The Government of South Australia

Response to the Productivity Commission's Draft Report

'Caring For Older Australians'

March 2011

Introduction

South Australia acknowledges the work that the Productivity Commission has done into the inquiry of *Caring for Older Australians* and this submission represents the South Australian Government's position on the draft report.

Summary of key issues for South Australia

The proposed new Aged Care Gateway

The proposed new Gateway to the aged care system seems broadly consistent with the Commonwealth's initiative of 'one-stop-shops'. South Australia would like to emphasise the importance of health services input into the Gateway, particularly in relation to the provision of aged care information, and more importantly aged care assessment. Clear processes and systems between health and aged care will be required to avoid duplication and possible lengthy delays in discharge from hospital for those people who no longer require acute care.

It should also be noted that there is a need to align the proposed Gateway with the other National Health and Hospital Network reforms (in particular the Medicare Locals and Local Hospital Networks) as this is not discussed in the report.

Interface between health and aged care services and disability services

The impact of the proposed reforms on the interface between hospital, subacute care and aged care, in particular future transition care arrangements, is a key issue for South Australia. The draft report focuses on aged care services having increased responsibility for the provision of restorative care and rehabilitation, aspects that are the primary responsibility of the Transition Care Program (TCP). TCP is not explicitly discussed in the draft report and it is unclear if this program is expected to be included within the proposed range of aged care and support services within the new system.

The draft report recommends expansion of in-reach health services to residential aged care facilities and the development of regionally or locally-based visiting multidisciplinary health care teams. These are supported and are consistent with SA Health directions. However, the extent of the reform noted in the draft report is expected to require a substantial health service investment over the next ten years that is over and above the current subacute Council for Australian Governments (COAG) initiatives.

The report recommends the adoption of separate policy settings for the major cost components of aged care, namely care (personal and health), everyday living expenses and accommodation. It is proposed that health services will be funded through a combination of a universal subsidy and consumer contributions. The universal subsidy must ensure it addresses the higher cost requirements of people with complex health needs.

The draft report recognises there are incomplete and overlapping interfaces, which include disability. Concurrent with this inquiry, the Productivity Commission is undertaking a separate inquiry into disability care and support. The policy response to this inquiry is not likely to be known for some time. Clear principles on the interfaces need to be explicit. This includes maintaining continuity of care, of a person with a disability transitioning into the aged care system at age 65, including standard of service and service provider.

Distribution of Aged Care Services and Equity of Access

The impact of the proposed regulatory reforms on the distribution of aged care services across all regions needs to be considered. Equity of access for special needs groups, particularly those from rural and remote areas, is a key concern.

The draft report notes that the Multi Purpose Service (MPS) model of care may play an important role in addressing viability issues in these rural and remote areas. This is supported. However, a number of issues require further exploration, these include: a review of existing quality accreditation requirements for MPS; detail about how the different aged care cost components will be identified within the current pooled funding arrangements across acute and aged care; and access to funding for capital improvements.

In relation to the proposed recommendations that older people increasingly contribute in part to their cost of care, it will be essential to ensure there is equity in the allocation of 'supported' places across all regions to avoid the possibility of a two tiered aged care system; one for those that can afford to pay and another for those who cannot. This has implications in rural and remote areas where there is a greater representation of those that are financially disadvantaged and where SA Health run facilities provide services of last resort.

Self Managed Funding

Self managed funding for older people, to promote greater choice and individual control over care is broadly supported.

However, in certain situations this model may be problematic and specific arrangements would need to be agreed to. For example the following situations would require further consideration:

- Older people who do not have the capacity to make informed choices about their care such as those with dementia;
- Where the consumer would benefit from short term interventions but would prefer to receive services in the long term; and
- Where consumers are declined a service from providers due to difficult behaviours.

Recognition of Specialised Service Responses

Community aged care services such as allied health therapeutic services, rehabilitation and chronic disease specialist responses have developed expertise across its workforce which may be lost if the 'price for care' does not take into account this level of specialisation.

Specialised service levels must be factored into the financial model to ensure that this level of expertise is provided. In some instances intervention is short term but requires intensive specialised expertise, for example, allied health or rehabilitation. It is these short term high cost services that need to be funded appropriately.

Whilst removing a restriction on 'places' will alleviate some pressures on current demand there will always be a limit on the amount of service that a provider can offer. This is primarily due to infrastructure and workforce capacity. Therefore, there may still be situations where clients cannot be discharged from hospitals or post acute/transitional care programs in a timely manner.

To resolve these issues consideration should be given to expanding block and/or grant funding to include specialist services.

Furthermore, it may be possible for specialist services to be provided across the community aged care service sector through a model of 'sharing expertise' via teaching or co-working. For example, a service provider that provides expertise in the form of allied health, dementia management, palliative care or rehabilitation could make this available to all service providers through a purchasing arrangement or visiting sessional arrangement. This would enable a greater number of providers to offer such services to consumers. This type of service could also be a resource/advisory service and assist with the piloting and evaluation of new services.

Safety Net Services

In situations where older people cannot be discharged from hospitals or post acute/transitional care programs in a timely manner, it may be beneficial to have an aged care response, which could be time limited. Such a response would be funded to provide:

- Short term intensive interventions to re-able and stabilise, e.g. rehabilitation services;
- Services for consumers where all other service options have been exhausted, due to their complexity and/or condition, e.g. a provider of last resort/safety net system. Traditionally where consumers are not provided a service by non-government agencies, it is the government services that provide a service for consumers with complex needs due to duty of care.
- Intermediate and longer term care services in home based and/or community settings until suitable placements became available, e.g. as a lower cost option than remaining in acute settings.

