CARING FOR OLDER AUSTRALIANS

KinCare

RESPONSE TO THE PRODUCTIVITY COMMISSION'S DRAFT REPORT, 21 JANUARY 2011

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Introduction

KinCare welcomes the draft report of the Productivity Commission. If adopted and implemented as a whole, the proposed model would significantly improve quality, availability and choice in Australian Aged Care Services.

Many of the proposed reforms would result in significant improvements in access to services and the quality of services for older people and their carers. Some proposals, such as improved pay and conditions for aged care staff are necessarily more costly, but will create a more sustainable aged care system. Other proposals, such as people being able to access services whenever they need them will increase the willingness of consumers to try restorative approaches knowing they can move in and out of services when they need them. This is likely to result in cost savings. Improved financing options, and means testing of some services, strikes a good balance between the quality of service our community desires and the affordability of publicly funded services.

While we are generally supportive of the nature of the proposed changes, there are some areas that warrant further consideration. Most importantly, the report acknowledges the inter-connectedness of the aged care and health systems but does not explore the possibilities of greater integration of these systems. We believe there are tremendous opportunities for “aged care” services to play a much stronger role in the delivery of “health” services – thus avoiding unnecessary hospital admissions and facilitating earlier and smoother discharges after hospitalisation. This could be achieved by introducing a variety of “supplements” as proposed in the report. However, given the range and diversity of health needs, other funding options that match those otherwise available in the health sector should also be considered. Consumers should be able to choose to receive health services in a hospital or in their homes.

Most other areas addressed in our response relate to clarification or further consideration around the edges of the main reform pillars proposed. For example, the structure of the Gateway proposed is an excellent response to immediate needs, but can be further restructured as other reforms are implemented. Similarly many aspects of the pricing arrangements proposed are likely to work well, but some require clarification or further consideration.

As reforms to the system are planned and implemented, it is important that the strengths of the current system are retained. One of the best elements of the current system is packaged care. Packaged care places give a significant amount of flexibility to consumers and providers when used well. It is this flexibility that often enables outstanding outcomes to be achieved in community care. It is important to ensure that flexibility to tailor services to individual consumers remains a priority as reforms to the system are implemented.

About KinCare

KinCare has specialised in providing community care for older people and their carers for almost 20 years. We operate in 4 states and territories. Our 700 staff deliver almost 500,000 hours per year of care to over 4500 people. We strive to provide "The Kind of Care We Want for Our Loved Ones…."

KinCare developed from a heath background and is very focused on helping improve the health and quality of life of consumers. We see aged care as an integral part of Australia's health system – providing daily support to older people who experience a disproportionate burden of disease and hospitalisation.

Because we specialise in community care, our response to the Productivity Commission report focuses exclusively on issues directly or indirectly impacting upon Community Care.

Integration with Health Services

Older people experience much higher rates of health conditions than the general population and as a result also have high rates of hospitalisation. An increasing number of health conditions could be treated or managed in the community, entirely avoiding costly hospitalisation. For many other conditions, community care incorporating monitoring by the consumer's doctor and specialist, and support from a Registered Nurse can shorten the length of hospital stays. Equipment developed for telemedicine is now suitable for remote monitoring of consumers with some conditions where a Registered Nurse provides appropriate support.

We believe it would be valuable to place a greater emphasis on further integration between health and aged care services. This would require funding mechanisms to manage a greater variety of health issues in the community instead of a hospital environment. There is a boundary issue here as aged care packages can already provide some health services, but there is presently no clear definition of what the health support expectations are within packages and there are many conditions that could be managed in the community more cost effectively than in a hospital that cannot be reasonably managed within existing aged care packages.

While medical care for older people provided in the community would be more expensive than many current aged care programs, it would relieve pressure from the hospital system, be more cost-effective than a hospital environment, and reduce the pressure for very costly new hospital infrastructure development.

The report suggests a mechanism for funding supplements to normal care packages. A greater variety of these supplements directed to health needs could help achieve this. However, we would like to see further work across the spectrum of health conditions affecting older people to identify the range of conditions that could be managed appropriately in the community. Community based care should be made a realistic alternative to hospitalisation for those conditions. Given this encroaches on services currently managed within the health system; there are different implications for the funding mechanism for people with or without private health insurance.

This may fall outside the scope of the current review of the Aged Care system, but it is increasingly difficult to draw a line between health services and aged care services. If this is not explored in the current review it would be helpful to identify this as an area for future work.

