health services who are able to more easily tailor packages of care than discrete agencies can.

The strong emphasis on consumer choice within the draft report clearly has merit – no-one would deny that consumers and their advocates should have an absolute right to choice with regard to their care, whatever their age. It does give rise to some questions that will need to be satisfactorily addressed in order to ensure that the choice aspect of the proposed reforms translates into practice effectively.

Vulnerable clients, such as those without effective family / advocacy support, or marginalised or special needs groups (e.g. mental health consumers, cognitively impaired clients) are arguably ill equipped to effectively make the kinds of care choices that are inherent in the proposed model. These vulnerable consumers need to be afforded adequate support and protection within the aged care system to ensure that they make choices to the extent of their capacity to do so, while receiving the care they need. In many cases, advocacy alone will not meet the needs of these clients who may lack insight into their care needs and therefore have great difficulty in directing their own care.

The second question that needs to be addressed is the fundamental issue of what consumers will be choosing between. Potential issues in the location and configuration of residential aged care facilities has been discussed elsewhere in this submission, and has implications for consumer choice. The proposed removal of current block funding arrangements for HACC services also has significant potential risks in terms of service availability within and across regions. Provision of support services such as home based personal care assistance, meals on wheels, home maintenance and modification and home help require a certain level of infrastructure irrespective of the number of clients serviced. Economies of scale dictate that these services are more economically viable at a higher level of demand. It is a concern that some current providers may limit or discontinue the services they currently provide without being guaranteed a base level of funding to ensure ongoing economic viability of infrastructure maintenance. There is a risk that some regions will, over time, have limited access to elements of the current support services available, particularly those provided by local government. This is of significant concern given the strong reliance on these services to support timely and safe discharges for consumers within acute and sub-acute bed based services.

RAFT RECOMMENDATION 8.3

The Australian Government should ensure that, through the Independent Hospital Pricing Authority, residential and community care providers receive appropriate case mix payments for delivering palliative and end-of-life care.

Palliative and end-of-life care services are undoubtedly labour intensive and costly aspects of service provision. To treat these as a seamless part of the care journey in terms of care is appropriate, but it is appropriate that funding streams recognise the additional resources required to ensure this occurs. As part of the implementation strategy, we submit that it would be useful to have some robust decision making support for providers to ensure that this phase of the care journey is well recognised and appropriately managed, inclusive of the capacity to recruit specialist consultancy as required to ensure care needs can be effectively managed at aged care service provider level without recourse to transfer to a specialist service. Specifically,

- the APRAC guidelines set are well designed to assist staff in residential facilities to provide a palliative approach to care, however there have not been adequate resources allocated to individual facilities to have the amount of training necessary to carry them out well
- in some circumstances residents have complex needs and specialist palliative care is required, community palliative care services are well placed to provide this in a consultancy capacity however there are not adequate Div 1 registered nurses available in the facilities to carry out the care planned for complex issues, this is a resourcing issue
- end of life discussions with residents and families require staff to have special training to do this well, community palliative care services are well placed to do this but additional resources would be required to make it feasible.

DRAFT RECOMMENDATION 8.4

The Australian, state and territory governments should only continue to directly block fund programs where there is a demonstrated need to do so based on a detailed consideration of scale economies, generic service need and community involvement.

With reference to the response to draft recommendation 8.1, some level of base funding for programs where there is a risk of diminution of services where this does not occur would be welcome. The mechanism where this would occur needs to be clearly defined.

DRAFT RECOMMENDATION 9.1

The proposed Australian Seniors Gateway Agency (draft recommendation 8.1) should cater for diversity by:

- ***ensuring all older people have access to information and assessment services***
- ***providing interpreter services to convey information to older people and their carers, to enable them to make informed choices***
- ***ensuring that diagnostic tools are culturally appropriate for the assessment of care needs.***

DRAFT RECOMMENDATION 9.2

The proposed Australian Aged Care Regulation Commission (draft recommendation 12.1), in transparently recommending the scheduled set of prices for care services, should take into account costs associated with catering for diversity, including:

- ***providing ongoing and comprehensive interpreter services (either within facilities or through telephone translators) for clients from non-English speaking backgrounds***
- ***ensuring staff can undertake professional development activities which increase their cultural awareness.***

DRAFT RECOMMENDATION 9.3

The Australian Government should ensure that remote and Indigenous aged care services be actively supported before remedial intervention is required. This support would include but not be limited to:

- ***the construction, replacement and maintenance of appropriate building stock***
- ***meeting quality standards for service delivery***
- ***clinical and managerial staff development, including locally delivered programs and enhanced use of technology assisted training***
- ***funding models that are aimed at ensuring service sustainability and that recognise the need for the building of local capacity to staff and manage such services over time.***