In circumstances where a person is not able to be discharged from an acute hospital bed due to the absence of available aged support and/or care services, the full cost of the patient remaining in the hospital should be funded by the Australian Government. This would provide a financial incentive mechanism for the aged care system to be responsive to actual levels of demand.

Gender analysis

It should be noted that while reference is made to sex differences, in experiences of ageing, there is a lack of explicit gender analysis in the draft report.

South Australia is concerned that the lack of gender analysis in the development of aged care policy and the provision of services has the potential to result in policy failure and the continued entrenchment of gender disadvantage in old age in the long term.

In particular, South Australia is concerned at the lack of explicit recognition of the feminised nature of the provision of both formal and informal care of older people. Women's caring roles across the course of their lifetimes result in lower incomes being available to them in retirement and a reduced capacity to contribute to the costs of their care in old age. Given that women experience greater life expectancy, but experience higher levels of age related disability than men, this has a clear impact on the fiscal sustainability of aged care services in the future.

Overview – Key Points

Under the proposed reforms, older Australians would:

'contact a simplified 'gateway' for: easily understood information; assessments of care needs; assessments of financial capacity to make co-contributions; entitlements to approved services; and care coordination — all at a regional level'

- The Gateway has the potential to streamline access to aged care services.
- The proposed simplified Gateway builds upon the Access Point Demonstration Project, a joint project between the Commonwealth Government and State and Territory Governments. South Australia's Access Point, Access2HomeCare for frail older people, with close alignment between health and aged care services, operates in the Western Metropolitan area and Barossa. Access2HomeCare will be rolled-out metropolitan wide in 2011.
- The recommendation that the Gateway provides coordination of the personal care and health care and of the providers of that care seems a very complex and resource intensive task for the Gateway. It may be more beneficial for the older person if the service provider at the grassroots level, who will have the face-to-face contact with the older person, to actually coordinate and monitor the personal care and health care, including any reviews. There is concern regarding the provision of care coordination at Gateway as there is a risk of duplication if the consumer requires long term services. Care coordination needs to be further defined.
- The Gateway needs to recognise that the 'trigger' for these services is often an 'event' relating to a person's health. In such cases a comprehensive multidisciplinary assessment of the health component of care has been undertaken within the state/territory operated health system. Mechanisms need to be in place to ensure this information is available to the Gateway to avoid duplication of assessment.
- A nationally consistent set of criteria and/or framework for eligibility, assessment of care needs and support services are required. Key stakeholders need to be consulted across all areas of ageing, health, disability, carers and volunteers.
- Oral health should be integrated into all 'gateway' assessments and included in case management and care coordination.
- If information provision also includes health care/primary care type services then there are resource implications in the development of links/relationships with the health sector.
- A national 1800 free call number would assist with publicity and streamlining people's access to information and services.
- An up-to-date user-friendly database containing service provider's information needs to be accessible at the Gateway to help people access the services they require in their local area. Service providers need to have access to change certain fields in the database so that information can be kept up to date and include the provider's capacity to accept people into their services
- A number of questions remain about how the Gateway agency would work, whether it would create a bottle neck and whether it would increase pressure on hospital beds if people could not find an aged care place or service once they are ready for discharge from hospital.

- Carer identification needs to prompt linkage of the carer with the local carer support service as a preventative and early intervention strategy. Carers need information that a range of services and support are available including information, referral, support, respite, advocacy, counselling.
- The National Disability Agreement proposes a similar target for people with disability (Priority J: Access to disability care focuses on systems for improving access and ensuring people are referred to the most appropriate disability services and supports, including consideration of single access points and nationally consistent assessment processes). The two entry services should have a clear interface.

'receive a flexible range of care and support services that meet their individual needs and that emphasise, where possible, restorative care and rehabilitation'

- Restorative care and rehabilitation is supported but further details of what this model would look like are required. Specialist expertise is needed to provide effective rehabilitation with access to multidisciplinary teams.
- Promoting empowerment, independence and capacity need to be key objectives of the Gateway. There is a risk that the Gateway is understood by the community and staff as a means of determining need (including previously unidentified need) and delivering services. This may generate a culture promoting increased dependency and increasing demands for service based on a sense of entitlement.
- This model should include the early intervention for providing older people with the right equipment, home modifications and assistive technology, advice and self management skills that would keep them independent longer. This would also reduce the demand on the formal workforce.
- Restorative care and rehabilitation needs to be offered and/or provided as early as possible and where appropriate provided either in a mainstream Geriatric Evaluation and Management (GEM) service or a rehabilitation service.
- Funds will need to be set aside initially to develop and support this model.
- The experience of the Transition Care Program in South Australia indicates that the understanding about the provision of restorative care and rehabilitation services is variable across the aged care sector. These types of programs should be goal focused, intensive and provided for time limited periods as required. There needs to be guidelines to ensure that the delineation is clear between these services and other components of a person's care needs.
- The role of the Transition Care Program (TCP) is not explicitly discussed in the draft report. Rehabilitation in aged care services needs to be aligned with state run rehabilitation services, even if funded through an aged care methodology. If separate rehabilitation type services are developed that are not integrated with state services and GEM programs they will inevitably compete for patients rather than provide an integrated care approach. Evidence from the TCP evaluation suggests that TCP complements and does not replace the state funded rehabilitation services. There is a risk that current TCP clients will be pushed back into the formal subacute system unless there is a dedicated response such as TCP. This issue should be clarified as a key priority in South Australia, as SA Health had 1278 TCP clients in 2009-2010.
- All restorative care and rehabilitation services should include the four basic oral health processes for maintaining oral health.