Scope of Services Under New Framework

The commission refers principally to Packaged Care, HACC and Residential Aged Care when discussing the detail of programs and fees. The feasibility of bringing Transitional Care under the same framework should also be examined[1]. Transitional care assists people for up to 12 weeks with their transition from a hospital to residential aged care, community care, or independent living. It is presently funded from the Commonwealth via State and Territory Governments. There would be significant benefits in improving access and choice in transitional care.

With COAG agreements for greater cooperation and Commonwealth involvement in health services there are opportunities to improve integration between health and aged care services. Transitional care, other early discharge programs, admission avoidance programs, home-based palliative care programs, sub-acute care, and community nursing services, should all be considered in a comprehensive review of aged care services. It is increasingly difficult to draw a line between aged care and the broader health system, particularly given the increasing need for integration between them.

There are many examples of the blurring of these lines. Area Health Services may be providing nursing care in a consumer's home post-hospitalisation that exceeds what can reasonably be provided in a consumer's EACH or EACH-D service. The EACH or EACH-D service plan may focus principally on other services, for example services needed to manage a consumer's dementia in their home. Providers and health services generally manage these issues constructively, but would benefit from increased clarity of roles and expectations.

Consumer Choice

REFERENCE:

INTRODUCTION: PAGE: XXV-XXXI

CHAPTER 8: CARE AND SUPPORT: PAGE: 244-256

The Productivity Commission's draft report indicates that the aged care system should aim to be: "consumer-directed, allowing older Australians to have choice and control over their lives" (XXV).

The terminology "Consumer Directed Care" is used to describe a variety of approaches to services and a specific program funded by the Department of Health and Ageing. Current Commonwealth initiatives are one option for increasing choice, but would only suit a small percentage of the population. Real consumer directed care will only occur when consumers can genuinely choose and change their provider, service model and service features.

To get the best outcomes for consumers it is important that they can communicate their goals and expectations directly with providers and that providers have sufficient flexibility to be able to respond to those goals. The Gateway agency should determine only the level of care approved for a consumer. The consumer and service provider require flexibility to then manage how those funds are utilised within package guidelines.

[1] Transitional care is acknowledged in Figure 1: Current modes of aged care in the aged care system, but is not widely discussed elsewhere in the report.

Increasing consumer choice will stimulate innovation as providers renew their focus on developing and delivering the services consumers want. A variety of models are likely to emerge that appeal to the preferences of different consumer groups. Increasing choice is much more useful than mandating particular service approaches as the market will then respond to consumer demand.

The model proposed by the Productivity Commission of uncapping places and removing the distinctions between care types and levels would significantly improve choice and solve many of the most critical issues affecting older people and their carers. Increased consumer choice has direct benefits for consumers and would also help improve quality and consumer focus across the industry. Consumers would choose providers that were responsive to their needs and preferences.

Real consumer choice would also contribute to achieving several of the other key aims outlined in the report including (XXV):

- Promoting independence and wellness of older Australians: Increased choice will increase independence; Uncapping of places will make wellness models more attractive to consumers.
- Ensuring all older Australians needing care and support have access to person-centred services that can change as their needs change: Uncapping places will ensure all older Australians can access support when they need it; Increased choice will ensure services are person-centred and respond to consumer preferences.
- Ensuring older Australians receiving support are treated with dignity and respect: With consumers able to choose their provider, the number of poor quality providers will diminish.
- Be easy to navigate: With real competition and the removal of boundaries that make communication of services difficult and expensive, providers will communicate clearly with consumers and help them access the services they need.

When consumers can easily enter and leave services as their needs change, enablement models will become much more attractive.

Gateway Agency

REFERENCE:

CHAPTER 8: CARE AND SUPPORT: PAGE: 226-243

Diversity and Choice

The proposed Gateway Agency would have several benefits in making the aged care system simpler to navigate and we support its key principles. However, there are also potential drawbacks with this approach. Much of the Productivity Commission draft report focuses on improving consumer choice, uncapping places and taking advantage of the market to ensure providers are responsive to consumer preferences and maintain high quality services. Introducing a single gateway agency may conflict with this objective.

Staging of the Gateway

It is very important to create a simplified access system where consumers can easily identify the services they need and obtain relevant referrals. Consumers should be able to contact the gateway in a variety of ways including face-to-face, by telephone and online. The gateway system should be developed in two stages.

