CARING FOR OLDER AUSTRALIANS

ACSA's Response

March 2011

Executive Summary

Aged care provides a space, engagement, companionship, care and support for older people to make the most of their lives. It's about caring for older Australians.

The *Caring for Older Australians* report has sought to unravel each layer of the multi-faceted system that strives against the odds to create a supported environment for people, who through no fault of their own, simply can't meet each day without some form of assistance.

ACSA applauds the Commission's work and supports the broad and far reaching reforms proposed in the report. However, the detail in the proposed changes which impacts directly on the sustainability of the aged care sector must be expanded, understood and analysed before the Commission delivers its final report.

Through residential and community-based aged care services, our sector delivers services and accommodation to more than a million Australians every day, and employs more than 260,000 workers representing almost a quarter of the total health care and social assistance industry workforce.

The numbers of older people are increasing and the numbers of people needed to care for them, including informal carers, will need to expand at a faster rate to keep pace with demand. The constants in aged care include the aspirations to provide more choice and better access to services delivered when and where they are needed; the need to fund those services to reflect costs; expertise in managing the undeniable links between ageing, mental health and disability; and a foundation which promotes everyone's desire to remain healthy and independent for as a long as possible with their individuality and cultural preferences respected.

This submission responds to the Commission's recommendations which directly impact on the ability of the sector to not only meet these fundamental drivers but the challenge of future expectations and demands.

Our recommendations, further developed in the body of the submission, highlight concerns central to ensuring a sustainable aged care system. Real funding which reflects the costs of care, services and accommodation is critical if the system is to have a secure footing and ensure all Australians have access to the same high standard of quality aged care. Another significant issue around funding concerns the wide ranging variance in service delivery costs for providers in rural and remote areas and between states. Workforce shortages, particularly in states such as Western Australia, compound problems with underfunding and the inability to pay salaries which compete with public sector rates.

The proposed Gateway to facilitate easier access to services is partially predicated on managing the fiscal risk to Government which has the potential to limit the range of services funded, and therefore impede aged care providers' ability to establish and maintain the breadth and standard of support older people need.

The Commission's suggestion that the Fringe Benefits Tax (FBT) should be reassessed for the sector if aged care salaries were increased would also strike at the heart of efforts to make the sector sustainable.

Dementia is a core business for our sector and as such must also be factored into any funding scenarios. ACSA supports Alzheimer's Australia in its call for a comprehensive strategy to address dementia including how best to meet the extra costs associated with caring for people with the condition.

ACSA commends the Commission for its work and its willingness to engage stakeholders in finalising the path for reform. Further discussion is required on a number of key issues from an industry perspective and ACSA is working in consultation with other stakeholders to analyse and develop these areas.

ACSA recommendations for the final report

Recommendation 1 - ACSA recommends that the Commission's final report includes the aim of ensuring the future sustainability of aged care services.

Recommendation 2 - ACSA recommends that the cost of accommodation be based on key construction principles and associated costs at a regional level and could include land, construction, financing and a margin for the associated risk of an increasingly competitive market place. The lifetime cost of the building must also be taken into account.

Recommendation 3 - ACSA recommends that the Commission's final report provides guidelines or an indication of how the periodic payment/lump sum conversion would occur.

Recommendation 4 - ACSA recommends that the Commission's final report include financial modelling to ensure that the proposed changes to accommodation payments, including the potential for more periodic payments, will provide a sustainable revenue stream for the provision of residential aged care.

Recommendation 5 - ACSA recommends that regional supported resident targets/quotas be based on the socio-economic profile of the particular region and should be regularly reviewed to accommodate changing circumstances.

Recommendation 6 - ACSA recommends that the cost of care study required to establish pricing, be independent of Government, and be undertaken either by the AACRC or other relevant body.

Recommendation 7 - ACSA recommends that the Gateway be subject to performance criteria and be monitored to ensure compliance.

Recommendation 8 - ACSA recommends that the care and support funding model provides flexibility to modify service mix and intensity as required to meet the needs of the individual older person.

Recommendation 9 - ACSA recommends that the final report acknowledges the role of aged and community care providers in health care services and recommends they be funded to provide such services directly, including block funding for Day Therapy Centres (DTC).

Recommendation 10 - ACSA recommends a blended funding approach is applied to services for people with a disability and ageing related needs.

Recommendation 11 - ACSA recommends:

- the creation of a "cultural pool" to assist paying for the increased costs of providing culturally responsive care if these cannot be covered in the schedule of prices developed by the AACRC and adopted by Government; and
- that capital grants and zero interest loans should be available to develop services for special needs groups.

Recommendation 12 - ACSA recommends the following for regional, rural and remote service delivery:

- Block funding of aged and community care services in remote locations based on local cost structures and agreed outputs and outcomes;
- Funding services in regional and rural areas on the basis of regionally determined subsidies plus a form of 'viability supplement' to deal with specific locational issues;
- Analysis by the AARC of the various indices to redress locational disadvantage to select or create that on is;
  - Equitable
  - Based on the cost of provision
  - Recognises communities of interest
- Development of integrated health and aged care models, akin to Multi-Purpose Services, as a service option; and
- A Regional, Rural and Remote (RRR) restructuring package of resources to enable existing services and regions to undertake strategic planning and organisational development.

Recommendation 13 - ACSA recommends the establishment, through the Remote and Indigenous Service Support program, of a network of support services in remote areas to support indigenous aged care provision.

Recommendation 14 - ACSA recommends that:

- The Australian Government work with Independent Living Unit providers to determine how this affordable housing stock can be preserved. A targeted NRAS round could be considered as a funding source.
- The Australian and State Governments recognise aged care organisations as legitimate providers of housing to older people and enable them to participate in relevant funding programs without having to incur additional regulatory costs.

Recommendation 15 – ACSA recommends that:

- A workforce planning project should be undertaken by Health Workforce Australia (HWA) for the vocationally trained personal carers and community care workers, who are the backbone of our industry, and for allied health workers.
- The Australian Government, via HWA or the Department of Health and Ageing, in collaboration with the aged care industry and its peak organisations, consider the development of a leadership and management quality framework and a leadership and management program.
- The Commission's proposed review of the temporary and permanent migration program should occur and the scope extended to include suitable skilled and "non-skilled" workers who can provide care services in areas of critical labour under-supply such as aged care.
- There should be a change to the labour agreement program to recognise the shrinking pool of workers from which to draw labour.

Recommendation 16 - ACSA recommends the quality and accreditation function in the ACSAA be kept independent of the AACRC.

Recommendation 17 - ACSA recommends a specialist advisory structure be established to guide and monitor quality assurance processes for community care services as part of the changed quality and accreditation arrangements.

Recommendation 18 – ACSA recommends a delay in implementing changes to prudential requirements to ensure the impact of PC reforms are taken into account.

Recommendation 19 - ACSA recommends:

- that the complaints process includes a numbers of internal appeals processes before moving to the AAT; and
- that the AACRC be located either in Sydney or Melbourne.

Recommendation 20 - ACSA recommends the repeal of the legislative amendment requiring approved providers to notify the Department of all missing persons' reports made to Police.

Recommendation 21 - ACSA recommends a review of compulsory reporting of assaults in the final report.

ACSA Recommendation 22 - ACSA recommends the Aged Care Implementation Taskforce include key consumer and provider stakeholders.

ACSA Recommendation 23 - ACSA recommends the maintenance of FBT for not-for-profit organisations.

In Conclusion

The implementation and transition to a new system of aged care has to be properly managed and supported by Government and all other stakeholders. To this end ACSA looks forward to receiving the Commission's final report and working in partnership with Government on the transformation of the existing system to one which is sustainable and able to provide the very best of care to older Australians.

Introduction

Caring for Older Australians is a landmark report which identifies that the aged and community care system needs major and far reaching reform. ACSA could not agree more. Over many years ACSA has raised the ongoing structural and funding problems which beset aged care. The Commission's summation of the issues facing the system and the drivers of demand are accurate and present a strong case for reform.

Stakeholders – consumers, providers, unions and health professionals –all agree that fundamental reform is required and have supported the report and the debate it has created.

With the changing demographics confronting Australia it is imperative there is a sustainable aged care system able to provide improved choice and access for older people who need support.

Overall, ACSA supports the shape and direction of the proposed reform. The concerns we have are more about issues that require further attention or detail rather than the overall direction of the reforms. This submission gives a provider perspective on the underlying reform principles, system architecture, financial arrangements, care and support delivery mechanisms as well as transition. All of our comments and views take into account the needs of residential, community and housing providers. ACSA is continuing, in consultation with a number of stakeholder partners, to analyse and develop further positions on some areas and will provide additional information to the Productivity Commission subsequent to this submission.

ACSA has analysed a number of areas, where the Commission report sought further feedback or was seen to require further consideration in greater detail. The ideas and key issues in rural, remote and regional service provision and workforce are summarised in the main body of the submission and an appendix with further detail is included.

A framework for assessing aged care

ACSA is supportive of the wellbeing framework being used to assess options for the development of future aged care policy. The stated aims of the aged care system are also supported. However they should be supplemented to include the aim of ensuring future sustainability of aged care services. This is implied throughout the report but should be stated explicitly - as without sustainable services frail older people will not be able to get the care and support they need.

ACSA Recommendation 1

ACSA recommends that the Commission's final report includes the aim of ensuring the future sustainability of aged care services.

Paying for aged care

ACSA contends that the current funding arrangements are not sustainable and supports in principle the general shape and direction of the proposed reforms. However, more development and discussion is required.

The separation of accommodation, care and everyday living expenses should occur and assists in clarifying personal and public responsibility for paying for aged care. We accept that more work needs to be done to define what would fit into each category. However we believe that the demarcation between personal care and living expenses must allow some flexibility in order to meet the needs of clients.

Accommodation

The report recommendations regarding all people paying for their accommodation, except for those who do not have the means, are strongly supported. The current approach is inequitable and should be replaced.

Draft Recommendation 6.3 – removal of supply restriction is supported as is the removal of the distinction between low and high care places. There should only be one class for federally funded residential care facilities.

It would be practical to remove supply restrictions on community care earlier and faster than residential care. Most older people want to remain in their own homes and there are many areas in Australia where people are unable to access community support, particularly at high care levels. There is less financial risk, particularly when pricing controls will continue to be in place initially. Increases need to be modest to ensure that provision of residential care does not fall further behind as there will continue to be a growing demand for it as well.

Draft Recommendation 6.4 – ACSA supports the removal of regulatory restrictions on accommodation payments and providing people entering residential care payment options including a periodic payment or a lump sum or some combination of both. The Commission has also recommended that the periodic payment and the lump sum must be equivalent, based on the cost of accommodation (and market conditions) and publicised.

While this sounds simple the recommendations of the report require a dramatic and significant change in the business model for aged care providers, particularly in relation to cash flow and capital liquidity.

