ACH Group
Leading Choices for Older People

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28th July 2010

Inquiry into Caring for Older Australians
Productivity Commission
GPO Box 1428
CANBERRA CITY ACT 2601

Dear Sir/Madam

Attached please find an ACH Group submission to the Productivity Commission Inquiry into Caring for Older Australians commissioned by the Australian Government.

ACH Group considers that there is a need for fundamental change to the Australian Aged Care system and for that change to be linked into commensurate Health reforms. We would like to thank the Commission for being able to make a submission to the Inquiry and look forward to a discussion with Commissioner Robert Fitzgerald, Associate Commissioner Sue Macri and Assistant Commissioner Paul Lindwall on 2nd August 2010.

Mike Rungie
Chief Executive Officer
ACH Group

Caring For Older Australians

Productivity Commission Inquiry into Aged Care

ACH GROUP Submission

July 2010

ACH Group welcomes the opportunity extended by the Productivity Commission to make a submission to its Inquiry, *Caring for Older Australians.*

With the release of the National Health and Hospitals Reform Commission Report, as well as the recently announced Commonwealth Health Reforms, there is the potential for significant synergy between the health and aged care systems. These Reports build on a series of reviews and recommendations aimed at bringing about constructive and fundamental change in aged care including

- Previous Reports by the Productivity Commission
- Hogan Report
- Senate Committee Inquiry
- Henry Taxation Review
- Intergenerational Reviews

These reviews indicate that government outlays to support the health and care of older people will grow against a decreasing workforce, a decrease in informal care and fewer working age people relative to older people. Consideration of Australia's challenges is within the context of understanding that estimated growth in health care and aged care costs in the long term will be affected more by the rising costs of professional service costs/referrals, technology and pharmaceuticals than they are by the "ageing" process itself.

Most reports indicate that other countries will have far more difficult issues than Australia to deal with to support their ageing population profiles. Together these facts, even on the worst projections, do not support the view portrayed in some media that there is an impending "crisis". Rather, ACH Group believes the positive support of the good lives of older people in the future is very manageable if planned for appropriately now. The Productivity Commission Inquiry is therefore very welcome as a means of forging the way ahead.

1. Who Is ACH Group?

ACH Group is a leading "not for profit" provider of aged care services in South Australia. It -

- Has contact with approximately 46,000 older Australians every year through its residential, community and housing services. ACH Group -
  - Operates over 1000 packages of care with people in their homes
  - Manages 7 Residential Aged Care Services that have over 500 places
  - Provides housing to over 800 older people
  - Provides restorative, therapy and health maintenance services to around 5,000 older people, including through a specialist transition care facility
  - Assists over 7,000 older people to stay at home by undertaking minor home modification and maintenance services
  - Supports over 23,000 veterans in several states and territories through the Veterans Home Care program.
- Employs over 1600 staff
- Works with over 800 volunteers
- Supports many older people with dementia/other neurological conditions and their families and carers through our specialist dementia services
- Delivers palliative care to many older people each year
- Supports a number of older people from CALD communities (including Italian, Dutch, Cambodian, Indo-Chinese and Polish)
- Supports older Aboriginal people, including through a specialist state wide Aboriginal respite and social support service.

2. What do older people say to us about how they want to live their lives?

While Australia's current Aged Care system has served it reasonably well, we support the view that our nation's changing profile, population diversity and consumer expectations necessitate a makeover of our aged care system. Ageism continues to limit the prospects of a good life as we age and the inherent inflexibilities in the current Aged Care system limit choice, individualization, control and autonomy.

While we are all waiting for the "baby boomers" to shake the foundations of ageing, generational change has already occurred. The so-called "silent generation" are already demanding from us -

- information in plain English
- use and understanding of IT applications and new technology
- environmentally sustainable practices
- options to support active lives
- a focus on maintaining and improving physical health
- greater choice and flexibility
- more control of their services.

Contemporary market research reinforces our own research and conversations with older people which tells us that the existing generation of older people have begun rejecting products and services sold by the anti-ageing messages of yesterday and have instead responded to a new desire and passion for healthy ageing.

