



A Vision for the Future

Submission to the
Productivity Commission
Inquiry into Caring for
Older Australians

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Executive Summary

Vision for the future of aged care

Benetas is one of the leading not-for-profit providers of first-class residential aged and community care services in Victoria. Benetas has strong Anglican connections and is a member of Anglicare Australia. We provide older people, their families and carers with outstanding levels of customer service and individualised care when they need it. We listen to their experiences, share their voices and strive to improve the wellbeing of all older Australians through advocacy and research.

Our vision for the future is to provide a positive, *fulfilling experience of ageing for all in communities of choice and support*. We are pleased to share our vision with the Productivity Commission in this, our submission to the Inquiry into Aged Care. Our vision is that when people age in Australia they receive the care and services they need so they can live as independently, and participate in the life of their local community, for as long possible. We want older Australians to be able to follow their interests, be connected with family and friends, be as healthy as possible and have a strong sense of wellbeing as they age.

The Benetas vision for the future is for an inclusive society for older people and provides a clear guide for an 'ideal' service for aged care. While this vision is by its nature aspirational we believe it is certainly achievable.

As part of this vision older people shall have the right to continue to enjoy a healthy, fulfilling life with security and active participation in the economic, social, cultural and political affairs of their communities.

Benetas will empower consumers to decide what services they need, when they want them and how they will be delivered as well as being an effective advocate in promoting the voices of older people. Consumers will shape service delivery and actively participate in service planning and evaluation. Technology will be critical for increasing consumer independence and maximising their life choices. Residential aged care facilities will offer high-level clinical care, allowing residents to fully age in place and meet end-of-life choices.

The seamless range of services available will allow consumers to move effortlessly across primary care, acute care and aged care services. Staff will follow their clients from community care to residential care providing continuity and ease of transition. Aged care will have a strong evidence base, and research findings will easily translate into service developments and improvements.

Development of community hubs will provide accommodation for older people as well as a range of services open to the local community such as a hairdresser, a café, a bar, shops, internet cafés and children's play centres. Housing will be universal in design with a full suite of technological supports to ensure older people live in secure, environmentally-friendly homes which can be adapted to meet their changing needs.

Aged care will be an attractive industry for potential employees. Benetas already has rewarding career paths, flexible working conditions, fair pay rates and a supportive environment which recognises and values the individual worker.

The following sections cover the key issues which Benetas has identified through its experience and which need to be addressed by this Inquiry.

Disadvantage and ageing

There is evidence to show that older people with few assets and on low incomes, who do not need complex health care, are finding it increasingly difficult to access residential aged care. Also older people on low incomes, who are on Community Aged Care Packages (CACPs), cannot afford to purchase needed extra services which the packages cannot provide because of their low funding levels. Also older people who are homeless or in insecure housing often need a great deal of time to be assessed and providers are not resourced to spend the amount of time required for this assessment. As a result these people can miss out on required services.

It is clear that older people with little income and few assets are being disadvantaged in terms of accessing the aged care service they need. Specific funding needs to be available to providers so they can deliver the services needed by this disadvantaged group of older people.

Research and development

Service delivery improvements and development of new services must be based on strong evidence provided by rigorous research projects and evaluation. While research in to the care of older people is already underway, much of it is focuses on physical health and clinical care. While this type of research needs to continue, there should be a greater emphasis on research which examines a more holistic view of the wellbeing of older people and their quality of life. Benetas is currently involved in a number of these projects. We believe that service providers need to partner with researchers so they can impart their knowledge to inform the research, and in turn improve their services as a result of the research results.

In addition to the actual research, there needs to be a focus on the transfer of the knowledge gained from research findings to service delivery providers and consumers so that these findings are easy to access, read and implement.

Consumer choice and participation

Greater choice for older people accessing aged care services needs to be closely aligned with greater participation by older people in aged care service planning, delivery and evaluation. Documents providing guidance for more active participation by service users have been released in the general health and mental health fields, but aged care is a notable absentee in this area. Production of national policies, action plans and guidelines could assist aged care service providers in ensuring client and resident participation in decisions affecting all aspects of their care.

Also a focus needs to be on marginalised groups who normally have difficulty accessing services, let alone participating in service decision making. These groups such as those from culturally and linguistically diverse backgrounds, those with dementia and those with mental health problems need extra assistance to take on an active role in this area.

To undertake this work effectively a specific program and funding stream needs to be established, as has occurred for consumer directed care. This program could operate initially as a pilot testing specific innovations and initiatives that have been put forward by service providers.

Interface with acute and sub-acute health

Aged care, acute and sub-acute health services continue to operate in silos despite falling under one government body's jurisdiction in most states. As a result older people have to fit into the different service systems rather than services being provided to meet the individual needs of older people. A much closer relationship between these services would provide service users with a continuum of care across a seamless range of systems.