The cost of accommodation

The pricing of accommodation is recommended to be pegged to the cost of supply, to move away from the charging of so called "super bonds" and take into account market forces. Agreement on what is taken into account in determining the cost of accommodation is critical for ensuring payments actually cover the building and ongoing costs of providing residential care. Determining the cost of accommodation should be tied to key construction principles and associated costs. At a broad level ACSA asserts that these principles and the broad cost headings would, as a minimum, include land, construction, financing and a margin for the associated risk given an increasingly competitive market place. These costs will vary across Australia with large variations not only in rural and remote areas. The final report should include these principle level categories for setting the cost of accommodation to guide development and support implementation.

But it must also be acknowledged that providers invest in accommodation over the life of the building and include harder to quantify contributions. This lifetime cost of the building needs to be taken into account when determining the accommodation charge, not just the initial upfront costs. This is where allowing market forces to impact on cost/pricing will assist in ensuring appropriate revenue streams for providers.

> ACSA Recommendation 2
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> ACSA recommends that the cost of accommodation be based on key construction principles and associated costs at a regional level including, as a minimum, land, construction, financing and a margin for the associated risk of an increasingly competitive market place. The lifetime building costs should also be taken into account.

Periodic payment/lump sum

The Commission has recommended that the periodic payment and lump sum must be equivalent. This must also translate to equivalent income for a provider as well as equivalent payment for a consumer. As this is not a straight forward calculation the underlying assumptions and conversion factor will be critical for ensuring payments cover the building and ongoing costs of accommodation provision. The final report needs to provide some guidelines or an indication of how this conversion should occur including an acknowledgement that interest rates (currently running at 7 – 9%) would have to be included to allow the capital funding stream to be replaced by bank borrowings.

> ACSA Recommendation 3
>
> ACSA recommends that the Commissions final report provides guidelines or an indication of how the periodic payment/lump sum conversion would occur.

Financial modelling

ACSA believes that the Commission's recommendations will result in a greater proportion of consumers remaining in their own home for longer, delaying entry into residential care and resulting in an increasing proportion of people entering with higher level care needs. It is likely that the creation of the Pensioner Bond Scheme and Equity Release Scheme will encourage more periodic, rather than lump sum, payments.

The final report should prove whether these arrangements will in fact create a sustainable aged and community care industry able to deliver more choice and accessible services to older Australians.

The final report needs to include financial modelling so that the Government makes decisions with clear knowledge of the impacts and consequences of the proposed changes. The following factors need to be taken into account in modelling the impacts:

- Non/supported accommodation payments;
- A benchmark average cost of accommodation for supported residents and associated regional variations;
- An accommodation bond that is equivalent to, but not more than, the relevant periodic payment charge;
- An assumed reduction in the level and quantum of lump sum payments in the future and the impact of the availability of capital funding;
- Likely borrowing and financial institutions lending criteria changes that would flow from the proposed changes;
- Impact of the cost of capital as a result of the industry moving to cash flow for capital needs rather than lump sum dependency;
- Index rates for converting daily charges to a lump sum;
- Impact of removal of the current bed/package allocation system to balance sheets and operational income for providers; and
- Impact of higher vacancy rates on the funding required to cover the lifetime facility cost due to more community care funding being available and greater competition.

This must be done as part of the development of the final report to ensure independence of the process. With this sort of financial modelling, Government and industry can move forward confidently in reforming the aged care system – both in terms of the end point and the transition steps and period. ACSA, in conjunction with ACAA, will work with the Commission over the coming months to achieve this.

ACSA Recommendation 4

ACSA recommends that the Commission's final report include financial modelling to ensure that the proposed changes to accommodation payments, including the potential for more periodic payments, will provide a sustainable revenue stream for the provision of residential aged care.

Draft Recommendation 6.5 – ongoing supply assurance for supported residents is supported. Regional targets should be based on the socio-economic profile of the area and should be regularly reviewed to accommodate changing circumstances. Regions should be consistent with the Gateway regions, be a reasonable size and meaningful to local communities.

ACSA understands the intent of the recommendations on trading but it is unclear how this system will work. Trading rules will need to be flexible and require minimal sensible regulation and monitoring. ACSA believes further work is required on the operation of this system. Competitive tendering (CT) should only ever be used in areas where there is an under supply and provision needs to be stimulated. This is because CT is a disincentive to providers who bear considerable ongoing infrastructure costs but may lose the right to provide, or its client base, on a periodic basis. Not many providers are able to bear this sort of financial risk to business operations.

ACSA Recommendation 5

ACSA recommends that regional supported resident targets/quotas be based on the socio-economic profile of the particular region and should be regularly reviewed to accommodate changing circumstances.

Draft Recommendation 6.6 – the Australian Pensioner Bond scheme will support consumers financially. However, ACSA is concerned that this system may create a disincentive to paying a lump sum which is the current basis of industry's ability to build required residential care. Structuring incentives which support consumers and providers is critical for the future sustainability of aged care provision.

Draft Recommendation 6.7 – ACSA was pleased that Commissioner Mike Woods recently publicly ruled out using a two-bed room with shared bathroom as the basic level of accommodation for supported residents. There are a number of reasons for this including:

- Community expectation and Government certification requirements have driven a move away from shared bed/bathrooms to single rooms with ensuites. There are very few shared bed/bath rooms available anymore (down from 1.23 persons per room in homes built before 1999 to 1.07 post[1]);
- It creates a two tier system with those people with limited means unable to have the same standard of accommodation as others; and
- There are care needs, including palliative care, where having a single room with ensuite is required to achieve successful quality of life and/or clinical outcomes. These outcomes should not be affected by ability to pay.

Acknowledging the regional cost variations of the supply of accommodation is essential and strongly supported.

ACSA also supports the report's suggestion that the cost of accommodation is built into the total care package price for short stay, more closely aligned to health care services, such as transition care, respite and rehabilitation.

[1] Report on the Operation of the Aged Care Act 1997 (July 2006 to June 2007) (p 51)

Unaddressed issue

The accommodation arrangements will work for those without financial means and those with. However, it is not clear how the current assisted residents or individuals with limited assets but high enough to fall outside of the "supported" residents definition will fare in the proposed accommodation payment system, particularly when there is still a partner/spouse living in the family home, or there is a dependent, such as an adult child with a disability, still living in the home. The final report needs to clarify what the options are in these instances.

Everyday living expenses

Draft Recommendation 6.8 – supported.

This recommendation will enable much more consumer direction and choice of the services they receive. The Commission has suggested that the AACRC would provide advice to Government about the appropriateness (or otherwise) of charging 84% of the pension for basic living expenses. ACSA is of the view that it is adequate if it is to cover hotel only services.

Draft Recommendations 6.9/6.10/6.11 – ACSA supports the introduction of an equitable approach to co-contributions, a life time stop-loss limit (with Government paying all care costs when the limit is reached) and transparent pricing establishment by an independent body. There must be an independent benchmark of care exercise to establish the base pricing, appropriate indexation factors and ongoing arrangements. ACSA does not support the Department of Health and Ageing undertaking this in the first instance as proposed by the Commission. It should be the first task of the newly created AACRC or an alternative body, potentially the soon to be created Hospital Pricing Authority, if the time frame is too long.

ACSA Recommendation 6

ACSA recommends that the cost of care study required to establish pricing, be independent of Government, and be undertaken either by the AACRC or other relevant body.

Options for broadening the funding base

ACSA believes the funding base needs to be broadened and supports the establishment of the equity release scheme. As stated previously, the Australian Pensioner Bond Scheme is also supported in principle but should not be used to discourage payment of bonds. Any income earned by Government as a result of the Scheme should be tagged for investment into aged care rather than used as a return to general revenue.

The Commission has stated that it does not support a social insurance scheme for aged care but sought further feedback on this point. Since this time, the Commission has released its report on disability care and support and has recommended a social insurance scheme be established for that purpose. ACSA, along with COTA, have done some work on social insurance as a possible funding source in the past. However, our primary concern is that funding to the industry is sustainable and if this can be achieved by funding services through consolidated revenue, using the broad tax base as the source of funding, ACSA will support that model.

Care and support

Getting assessment and entry to the system right is absolutely critical as it establishes everything that follows for the individual older person and for service providers.

Draft Recommendation 8.1 – The Gateway will, if adequately resourced and skilled, provide a clear point of entry for consumers and provide support to navigate the system. Under those circumstances ACSA would support the creation of the Gateway noting that further clarification is required regarding its scope and operation. The final report should address this and give consideration to the following:

- Providing adequate resourcing and expertise to ensure timely assessments and access to services. Aged Care Assessment Teams (ACATs) currently struggle to meet demand and the Gateway task will be significantly larger with the inclusion of the Home and Community Care (HACC) Program;
- Maintaining access and links to specialist health and medical expertise, such as geriatricians, while moving assessment away from a medical model;
- Independence of the Gateway from Government;
- The use of standardised and consistent assessment tools and processes;
- Ensuring assessments accurately capture an individual's needs and environmental circumstances so that service provision matches needs. This can be problematic with phone/internet assessment where the older person can under represent their needs. To overcome this issue, the Gateway assessment should be an initial/provisional assessment until a provider can confirm requirements;
- Timely and streamlined reassessment process. This should ideally be based on current residential care processes where the provider reassesses and claims any required increased resources. This would be accompanied by a risk based review process. Any funding level adjustments would need to be backdated to the date the provider advises of the changed level of needs. Community care providers would need transitional support to manage such a process.
- Regions covered by the Gateway need to enable physical access (either individuals able to visit it or the provision of outreach visits). This is particularly important in rural, remote and regional areas and for CALD and special needs clients.
- Ongoing case management/coordination provided by service organisations as they have a close relationship with the client.
- Flexibility to enable funding/services provided to be modified to meet changing individual needs over a year.

The Gateways should be subject to key performance indicators and monitored to ensure compliance with these requirements. The relationship between the Gateway and the service providers in their catchment region will be critical to ensure people are able to access the services that they need and want. Creation and maintenance of effective relationships should be included in the Gateway KPIs.

The Commission has suggested that the Gateway undertake a review of services to an individual being delivered in accordance with care plans and quality requirements. ACSA does not support this role resting with the Gateway as it is a duplication of the role of the accreditation/quality process that will be the responsibility of the proposed Regulatory Commission.

The Gateway will be the mechanism through which Government controls its fiscal risk. ACSA understands that this needs to occur but suggests that the design and process needs to consider how this is achieved without undermining access and service provision. In the final report the way funds are allocated (i.e. on a notional individual or regional basis) and how supply is ensured throughout a financial year needs to be addressed. Allowing the establishment of what effectively could become 'waiting lists' at the front end of the system will likely result in greater cost burdens arising in the health system as peoples' care needs increase due to the lack of earlier support.

ACSA Recommendation 7
ACSA recommends that the Gateway be subject to performance criteria and be monitored to ensure compliance.