- Carer health and wellbeing are compromised by the caring role. Carers' capacity to continue to provide care requires maintenance of their own health. Carers are likely to ignore their own health and wellbeing issues due to time pressures and lack of acceptable, temporary, alternate arrangements for the care recipient if this is required.
- Early intervention that supports maintenance of carer health and wellness, including connection to the community is suggested. The South Australian carer support service model, with respite being one option of carer support, enhances the maintenance of carer health and wellbeing.
- Need to ensure that older people with a disability and older people from Culturally and Linguistically Diverse (CALD) backgrounds etc, are given a detailed explanation of these services and have an option of having advocates.

'choose, where feasible and appropriate, to receive care at home or in a residential facility and choose their approved provider'

- This option is supported with the recognition that this is more likely to work for planned decisions. People waiting in hospital after a health 'event' may not have the same opportunity or capacity to choose and consider care options.
- In rural and remote communities there is limited choice. In South Australia, a SA Health facility is the only provider in some areas. As well, in-home services are not always feasible in rural and remote communities because of distance.
- Older people with a mental illness or severe behavioural and psychological symptoms of dementia will have reduced capacity to choose providers without the assistance of family and/or advocate. The role of advocacy services as described in the report may not be sufficient to enable these older people to exercise choice. This may result in an increased role for the state based agencies such as the Guardianship Board. An increase in the availability of guardianship board resources as well as specialised staff such as geriatricians, psychogeriatricians and neuropsychologists who provide the complex assessments of capacity that guide Guardianship Board decisions may be required.

'contribute in part to their cost of care (with a maximum lifetime limit) and meet their accommodation and living expenses (with safety nets for those with limited means)'

- Making the system fairer in terms of consumer contribution will assist in resolving problems with consumers reluctant to move between services.
- Strategies are required to address situations where the consumer will not contribute to the cost of their own care to the detriment of their health or wellbeing.
- How do you determine what a maximum lifetime limit is and how is this determined on a yearly basis?

'have access to a government sponsored equity release scheme to pay for their care and accommodation charges if they have assets but limited annual incomes'

- South Australia cannot see the benefit of government sponsoring an equity release product unless it was to offer a subsidised, lower rate. Currently nearly all reverse mortgage customers are protected from either losing their house (forced sale), or owing more money than the home finally sells for, through 'no negative equity' guarantees which are currently standard in existing reverse mortgage

products. Regulators have forewarned that significant changes to the reverse equity product are likely to be included in the next National Consumer Credit Protection review. Reverse mortgages can play an important part in comfortably maintaining older Australians in their home with home care and therefore taking pressure off hospitals and aged care places.

- How would this work for families who have assets but limited income due to children living in their properties for free and/or cheap rent?
- Is this based on each financial year as some years, people's portfolios payouts can change?

'choose whether to purchase additional services or a higher quality of accommodation if that is what they want and can afford to do so.'

- The capacity of some areas to offer additional services may be limited. In rural and remote communities there is limited choice. In some areas of South Australia, a SA Health facility is the only service provider.

Safety and quality standards would be retained but current limits on the number of residential places and care packages would be removed, as would the distinctions between low and high care and between ordinary and extra service status.

- Removing the current limits on aged care places is supported.
- Removing the distinction between levels of care will greatly assist with continuity of care/ageing in place.
- Apart from quality accreditation assessments for community care published by the accreditation agency, there should also be a mechanism for service users and their carers to provide feedback about the quality of services.
- This recommendation addresses the issue that current funding formulas do not capture emerging demographic ageing trends. This is particularly important for South Australia whose 85+ population is higher than other States.
- Removing the current limits on places will allow greater flexibility and a more seamless continuum of care, particularly in rural and remote communities that have smaller numbers of older people that can vary between towns and communities.

A new independent regulatory commission would transparently recommend to the Government the price for care services and for standard accommodation for supported residents, be responsible for quality accreditation, and address complaints.

- Will there be a link between the price for care and the quality of care? Will instances where a provider can demonstrate better outcomes but at a higher cost be factored in?
- Need to ensure Multi Purpose Services are included in quality accreditation processes as they are currently not required to meet these under existing regulations.

Recommendations

A framework for assessing aged care

Recommendation 4.1

To guide future policy change, the aged care system should aim to:

'promote independence and wellness of older Australians and their continuing contribution to society'

- An improved emphasis on self-management, early intervention, prevention, restoration and community capacity will encourage the system to be proactive and less focussed on the provision of maintenance care.
- Having home modifications, access to equipment and assistive technology and a time limited intervention focusing on regaining independence should be a starting point before accessing ongoing basic care.

'ensure that all older Australians needing care and support have access to person-centred services that can change as their needs change'

- It is critical that access to care is flexible and that changes in need are managed proactively and in a timely manner. This will help prevent inappropriate and avoidable admissions to hospital.
- Standards for person-centred services require further development with consideration given to how these standards will be measured.

'be consumer-directed, allowing older Australians to have choice and control over their lives'

- Need to take account that not all older people have, or will have, the capacity to make their own decisions without support and/or assistance.
- Funding and service models must adequately reflect the complexities of the care needs of older people, e.g. older people with complex health needs; and readily allow consumers to move between levels of care.
- The new system needs to ensure that consumers are not penalised financially if they change providers.
- Services also include counselling, information and advocacy and are available locally, either by a centre based service or outreach.

'treat older Australians receiving care and support with dignity and respect'

- It is particularly important that supported residents (disadvantaged residents) have the same level and quality of care as other residents.
- The measurement of this needs to be through a simple, yet comprehensive approach.

'be easy to navigate — Australians need to know what care and support is available and how to access those services'

- Carers often assume the role at a point of crisis and will be unfamiliar with services, supports, access points and eligibility criteria. Information for carers is currently cited as a confusing maze which carers may stumble across after many years of caring. This is further complicated as carers typically don't self identify, especially in the early stages of the role. Consideration of how to direct carers at this early stage to services and supports will be critical. At the first point of contact for the carer, information, access and or guided referral to supports and services should be available.