A common assessment by a multi-disciplinary team would help to integrate these services. Subsidies for carers and user payments could be aligned right across all these services, which would entail separating care costs from accommodation costs. Partnerships need to be formed to plan the process and smooth the pathways between the services. New policy and program development could occur so that older people are funded according to their assessed needs not as dictated by a service delivery system.

Positive ageing

Many reports and general public perception portray older people as a burden on our society, while the positive contributions made by older people, are often overlooked and rarely mentioned.

A research project undertaken by Benetas in partnership with Deakin University discovered a common attitude that old people are unproductive and lack ambition. This ageist viewpoint is reinforced by media portraying older people who are forgetful, in poor health and senile. In response to these findings Benetas has produced a policy paper which includes a range of actions to promote positive ageing. It includes four pathways developed by Benetas to ensure all older people have the opportunity to enjoy a positive ageing experience:

1. Improve Benetas services
2. Improve the standard of service in the aged care industry
3. Increase public awareness of the worth of older people
4. Influence government policy on ageing and aged services

Older people make a valuable contribution to our society and many organisations assisting people would not function without this involvement by older people. This contribution needs to be recognised and celebrated.

Community Care issues

A major problem present in the community services area is the large gap between the CACP subsidy and the EACH subsidy, creating an inflexible system. People not assessed as needing EACH subsidies but who still have a moderately high level of need, can only receive the same services as those assessed with low care needs. Examples are given of the impact this is having on service users in this submission, as are examples of the impact of EACH services not being funded at the highest residential care level. It is clear that a funding system with the same principles as residential aged care needs to be implemented in Community Care.

Older people in rural and remote areas have particular special needs. These clients do not have access to the Community Aged Care Viability Supplement, which needs to be reviewed so these clients' needs are taken into account.

Further funding is also required for extra services for older people from other special needs groups, such as those who are homeless. A great deal of time has to be spent initially when developing a rapport and building trust before any form of assessment can begin and this time needs to be funded as part of a service delivery package.

Residential care issues

Under the ACFI there is little incentive to admit people who cannot pay a bond and who do not have significant care needs into low care residential facilities. These consumers mainly have behavioural problems and behaviour supplement payments under the ACFI are extremely low. An example is provided to demonstrate the impact these conditions have on low income consumers. It is recommended that graduated additional supplements be offered as an incentive to facilities that have high numbers of supported residents.

An example in this submission also highlights the lack of support provided by external agencies in assisting facilities in the management of residents with challenging behaviours. External agencies such as psychogeriatric and drug and alcohol teams should be available to residential aged care staff when required.

A major problem for residential aged care staff is the resident who continually wanders and leaves the facility without notifying a member of staff. A number of these residents have dementia but the condition is not advanced enough for them to be admitted to a dementia secure unit. A possible solution is the establishment of a scheme to provide tracking devices at a subsidised price.

As residential aged care facilities become increasingly equipped to manage residents in the last stage of their lives, questions are raised about the right of people to choose the place they wish to end their life. Advance care plans are currently used by a number of facilities, but as they have no standing in law they are often ignored by acute health providers. It is recommended that legal status be given to these advance care plans.

The artificial barrier between low and high care should also be removed and service providers be funded to provide the care as assessed. This would mean all residents are treated the same financially and those with the financial means would be expected to pay an accommodation payment.

Culturally and Linguistically Diverse (CALD) communities

Services need to become more accessible to people from CALD backgrounds, particularly in regard to communication. A possible solution for improving communication is to have interpreter services use visual links such as Skype or webcam.

A major problem when trying to make services accessible and culturally appropriate for people from CALD backgrounds is the lack of data in terms of the requirements of these consumers. Funding is needed for more research into the needs of people from CALD backgrounds so that suitable culturally appropriate services and programs can be provided.

People from CALD backgrounds often have little knowledge of the services available to them, so their choice of services is often very limited. It is important that aged care staff receive appropriate training in providing culturally appropriate services and information about how to publicise these services so that people from CALD backgrounds can make informed choices about the services they wish to use.

Workforce issues

Current research data indicates most aged care providers including Benetas will face issues relating to reduced workforce growth over the next 10 years, as well as an ageing workforce. To meet these challenges a number of initiatives to retain current workers and attract new ones are recommended, such as ensuring salary equity between acute health and aged care in regard to nurses' salaries.

Nurse practitioners should be made widely available for aged care and we suggest trialling a two-tiered case management system so that skilled people without tertiary qualifications can be recruited and offered a career path.