The Commission's model of care and support

The Commission has recommended a building block approach to funding for aged care and support with different sorts of funding arrangements for different service types – case mix for palliative care, block funding for meals and social inclusion services and ACFI type arrangements for personal care and domestic assistance. This means that some providers will have a complicated mix of funds and it will be imperative to have a simple administration regime.

ACSA Recommendation 8 ACSA recommends that the care and support funding model provides flexibility to modify service mix and intensity as required to meet the needs of the individual older person.

Draft Recommendation 8.2 – Making aged care an entitlement, based on assessed need, is strongly supported. Giving individuals the option of choosing their provider/s and signing over their allocated funding and co-contribution is strongly recommended as opposed to "cashed out" options. Evidence from Consumer Directed Care (CDC) pilot programs indicates a range of problems with cashed out CDC options (eg Howe, 2003, Tilly and Rees, 2007), including:

- Cash amounts being based on marginal rather than average costs of services, resulting in effective under-funding of assessed needs;
- Carers or self-caring recipients of funds not having the capacity to negotiate optimal care and manage funds; and
- Carers (or self-caring recipients) become employers and as such are legally bound under all relevant workplace laws.

Best practice points to the need for professional case management to support consumer directed programs.

ACSA supports the removal of the discrete care packages and integration to a single stream of funding care in residential or community settings. Further work is required on the operational aspects of such a system. The inclusion of HACC is critical for the success of this model for community care.

Removing the barriers between different levels of care and support should enable services to adjust provision to meet a person's need at any given point in time. However, complex or untimely reassessment processes and outcomes will see this potential go unrealised to the detriment of the client.

ACSA accepts that pricing (including an appropriate margin for the service provider) will be recommended by the proposed Australian Regulatory Commission and ultimately set by Government. The price should cover the full cost of service delivery with all that entails (such as staff training and education, workers compensation, superannuation and competitive wages).

The report acknowledges that there are variances in service costs based on location. This needs to be recognised either within the pricing mechanism or alternative funding arrangements. The report suggests transactional surcharges, presumably from Government, for services such as transport in remote areas would be paid. This is crucial to ensure access and equity in rural, remote and regional areas.

Delivery of care across different forms of accommodation

While the report does not have a specific recommendation on this subject it canvasses arguments around aligning care fees and funding across residential and community care provision. ACSA agrees

with this in principle but points out that community care, at an individual unit price level, can be more costly to provide than residential care (e.g. domestic assistance, showering) as it includes, for example, travel costs for workers. This will need to be addressed to ensure that community care service delivery is not underfunded. However we do not want a situation where prices vary across accommodation types and differ when a person moves between home and residential and respite care. It may be that clients will need to pay more when their choices, such as the nature of the accommodation, means that the service costs more.

Draft Recommendation 8.3 – ACSA supports the provision of casemix funding for palliative care, bringing aged care providers in line with other providers of such services. It can be difficult in an aged care context to accurately determine when palliation begins and this will need to be addressed.

In addition, the report envisages a time when additional health services may be provided within residential care such as medical teams providing services on site, post acute and sub acute support. The report sees these services as reducing the burden on the acute health system and should therefore be funded under a health funding model not ACFI. ACSA can see the logic of this position but it may be difficult to determine which services are health and which should be seen as good quality aged care. If speciality staff visit and provide expert care or if a person is discharged early from hospital and comes to residential care for post acute support only then these are clearly health services. However for administrative ease the regular care provided within residential care to long term clients by facility staff should be covered under aged care, ACFI type, funding.

Draft Recommendation 8.4 – ACSA supports the retention of block, and other funding approaches, to ensure delivery of critical services such as transport, social inclusion and support as well as services to types of clients such as Indigenous or homeless people whose needs are not well met by a standardised unit or case mix approach. One of the potential disadvantages of unit/case mix funding is a lack of flexibility in how service providers can respond to the needs of the individual. The funding system needs to flexible and provide the ability to modify the service mix and intensity as required by the older person and without any penalty to the provider.

Improvements to the interface between aged care and health

The report, underscored by a principle of supporting people's independence and wellness, discusses some of the issues and improvements that have occurred around the aged care/health interface. The final report should include specific recommendations on the aged care role in providing wellness and restorative care.

Aged care is a specialist setting. Aged care nurses, allied health professional and care workers are attuned to providing optimal clinical and personal care where older people are concerned. They have specialist expertise in health conditions and consequent problems found in higher prevalence among older people including continence challenges, cognitive disturbance, nutrition deficits, movement and mobility problems, sensory and communication problems, and skin trauma and chronic wounds.

Residential care facilities should be funded to provide transition care beds and supports as a matter of course. Community care services should be funded to undertake low level rehabilitation type services, and Day Therapy Centres (DTC) should be funded appropriately (block funding). DTC are an important and under utilised resource which have strong connections with local health services and provide a long term restorative approach to support older people to live well in the community.

For many reasonably independent older people, day therapy is the only aged care service they receive. The DTC service helps maintain their independence by providing health promotion across the continuum of care in later life which could be from physiotherapy, to Tai Chi, to group work.

By enabling residential and community aged care providers to provide an increased range of these health interface services, access for older people would improve. Aged care services are distributed more widely and locally than hospitals which means that people can receive care closer to home with the potential benefit of their own family doctor as a partner in their care.

ACSA Recommendation 9

ACSA recommends that the final report acknowledges the role of aged and community care providers in health care services and recommends they be funded to provide such services directly, including block funding for Day Therapy Centres (DTC).

Interfaces with the disability sector

ACSA has undertaken a preliminary review of the PC *Disability Care and Support* report recommendations on the interface with aged care. The report recommends a simplistic approach for people from the age of 65 to choose to either continue to receive support through the disability care system or transfer to the aged care system and be subject to all the financial and assessment arrangements which are proposed to exist in that system.

This is of concern as the funding per individual is generally significantly less for older people than for a person with a disability. The highest subsidy for a person in residential aged care is $43,689 per annum compared with $63,000 for disability services. Using this scenario a person with a disability over the age of 65 would be unlikely to elect to transfer to the aged care system even though more appropriate and expert care was available.

People who have had a disability throughout their life, such as an intellectual disability or quadriplegia, will still have that disability but may have other needs as a result of ageing such as dementia. In these circumstances both disability and aged care funding would be required to effectively support that person. The same would be true if a person acquired a disability, such as quadriplegia, after the age of 65.

Any person should be able to age in place – be that their own home, a residential care facility or a group home. Where a person has both ageing and disability related needs a blended approach to funding is required to support them, regardless of where they choose to reside.

ACSA Recommendation 10

ACSA recommends a blended funding approach is applied to services for people with a disability and ageing related needs.

Catering for diversity – caring for special needs groups

This section of the report covers a number of special needs groups. ACSA is particularly commenting on:

- people from CALD backgrounds;
- rural and remote service providers; and
- Indigenous aged care.

People from CALD backgrounds

ACSA supports the thrust of recommendations 9.1 and 9.2 aimed at improving the quality of aged care services for people from CALD backgrounds.

ACSA has argued previously that formula funded services, including residential and packaged care, do not necessarily have the capacity to cover the additional costs that can result from caring for people from a great diversity of backgrounds. Some ACSA members have estimated the cost of providing the additional services required of at least 3 to 5% of their total budget.

ACSA has recommended the creation of a "cultural pool" to assist paying for these costs. This initiative may not be necessary if the proposed cost of care study and the schedule of prices developed by the Aged Care Regulation Commission includes coverage of these costs. It is difficult to see how the Gateway will be able to include additional funds in their assessment for the chosen provider to provide culturally responsive care and ACSA would welcome the Commission's views on this.

It is worth noting that culturally competent care is not only about language services. Cultural responsiveness should permeate all aspects of service provision - from the structure of the Board, services policies and procedures, staffing profiles and the nature of care provided.

There is currently capacity in the system for organisations to receive capital grants or zero interest loans to provide services for people from special needs groups such as for homeless services. ACSA believes that these grants should remain to ensure that specialist services can be developed when required.

ACSA Recommendation 11

ACSA recommends:

- the creation of a “cultural pool” to assist paying for the increased costs of providing culturally responsive care if these can not be covered in the schedule of prices developed by the AACR and adopted by Government; and
- that capital grants and zero interest loans should be available to develop services for special needs groups.

Regional, rural and remote service provision

The issues facing older Australians living in regional, rural and remote (RRR) areas are well documented and recognised by the Productivity Commission. Similarly the locational difficulties faced by providers are acknowledged in the report.

ACSA supports Draft Recommendation 9.3 but we believe that the Commission needs to go further in its advice to Government in relation to:

- how its recommended system would impact on RRR areas and their service provision;
- suggest what aged care services could and should look like and how they should be funded; and
- recommend transition arrangements for RRR Australia that will ensure that services remain local, relevant and viable.

We have explored these issues and made recommendations regarding future directions in Attachment 1.

ACSA Recommendation 12

ACSA believes that governments have a social responsibility to provide accessible, quality aged care services to older Australians who live in RRR areas and that fostering a co-operative environment among providers of all human services is likely to produce the best outcomes for clients and providers alike. Therefore ACSA recommends that the Commission recommends:

- Block funding aged and community care services in remote locations based on local cost structures and agreed outputs and outcomes;
- Funding services in regional and rural areas on the basis of regionally determined subsidies plus a form of 'viability supplement' to deal with specific locational issues;
- that the AACRC analyses the various indices to redress locational disadvantage and select or create on that is;
    - Equitable
    - Based on the cost of provision
    - Recognises communities of interest
- Development of integrated health and aged care models, akin to MPSs, as a service option; and
- A RRR restructuring package of resources to enable existing services and regions to undertake strategic planning and organisational development.

Indigenous aged care

ACSA supports draft recommendation 9.3 and its emphasis on service sustainability and the building of local capacity. In our previous submission we expressed concern regarding the delay in rolling out the Remote and Indigenous Service Support (RISS) program. The Service Development Assistance Panel (SDAP) has since been established by the Department and it is a disappointing interpretation of the original goals of RISS. Many of those who were consulted during the development of RISS, including the consultant employed by the Department, believed that it was important to develop a network of support services that could develop relationships with the indigenous services on the ground and work together to identify and resolve issues. Instead the Department has developed a panel of experts that can be used to address specific problems. This strategy ignored the advice that the Department received about the importance of personal relationships to Indigenous people. It also assumes that services recognise and understand the problems they have. The SDAP does not have at its core the ongoing building of local capacity and is simply a more sophisticated method of doing what the Department has always done - providing expensive resources once a service is in trouble.

ACSA would prefer to see a network of support services operating in remote areas with the capacity to purchase specialist assistance if required.

ACSA Recommendation 13

ACSA recommends the establishment, through the RISS of a network of support services in remote areas to support indigenous aged care provision.