Stage 1:

Setting: In the current environment, supply is constrained and providers are only able to deliver service in locations in which they have won tenders or packages. For example, a provider may be able to deliver domestic assistance in Hornsby but not Baulkham Hills and Personal Care in Baulkham Hills but not Hornsby (which can be as close as different sides of a street). This makes communication extremely difficult and expensive for providers, and makes navigating the system incredibly complex for consumers.

Solution: Implement a single gateway agency, as proposed, that creates a focal point for people seeking aged care services, provides assessment and helps people identify and access the service they need.

Stage 2:

Setting: The new environment proposed by the Productivity Commission where supply is not constrained so service providers can make rational decisions about where they deliver each type of service and cost-effectively communicate their offering to consumers.

Solution: A single gateway agency is no longer needed. Providers can easily and cost-effectively communicate with consumers and have strong incentives to so do. In stage 2 a competitive environment characterised by a variety of models and consumer choice for gateway services is likely to get better results.

Limitations of a Single Gateway

A single gateway limits choice for consumers. It is not subject to competition and would not have the same incentive to be highly responsive to consumer needs and preferences. The lack of choice could also impact on providers. The gateway agency would become a powerful influencer of consumer choice and may limit innovation and competition in the market.

If a single Gateway agency is created it will be important for it to have strong, transparent, consumer focused KPIs, and transparent referral processes to maintain high levels of accountability.

Regional Variations

We deliver services across a large number of regions across four states and territories. Needs and preferences of consumers vary widely between regions. Current assessment processes for packaged care are also variable – they are very effective in some regions, and at times frustrating for consumers in others. Consumers are forced to accept whatever is in place in their region. A single Gateway is unlikely to be as responsive to regional variation in need as a more dynamic market.

Transitional Arrangements

We believe it is important to consider alternatives that would create choice at the Gateway as well as in service delivery. We have proposed a single Gateway agency to facilitate service access as a transitional measure. Despite the limitations of a single gateway it would bring significant improvements for consumers in the present environment. However, when places are uncapped and there is genuine choice for consumers this will no longer be required.

Stage 1: Single Transitional Gateway

As a transitional measure, while places are capped, it would be helpful for a Gateway to act as a high profile point that can help consumers navigate the service system and access the services they need. The gateway should maintain a record of availability and manage waitlists for each region to help match demand with supply.

Stage 2: Competitive Environment for the Gateway

When places are no longer capped and services are actively able to promote their services to consumers some functions of the gateway agency will no longer be needed. A competitive environment could be created for the functions of the transitional gateway agency that are still needed. This will include, in particular, the assessment function. Organisations should be able to be accredited as gateway agencies and to tailor services to niche areas of consumer demand, regional differences, etc.

This model has been implemented successfully in other areas of health and social services. In employment services, Centrelink acts as a default gateway to job services, but unemployed people can also approach other organisations in the Job Network for assistance. Some of these specialise in particular niches and create diversity and choice. In medical services, GPs act as a gateway to specialist services. There are a diversity of GPs available to provide this service and they offer a variety of specialisations and approaches at a variety of price points. In both these markets consumers are generally well served by the diversity.

Whatever model is used for developing service gateways, gateway agencies would need to be accredited for their role in assessment and it would be important to develop strong data management and sharing protocols to make it easy for consumers to change providers if they choose. These same protocols could be used for passing data from the Gateway to the consumer's selected service provider as proposed by the Productivity Commission.

Review of Gateway Decisions

It is important that there is scope to review decisions made by the service gateway/s. People's lives are complex and variable. Phone and hospital-based assessments may not be sufficient to fully understand the extent of a consumer's need. Consumers do not always disclose all relevant information at initial assessments. As a result, there will inevitably be discrepancies between assessment outcomes and what providers observe on commencement of services. Reviews in

these circumstances need to be conducted expeditiously to maintain the confidence of consumers and providers in the assessment process and agency.

Changing Care Needs

The Draft Report suggests the Gateway Agency would determine the level of support a consumer was entitled to and have more options than the current very broad categories of CACP, EACH and EACH-D. We support this approach. However, it is important to recognise that one of the strengths of the current community care system is its flexibility. In packaged care services, service providers are able to take a portfolio approach. This recognises that at any given time some consumers will have higher needs and others lower needs. Providers can average this across a whole program. This enables providers to respond very quickly to changes in consumer need by offering additional services so long as the overall mix of consumer need can be managed within the service budget. Similarly in HACC services, because providers are trusted with assessing the level of need of their consumers, changing consumer needs can be accommodated very quickly. This flexibility enables consumers, family members and their providers to respond quickly to changing needs and circumstances.