'assist informal carers to perform their caring role'

- All carers identified at Gateways should be linked to the local carer support service to ensure information and access to services and support are available from the first point of contact. Services per se may not be required at that early stage however, the information and connection with the carer service will enhance the carer's knowledge and therefore sense of control.
- Carers require information and knowledge of the range of products available to them for services and support. Carers need to be in control and make their own decisions about the timing and uptake of services. The philosophy of the model of carer support services in South Australia is to work with and alongside the carer, through their journey as a carer.
- In South Australia independent carer support services are located in all regions Statewide. The principles and philosophy which drive the model are centred on the service being carer-driven, carer-focussed and an empowerment model which recognises carers 'in their own right'. Emphasis is placed on providing a centre where carers feel comfortable to drop-in thereby enabling carers to develop friendships with other carers. The centres provide time out, opportunities for recreation and fun and a sense of fellowship and a chance to talk to others who understand. This occurs by holding 'retreats' or 'time out' for carers, and ongoing support groups. When carers connect with one another it takes pressure off service providers as networks build between carers.

Paying for aged care

Recommendation 6.2

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

'accommodation and everyday living expenses should be the responsibility of individuals'

- It should be noted that separation of different cost components would be more difficult for State-run facilities in rural and remote communities that operate on a combined service and funding model of acute and aged care.

'health services should attract a universal subsidy, consistent with Australia's public health care funding policies'

- The subsidy should be based on a level that adequately addresses people's needs and is not capped too low. This subsidy needs to include oral health and allied health.

'individuals should contribute to the cost of their personal care according to their capacity to pay, but should not be exposed to catastrophic costs of care'

- The draft report appears to assume that the majority of older people have a housing asset they can use to finance their needs in old age. For increasing numbers of low income earners, particularly women, this is not the case, with many either falling out of the housing market e.g. because of divorce or separation or through never having sufficient income to enter the housing market in the first place.

Recommendation 6.3

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

- Opening up the market to competition will certainly pressure providers to raise the quality of services which may drive some providers out of business. If this is the case it will likely be the smaller providers who will suffer with reduced capacity to demonstrate quality but also reduced capacity to 'advertise' to potential consumers on what they can offer. Will it be the large providers with the big marketing/advertising budgets that will saturate the market place and in the end reduce consumer choice?
- The current population based quotas for aged care packages and residential care places restrict options to provide the most appropriate care if specific care options are not available. Removing the quotas will allow for more care options where needed, greater flexibility and a more seamless continuum of care, particularly in rural and remote communities that have smaller numbers of older people that can vary between towns and communities.
- However, there remains a continued need for a spectrum of care. For example:
  - Residential lower care placements are required for older people isolated on properties or where the delivery of in-home care services is impractical for the workforce; and
  - Sufficient higher care placements are required for people with complex high care needs to ensure that delays do not occur in discharging older people from hospital once they no longer require acute care services.

Recommendation 6.4

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

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

- The abolition of the bond retention amounts would be a cost impost for services in rural and remote communities to access funding for capital improvements unless the daily periodic payment is comparable to previous funding amounts.

Recommendation 6.5

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

- There is a concern that this proposal would advantage those providers who have the resources to provide more upmarket facilities for those that can afford them and leave other providers to provide for the less well off. This will further reinforce the availability of very high level facilities for the few. There are already some providers who have up to 75-80% 'disadvantaged' residents (to be called supported residents). This measure could entrench inequity in the market, remove the obligation of all providers to accept their share of supported residents and reduce consumer choice for those people with less financial assets.

Recommendation 6.7

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

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

- This does not reflect the basic standard of people's lives. Most adults do not share accommodation with people who are not family, let alone bedrooms and bathrooms. In the disability services area it is acknowledged that the aim is to maintain a 'normal' life and congregate care (let alone the sharing of rooms) is not considered acceptable. Dignity, respect and privacy, as well as, health, safety and infection control etc are significant for all residents irrespective of their ability to pay and should be recognised. Basic standard accommodation should be set to meet community standards on the basis of single rooms with bathrooms to ensure older people maintain as much as a 'normal' life as they age.
- It would be inappropriate to accommodate people with dementia or challenging behaviours in a two-bed room.

Care and support

Recommendation 8.1

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

- *A platform within the Gateway would provide information on healthy ageing, social inclusion and participation, age-friendly accommodation, and also information on the availability, quality and costs of care services from approved providers, and how to access those services.*
- *Assessments of the needs of older people would be undertaken for their potential entitlement to approved care services, with the level of assessment resourcing varying according to anticipated need.*
- *An aged care needs assessment instrument would be used to conduct assessments and an individual's entitlement to basic support, personal care and specialised care, and carer support. Assessments of financial capacity to make care co-contributions toward the cost of the services would also be arranged.*
- *Initial care coordination services would be provided, where appropriate, as part of the Gateway. If required, case management would be provided in the community or in residential aged care facilities by an individual's provider of choice.*

- The Gateway has the potential to streamline access to aged care services.
- The proposed simplified Gateway builds upon the Access Point Demonstration Project, a joint project between the Commonwealth Government and State and Territory Governments. South Australia's Access Point, Access2HomeCare for frail older people, with close alignment between Health and Aged Care services, operates in the Western Metropolitan area and Barossa. Access2HomeCare will be rolled-out metropolitan wide in 2011.
- The recommendation that the Gateway provides coordination of the personal care and health care and of the providers of that care seems a very complex and resource intensive task for the Gateway. It may be more beneficial for the older person if the service provider at the grassroots level, who will have the face-to-face contact with the older person, to actually coordinate and monitor the personal care and health care, including any reviews. There is concern regarding the provision of care coordination at Gateway as there is a risk of duplication if the consumer requires long term services. Care coordination needs to be further defined.
- The Gateway needs to recognise that the 'trigger' for these services is often an 'event' relating to a person's health. In such cases a comprehensive multidisciplinary assessment of the health component of care has been undertaken within the state/territory operated health system. Mechanisms need to be in place to ensure this information is available to the Gateway to avoid duplication of assessment.
- A nationally consistent set of criteria and/or framework for eligibility, assessment of care needs and support services are required. Key stakeholders need to be consulted across all areas of ageing, health, disability, carers and volunteers.
- Oral health should be integrated into all 'gateway' assessments and included in case management and care coordination.