Age-friendly housing and retirement villages

ACSA commends the Commission for addressing the seniors housing issues in some detail as the importance of housing is often ignored when looking at an ageing population.

All the recommendations in Chapter 10 are supported along with the Commission's view that a national policy framework developed by COAG is essential. Housing is a first order issue and it had a much greater prominence with the Government when there was a Cabinet Minister for Housing.

The housing portfolio has now been split between departments and ministers and ACSA believes this is a retrograde step.

Home ownership is the cornerstone of housing policy for older Australians:

- It reduces housing costs and therefore total living costs;
- It provides security of tenure;
- It offers psycho social benefits; and
- Housing equity assists in paying for support and care for people as people age.

However, the rates of home ownership are decreasing and the number of older renters increasing. Older renters are caught between a partial and inadequate social housing system and an expensive under supplied private rental market. The demand from older people for rental housing is estimated to grow at a rapid rate of 120% between 2010 and 2028.[2] Aged care and community housing providers should be supported to provide affordable housing.

ACSA & COTA have been concerned for some time about the plight of the independent living units (ILU) developed by the not-for-profit sector between the 1950s and the 1980s. It is estimated that around 32,500 were constructed at this time under the *Aged Persons Homes Act*. FAHCSIA recently funded the development of a national database of ILUs. This has enabled some comparison between the findings of an AHURI 2002 study of these ILUs. Preliminary unpublished findings suggest that 26%[3] of the ILUs counted in 2002 have been lost as a housing service for people on low incomes.

The reasons for this were not fully investigated in the study but it appears that:

- Providers have opted to change the target group for the ILUs to people who can pay a higher ingoing contribution (often this is to compensate for inadequate aged care funding); or
- The organisations no longer operate ILUs.

The situation will only get worse unless Governments take some remedial action to ensure that this valuable housing stock is not lost.

The situation is further exacerbated by the fact that aged care providers are not uniformly recognised as housing providers by State Governments and are therefore not eligible for funds that could rescue their ageing ILUs or redevelop those sites to provide more housing stock.

Some ACSA members have suggested that enabling the proposed Pensioner Bond Scheme to be used by older people entering seniors housing.

ACSA Recommendation 14

The final report should include recommendations on:

- The Australian Government work with ILU providers to determine how this affordable housing stock can be preserved. A targeted NRAS round could be considered as a funding source.
- The Australian and State Governments recognise aged care organisations as legitimate providers of housing to older people and enable them to participate in relevant funding programs without having to incur additional regulatory costs.

[2] National Housing Supply Council, 2nd state of supply report 2010
[3] Swinburne Institute of Social Research Draft National Survey of Providers of ILUs for people with relatively low incomes and low assets Feb 2011

Delivering care to the aged – workforce issues

Aged care is a labour intensive industry and the future supply of appropriately qualified staff in the right locations is problematic. There are no simple solutions. ACSA agrees with the Commission that there are a range of strategies that will improve the workforce dilemmas. The workforce should be dealt with from a holistic industry perspective and not as an offshoot of the health sector. Government must take leadership on this matter.

ACSA supports all of the individual recommendations in the workforce chapter but we believe that the Commission's thinking should be expanded on competitive wages, workforce development, management and leadership and the employment of overseas workers. Attachment 2 outlines ACSA's thinking and positions on these areas.

ACSA Recommendation 15

ACSA believes that a workforce planning project should be undertaken by HWA for the VET trained personal carers and community care workers, who are the backbone of our industry, and for allied health workers.

The Australian Government, via HWA or the Department of Health and Ageing, in collaboration with the aged care industry and its peak organisations, consider the development of a leadership and management quality framework and a leadership and management program.

ACSA supports the Commission's view that a review of the temporary and permanent migration program should occur and extend the scope to include suitable skilled and "non-skilled" workers who can provide care services in areas of critical labour under-supply such as aged care.

ACSA also recommends a change to the labour agreement program to recognise the shrinking pool of workers from which to draw labour.

Regulation – the future direction

ACSA is supportive of the general directions proposed for the future regulation of the aged care system.

Quality and accreditation

The establishment of a truly independent accreditation office is supported, however, it is not clear whether making it part of the Australian Aged Care Regulation Commission (AACRC) will achieve this aim. Placement in the AACRC will potentially maintain the current quality/compliance confusion.

In the proposed system, the Department would set the accreditation standards. The Aged Care Standards and Accreditation Agency (ACSAA) would accredit services, monitor adherence to the standards between accreditation periods and would also instigate compliance action where problems are discovered.

In general accreditation bodies have a simple task – they accredit (or not) services – and they operate on a quality improvement basis. ACSA contends that the Australian residential accreditation system should also operate this way. It would assess against standards, set by Government, and provide a report to the regulatory body to determine any compliance action required. It would have no role in recommending formal action as a result of its accreditation decisions and would not be involved on

the basis of complaints investigation. This approach would ensure clarity of roles and separate out the quality improvement/assurance approach from any regulatory action required as a result of breaches.

To ensure real independence is achieved, the ACSAA should remain separate from the AACRC and compete to accredit aged care services under the JAS-ANZ framework already used for disability employment services.

ACSA Recommendation 16

ACSA recommends the quality and accreditation function in the ACSAA be kept independent of the AACRC.

Community care quality

The report also recommends that accreditation and quality monitoring of residential and community care come under the ACSAA. This recommendation is cautiously supported as it clearly makes sense in terms of streamlining existing arrangements. However, community and residential care are not the same thing and can't be accredited and regulated in the same way. Community care delivers services to an individual in their own home and is only responsible for that interaction and not other aspects of the person's life.

Residential care accreditation and regulations cover a 24 hour service which moderates the environment to ensure safety above individual rights. This can not, and should not, be carried into community care where people may receive as little as 1 hour of support per week/fortnight and anything up to 15+ hours – a fraction of their life.

Different techniques are required too for monitoring ongoing quality. The most obvious example here is the notion of a spot check or unannounced visit. While ACSA doesn't fully support this approach in residential care, it is unrealistic to consider (as the Australian Government currently still is) that they could operate in community care. This is because in residential care an accreditor can see the care being delivered by going into the aged care home but they will not be able to enter an older person's home and a visit to an administrative office will not yield any additional information on operations than that of a planned visit.

Considerable work would need to occur to ensure that quality monitoring of community care, within ACSAA, does not just seek to replicate the current residential care accreditation model. To this end there should be a specialist advisory structure to develop and support community care accreditation within this structure. It could be merged into the ongoing governance arrangements after it has been bedded down and is operating effectively. It is suggested that this would not be until after one full accreditation cycle and review (approx 4 years).

ACSA Recommendation 17

ACSA recommends a specialist advisory structure be established to guide and monitor quality assurance processes for community care services as part of the changed quality and accreditation arrangements.

Regulating prices

ACSA supports independent setting and monitoring of prices.

The reports emphasis on the differential costs of delivering services in different areas is strongly supported and needs to be taken into account in setting and regulating the prices.

The ongoing review and adjustment of prices is critical to the overall health of the industry. The current COPO indexation approach has seen providers reduce hours/level of services to balance the books and only 40% are operating in the black as a result of this approach.

Conducting an independent cost of care study to set the initial base prices, determine the appropriate review approach and indexation mechanism is absolutely critical. ACSA does not support the Commission's recommendation that this could be done by the Department of Health and Ageing prior to the establishment of the AACRC.

A sensible approach to regulation will be required given pricing will be a complicated mix of the actual costs and what the market can bear.

Prudential regulation

ACSA supports the AACRC being responsible for prudential regulation. DHA is currently consulting on reform of prudential regulation as a result of the Australian National Audit Office (ANAO) report which requires a new system in place by July 2011. ACSA has argued against proceeding with changes to the prudential arrangements before the major reforms proposed by the Productivity Commission have been considered and action determined by Government. It would be appropriate for the final report to recommend a delay in implementing changes to prudential requirements to enable this to be part of the overall reform process.

> ACSA Recommendation 18
>
> ACSA urges that the final report recommend a delay in implementing changes to prudential requirements.

Setting the quotas for supported residents, and regularly reviewing these, will be undertaken by the Australian Government and should be set in line with regional socio-economic indicators. ACSA supports the AACRC taking responsibility for oversight of related regulations and compliance.

Complaints handling and appeals

ACSA supports the recommendations made by the Walton Review and the Productivity Commission to create greater independence and a more conciliatory approach to complaints handling.

ACSA also supports the independent appeal mechanism and is comfortable with the notion of the Administrative Appeals Tribunal (AAT) being the ultimate appeals mechanism. However, there should be a number of internal steps before this mechanism is required as it can be a costly exercise particularly when legal representation is involved.

Draft Recommendation 12.1 – Supported.

The creation of the AACRC is a critical step in developing a transparent aged care system.

ACSA recommends that to ensure appropriate independence and differentiation from the current arrangements that the AACRC be based in either Sydney or Melbourne. This is in line with most other regulatory bodies' locations.

ACSA Recommendation 19

ACSA recommends:

- that the complaints process includes a numbers of internal appeals processes before moving to the AAT; and
- that the AACRC be located either in Sydney or Melbourne.

Draft Recommendation 12. 2 – supported with the exception of having effective intermediary appeals mechanisms before matters advance to the AAT.

Draft Recommendation 12.3 – Publishing the results of either residential or community care quality assessments needs to be done in such a way that is meaningful to any person reading it. This is not the case currently and reports can be misleading. Plain English versions are needed.

Draft Recommendations 12.4, 12.5 and 12.6 are supported. The principles – transparency, consistency and proportionality - that underpin the system are supported as is the move to a risk management approach.

Draft Recommendation 12.7 – ACSA supports the provision of such prudential information on request rather than as an automatic requirement.

Removing other restrictions

ACSA has supported previous Commission recommendations to reduce unnecessary and duplicative regulation in residential care which create reporting burdens and limit an individual older person's choice and flexibility.

Missing residents

The draft report discusses the existing notification of missing resident's requirement. The extent of missing person's reports is unclear as there has been no feedback to the industry on the number of reports made. The requirement does not include measures to either prevent residents from unexplained absences or to assist locating missing residents. It also ignores the right of residents to make their own decisions and act as they wish.

The necessity of notifying the Office of Aged Care Quality and Compliance (OACQC) of reports made to Police has created additional administrative procedures for approved providers that appear to have no benefit to the resident, the industry, the Department or the Police. The OACQ follow-up of reports

adds additional scrutiny and stress for the provider, further stretches the resources of the OACQC , adds no value to Police procedures, the care of residents and provides no comfort to families.

Draft Recommendation 12.8 – Supported, but this recommendation does not go far enough. ACSA recommends the repeal of the legislative amendment requiring approved providers to notify the Department of all missing persons' reports made to Police.

ACSA Recommendation 20

ACSA recommends the repeal of the legislative amendment requiring approved providers to notify the Department of all missing persons' reports made to Police.