If the Gateway Agency becomes much more specific about the level of service approved for a given consumer there are important implications:

- Once a consumer has commenced service, the provider will still need some flexibility to change the levels of service without reverting each time to a gateway agency. Very frail consumers and consumers on restorative or enablement pathways may have frequent upward and downward changes in their level of need. If approved levels of service are very narrow, and it is difficult to move consumers between them, it is likely to impose a significant administrative cost and discourage providers from innovating. If providers have been accredited to provide the services they should have a responsibility for making such changes responsibly with a simple but reviewable process of documenting the changes.

- It is important that Gateway Agencies are not overly prescriptive or process-oriented in their approvals. Their assessment should focus on the approved level of need, not the mix of services finally delivered. Providers and consumers need flexibility to look at the totality of their services, supports and goals and to make decisions about the best use of the available resources to achieve their goals. Approved providers should aim to achieve particular outcomes. They should not simply focus on outputs measured in hours of given service types as tends to occur in programs using a very prescriptive model. There should be wide discretion for consumers and providers within program guidelines to maximise opportunities for consumers to set their goals and direct services.

Further consultation with providers will be essential in planning the detail of these arrangements. Careful planning will ensure the strengths of the current system are retained in the reform process.

Deregulation

REFERENCE:

CHAPTER 12: REGULATION – THE FUTURE DIRECTION: PAGE 381-428

In general we support proposals to reduce and better target regulation.

As caps are removed and consumer choice increases, a dynamic market would encourage providers to strive to respond to consumer demand, introduce innovative services and offer good value for money. Regulation should target areas the market does not address well. For example:

- Minimum standards should be regulated and enforced.
- Providers should be accredited for the types of service they wish to provide to guarantee certain service standards.
- Points of market failure that may emerge in some regional areas or special needs groups may need to be addressed through a combination of incentives and regulation.

Base Support

We support increasing consumer choice and a diverse and competitive market. However, any provider of base or specialised care that wishes to receive a government subsidy should be accredited and subject to regulation.

To achieve the best outcomes for consumers and efficient outcomes for the community, based aged care services such as domestic assistance should be viewed as an early intervention health service, not simply as a cleaning service. Aged care staff, including those providing domestic assistance, need to be appropriately screened, trained in interacting positively with older people, trained to understand the importance of restorative interventions, and trained to identify and report changes in the consumer's needs, preferences, environment or supports. An aged care service offers significant value beyond just cleaning, even when providing base levels of care.

The definition of relevant minimum standards will be important. At a basic level there should be a focus on safety and security, qualified staff, links with the broader health and community services system, complaints management processes, and the financial viability of the organisation. Providers should also be expected to have strong systems to manage their personnel, strong OH&S systems and the ability to promote healthy lifestyles and identify opportunities for early intervention.

Personal Care and Specialised Care

Personal and specialised care require higher standards and levels of regulation than base support due to the potential invasiveness of these services. Complex services will often involve nursing and allied health interventions. Organisations providing complex care need appropriate clinical governance and procedures.

Regulation for complex care should include the foundation used for basic care, plus a layer covering clinical issues, research and evaluation, and procedures to support very vulnerable consumers.

Management of Complaints

REFERENCE:

CHAPTER 5: ASSESSMENT OF THE CURRENT AGED CARE SYSTEM: PAGE: 112-125

The Department of Health and Ageing is also presently conducting a review of Aged Care complaints processes. We generally support the model proposed by the Productivity Commission and the department to increase the range of mechanisms available to deal with complaints. We also support the proposal from the Productivity Commission to move complaints management to an external agency.

The model of increased choice proposed by the Productivity Commission will reduce the current challenges with complaints as providers will be forced to be more responsive to consumers, and consumers will know that they have the option of changing provider at any time. Exercising this right will always be simpler in community care than residential care, so some additional protections may continue to be needed in residential care.

It will be important to develop strong systems to protect consumer rights particularly for people who are very vulnerable. These protections should include: mandatory information about consumer rights that all services provide to consumers; a network of advocacy services that consumers can elect to represent them; and a requirement to have a strong complaints process to achieve accreditation. Providers should be required to work with any family member, carer or advocate the consumer asks to represent them.