ACH Group's long history of values based care has evolved into a focus on what we call "good lives". Everything ACH Group does aims to support ongoing, fulfilling and healthy lives *(good lives)* of older people in their own homes and communities, and alongside those people who are important to them – spouses, families, friend's neighbours etc.

Every year, ACH Group conducts at least three *Board Conversations* with the older people we serve through our Housing, Residential, Health and Community services. We have spoken to more than 700 people since 2004 and their feedback to us about what is a *good life* suggests there are 7 elements –

1. A good life is unique. No life has ever been lived before and it won't be lived again.
2. A good life is "mine" – I am my own boss and I make my own decisions – good and bad.
3. A good life is optimistic – it has a sense of future.
4. A good life includes interests and passions like sport, work, art, music, entertainment, faith, eating and drinking, roles at home and in the community, volunteer work etc.
5. A good life is much more than just having things to do however. It includes everyday things that are part of life at any age such as responsibilities, decision-making, the right to be wrong, looking after others, being happy and sad, weighing up options and managing money.
6. A good life is companionable – it involves other people.
7. A good life is as healthy as it can be.

So what does all this mean for the makeover of services?

3. How is ACH Group changing to respond to what older people tell us?

ACH Group began to offer consumer directed care (CDC) using an individualised budgeting approach in July 2009. Our CDC offers 25 older people receiving HACC, CACPs, EACH and EACHD the option of managing their own budgets, based on average levels of subsidy. Our CDC model opens up choice and control over what, where, when, who, how and when services are delivered and is currently being evaluated by Alt Beatty.

Where people move to Residential Care we are developing new approaches based on the above elements. At our newest Residential Aged Care facility (Highercombe Residential Aged Care Service) we are developing a *Partners in Positive Ageing Approach* (PiPA). New residents are asked to 'pledge' to 6 key understandings that underpin the model -

1. Active Ageing
2. Learning and Living,
3. Savouring our Senses,
4. Roles and Relationships
5. Positive Emotions
6. Strong Voice

Additionally, we have supported through the development of transition care services, including a 40 place specialist transition facility, the better use of short term residential care to support ongoing community lives and the recovery of optimal functioning.

ACH Group has offered housing for older people, including affordable housing, since 1952. It is an area of great vulnerability for older people. We recently reviewed some of the people who left our community services to move into residential care and in almost all instances the person's housing had not kept up with their needs. It was run down, it was insecure, it was in a neighbourhood where they felt threatened, it was too big, the garden had overtaken them, the decision-making about moving had been too hard, the value of their current housing wasn't enough to buy what they needed and so on. While other factors also mattered too, housing was a major factor.

We are continuing to explore better ways of supporting older people to remain in their own home through -

- Linking housing and community services
- Developing small clustered approaches of housing
- Providing small levels of domestic support and maintenance to reassure older people that they can continue to remain in their homes
- Working with people to support/develop their connectiveness back into their families, neighbourhoods and society in general

Our housing developments now and into the future has/will continue to develop an emphasis linking people to their local communities, to wellness, health and fitness, to information and technology through our own Customer Service Centre as well as other information/resource points.

4. What does ACH Group consider needs changing in the transition to the new system?

The makeover of aged care (**new aged care**) calls for the **promotion of good health and a sense of wellness** to be a central theme. This means the active management of disabilities, chronic conditions and ill health and access to recovery. For too long, the community (and older people themselves) have accepted that health crises (and their aftermath) are inevitable. The evidence suggests the opposite.

Our Board has just supported the roll out of ACH Group Fitness across all of our residential, housing and community services – breaking down barriers and stereotypes to exercise. In time ACH Group will be seeking to offer fitness options to all older people supported by ACH Group services as well as looking to expand to their friends, family, neighbours and other older people living in the community.

New aged care in ACH Group is developing and implementing positive ways of working with people with neurological conditions such as **dementia** by adopting Montessori based approaches and other best practice techniques which offer great potential to support people to retain mastery of their environments and lives for much longer than they currently do. Our practices in Residential and Community Care are seeing older people with dementia involved in fitness, lifestyle and learning activities – even into late stage palliative dementia.