- If information provision also includes health care/primary care type services then there are resource implications in the development of links/relationships with the health sector.
- A national 1800 free call number would assist with publicity and streamlining people's access to information and services.
- An up-to-date user-friendly database containing service provider's information needs to be accessible at the Gateway to help people access the services they require in their local area. Service providers need to have access to change certain fields in the database so that information can be kept up to date and include the provider's capacity to accept people into their services
- A number of questions remain about how the Gateway agency would work, whether it would create a bottle neck and whether it would increase pressure on hospital beds if people could not find an aged care place or service once they are ready for discharge from hospital.
- Carer identification needs to prompt linkage of the carer with the local carer support service as a preventative and early intervention strategy. Carers need information that a range of services and support are available including information, referral, support, respite, advocacy, counselling.
- The National Disability Agreement proposes a similar target for people with disability (Priority J: Access to disability care focuses on systems for improving access and ensuring people are referred to the most appropriate disability services and supports, including consideration of single access points and nationally consistent assessment processes). The two entry services should have a clear interface.

Recommendation 8.2

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

- There will still need to be a continuum of care, including consumers with episodic needs , addressing how care options are determined and reviewed.
- Will consumers be able to 'shop around' for different services across a range of providers potentially creating a need for case management of these services?
- Conversely, not all providers offer the suite of services a consumer requires, so how will the interface work and payments be split between providers?
- This may not be appropriate for clinical and other specialist services. The interface with the health system will be critical to ensure the associated funding mechanisms and levels are in place for services such as clinical care, oral health, mental health and rehabilitation as these services are currently limited.

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

- It should be noted that the choice of an approved provider is not always possible in rural and remote communities.
- This recommendation is good for care services where quality of care can be easily determined by the consumer. Quality of clinical care is harder for a consumer to determine.
- Some people have high health needs as well as personal care needs. Determination of how these services could effectively work with State health services is required.
- If the entitlement system is to include aged care providers undertaking rehabilitation similar to TCP then there will need to be some time limited, but high cost packages built into the system. Current TCP pays significantly higher than nursing home rates for the initial period until the client is stabilised at a new lower level of care requirement.
- What will the incentive be for providers to take 'difficult' consumers? Can service providers say no? Will the assessment instrument factor in psycho-social needs to a degree to warrant additional funding? Perhaps there needs to be a safety net for consumers who are not accepted by service providers.

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

- The schedule price needs to be flexible enough to allow people to move between levels of care as their needs change. For example in the TCP program a payment of $229 per day per consumer is received but the actual cost of services can be up to $251 per day per consumer. In addition, the service has developed core service infrastructure that is available to all consumers and includes case managers, geriatricians, social workers and therapists employed to support client's health needs. A capped price would be restrictive with the client receiving a set amount of service provision. Currently in the TCP program some consumers receive less and some receive substantially more than is set down in the price.

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

- As noted in the overview, advocacy services as described may not be enough. An increase in the availability of guardianship board resources as well as specialised staff such as geriatricians, psychogeriatricians and neuropsychologists who provide complex assessments of capacity that guide guardianship board decisions may be needed.

Recommendation 8.3

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

- Consideration should be given to whether there is a need for specialist community palliative teams to provide advice or services to providers.

- There needs to be a clear determination that the role of the Independent Hospital Pricing Authority (IHPA) is to set the price, not facilitate the distribution of funding. It should also be noted that these prices are currently based on hospital and related services. Community based services to patients in residential and community aged care services currently fall out of scope of what the IHPA is required to do.
- Payment for basic care as well as overnight nursing support and equipment provision should be included. It would be preferable if it could be provided by the aged care service already delivering care. However, the specialised nature of palliative care means that the skills and knowledge is not widespread and may need to be bought in.
- Considerable discussion is required to ensure the seamless provision of care between the health and aged care service providers. Many state funded specialist palliative care services in-reach to residential aged care facilities in a shared care model. Determining the appropriate case mix payments for health and residential and community aged care providers will need to reflect this. At the moment significant differences in models of delivery exist between states and territories.
- Payments for differing 'categories' of consumers who may otherwise be discriminated against e.g. CALD and Aboriginal people, those living in Supported Residential Facilities, people with dementia, rural/remote – due to their often complex (and therefore more costly) is required.

Recommendation 8.4

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

- Agree in principle, but a very complex issue that will need to be addressed over time to ensure sector sustainability.
- Block funding should include the provision of specialist expertise such as rehabilitation, chronic disease prevention/management to ensure good clinical pathways with acute sector and to ensure that workforce remains in community such as allied health.
- Consideration should also be given to block funding for innovative services, where a need requires specialised input or where the required skills are not widespread. For example, restorative care for people with high chronic health needs and high levels of dependency.

Recommendation 8.5

The Australian, state and territory governments should, subject to further evaluation, promote the expanded use of in-reach services to residential aged care facilities and the development of regionally or locally-based visiting multidisciplinary health care teams.