Mandatory reporting of assaults

The Commission sought comment on the regulations on mandatory reporting of assaults.

ACSA's initial submission raised concerns about the denial of rights of older people inherent in the compulsory reporting of assaults and the impact of compulsory reporting on providers and their staff.

ACSA undertook a national survey of members in 2009 to establish their views of the first 18 months operation of compulsory reporting of assaults.[4] The survey found compulsory reporting had increased awareness of abuse and encouraged better policies and procedures by service providers. But this had come at a cost of half of all reported cases being unsubstantiated, expensive additional bureaucracy and limited evidence of improvement in obtaining criminal convictions where real assaults have occurred. When asked what they thought should happen to the mandatory reporting legislation, more than 7 in 10 respondents said it should be repealed outright or amended.

ACSA believes a review of compulsory reporting of assaults is essential and overdue and should be recommended in the final report. If the legislation is not repealed, the reporting system should be amended to address some of the concerns.

Options would include:

- Removing the obligation to report resident-to-resident cases;
- Extending the timeframe to report incidents to DoHA, so vexatious or unsubstantiated cases are excluded by preliminary investigations by police and approved provider;
- Requiring DoHA and the police to meet timeframe benchmarks for investigations;
- Resolving the conflict between whistleblower protection and industrial relations due process; or
- Establishing an additional aged care standard on protection of older residents from abuse and including review of systems to achieve this in the accreditation process, eliminating need for DoHA involvement entirely.

ACSA Recommendation 21

ACSA calls for a review of compulsory reporting of assaults in the final report.

Clarifying and simplifying jurisdictional responsibilities and harmonising regulation

Draft Recommendation 12.9 – Supported.

Aged care policy research and evaluation

[4] P Sadler (2009) *Elder Abuse: one report too many. Results of ACSA online survey on compulsory reporting of assaults,* http://www.agedcare.org.au/PUBLICATIONS-&-RESOURCES/General-pdfs-images/Elder%20Abuse%20Reporting%20survey%20report%20Oct09%20edits.pdf.

ACSA supports Draft Recommendation 13.1 for better data availability to support evidence based policy, research and evaluation.

ACSA believes that the aged care sector would benefit from a research body similar to the Australian Housing and Urban Research Institute (AHURI) which is a not-for-profit organisation that funds, conducts and disseminates high quality research to inform the polices and practices of government, industry and the community sector. It is funded from the Australian, State and Territory governments and receives contributions from universities and other parties. It has provided an evidence base for the housing sector that is lacking in aged care.

Reform implementation

Implementation of such far reaching reform requires an adequate time frame and correct sequencing if risks to continuity of care for clients, service availability and sustainability are to be effectively managed.

ACSA understands that the final report will include a much more detailed and thought through implementation time table. It is our contention that a period of more than five years is likely to be necessary for a smooth transition process, particularly with respect to residential care.

ACSA is working with the Campaign for the Care of Older Australians (CCOA) to review and recommend a transition process. CCOA will be meeting and discussing this issue with the Commission and will make a full submission on this issue following that discussion. However, some preliminary thoughts on transition, developed by CCOA member Nick Mersiades of Catholic Health Australia, are at Attachment 3 for consideration.

Draft Recommendation 14.1 – Supported.

The Aged Care Implementation Taskforce is recommended to include, as a minimum, senior officials from the Department of Prime Minister and Cabinet, the Department of the Treasury, the Department of Finance and Deregulation, the Attorney – General's Department and the Department of Health and Ageing. The report recommends that it be tasked to consult with stakeholders extensively. This is not enough.

Implementation of this level of reform requires a mix of policy, finance and practice expertise. The proposed membership of this Taskforce will only have Government policy and finance expertise. This needs to be supplemented with people who will understand the translation and impact of policy on the ground in peoples' lives.

It is consumer organisations (such as COTA) and service provider representatives (the main peak bodies ACSA and ACAA are recommended) who will be able to bring the real effect to the reform table to ensure a successful transition for Government, older people and for those who care.

ACSA Recommendation 22

ACSA recommends the Aged Care Implementation Taskforce include key consumers and provider stakeholders.

Other Issues

Dementia

ACSA supports Alzheimer's Australia in its call for reforms to be underpinned by a comprehensive strategy to address dementia. We agree that dementia is a core business of aged care and an area that will expand as the numbers of people affected by the condition are forecast to rise dramatically in coming years. *"The majority of residents in aged care have dementia; it is the most disabling of all conditions among older people and one of the main causes of institutionalisation."* [5]

The care of people with dementia is therefore inherent in the Commission's recommendations but given the growing predominance of the condition it is incumbent upon all stakeholders, including the Commission and the Government, to factor comprehensive planning on dementia into any reforms. More research is critical to assist our understanding and therefore our capacity to effectively support and accommodate these individuals.

Respite care should also properly be recognised as a critical cog in both the aged care and broader health sectors with adequate resources and support.

Fringe Benefits Tax (FBT) in the not-for-profit sector

ACSA does not support the Commission's comments that in the event of a significant increase in age care salaries, the efficacy of the FBT concession should be re-examined (page 119, PC draft report). The Commission reiterated the conclusion of a former report (*The contribution of the not-for-profit Sector* (NFP Report) 2010) that the FBT concessions be phased out slowly, a recommendation already rejected by the Australian Government.

Not-for-profit aged care organisations have made a significant contribution to providing services to:

- the most socially marginalised older people in Australia, including Indigenous and homeless people;
- rural and remote towns and communities where if it were not for the social capital provided by those communities, no service would be provided;
- housing for older people with low incomes; and
- older persons from diverse cultural communities.

These groups provide little incentive, or operational viability for the for-profit sector.

Not-for-profit aged care providers operate in a manner consistent with the mission of their owners - the churches, community groups and other secular charities - to provide care rather than to generate a return on capital. Not-for-profit organisations are able to obtain certain tax concessions in recognition of their service to the common good. For-profit organisations are also able to access concessions, such as the subsidy to offset the costs of payroll tax.

The range of tax concessions available to not-for-profit organisations, including FBT, is critical to the capacity to operate in a competitive environment. ACSA believes that the phasing out of FBT would have the following effect:

- Loss of salary packaging which would have significant impacts as packaging is a major tool in recruitment and retention of staff, particularly within aged care – where pay rates are significantly less than in the acute sector.

[5] *Alzheimer's Australia Productivity Commission submission.*

- Removal would lead to upward pressure on labour costs resulting in decreased access to care for the more vulnerable in the community and increased demand on public funding.
- If changes made to FBT led to the requirement that employers compensate employees for the loss of benefit then this may induce serious viability issues for some aged care providers.
- Surpluses generated by not for profit providers are reinvested in the business rather than being paid to proprietors or shareholders. Any reduction in the viability of not for profits will reduce this reinvestment and lead to a net reduction in supply.

ACSA urges the Commission to reject the phasing out of FBT to ensure that not-for-profit organisations are not compromised in the provision of services to older Australians, particularly the more vulnerable and socially marginalised sector.

> ACSA Recommendation 23
>
> ACSA urges that the final report recommends maintenance of FBT for not-for-profit organisations.

Feedback Sought

The Commission sought feedback on a number of specific issues. Some have been addressed throughout this submission – regional concessional targets/trading/competitive tendering; social insurance and mandatory reporting requirements.

ACSA provides feedback on the following issues:

Varying the accommodation subsidy from Government on facility age

ACSA does not believe this is warranted and is not supported. Providers have to maintain capital infrastructure throughout the life of the building and to be able to afford replacement/refurbishment as the building ages. Costs are higher as the building ages so providing a lower accommodation subsidy to aged buildings will limit capital when it is needed the most.

Merging Veterans' Assessment with the Gateway

ACSA supports all community care programs coming together and being combined in the Gateway so the agency would need a broad range of skills, including in mental health and dementia assessment.

ACSA was disappointed that DVA was not included in the original terms of reference of the inquiry as they fund many of the suite of services that are the subject of this inquiry. Many ACSA members provide services to DVA clients and they will have to continue to operate different funding, fee and accountability systems. Inequities in the system will remain with DVA clients paying substantially less for their services.

Conclusion

ACSA commends the Productivity Commission for its work in identifying reform which will address long running issues faced by the aged care industry. Further discussion is required on a number of key issues particularly from a provider perspective on the recommendations and modelling to ensure that the proposed funding reforms will deliver a more sustainable base for the provision of vital aged and community care services.

ACSA is continuing, in consultation with a number of stakeholder partners, to analyse and develop further positions on some areas and will provide additional information to the Commission subsequent to this submission.

Getting implementation of the reform right is critical. ACSA strongly believes that this will only occur if a partnership approach between Government and all stakeholders is adopted.

ACSA looks forward to receiving the Commission's final report and working in partnership with Government on the transformation of the existing system to one which is sustainable and able to provide the very best care to older Australians.

The issues facing older Australians living in regional, rural and remote (RRR) areas are well documented and recognised by the Productivity Commission. The seven million people of rural and remote Australia experience significantly higher health risk factors, higher rates of mortality and morbidity and substantially less access to health and aged care services than those in major cities.

Similarly the locational difficulties faced by providers are acknowledged in the report. "To ensure that the aged care system operates efficiently, aged care services delivered in rural and remote areas should be funded at a level which has regard to the additional costs incurred in supplying the services. The Commission is proposing the development of an independent regulatory commission to recommend to the Australian Government the appropriate subsidies for providing aged care services. A further role for the body should be to determine the sustainable costs of service provision in rural and remote locations."[6]

ACSA applauds the Commission's suggestion that subsidies should be differential, based on the additional cost incurred. The Commission also acknowledges that block funding may be appropriate where economies of scale are not relevant or the environment is not right to support their proposals.

ACSA supports Draft Recommendation 9.3 but we believe that the Commission needs to go further in its advice to Government in relation to:

- how its recommended system would impact on RRR areas and their service provision;
- suggest what aged care services could and should look like and how they should be funded; and
- recommend transition arrangements for RRR Australia that will ensure that services remain local, relevant and viable.

Relaxation of Supply

The Commission's proposal to gradually relax supply and allow the market to determine the location and nature of services is of concern to providers in rural areas. Generally RRR providers face different or more extreme issues compared to metropolitan providers:

- Services are often smaller and operate on smaller margins. It is interesting to note that the bulk of services provided in RRR areas are not for profit providers.
- They often have volunteer Boards without the aged care knowledge or business acumen to operate highly efficiently.
- They have greater difficulties attracting and retaining service staff – often having to compete with state run health centres and acute facilities.
- Cannot always attract the medical and allied health professionals their clients require.

While a sense of belonging and place is important to most people it is often heightened in rural Australia where isolation builds and enhances a sense of community. Often their residential facilities have been developed as a result of local fundraising and lobbying creating a strong sense of ownership of the facility and a substantial volunteer contribution. These services are not seen as commercial operations but as critical community infrastructure that will provide local older people, who built the community, with care and support regardless of funding or government rules.