Special needs groups are clearly defined by the current draft recommendations. There is no question that these groups require specific management, and building capacity within provider groups adds value. However, the nature of diversity appears to have been narrowly defined. We submit that there are other groups requiring consideration in addition to those currently outlined. The body of the draft report addresses the issue of consumers with dementing illnesses, with or without associated behavioural issues; however, the special needs of this group have not attracted specific attention with respect to recommendations. This appears to be a significant gap given the anticipated growth in this cohort in the foreseeable future. In addition, the particular needs of consumers with mental health presentations require consideration. Currently, this group is poorly served by the service system. The ACFI, with its weighting towards those consumers with personal care needs, does not adequately recognise the significant care needs of consumers whose primary care needs relate to mental health disorders who may be functionally independent when in a structured environment but fail in an environment without skilled staff and structured support. The behavioural parameter of ACFI is both low weighted in revenue terms and narrowly defined in terms of the issues recognised. The care needs of this sector of the population as well as the skill set of staff required to provide the care they need, must be factored in to the service system reform agenda if it is to truly meet community need into the future.

DRAFT RECOMMENDATION 11.2

The proposed Australian Aged Care Regulation Commission (draft recommendation 12.1), when assessing and recommending scheduled care prices, should take into account the need to pay competitive wages to nursing and other care staff delivering aged care services.

DRAFT RECOMMENDATION 11.3

The Australian Government should promote skill development through an expansion of courses to provide aged care workers at all levels with the skills they need, including:

- ***advanced clinical courses for nurses to become nurse practitioners***
- ***management courses for health and care workers entering management roles.***

DRAFT RECOMMENDATION 11.4

The Australian Government, in conjunction with universities and providers, should fund the expansion of 'teaching aged care services' to promote the sector among medical, nursing and allied health students.

The difficulty in attracting suitably qualified and skilled staff into aged care is an ongoing one. The draft report addresses the issue of nursing staff with a degree of specificity. It would be useful to consider the entirety of the aged care workforce, both from the perspective of training standards and remuneration, and from the point of view of required skill mix. The complexity and frailty of those entering the aged care service system, particularly at the residential care end of the spectrum, is increasing. With the growing emphasis on providing as much care as possible within the facility, the likelihood is that the expectation for residential aged care staff to recognise and manage an increasing complexity.

The skill mix required to adequately assess for and recognise changing care needs requires specific articulation. It is also arguable that in this context, competitive wages will not be sufficient to attract and retain appropriately skilled staff who may expect parity with their acute colleagues.

DRAFT RECOMMENDATION 12.4

The Australian Government should provide a broad range of enforcement tools to the Australian Aged Care Regulation Commission to ensure that penalties are proportional to the severity of non-compliance.

Local service providers regularly meet and in some cases exceed current regulatory standards. We welcome transparent and accountable regulatory frameworks for aged care service providers in order to protect this vulnerable group of consumers. However, should enforcement mechanisms become more stringent, it may be useful to prescribe obligations for the regulatory agency to make information available to providers in a systematic way, particularly where patterns of non-compliance are identified across the sector, to allow providers to address any gaps proactively rather than be penalised for known systemic gaps. A key example of where this could have been useful was the recent identification of a gap across large parts of the residential aged care industry in relation to statutory declarations.

Despite this being identified in a number of surveys and unannounced support visits, suggesting a knowledge gap across the sector, there was no mechanism by which all facilities could be notified to review their compliance with this standard, hence non-compliances continued to be identified after a pattern had begun to emerge.

DRAFT RECOMMENDATION 12.9

The Council of Australian Governments should identify and remove, as far as possible, onerous duplicate and inconsistent regulations, including in relation to infectious disease outbreaks, occupational health and safety, food safety, nursing scope of practice, power of attorney, guardianship and advanced care plans.

This is strongly supported.

Conclusion

The Productivity Commission draft report "Caring for Older Australians" outlines significant proposed reforms to the gamut of services considered to form part of the aged care service system. For these to be effective, considerable work is required to clarify the practical implications of many of this for both consumers and providers. The theoretical constructs included in the recommendations are by and large well supported; however, there is significant work required to answer the pragmatic implementation questions raised as a result. The current system undoubtedly requires reform.

Our member agencies are willing to participate actively in the ongoing debate and practical work of determining how best to move forward from here. Providers and consumers must be integrally involved in the process to ensure that the risk of unintended consequences is minimised and the industry has opportunity to ensure that the good work currently being done is not lost.