- This service model should also be considered for community service providers who do not have the expertise 'in house' to provide services such as allied health but can provide basic support services or a package of care. For example, a client may be receiving a package of care from a specialist CALD agency and have a fall in the home. A community multi-disciplinary rehabilitation team could be put into action to conduct a home safety assessment, prescribe equipment

and home modifications and plan a program of therapy to regain independence. The client is able to remain with their existing provider maintaining continuity with their carers who speak their language and understand their particular care needs.

- The expansion of in-reach services will require a substantial investment over the next ten years in health services over and above the current subacute COAG initiatives.
- The SA Health Service Framework for Older People and Statewide Palliative Care Service Plan describe this model of care and services and are currently being developed. Appropriate payment through the IHPA will be important to support these services.
- For rehabilitation and restorative care programs a whole of staff approach including all nursing and support staff is required to promote independence and restorative goals not just the visiting clinical team.
- Multiple discipline input is required when there are more complex nursing needs that are beyond the usual scope of residential facilities to manage and additional resources would need to be included.
- Dental care and the multi-purpose treatment rooms must be able to accommodate dental treatment teams and portable dental equipment. Portable dental equipment needs to be affordable and equipment should be shared across clusters of residential aged care facilities to maximise the return on the purchase cost.
- In-reach services should include mental health expertise.

Recommendation 9.1

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

'ensuring all older people have access to information and assessment services'

- The Gateways number should be a national 1800 free call number so it does not disadvantage people from rural and remote areas and special needs groups.
- There is potentially an inherent tension between a 'one size fits all' Gateway and the recommendations regarding flexible, individualised services. Special needs groups (CALD, Aboriginal and Torres Strait Islander people (ATSI), people with dementia and people with disabilities) will require the Gateway to be flexible enough to meet their needs. For example, a centralised telephone intake service with assessment over the phone may not meet these people's needs.

'providing interpreter services to convey information to older people and their carers, to enable them to make informed choices'

- Nationally developed and translated publicity material will help to ensure consistency of information
- Older Aboriginal people should be included as some do not have English as their first language.
- Information should also be provided in a number of formats for people with disabilities, for example, Teletypewriter, braille, large font, simplified text using accessibility principles.

Recommendation 9.2

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

'providing ongoing and comprehensive interpreter services (either within facilities or through telephone translators) for clients from non-English speaking backgrounds'

- The provision of CALD appropriate services goes beyond interpreters and training.
- The costs associated with providing services also needs to consider that the time taken to provide a service could be extended where interpreters are involved and where culturally appropriate services need to be provided.
- Consideration also needs to be given to the need to travel long distances, the need to work with lifelong disability and the need to spend extra time establishing trust/rapport.
- This should include older Aboriginal people as some do not have English as their first language.
- Ongoing comprehensive interpreter services should include services for people with disabilities.

'ensuring staff can undertake professional development activities which increase their cultural awareness'

- This is a vital area however, often complicated by the costs and availability of backfilling. Creative training solutions need to be developed.
- Consideration also needs to be given to strategies in recruiting and retaining workers from ATSI and CALD backgrounds with a mechanism to utilise their specific skills across the service sector instead of being employed by individual providers.
- Carers resist respite or other support unless they have confidence in the competence, training and skills of the worker. This is particularly an issue in rural and remote areas where workforce limitations may exist. Services for culturally diverse carer groups including ATSI carers require appropriate resourcing and service models including human resources.
- Disability awareness should also be considered as a vital part of staff professional development.

Recommendation 9.3

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

'meeting quality standards for service delivery'

- Service Delivery should be undertaken in a culturally appropriate manner.

'funding models that are aimed at ensuring service sustainability and that recognise the need for the building of local capacity to staff and manage such services over time'

- Some Aboriginal clients wish to have the choice of whether they go to a specific Indigenous service or a mainstream one that is inclusive of their needs. We should not assume and build the system on a siloed approach but build capacity and options for older Aboriginal people.

Age-friendly housing and retirement villages

Recommendation 10.1

The Australian, state and territory governments should develop a coordinated and integrated national policy approach to the provision of home maintenance and modification services, with a nominated lead agency in each jurisdiction.

- A system to ensure effective funding of home modifications and compliance with standards is welcome. Need to clarify the role of government in funding major home modifications to privately owned dwellings. For example, should the government improve a private asset with a $20,000 modification?
- In South Australia, the Department for Families and Communities (DFC), through Housing SA has been building aged friendly housing in accordance with its *Design Criteria for Adaptable Housing* Guideline since 2005. The Housing SA Disability Action Plan commits to the construction of a minimum of 75% of housing in accordance with these principles as some multi-storey developments and dwellings on steeply sloping sites are not able to comply.
- However, Housing SA does have concerns about design detail and construction implications in respect of the Livable Housing Design Guidelines promoted by National Dialogue on Universal Design (refer to FAHCSIA website).
- The provision of equipment and assistive technology that can increase a person's independence needs to be included.
- This may have implications for providers who are currently grant funded for these services.
- An agency should also be nominated to provide a time limited rehabilitation, early intervention and/or wellness approach in conjunction with home modifications, equipment and/or assisted technology.

Recommendation 10.2

For older people with functional limitations who want to adapt their housing, the Australian Government should develop building design standards for residential housing that meet their access needs. Those standards should be informed by an evidence base of the dimensions and capabilities of people aged 65 and older and of the dimensions and capabilities of contemporary disability aids.

- DFC is developing South Australian Age Friendly Environments and Communities (SAAFEC) under the State Reform Agenda.
- This initiative focuses on the safety and wellbeing of older South Australians by developing planning and design guidelines for age friendly housing, neighbourhoods, residential developments and cities. These guidelines are based on existing state, national and international standards. It is anticipated that SAAFEC outcomes will provide universal benefits for all people, regardless of age and ability.