Aged care services in rural communities are important players in the local economy. They provide local employment, primarily to women, they purchase supplies locally supporting the retail sector and use local contractors. They have regular and consistent operations in areas that are subject to the vagaries of agricultural industries. They are often the only 24 hour service in town.

[6] Productivity Commission Draft Report – Caring for Older Australians – January 2011

The Commission sees the relaxation of supply as a vehicle to provide choice to consumers, act as a downward pressure on bonds and promote innovation. For many rural and remote areas this reform will:

- Not provide additional choice as the areas will not be able to support a number of viable services;
- Not reduce bonds substantially as the bonds are already low due to the lower socio-economic profile of rural Australia; and
- Will not necessarily promote innovation as creative services and practices are usually the result of good management who have a detailed understanding of their communities and their needs and close relationships with other providers in order to understand gaps in provision.

Co-operation v competition

Our members have argued that in rural areas where there is often a dearth of services and staff and that client outcomes would be enhanced by greater co-operation between health, community and aged care services, not competition.

The recent project conducted in North West Tasmania highlights the poor client outcomes when services operate in a competitive and uncoordinated environment. The consultant found:

- The region is undersupplied in residential and community care but demand is being blunted by a lack of information;
- The region is oversupplied with hospital beds so there are inappropriate presentations at hospitals emergency departments; and
- They suggest that parochialism and competition between services leads to service gaps resulting in persons in discreet communities resisting or refusing higher level services as they have never had experience with the service system or are seen as one agency client[7].

In high functioning areas there are inevitably well established networks that can be auspiced by a group of bodies including local government, large providers, state government, that work together to:

- Support transitions between services;
- Coordinate local service provision;
- Offer support to members;
- Share resources and information;
- Identify service gaps; and
- Lobby for funding for their region.

The Federal Government has recently introduced Medicare Locals that "will be responsible for making it easier for patients and service providers to navigate the health care system. Medicare Locals will support health professionals to provide more co-ordinated care, while maintaining the important role that general practice plays in the primary health care sector. Medicare Locals will facilitate improved access to services for patients and encourage greater integration between the primary health care, hospital and aged care sectors. Improvement in primary health care is critical to improving the overall health care system."[8]

It is difficult to see how Medicare Locals will be local enough to have an impact on the local planning and delivery of service. For example in Western Australia all but Perth is one Medicare Local Area.

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[7] Verso Consulting – A Sustainable Model for Regional and Rural Aged Care Services – September 2010 pg5.
[8] Department of Health and Ageing Medicare Locals – Discussion Paper on Governance and Function.

Funding

The broad thrust of the Commission is to have an independent authority benchmark the cost of care and subsidies may be different around the country. The Commission has also suggested that block funding and supplements may be appropriate under some circumstances.

ACSA would argue that block funding is appropriate in remote Australia where services have a range of unique and more extreme factors such as:

- Having to fly staff in and out;
- The 2008 NILS census report found that rural and remote providers used seven times more nursing and allied health agency staff than the national average.
- Having to provide subsidised housing in order to attract professional staff. A remote service in Western Australia has recently reported that they may have to close their service as "rents are tripling and local staff cannot sustain a family in these circumstances.";
- Cover huge travel costs for staff and goods. In our 2009 Community Care Viability Supplement research project we were told that food costs were on average 70% higher in remote areas and up to 300% higher in very remote areas largely due to transport costs; and
- Even travel in regional areas can have a profound impact on the amount of service that can be provided. A provider in Tasmania is paying travelling allowance of $1.05 per kilometre for staff to visit clients. An EACH client might require 3 visits per day with a round trip being 40 kilometres. The travel alone for these visits would be $126 leaving only $6.89 per day to cover direct care out of a subsidy of $132.89. This is not an extreme case.

Formulaic funding in these areas simply has not worked.

Our members' report that the way they keep the doors open is to:

- Cross subsidise from other organisation's services or use the organisation's reserves;
- Pool funds from a variety of programs which is often against program guidelines; and
- Overwork staff, particularly middle managers.

There are many examples where the Government has accepted that block funding is warranted. In the COAG communiqué in April 2010 it was noted that "some small regional and rural public hospitals, and other agreed services, will be block funded consistent with Community Services Obligations, reflecting the higher costs associated with delivering services in these areas".

If the Commission decides to go down the path of supplements for the regional and rural areas, then ACSA would suggest starting with a base regional subsidy and then build up additional funding based local costs and locational factors. We note that the Commission is aware of problems with measures of remoteness. In its *Report on Government Services, Indigenous Compendium April 2010* the Commission specifically notes that remoteness indexes currently in use are "imperfect indicators" of the cost of services. There is a necessity to look beyond locational factors alone.

The Government currently uses the Accessibility/Remoteness Index of Australia (ARIA) as a way of measuring remoteness in its residential and community care viability supplements. For residential care the ARIA score is then tempered by the size of the service, with smaller services and those catering for large percentages of special needs groups receiving greater weighting .

ACSA agrees with the Commission regarding systems such as ARIA being "imperfect indicators" of costs. ARIA being a purely geographic scale makes assumptions around car ownership and road conditions. It throws up some unusual results. The Cherbourg Aboriginal community, 260kms by road from Brisbane, with a population of 2,600 and the closest hospital 50kms away at Kingaroy has an ARIA rating of 2.9. The cities of Darwin, Cairns and Townsville have ratings of 3.0. And surprisingly

Alice Springs has a rating of 6.0. ARIA defines 81% of the population as living in the most accessible category while other instruments such as the ASGC classifies 66% in this class.

During our research into the efficacy of the Community Care Viability Supplement, a number of services told us that their most remote clients do not attract the supplement, or attract a lesser supplement than clients who are more easily accessible. These anomalies in eligibility could easily be remedied by consulting with services and negotiating better outcomes, as has occurred with one remote service.

ACSA is not in position to rigorously analyse all the possible indices. The Australian Standard Geographical Classification (ASGC) is used by the Australian Institute of Health and Welfare but has been criticised by the Rural Doctors Association and the National Rural Health Alliance.

The Griffith Service Access Frame (GSAF) was developed in 1996 specifically to "assist policy makers and administrators to target and quantify relative disadvantage[9]. It is fairly widely used by Government sectors for quantifying service access. It is most usually used by the Education Sector. The GSAF also includes variables of accessibility such as time, cost, socio economic status and distance from service centre.

ACSA believes that the Commission should specifically recommend to Government that the ARIA should no longer be used and that the Independent Regulatory Commission should evaluate the various methods used by Governments to redress locational disadvantage and select or create one that is:

- Equitable;
- based on the cost of service provision; and
- recognises communities of interest

Service models

In our previous submission ACSA advocated for the development of integrated health and aged care services as one strategy for ensuring that viable, relevant and local services operate in RRR areas.

The integrated service is similar to multi-purpose services (MPS) but with a shift from the more traditional health focus. It would have the support and wellbeing of the older person as its primary focus and may offer a range of community and health services as adjuncts. Local communities and service networks would decide if an integrated service is appropriate for their area and individual services could choose whether or not to join or remain as a stand alone service. It would be important to ensure that these services do not simply run a state health agenda which is the case in some states.

This is still our position and we believe that it may be an appropriate model in many areas particularly with a greater government emphasis now on primary care but critical areas for success are:

- Local service planning that allows flexibility and the ability to respond quickly to changing circumstances
- Planning that is accepted by funding bodies;
- Strong local relationships between all health and aged care services in the region (including stand alone aged care services) and effective community engagement strategies;
- Strong local governance;
- Commitment from the 3 levels of Government to funding being pooled and used to implement an agreed service plan; and
- Streamlined reporting that replaces programmatic reporting.

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[9] D.A. Griffith – The Griffith Service Framework. A Practical Model Aug 1997.

We already have established services battling to survive under current arrangements and for many the option to become an integrated service will not be appropriate. There are examples around the country of small, local services that have turned their situation around or are in the process of taking some big steps forward. The North West Tasmanian project mentioned earlier is a case in point.

Another interesting Tasmanian development is a project to "design, develop and implement a Statewide Strategy to secure the long term future of:

- aged and community care services to clients throughout Tasmania's metropolitan, rural and remote communities
- aged and community care organisations in a range of sustainable service/business models and structures."

It is based on provider collaboration and openness and building local capacity to sustain a local service for the community with such approaches feeding into a statewide strategy. Considering the role of the Tasmanian State government in aged care and community health facilities their engagement and contribution to this process is crucial.

Other successes have been driven by individual services for example the Alcheringa story where a residential facility in regional Victoria with massive losses, a dysfunctional Board and poor management was turned around in two years to be financially sustainable, engaged with their local community with a new Board and management. They have in turn rescued two failing small rural residential services which are now fully compliant and financially sustainable.[10] The consultant who guided the process believes that the critical success factors were:

- Governance – being able to get to the boardroom to bring about change; and
- The involvement and commitment of the critical bodies, in this case the department, the Standards Agency, the provider and the consultant.

Not only have these local services survived allowing local people to remain in their communities but local employment has been retained.

ACSA believes that there are many models that could operate in RRR areas – amalgamations and mergers similar to the Alcheringa experience, more formally networked regional services that might share resources such as HR or IT expertise, formal partnerships or pooled tender approach. The answers will be different for different areas depending on local personnel and existing infrastructure. The critical elements that are currently missing are resources, leadership and expertise. These Tasmanian and Victorian projects have had the benefit of expertise to drive the processes.

The PC also suggests that in rural and remote areas, team based, multidisciplinary health service models are important mechanisms to attract and retain the services of health practitioners. While many of our members would ideally agree they question whether these teams will be able to attract enough staff to be effective. They have similar concerns with the Gateway as some members have reported that their local ACATS have never had a full staff complement.

Transition

The Commission's report addresses implementation of the new system and ACSA will comment on this elsewhere in the submission. However, we believe that RRR areas have special requirements to not only deal with the realities of the new arrangements but to address that major viability and governance issues that they have been facing for years.

[10] Presentation from Michael Goldsworthy from ASSPL to the ACSA Rural & Remote Committee

Since the reduction in staff at state offices of the Department (and its predecessors) very little development support has been given to services. Peak bodies have provided information but have not had the resources to assist services to analyse their business and undertake strategic planning and redevelopment. The Department has been reactive in providing support once a service has real problems with compliance or viability rather than proactive in providing support before issues become critical.