New aged care must also be mindful of the whole context of people's lives well beyond meeting functional needs. For many frail older people **isolation, loneliness and boredom,** quite simply, make them sick. Much of the work that our staff and volunteers undertake involves them working with older people and their families to develop roles and relationships that have run down/been lost. Much of this centres around the involvement of older people in activities such as fitness, being involved in community clubs, renewing past interests etc. Importantly though we strive hard to ensure that services do not overwhelm people and come to direct their lives.

At ACH Group, we have used an internal peer review process we called the Service Impact Project (SIP) since 2004 to assess the impact of our services on older people. The review teams ask questions including –

- Were the person's informal and formal supports blended together so that the services did not overwhelm the person's informal world?
- Were strategies to increase the older person's participation used?
- Did we pay attention to the way the person passed time? Time use and meaningful lives are always our greatest challenges.
- Did we waste a person's time through too much "assessment" and involvement in non relevant and meaningless activity
- Are the supports encouraging important others to stay involved in the person's life?
- Did our services provide the maximum support for a person to live "a good life"?

If the answer to any of these questions is no then we seek to set things right.

We are looking to make aged care **simpler**. We are undertaking business process improvements to apply what we call the "IKEA" principles. Powerful consumers need services that are easy to find, easy to use, which fit together and which are offered at a good price and that meet their needs how when and where they require them. We want to give options for "DIY" which means our instructions need to be simpler and the services should click together as if they were mix and match. It will be important of course, to prevent aged care becoming like Lego bricks of limited colour and shape, unable to bend with need.

Much of aged care is **invisible** to the community and so many older people delay the use of aged care which may prevent or delay admission to residential or hospital care. Community care must be louder and bolder, offered through information and resource centres which showcase what is possible, and support the timely use of low level services and support.

More older people than it is thought, who experiences difficult health issues, are capable of undertaking restorative and rehabilitative approaches to care. Our experience is that even for the most frail older people who go into transition care only about 20% of them move into residential care. It is also important that new aged care make it a priority to **restore function** and not just allow it to decline. ACH Group has provided Transition Care for a decade. An ACH Group initiative in this area is the Teaching Nursing Home that we are developing on the grounds of the Repatriation General Hospital. The facility is a

- 60 place Residential Aged Care Service
- A 40 place Transition Care/Care Awaiting Placement/Step down Service
- A 20 place Rehabilitation Service

The service will run as a partnership between the Department of Health, Flinders Medical Centre, The Repatriation General Hospital, Flinders University (with involvement of Adelaide University, the University of South Australia and TAFE) and ACH Group. It will cater for a range of student placements in a deliberate attempt to better skill the workforce particularly around the nursing and the allied health needs of older people. The approach to teaching will have a particular focus on working with people with dementia and their families/carers, using a restorative approach. We think it very important that **new aged care give people hope** that they will be able to recover from a health crisis and through transition care and rehabilitation move back to their own homes. The proposed Teaching Nursing Home will push this possibility to its limits.

5. How does the aged care system need to change in the future?

Notwithstanding the many innovations which are starting to change the underlying its philosophy and practice, the aged care system does need more substantial reform than the somewhat glacial pace that it seems to move at.

In the new aged care older people and their families and advocates should be able to -

- Get information more easily – information should be independent, comprehensive, accessible by all in a diverse society, have many outlets mediums and backed up ways in which people can see how things work (e.g. resource centres). This information should enable older people to assess their own needs and to assist their access to services and supports.
- Access to the aged care service system ought to be an entitlement based on need through a national universal approach to eligibility (similar to Medicare, Carer Allowance etc). "Capping" might be better achieved by some form of "means testing"/co-payment/etc rather than limiting the places available. Older people should be informed of the entry level "price points" that relate to their level of eligibility and then be allowed to choose how that care is delivered, by whom, etc

  This entitlement should not artificially cap services through constructs like aged care ratios and predetermined places in prescribed regions. The current allocation of care places results in -

  - Care being skewed away from care in the community
  - Inequity – some people who are just as frail as others cannot access certain types of services e.g. EACHP's and EACHD's even though they are just as eligible
  - Aged Care service providers having to make inequitable decisions about who gets care and who doesn't get in based on factors other than relative need.