Recommendation 10.3

The Council of Australian Governments should develop a strategic policy framework for ensuring that sufficient housing is available that would cost effectively meet the demands of an ageing population.

- South Australia is supportive of a strategic policy framework that takes into account affordable housing options for older people so that they can afford to live in the community if they choose to. South Australia is working to increase the supply of affordable housing through implementation of its 15% inclusionary zoning policy which delivers affordable housing opportunities, including retirement living, to low to moderate income households.

Delivering care to the aged — workforce issues

Recommendation 11.1

The proposed Australian Seniors Gateway Agency (draft recommendation 8.1), when assessing the care needs of older people, should also assess the capacity of informal carers to provide ongoing support. Where appropriate, this may lead to approving entitlements to services and/or assisted referral for:

'carer education and training'

- Research indicates carers' health can be negatively impacted by the caring role. Carers need opportunities to participate in education and training to gain knowledge and practical skills to provide care to sustain their own health and wellbeing. Carers may continue to provide levels of care beyond their own capacity in absence of actual or perceived options.
- In South Australia the Carer Support Centres identify pressures and issues for the carers who present to them and provide information and supports to sustain the carer in their role. Agencies providing services or supports for the person receiving care need to understand and incorporate the issues for carers in assessing for services or assistance to be provided.
- Employees who are carers would be a great pool to target as they are able to access information readily as this could assist in keeping them in the workforce.

'planned and emergency respite'

- The Gateway should interface with intake for disability services so that carers have a centralised access point regardless of the age of the person they care for.

Carer Support Centres should be developed from the existing National Carelink and Respite Centres to provide a broad range of carer support services.

- This is a complex issue and touches the core of the South Australian service system for carers.
- The Carer Support Centres in South Australia adhere to a model of practice (Carer Support Model) which provides a cost effective, integrated, community development model. The model has evolved in South Australia in line with carers' expressed needs and requests.
- In accordance with the 'Carer Support Model', emphasis in South Australia is placed on Carer Support Centres being accessible and welcoming and a place where carers feel they can 'drop in'. Emphasis is placed on: enabling carers to develop friendships with other carers; providing time out; opportunities for

recreation and fun; a sense of fellowship; and a chance to talk to others who understand.

- In some instances in South Australia the Carer Support Centres are situated with the Carelink and Respite Centres. Other Centres not in this position connect or broker respite and other services for carers. Centres in either position 'walk the journey' with the carer in line with the 'Model'.
- Co-location of Carer Support Centres with Carelink and Respite Centres would create a one-stop-shop for carer support allowing carers booking into a support activity to also access respite care for the person they care for.
- However, unless managed, there is a risk in collocating Carer Support Centres with existing National Carelink and Respite Centres that 'respite' is reinforced as 'the' service required by carers, rather than only one of a suite of services required by carers under the umbrella of 'carer support'. There is also the risk that Centres develop with a bureaucratic feel which is off-putting for carers and potentially destroys the unique South Australian system which is successful and well regarded by carers this State.
- It is recommended that the South Australian Carer Support Centres model, which incorporates respite as an important component of carer support needs, is part of aged care reform and rolled out nationally.

Recommendation 11.3

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

'advanced clinical courses for nurses to become nurse practitioners'

- The skill level of the Gateway assessors who would provide information, screening and base assessments needs to be determined as it is a complex role that encompasses all areas across the aged care sector. Careful consideration should be given to this, if the older person's first experience with the gateways is aimed at being a positive and satisfactory interaction.
- Training needs to include, or workers need to have access to, therapy and/or rehabilitation training similar to therapy aides so they can support the independence and wellness programs.
- Specific strategies are required for entry level care workers.
- Training needs to inform workers regarding carers issues and needs and best practice responses in health and welfare service to carers.

Recommendation 11.4

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

- The report has consulted with the Community Services and Health Industry Skills Council (ISC) which is the authority for trends and demands in the industry and South Australia is confident that as a result of the increase demand for workers in this field, it will be essential to increase access to skills development across this high growth area.

- Promoting the sector to prospective employees engaged in education and training is one of the many strategies that can assist in creating a supply of skilled workers. Other strategies need to be put into place as discussed in the report.
- The ISC has been developing a suite of oral health competencies for non-dental providers with the aim of developing training programs. These competencies include the undertaking of simple oral health assessments and care plans by a range of non-dental personnel including medical practitioners and registered nurses.
- The ISC needs to liaise with the relevant educational authorities with a view to having oral health training components included in the base education of doctors, registered nurses and other health and human service providers as well as in their continuing professional development.
- DFC, through Domiciliary Care, is well placed to continue to be a teaching environment for allied health staff. Domiciliary Care is the largest provider of allied health placements in metropolitan Adelaide.
- A good example of 'teaching aged care service' was recently announced in South Australia. The 120 bed Teaching Aged Care and Rehabilitation Facility will be located at the Repatriation General Hospital. This is a joint venture between the South Australia and Commonwealth Governments, a non-government aged care service provider and a local university that will combine health and aged care services with research and training. It will have a strong focus on rehabilitation and capacity building.

Recommendation 11.5

The proposed Australian Aged Care Regulation Commission (draft recommendation 12.1), in assessing and recommending scheduled care prices, should take into account the costs associated with:

'volunteer administration and regulatory costs'

- It is acknowledged that the costs associated with administration of volunteer roles, liability and insurance present a barrier to agencies taking on volunteers. However, the benefit to recipients, community and volunteers themselves is significant. Their contribution would outweigh the alternate costs of providing this care in other ways.
- It is important to have resources to ensure volunteers are properly inducted, have the mandatory checks (such as police) and are recognised and rewarded for their efforts.