ACSA believes that people living in RRR areas have a right to receive the care the support they require in their local community and that Governments have a social responsibility to provide a network of local health and aged care services. The Commission has noted in previous reports when discussing competition policy that "governments have specific social welfare and equity objectives that need to be taken into account in the reform process."[11] While this report argued overall that national competition policy would have long term benefits nation-wide, it argued that adverse effects, including in regional and rural areas, should be directly addressed by governments in line with socially recognised community service obligations. They go on to say that:

> "employment reductions in rural and regional Australia, due to reduced economic activity or industry restructuring, can have repercussions for the social infrastructure of some communities. Job losses in small communities, where alternative employment opportunities are limited, often lead to population decline. This may have adverse flow-on effects for local businesses and service provision and may threaten the population threshold
> necessary to sustain the continued provision of important social services (such as schools and medical facilities) (PC February 2005: 115).

In this report the Commission argues for the need for "transitional adjustment support arrangements" for affected rural communities and regions. They believe that transitional planning is best done 'up-front' and guided by agreed principles "increasing the likelihood that the process of change is managed well and lessening perceptions that responses are ad hoc." ACSA wholeheartedly supports this view.

ACSA believes that the Government should move with some urgency to provide restructuring resources to individual services and regions to work through provision, viability and governance issues. We see this as a dual responsibility of Government and providers. The funds should be available in the first stage of the implementation if not sooner. The Department has a number of existing models for providing such support for example:

- An allocation of a number of dollars per bed or place;
- A risk assessment identifying priority services and areas;
- Perhaps with a weighting for small stand alone services;
- A regional allocation; and
- Identify a panel of experts to provide guidance with strategic planning and governance.

The projects should be overseen by those in a region responsible for service planning and provision and may include local and state governments, health and aged care service networks plus bodies such as the Standards Agency. They should have a capacity building focus. There is a plethora of regions used by Governments for planning and allocations purposes. We are not in a position to recommend that regions that the PC should use for its subsidy setting and supported resident trading but the regions should be small enough to have relevance to those on the ground; recognise communities of interest and have some commonality with the regions used by other health and community services programs.

ACSA would be happy to work with the Commission to develop this idea further.

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[11] Productivity Commission – *Review of National Competition Policy Reforms* February 2005 page 87

Recommendation

ACSA believes that governments have a social responsibility to provide accessible, quality aged care services to older Australians who live in RRR areas and that fostering a co-operative environment amongst providers of all human services is likely to produce the best outcomes for clients and providers alike. Therefore ACSA recommends that the Commission recommends:

- ***Block funding aged and community care services in remote locations based on local cost structures and agreed outputs and outcomes;***
- ***Funding services in regional and rural areas on the basis of regionally determined subsidies plus a form of 'viability supplement' to deal with specific locational issues;***
- ***that the AACRC analyses the various indices to redress locational disadvantage and select or create on that is;***
    - ***Equitable***
    - ***Based on the cost of provision***
    - ***Recognises communities of interest***
- ***Development of integrated health and aged care models, akin to MPSs, as a service option; and***
- ***A RRR restructuring package of resources to enable existing services and regions to undertake strategic planning and organisational development***.

ATTACHMENT 2 WORKFORCE CONSIDERATIONS

Competitive Wages

It has long been recognised that workers in the aged care industry should be remunerated at wage levels that take into consideration their skills, competence and dedication to caring for older Australians. The cost of caring for older Australians is largely about the cost of wages and salaries for those who care for them, including personal care workers, nurses, allied health professionals, support staff, doctors and administrators. Therefore the proper funding of wages and salaries should be a significant component of the funding formula of cost of care to older persons. Any formula should take into consideration, wage relativities with comparable industries, i.e. health and community services, wages movements, cost of living increases and price index movements.

The Commission supports the notion of workers in aged care being paid competitive wages. The dilemma is how to increase wages while having sufficient funds to make services available to increasing numbers of older people and protecting Government expenditure and service viability. Higher wages might be able to be funded by the additional money the proposed changes will make to the system.

ACSA is currently working with the National Aged Care Alliance (NACA), which includes the unions, to look at ways of increasing wages while not threatening service viability. The industry is willing to pay higher wages if the funding/revenue is there to support them.

Workforce planning

In our previous submission ACSA argued that that our industry requires a more sophisticated workforce planning approach at a strategic and operational level because at present we do not know how many workers we will need in given areas, what qualifications they will require and where they are going to come from. The work done to date is at a broad industry level with the Department's submission to the PC suggesting that if under current policy settings by 2050 4.9% of the population, some 827,100 people, will be engaged in the provision of aged care. This is an increase of between 2 and 3 times. While this is useful for lobbying value it does not help us answer the questions above. We know that in Western Australia they will require an additional 400,000 workers across the state in the next 10 years but on current projections there will only be 150,000. Yet in some areas of the major capital cities our members report that there is no labour shortage. Regional and local understanding of workforce needs is critical. Providers need assistance to understand about competitors in the market from within the industry and from outside; the qualifications that will be in greatest shortage; and local labour shortage numbers. We had recommended that the newly formed Health Workforce Australia (HWA) should take responsibility for this.

Subsequent to our submission HWA has established a new and critical project. Its objective is "to develop a National Training Plan for medical officers, nurses and midwives that delivers national self sufficiency by 2025 with a preferred geographical spread, recognising that Australia exists within a global context." The two key deliverables are:

- A report to the Australian Health Ministers' Conference outlining a range of target numbers for training; and
- An electronic planning tool that can be used by stakeholders.

Undoubtedly this project is a great advance for planning for nurses in the aged care industry but they are only about 30% of our workforce. No national plan is envisaged for the other 70% of workers.

Recommendation

ACSA believes that a similar project should be undertaken by HWA for the VET trained personal carers and community care workers, who are the backbone of our industry, and for allied health workers.

Workforce development

The key document capturing the workforce development strategies for the industry is the *National Aged Care Workforce Strategy* 2005 which was developed by the Department of Health and Ageing. While it is a useful document it is out of date and only addresses direct residential aged care staff. It fails to plan for community care, allied health and ancillary workers. This document should be updated and made more inclusive of all health care professionals that work in the industry as a matter of urgency. It would capture the myriad strategies that are required to address this multifaceted problem in a practical way within a broad environmental analysis. HWA or the department could be the appropriate bodies to develop this plan.

Recommendation

That HWA or the Department of Health and Ageing develop a new National Aged Care Workforce Strategy in consultation with relevant stakeholders.

Ratios and licensing

Staffing ratios and licensing of workers have been put forward by some in the industry as a means of improving the quality of care. The Commission's draft report has not supported these views. They concluded that the variable nature of aged care clients' needs and the accreditation requirements to provide quality care means that mandatory staffing requirements are not necessary. ACSA supports this view.

ACSA sees aged care primarily as a social and independent life care model rather than a pure medical or clinical one. Within this clients are able to exercise choice about the nature of the care they want to receive. Therefore providers must have the capacity to change the staff mix depending on the needs and desires of clients. There is no evidence to suggest that set ratios provide or guarantee better quality care. The Victorian Public Sector residential facilities operate with ratios and they do not argue that their care is better than other providers.

On a practical level it would be non-sensical to establish nurse ratios in areas where they can not fill nursing positions at present.

Similarly licensing workers has been seen as a measure that would improve quality. It is argued that these workers would be more accountable for their actions given an articulated scope of practice, minimum qualifications and a commitment to professional development. Again there is no evidence to support this assertion. The 2007 NILS report found that 65% of personal carers and 54% of community care workers have a certificate III or above. They are predominantly a female, middle aged, part time workforce. If licensing was introduced then a large number of current workers would not comply and our experience is that many do not want to pursue formal qualifications. Licensing would make it even more difficult for providers in RRR and mining areas to fill positions.

We would also argue that professional development and role definition are the legitimate role of the employer in conjunction with the employee.

The debate seems to rest on how we ensure that quality care is provided and we suggest that ratios and licensing are blunt instruments that have no evidence in fact. ACSA would argue that it is done via a variety of mechanisms including:

- Client centred care;
- Accreditation;
- Good management;
- A commitment to training and professional development;
- A good complaints system; and
- Sophisticated risk management strategies.

The introduction of a market approach to the supply of aged care should theoretically raise the standard of aged care and allow providers to market their services using comparative measures of quality.

Management and leadership

There are a number of Australian Government initiatives currently available to encourage development of leadership and management in aged care, through awards and additional funding/programs for education and training such as the Aged Care Nursing Scholarship Scheme and the provision of postgraduate scholarships for community aged care. However, the focus of these programs/initiatives has been rewarding a limited number of managers or facilities for their excellence, or towards training and education for staff involved in direct care and supervision. None of the initiatives provide a systematic and strategic direction for the development of leadership and management roles for middle managers.

Associate Professor Yun-Hee Jeon undertook a literature review and found that strong, effective leadership and management promotes staff job satisfaction and retention, high quality care, the well-being of care recipients and reduces associated costs. However, successful leadership outcomes depend on good organisational leadership that enables managers to feel confident they have sufficient resources at their disposal to ensure the delivery of high quality care and sufficient support for their staff, for example adequate skill mix of staff, clear human resources practices and communication policies, administrative support, attractive incentives/rewards and career pathways.

There is a paucity of work in Australia on leadership and management development in the aged care sector. There is inadequate preparation for the middle management leadership role in the residential care sector, and lack of clear guidelines and key performance indicators to assess leadership and management skills.[12]

A 2009 South Australian survey of middle and senior managers working in aged care[13] indicated that many respondents were considering leaving the industry. The main reasons given were

- continually increasing workload (25.2%);
- over-regulation of the industry (16.3%);
- the poor working environment (11.9%); and
- low pay (8.9%).

As the skills shortage worsens, so does the management workload volume. Couple this with the increasing complexity of the work and the level of responsibility e.g. duty of care, documentation, occupational health, safety and welfare and legislative/funding compliance, managers find themselves working extensive additional unpaid hours in order to achieve their expected outcomes. Most do this because of their dedication and genuine commitment to quality outcomes for their residents and clients, despite their pay not reflecting the actual hours worked and being lower than that paid for similar work in the acute health sector.

[12] Yun-Hee Jeon - Optimising Residential Aged Care Workforce: Leadership and Management

[13] Workforce Committee Managers Workload Survey, Sept 2009, Aged & Community Services SA & NT Inc P.2

Of significant importance to managers is the way they are treated by the Department of Health and Ageing, the Aged Care Standards and Accreditation Agency (in particular) and the Complaints Investigation Scheme. The most common issue reported was the culture of blame and "guilty until proven innocent" behaviour exhibited by Departmental staff.

The punitive approach currently in force is outdated and should be replaced with a process of "working together" to investigate any short comings with a view to fostering improvements in outcomes.

This affirms the Productivity Commissions draft recommendation to reduce the regulatory burden in the aged care sector to improve the quality and diversity of services[14].

Recommendation

The Australian Government, via HWA or the Department of Health and Ageing, in collaboration with the aged care industry and its peak organisations, consider the development of a leadership and management quality framework and a leadership and management program.