  Naturally some people might choose to work with the current range of providers but the point is that they would still control their entitlement – the entitlement should not default to the provider
- Access a "safety net system" for people who have difficulty with exercising options under a CDC approach. Such a system should facilitate and support personal choice, control and autonomy as much as is possible.
- Access recurrent funding for Residential and Community Care which ought to be aligned through "price points". There may be an additional accommodation funding component if the person needs Residential Care but accommodation needs should also look to be met through improved housing options.

  Development of those "price points" should be based on research into the actual cost of care. "Price points" need to be indexed against a basket of measures including the CPI, significant wage movements, movement in the cost of various commodities that might lay outside of the CPI basket etc.

If the recurrent subsidy system to agencies is maintained then the rate of subsidies needs to be calculated against these factors and not the reduced cost of living rates that are currently evident.

- Approach a provider of their choice to obtain services that best supports their life – that provider might be a family member, private provider, aged care operator etc. People should be able to choose to give their "entitlement" to an aged care provider but also have the right to withdraw it.
- Be able to move in and out of services through the national eligibility assessment process (for "respite", transition care, restorative care etc), encouraging recovery and the use of short term supports.

  If people access respite care, transition care etc then entitlement also ought to be assessed independently and a voucher/personalised budget issued. This raises the potential of "bundling" which is discussed later in this submission.
- Be protected in their dealings through a range of consumer safeguards – see comments later in this submission
- Develop and maintain a strong consumer led relationship with the provider/s of their choice

The interface between health and aged care is a critical one for older people, and is a point at which many older people lose control of their destinies and decision-making. A number of changes are proposed -

- The system needs to be more seamless across the aged care and health care interface by linking primary care and restorative care with the aged care system and providing more community based (out of hospital) health services (palliative care, chronic condition management, preventative health etc).
- There needs to be incentives in the system that encourage people to use their GP appropriately and for General Practice and aged care providers to work together better with older people.
- Some of the work that is developing in the UK where separate "bundles" of health, aged care and income support dollars are brought together into one bundle ought to be further researched.
- Too many primary health care/"out of hospital" programs continue to be run by the acute care/government health sector. In general terms they are, too concentrated on short term results (particularly freeing up hospital beds" rather than long term outcomes, more expensive, not well linked into aged care services and as such are not as focussed on broad health, wellness and lifestyle outcomes

6. Other issues

Further issues that need attention include the need for

- Better research and development of "best practice" approaches across a number of areas including
  - Fitness and wellbeing
  - Maximising preventative and restorative practices
  - Maintaining and developing valued roles as people get older
  - Dementia/other neurological conditions
  - Palliative Care
  - Models of housing and care for older people where housing and care are considered separately but are linked
- Developing appropriate safeguards including

- Independent advocacy
- How to apply "standards" in the new aged care – approaches might include
  - Registration of "aged care" organisations based on national standards
  - Default to ordinary consumer protection mechanisms
  - Maintain the current approach but adapted to the "new aged care"
- Appropriate consumer control mechanisms put in place including
  - Standard user friendly agreements
  - Complaint mechanisms/grievance mechanisms
  - National rating system for aged care agencies

- Capital and recurrent funding. Elements that need to be considered include
  - Co-payments based on financial capacity
  - Uniform national financial assessment principles around co-payments
  - Recurrent rental equivalent to a capital contribution
  - Access to the taxation system including a levy/ies
  - Access to Superannuation (Superannuation Funds as well as individual payouts)
  - A National Aged Care Insurance Scheme
  - Reverse mortgages/other financial options to gain access to capital
  - deferred payments against a person's estate
  - The adequacy of capital funding needs to be reviewed against a "benchmark" and be subject to regular review against rate of inflation, building costs etc
- If major elements of the current aged care system are maintained then ACH Group would want to make the following points
  - There is insufficient capital currently generated by the system to pay off existing loans by aged care organisations on current developments let alone expand at the levels of the demographic imperative. It may be more effective to simply uncap bonds on the basis of a person's capacity to pay (safety nets such as concessional ratios etc will need to be put in place).
  - The supply levels of Community Care needs to be increased significantly, with many more options for high level community care, including beyond current EACHD level care.
  - An improvement in the amounts paid for community care to maintain the real value of care over time.
- Better funding and support for a well trained workforce and volunteers across the health and aged care interface. There is the need for more inventive ways of encouraging attraction and retention of workers into health and aged care. There are a range of current workforce initiatives that ought to be further developed and expanded.