'reimbursement of out-of-pocket expenses for those volunteers who are at risk of not participating because of these expenses'

- Reimbursement is simply one way of acknowledging, sustaining and facilitating the important role of volunteers.
- If block funding is going to be associated with programs such as community transport and meal delivery which draw on the services of volunteers, then reimbursement for petrol and other expenses should be taken into account as part of the costs of these programs.

Regulation — the future direction

Recommendation 12.1

The Australian Government should establish a new regulatory agency — the Australian Aged Care Regulation Commission (AACRC) — under the Financial Management and Accountability Act 1997. This would involve:

'establishing a statutory office for complaints handling and reviews within the AACRC'

- Many organisations would have well established complaints management systems. A statutory office would need to recognise these and still have the capability for uniform complaints management processes and/or reporting.
- In South Australia the Health and Community Services Complaints Commissioner (SA HCSCC) currently handles complaints, reviews and reporting across health and community sectors.

The AACRC would have three full time, statutorily appointed Commissioners:

- *a Chairperson*
- *a Commissioner for Standards and Accreditation*
- *a Commissioner for Complaints and Reviews.*

- Clear role definition between the Commissioner for Complaints and Reviews and the SA HCSCC would be required to minimise duplication of role, function and responsibility.

Key functions of AACRC would include:

'responsibility for compliance checking and the enforcement of regulations covering the quality of community and residential aged care'

- There needs to be strong links between AACRC and those managing contracts for the provision of care services. Complaints need to be fed into the contract management process to ensure that the service provider's performance can be adequately assessed.

'handling consumer and provider complaints and reviews'

- Consideration should be given to providing uniform and consistent complaints management processes. Consideration could also be given to providing complaints management standardisation/guidance to organisations delivering direct client services.
- SA HCSCC handles complaints, provides community accessibility to an impartial body and monitors reporting across health and community sectors in South Australia. Merits of local handling of complaints include increased effectiveness, speediness and greater contextual knowledge (e.g. environment, resourcing and contacts).
- Risk assessment is usually applied to the probability and impact of a future event/occurrence. In the case of a complaint, the event/occurrence has occurred (even if the complaint refers to the possibility of something adverse happening in the future e.g. broken bed may lead to patient injury). Therefore, risk assessment is not applicable in the strictest sense of the word when assessing a complaint. A complaint needs to be addressed/ resolved as soon as possible. Assessing the

severity of a complaint should be based on the impact to the client/complainant/organisation at the time of event/occurrence.

- Nevertheless, risk assessment is critical post complaint resolution phase. Effective risk assessment may be applied following periodic complaint reports in an organisation where trends can be analysed, risks identified and risk mitigation strategies applied. This process is critical for continuous improvement.

Recommendation 12.2

The Australian Aged Care Regulation Commission's (AACRC) Commissioner for Complaints and Review should determine complaints by consumers and providers in the first instance. Complaints handling and reviews should be structured into the three areas: assessment, early resolution and conciliation; investigations and referral; and communication, stakeholder management and outreach. The Australian Government should abolish the Office of the Aged Care Commissioner.

- Theoretically this appears to address a comprehensive approach to complaints management. However it may lend to an increased length of time to resolving complaints and/or issues which should be avoided at all costs.

Recommendation 12.3

The Council of Australian Governments should agree to publish the results of quality assessments using the Community Care Common Standards, consistent with the current publication of quality of care assessments of residential aged care.

- Meeting the Standards alone is not evidence of a quality service as it is mainly paper based. It has to include regular and ongoing feedback from the people who use the service and/or their carers. People should be able to add their comments and feedback to the results of the published quality assessments.
- Carers need a mechanism to provide feedback regarding the services they, or the person they care for use, without the risk of retribution and without it becoming a time consuming and stressful task.
- Results of published quality assessments should incorporate this feedback as well as statistics on complaints.

Recommendation 12.9

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

- Reciprocal arrangements for the recognition of Enduring Power of Attorney and Enduring Power of Guardianship are embedded in several state statutes including South Australia. Medical Attorney and Advance Directives operate under a single piece of legislation with no interstate reciprocity. Changes to these and other pieces of legislation and/or regulations would have implications beyond the aged care sector.

Aged care policy research and evaluation

Recommendation 13.1

To encourage transparency and independence in aged care policy research and evaluation, the proposed Australian Aged Care Regulation Commission (draft recommendation 12.1) should perform the role of a national 'clearinghouse' for aged care data. This will involve:

'making these data sets publicly available in a timely manner for research, evaluation and analysis, subject to conditions that manage confidentiality risks and other concerns about potential data misuse'

To maximise the usefulness of aged care data sets, reform in the collection and reporting of data should be implemented through:

'adopting common definitions, measures and collection protocols'

'linking databases and investing in de-identification of new data sets'

'developing, where practicable, outcomes based data standards as a better measure of service effectiveness'

- This recommendation is supported. However, there are considerable cost implications which would need to be assessed.
- It is recommended that aged care data sets should be capable of disaggregation by sex, ethnicity, socio-economic status and location. Such data would allow for more nuanced understandings of the needs of particular groups of older people and allow for the development of appropriate policy approaches and service provision.
- Consideration should be given to comparing service provider performance on consumer outcome measures as part of the quality assessment for consumer choice.

Reform implementation

Recommendation 14.1

In implementing reform, the Australian Government should:

'announce a timetable for changes and how they are expected to affect the sector'

- This will have an impact on the National Health and Hospitals Network - Aged Care Reforms Implementation timetable.

'consult with providers, consumers, carers and government agencies on issues expected to arise from the implementation of the new system'

- Consideration will need to be given to feedback and comments from the sector around the consultations that have already commenced on the National Health and Hospitals Network - Aged Care Reforms.
- Consultation needs to occur with carers as a separate group.