With these protections in place, the Department of Health and Ageing or external complaints body should always strongly encourage consumers and providers to resolve complaints directly with each other. Direct communication is the foundation of strong relationships. Providers want good outcomes for consumers and a strong partnership with them. Direct external involvement in complaints management should only be required where:

- there may be imminent risk of harm to consumers or staff,
- there may have been a gross breach of the standards required for the provider's accreditation, or
- the consumer and provider have attempted to resolve the issue and been unable to, and it is not practical for the consumer to choose an alternative service provider.

It is important to recognise that providers generally want to achieve an outcome that is satisfactory to consumers, but it is not always feasible to give consumers the exact outcome that they want. In many circumstances providers need to exercise judgement. If providers are accredited to appropriate standards they should be respected as professional organisations and their judgements respected unless there is evidence of very poor judgement, malpractice or a clear breach of relevant standards.

Building Block Approach

REFERENCE:

INTRODUCTION: PAGE XXVIII-XXIX

CHAPTER 8: CARE AND SUPPORT: PAGE 254-257

The general structure of the building block approach is helpful. However, it is also important to recognise that consumer needs do not always progress in a simple linear manner. It is important that once services commence, providers have reasonable flexibility to respond to changes in consumer needs that require increases or decreases in services.

Pricing and Financing

REFERENCE

CHAPTER 6: PAYING FOR AGED CARE: PAGE 133-200

CHAPTER 7: OPTIONS FOR BROADENING THE FUNDING BASE: PAGE 201-224

The pricing and financing options proposed by the Productivity Commission are likely to be more effective than the current system. Payments and indexation would better reflect the cost of services and thereby create a more viable industry that can invest and respond to the increased demands expected over the next 20 years. The financing options proposed will better target government subsidies and ensure the cost to government is sustainable. Improved financing arrangements for the industry will result in innovation in services and increased choice.

In principle, we support means testing for some service types, higher co-payments, the stop-loss mechanism and a government supported equity release scheme. However, there is a need for public debate and more detail around some of these mechanisms.

Consumer Co-Contributions

It is unclear from the draft document whether it is proposed that regulation will apply to the whole fee including consumer contributions, or only the government subsidised portion of the fee.

Only the government-subsidised portion of service fees should be regulated. Providers need flexibility to innovate in the features and experience offered to consumers. Some of these features will be more costly than others. Flexibility in fees will increase the variety of service models and features offered and thereby increase consumer choice. Incentives or regulatory interventions may be required where a dynamic market does not emerge. In areas where there is a dynamic market services will emerge at a variety of price points that are supported by consumers.

If the fee for government-subsidised services is completely capped (subsidy and co-contribution), providers will offer consumers value-added services that they request outside of their government

funded care package. This complicates administration and takes a portion of the consumer's services outside of the regulated system. Many consumers would prefer all their services, including value-added services that go beyond their assessed level of need, were delivered within the regulated system. Achieving this will require greater price flexibility.

If consumer fees are not capped the minimum asset floor for the equity release scheme and maximum lifetime care costs would need reconsideration or they would impose inappropriate costs on the community for premium services the consumer had elected to receive.

The commission has proposed an upper lifetime limit for co-contributions. It is unclear whether this is a straight dollar limit or a percentage of assets. For example, wealthy older people should not benefit from a dollar cap at the same level as the disadvantaged.

The commission has proposed an indicative range for co-contributions of 5-25% of service costs. An assumption was applied that for those on an income of less than $20,900 and assets below $313,250, this would be no more than 5%. Services that are provided infrequently or in low volumes sometimes presently charge co-contributions that are higher than this. These are affordable because the services are short-term or have a lower intensity. This is most common in some domestic assistance, social support and respite models.

Fees that Reflect Underlying Cost

The commission has proposed introducing an independent pricing authority that sets prices based on the underlying cost of service. It is important in calculating that cost that it is set at a level that reflects the cost of capital and allows providers to achieve a sustainable return on capital. Achieving an adequate return enables providers to invest in research and development, innovation, the consumer experience, service features, training of staff, services for special needs groups, efficient management and IT systems, productivity gains, improved communication and the application of current and emerging technologies.

Without an adequate return on capital, providers turn to government for capital and non-recurrent funding for service development. If fees are set appropriately, the need for capital and non-recurrent grants will be reduced and a much wider range of innovation will emerge organically as providers seek to invest in services that appeal to consumers and achieve efficiency gains.