  New approaches need to be adopted that de-regulate the "scope of practice" that only certain professionals are allowed to do and for the development of more positions such as Nurse Practitioners and para-professional allied health workers etc.
- Volunteers are a major positive factor in providing support to older people as well as being a very valuable role that older people take on in their own lives. With people being encouraged to stay in the workplace longer and with other pressures in life it is becoming more difficult to attract and retain volunteers. Research needs to be done around ways of attracting and retaining volunteers so that a systemic range of incentives (e.g. tax credits) can be put in place that reinforce the efforts that organisations go to in maximising volunteer effort

The new aged care system needs to be able to work with a diverse population including -

- Older people from CALD backgrounds. ACH Group works alongside of a number of CALD communities to support them in their delivery of care to their older people (including Italians, Polish, Indo-Chinese, Dutch and Cambodian community organisations)

This is the fastest growing group of people aged 80+ in the aged care system. Issues in relation to universal eligibility and control of services are very important to this group of people given the almost doubling in demand that will occur over the next 10 -15 years. Issues including control of diet, other cultural requirements, a workforce they can communicate with, volunteering, proper translating services, maintaining community harmony, how a community can integrate the service and non service aspects harmoniously and how small communities can meet government accountability requirements etc are all significant issues. ACH Group supports the Policy Position of ACSA *"STRENGTH THROUGH DIVERSITY - Culturally & Linguistically Diverse Aged and Community Care"* on this issue which is available at

http://www.agedcare.org.au/POLICIES-&-POSITION/Policies/2006_CALD_Policy.pdf

- Aboriginal people who in the main require support at an earlier age than others and for whom current health and aged care approaches need much development. There has been little action by the Commonwealth Government since the mid 1990's in relation to a Comprehensive ATSI Aged Care policy which is in harmony with mainstream Aged Care policy. In the main Aboriginal people are meant to conform to the larger system. "Special funding" has been made available but it lies outside of the Aged Care Act and in effect means a process of separate development for older ATSI people and ATSI organisations. Again ACH Group considers that ACSA has put together a very useful call for action by the Commonwealth Government in their 2008/09 Budget Submission on this issue which the Commission ought to consider –

  http://www.agedcare.org.au/POLICIES-&-POSITION/Submissions/2008-2009-Budget-Submission.pdf

- People in rural and remote areas where the type/levels of service can be a major issue but also where the system of service can mitigate against smaller populations (e.g. the issue of small nursing homes, husbands and wives having to be separated because of the non availability of services in small communities etc). Multi Purpose Services (MPS's) have been a very useful initiative. However, ACH Group's experience would indicate that
  - The costs associated with care are in general more expensive in rural and remote areas and this needs to be addressed otherwise there will be a continual de-population of rural areas and families will need to live more separate lives
  - Health and care services are less present (e.g. GP's, hospitals, care services etc) and that incentives need to be put in place to overcome these issues
- Gay, Lesbian, Bi-sexual and Transvestite people/couples find the intrusiveness of the current aged care system limits the ways in which they would choose to best live their lives. ACH Group would draw the Commission's attention to the issues raised in the round of 2009 consultations following the Alzheimer's Australia Paper "Dementia, Lesbians and Gay Men" at

http://www.alzheimers.org.au/upload/Paper_15_final_web.pdf

on the basis of resolving issues raised during that consultation

ACH Group welcomes the opportunity for further discussion with the Commission on the views outlined in this paper.