Overseas Workers

Future workforce shortfalls already acknowledged and covered in the Commission's report and elsewhere, are unlikely to be completely filled with local labour, even if all the Commission's workforce recommendations are agreed to and fully implemented. At the height of the mining boom in Western Australia services simply could not find staff and they reported that around 39% of their rosters were made up with agency staff.[15]

Despite references to a number of submissions arguing for greater temporary or permanent migration of nurses and care workers, the report gives only scant consideration and makes no formal recommendations relating to foreign workers or international migration.

Of particular concern is the growing demand for personal carers. As a result of restructuring within the aged care sector over recent years, approximately 64% of residential and 69% of community aged care workers are now personal carers.

As stated in our previous submission, ACSA firmly believes that all local avenues should be exhausted before looking overseas for staff, and there are some ethical issues to address when considering attracting staff from third world countries. However, there is a limited pool of people within the current population from which the industry must compete in order to fill these carer roles, and the reality is that the situation will only worsen.

Therefore, in order to accommodate the current and growing future demand for aged care workers, ACSA believes it is imperative to look at alternative solutions. This includes utilising an international workforce made available through the temporary and/or permanent migration program. While sourcing overseas workers is seen by many as a short-term solution to the aged care workforce problem, in some areas this may need to be a more permanent strategy to provide an additional pool of care workers.

Two of the main barriers identified to sourcing labour from overseas, are related to language barriers and lack of care skills. However, these are also problems encountered with locally recruited workers. For example, some aged care providers in WA have a multi-cultural workforce complement as high as 90% of their total staff.

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[14] Section 12.4 Reducing the extent of regulation, Caring for Older Australians, Productivity Commission draft Report, January 2011 P.419

[15] Research done by ACSWA

The industry acknowledges these challenges; however, strategies to improve language and care skills need to be considered when preparing to recruit overseas workers for aged care roles.

The most common immigration route used by Australian businesses unable to meet their skill needs from the Australian labour market is to sponsor skilled overseas employees under the subclass 457 visa program. Overseas nurses and other allied health professionals are regularly recruited on a 457 visa. It is impossible under the current rules applying to the program to recruit personal carers. They are not considered to be in a skilled occupation and the temporary skilled migration income threshold of $47,480 per annum is higher than a personal carer's income.

Formal labour agreements between the Australian Government and employers are mechanisms for the recruitment of overseas workers. These arrangements are negotiated to meet special labour market circumstances that are not covered by standard business sponsorship arrangements. They have been limited in their application and tend to be valid for only two to three years.

Labour agreements are designed to ensure that overseas recruitment supports the longer term improvement of employment and training opportunities for Australians. Accordingly, as part of the agreement, employers or industry associations are required to make commitments to the employment, education, training and career opportunities of Australians.[16] While ACSA has no issue with this, if there are no Australian workers to train, meeting these conditions will be an impossibility.

Recommendation

ACSA supports the Commission's view that a review of the temporary and permanent migration program should occur and extend the scope to include suitable skilled and "non-skilled" workers who can provide care services in areas of critical labour under-supply such as aged care.

ACSA also recommends a change to the labour agreement program to recognise the shrinking pool of workers from which to draw labour.

[16] DIAC Booklet 1154 -Temporary Business (Long Stay) (subclass 457) visa p.4

ATTACHMENT 3

CARING FOR OLDER AUSTRALIANS – REFORM TRANSITION ARRANGEMENTS

Introduction

The Productivity Commission's draft recommendations for aged care reform would result in a significant liberalization of the current highly regulated system of aged care service provision, to one founded on the flexibilities and responsiveness of a more market informed system. The transition to the new arrangements not only poses risks for the providers of those services, but also to the vulnerable population whose immediate and future welfare is dependent on these services, and to the Government which initiates the reform.

The aged care sector is no stranger to reform, and indeed the current reform proposals may be seen as the next steps in a line of reforms undertaken to date which have helped pave the way for further reform. However, the extensive nature of the current proposals must be acknowledged. This situation calls for a transparent and comprehensive implementation plan to transition to the new arrangements and to manage the risks involved.

Objectives

The implementation plan should comprehend the following inter-related objectives:

- Ensure the continuity of quality services for consumers and their families while at the same responding as soon as possible to community expectations for greater consumer choice and increased service flexibility.
- Allow service providers time and flexibility to adjust their operations and business models, and provide the incentive and certainty to invest in the sector.
- Address the underlying distortions in the current system which are threatening the sustainability of the sector as soon as possible
- Avoid the emergence of opportunities for price exploitation of consumers.
- Manage the potential for market failure.
- Ensure continuity of access for special needs groups.
- Manage the Government's fiscal risk.
- Recognize the inter-dependencies in the reform measures and the lead times required for their implementation.
- Ensure community support for reform is not eroded by implementation stumbles and mistakes.

Assessment of implementation risks

The following identifies the major risks which could arise during the implementation of the reforms, along with options to mitigate those risks (and some observations).

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Risk	***Mitigation Options***
Threat to viability and valuations of residential aged care homes due to reduced occupancy rates, especially in relation to older multi-bed services.	• Allow providers time to adjust by increasing the provision ratio for community aged care gradually, and delaying the lifting of residential care provision ratios and the removal of all restrictions - all the while tracking the absolute increase in the number of older people needing care due to an ageing population profile. • Move early to reflect the cost of care and accommodation in prices • Increase flexibility by removing the low/high distinction and allow residential places to be converted to community care • One off grants to eligible small providers to obtain financial advice on business prospects and options. • Move early to widen business model opportunities for aged care providers eg palliative care and sub acute restorative care (incorporating transition care).
Threat to viability of residential providers because of reduced bond sizes and a possible flight to rental payments	• Move early to reflect market based costs of supply in prices for accommodation • Refinancing of bonds will occur over a couple of years and the pool from which bonds may be drawn will be larger. May impact most on providers who have based new developments on the availability of large bonds (compared with average bonds). • The extent of a flight to rental is not certain. Individual circumstances will vary and choice will involve judgments about CPI rates and likely care costs (eg likely length of stay, care need levels, stop-loss limit etc).
Continued under investment in residential high care which has been dependent on cross subsidies	• Move early to implement market based rentals and to reflect regional costs of supply of accommodation for supported residents
Under investment in services and accommodation for supported residents and special needs groups (market failure for residential aged care and community care packages)	• Maintain existing capital programs and viability supplements until new funding arrangements are in place • Emphasize the commitment to introduce new funding arrangements which will recognize the additional costs of services for special needs groups • Maintain regional quotas for supported residents during the transition phase • Continue expansion of MPSs
Market failure of HACC services with introduction of entitlement based funding and choice of provider	• The move to entitlements for basic community care and choice of service provider needs to be developed further and phased in carefully, including the identification of Lead Agencies, use of brokers, enablement approaches and any role for residual 'block funding'.
Exploitation of consumers (accommodation payments and additional services) pending deepening of the market	• Lift provision ratio for community care packages earlier than for residential places, noting that community care has greater elasticity of supply • Move early to update Specified Care and Services or equivalent

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Community resistance to increased copayments	• Move early to increase community care and increase opportunity to age in place • Move early to introduce the Pensioner Bond Scheme and a Government-backed equity release scheme
Consumer expectations regarding choice and flexibility not met quickly enough	• Move early to increase the supply of community care places pending the development of the single integrated system of care provision, and allow community care recipients to age in place as their care needs change. • There is a case for moving early on entitlement based funding for higher levels of care need, especially if there is a decision to pilot entitlement for basic care services.
Extent of change may compromise the quality of care	• The system as it changes will continue to be underpinned by a mature and robust accreditation, compliance and complaints review system. • Attune risk assessment processes for current quality assurance mechanisms to the risks posed by the changing environment. • Assist adjustment in the sector through short term financial assistance to small providers to obtain business planning advice. • Move early to expand the advocacy services.
Fiscal risk to the Government if needs based assessment is not effective	• Full implementation of entitlement-based funding not to proceed until Gateway Agency, the new assessment tool and the integrated care funding classification system has been developed and piloted in selected hubs. • There is a case for moving early on entitlement based funding for higher levels of care need.
Risks associated with the development and implementation of assessment tools and care funding classification system across residential and community aged care and carers, and the roll out of the Gateway Agency eg navigation not improved, blockages and delays in processing, enablement approach ineffective, administrative complexity and inefficient processes	• The success of the reforms will depend on the successful roll out of the Gateway Agency and the effectiveness and efficiency of its operations. • Successful and robust Gateway operations to precede any substantial liberalization of the current system. • Because of the complexity of this task, it will require its own detailed project planning and risk assessment process.

Implementation plan

An indicative high level implementation plan for the transitioning of the reforms which takes into account the above objectives and analysis of implementation risks follows. As well as having to be adapted to the package of reforms which the Government may endorse, there will also need to be more detailed project plans developed for most of the activities.

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ATTACHMENT 3

Activity	Year 1 (2012) [17]				Year 2 (2013)				Year 3 (2014)				Year 4 (2015)				Year 5 (2016)				Year 6 (2017)			
Government announces reforms, implementation plan and timetable		☺																						
Complete takeover of HACC and ACATs in relevant States and implement ‘one stop shops’(pending creation of Gateway Agency with wider scope)																								
Increase the provision ratio for community aged care packages gradually, allow community aged care package recipients to age in place																								
Expand advocacy services																								
Independent cost of care study to inform prices for 2013 pending AACRC																								
Develop new funding classification, assessment, entitlement and review arrangements and processes for integrated care system																								
Develop national home modifications and aids scheme																								
Develop new specified care and services or equivalent																								
Progressively increase supported resident supplement to reflect cost of supply of agreed standard of accommodation																								
Introduce new regional quota arrangements for supported residents																								
Remove low/high distinction and implement market based and flexible accommodation payment arrangements																								
Introduce pensioner bond scheme and equity release scheme																								
Allow ‘additional services’ for all new residents and remove Extra Service																								
Introduce case mix payment for palliative and end of life care and sub acute restorative care																								

[17] Calendar years, and assumes a Budget announcement

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Activity	Year 1 (2012)	Year 2 (2013)	Year 3 (2014)	Year 4 (2015)	Year 5 (2016)	Year 6 (2017)
Establish AACRC						
Establish Gateway Agency						
AACRC issues first recommendations for prices and subsidies (for 2014 Budget)						
Introduce new AACRC-informed prices, co contributions, subsidies and stop-loss limit						
Gradually increase residential aged care provision ratio						
Discontinue capital programs (except for eg MPSs and certain indigenous services)						
Identify pilot hubs and lead agencies to introduce new integrated care arrangements and progressively roll out in relevant states.						
Review pilot arrangements for integrated care system, including entitlements for basic care						
Review need for regional quotas for supported residents and access by special needs groups						
Remove provision ratios for higher level community and residential aged care						
Risk assessment by existing quality assurance arrangements to be attuned to changing environment and transition issues						
Grandfather arrangements for existing residents						

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