Base Subsidy and Supplements

The commission suggests that in higher need services, funding should be applied as a base subsidy and supplements. It proposes that supplements are paid for only at their marginal cost. For a one-off service it can be argued that supplements do not impose significant additional costs and should be paid for at marginal cost. However, reality is quite different. All costs are ultimately variable and should take into account overhead and the cost of capital. It is also important to note that costs associated with more complex care go significantly beyond the direct costs. Indirect costs include: more highly skilled staff such as clinical nurse consultants, nurse practitioners and allied health specialists, additional travel and management costs, and other support costs. It is just as important that providers have the financial resources to plan for and invest in very complex "supplemental" services, as in other services.

As the population ages and a greater percentage of consumers require complex care, a marginal-cost funding model for all supplements is unlikely to be sustainable.

Block Funding

REFERENCE:

CHAPTER 8: CARE AND SUPPORT: PAGE 261

The Productivity Commission proposed block funding in areas of unmet need and a variety of other circumstances. Examples of the need for block funding include meals services, community transport programs, innovative service pilots, some rural and remote areas, some Aboriginal programs, and programs for wellness, social inclusion and groups.

If block funding is available, it will be important that there are transparent guidelines outlining the circumstances for its use and a competitive tender or EOI process.

How widely block funding is used needs careful consideration. In general, with increased consumer choice, if providers are offering an innovative model or new wellness, social inclusion or group programs that are attractive to consumers there should be no need to block fund them. Consumers can simply choose the new service model and the onus is on providers to ensure their models can attract a viable number of consumers. However, it would helpful to have a block funding option for innovative models that require significant upfront investment or require significant research components.

In many circumstances points of market failure will be adequately addressed by decisions of the pricing authority. Where these decisions or other incentives are not able to stimulate a dynamic market, block funding should be seen as the final option to ensure the unmet need is addressed. Block funding should not be used routinely for special needs groups in areas that have a flourishing market as generally the market will respond to the demand if the pricing authority sets the pricing appropriately.

Where block funding is used, the ongoing need for it should be regularly evaluated with the goal of ultimately developing a market and removing block funding. Without this, an important incentive for innovation, and many of the benefits of the market driven approach for quality and choice are removed.

Special Needs

REFERENCE:

CHAPTER 9: CATERING FOR DIVERSITY: PAGE 269-300

The commission identifies certain specific special needs that may require additional funding. It is important to recognise that additional service related costs are incurred with a variety of groups of people with special needs within and outside the “official” special needs categories. For example some consumers with chronic illness or mental health issues may be as expensive to provide care for as someone from a rural or remote area, from an Aboriginal and Torres Strait Islander background, from a CALD background or living with dementia.

The need for interpreter services is referred to as an additional cost for the Gateway Agency and residential aged care, it is an equally important cost consideration in community care.

Veterans are presently treated uniquely in the aged care system having access to both the normal aged care system and a separate system for veterans. They also have a separate assessment system. The veteran's stream offers some services such as alcohol management and suicide prevention programs that are not available in mainstream aged care services. Where services overlap, a key argument for the dual system has been the entitlement approach for veterans to ensure veterans can access services as soon as they need them. Uncapping of places across the aged care system as a whole will counteract this argument. When this occurs programs should be brought together rather than continuing to operate separately.

In community care the costs of delivering service to special needs groups go significantly beyond direct costs such as interpreting. Costs can include:

- different management processes,
- additional staff training,
- a smaller workforce pool (leading to greater unproductive travel time and travel costs),
- specialist skills such as allied health, clinical nurse specialists and nurse practitioners,
- communication resources,
- investment in understanding the special need and developing appropriate service models.

If funding realistically reflects the cost of responding to special needs groups, service providers will emerge to respond to those needs.

Aged Care Workforce

REFERENCE:

CHAPTER 11: DELIVERING CARE TO THE AGED – WORKFORCE ISSUES: PAGE 345-380

We support the commission's proposal to enable providers to pay competitive rates for nursing, allied health and other care staff and for these to be reflected in the pricing calculations.

We support additional training of the aged care workforce and improved opportunities for developing career paths.

To attract strong clinicians and a more diverse workforce, it is important that Aged Care is positioned as a cutting edge career, founded in strong research. Staff need to be seen as professionals, be well trained to make decisions, and given professional credibility. Aged Care is an integral part of the health system - it is not a separate community service. When it is seen and remunerated in this way, better consumer outcomes and greater efficiencies will be achieved through the focus of specialised staff.

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