Housing and aged care

Older people who are homeless often seek access to residential aged care because of accommodation needs rather than care. However they often do not have the capacity to pay bonds and score low on the ACFI. They therefore find it difficult to gain admission into residential aged care. Older people living in insecure housing often find it difficult to secure Community Care because of their transient situations. Affordable housing for older people is needed urgently and this housing needs to be designed specifically for older people. As a result, it is recommended that an aged care advisory body be established to work with the housing sector when planning housing for older people.

New opportunities need to be created for partnerships between not-for-profit aged care organisations (NFPs), local municipalities and housing authorities to provide housing for older people. In order to facilitate this it is recommended that NFPs be able to access to government housing grants and funding without becoming registered housing organisations.

The time allocated for making residential aged care places operational once the places are provisionally allocated needs to be extended. There are numerous delays that often occur in the planning process including dealing with objections to the planned developments. As the planning process is outside the control of the operator these delays need to be recognised and additional time allocated for places to be operational once planning delays occur.

Response to Productivity Commission Inquiry

1. Introduction

This response to the Productivity Commission Inquiry into Aged Care begins with a vision of what aged care could be in the future. All the inclusions in this vision are possible and are not impractical dreams. Realisation of this vision depends upon all stakeholders committing to the best possible model of aged care. Benetas is working towards making this vision a reality. Our submission puts forward suggestions for positive changes that build on our existing infrastructure, knowledge and philosophy, and if implemented would start to put our vision into practice.

2. Our vision for the future of aged care

Benetas has vision for the future which presents an ideal scenario for the provision of aged care, and the establishment of an inclusive society for older people. Benetas is continuously working towards achieving this vision by *providing a positive, fulfilling experience of ageing for all in communities of choice and support.*

This vision supports the rights of older people as described in the 2002 Madrid International Plan of Action on Ageing¹ which recognises that persons as they age should enjoy a life of fulfilment, health, security and active participation in the economic, social, cultural and political life of their societies.

In future, Benetas will be the preferred choice for Victoria's older people, and their families. Known for our first-class approach, expertise in dementia and culturally appropriate services, we will provide a suite of services designed to enable older people to live positive and fulfilling lives in their own home or in a Benetas home.

With our strong presence in communities across Victoria, older people will choose Benetas services for many different reasons such as social engagement, home care, personal care, respite care and nursing care. Potential clients will decide what services they feel they need, when they want them and how they will be delivered. Consumer-directed care will be mainstream. This means that if consumers so choose, they are responsible for holding the purse strings of their care entitlements and recruiting/purchasing care according to their own needs and expectations. Consumers will shape our service delivery and actively participate in our service planning and evaluation.

¹ The Madrid International Plan of Action on Ageing (MIPAA), adopted at the Second World Assembly on Ageing in 2002, is the first international agreement that specifically recognises the potential of older people to contribute to the development of their societies.

Carers may choose Benetas for our innovative respite services which provide accessible and flexible support options on an hourly, daily and overnight basis and enable all parties to live full and active lives. We believe in and promote the concept that the provision for a loved one's care should be a choice and not something that is forced on them by circumstance.

Our homes will be located in areas where they are needed, have a six-star environmental rating and provide a first-class experience which focuses on individuals and their lifestyle choices. Benetas will implement a 'Life Story and Image' program which allows our staff to really know our residents and the journey they had before coming to live with us. Older people with severe dementia and other cognitive disorders will no longer be locked behind doors with keypads; they will have the freedom they want with the security they need provided by our 'Life Tracker' system – just one of the many technological innovations which will be in operation across our service network.

The 'community hub' will be the heart of each older person's home and residential aged care facility, with a range of services designed for the local area including internet cafés, shops, children's play centre, a bar and a hairdresser. Open to the public, these hubs will encourage interaction between community and residential services and help to keep our residents engaged with their local communities. Benetas staff will be engaged to work between community and residential services, providing continuity of care and ongoing support to ease the transition for people moving between our services.

Older people will only have one comprehensive assessment which enables them to access a range of community or residential services. A common funding model will support their choice of affordable, accessible and comprehensive services.

The Benetas team of aged care nurse practitioners will ensure our clients receive first-class clinical care. Our nurses will work with consumers and their families to understand and fulfil each person's end-of-life choices. People will no longer be shipped off to hospital for intravenous antibiotics or rehydration. Benetas will routinely provide these services on site in the comfort of familiar surroundings. For those requiring acute care, our electronic records will transfer seamlessly so that the acute care team has the information they need to provide the best care possible, as well as access to advance care plans which are completed as part of the admission process at Benetas.

Similarly, electronic records will enable a smooth transition of clients back from acute care to Benetas' care, and all necessary information regarding their health status and needs is provided to our teams.

Our sub-acute care services will provide a bridge for older people between primary care, acute care and aged care. At one end, we will allow people to avoid acute care, and at the other end we will be actively working with consumers to plan their discharge into the environment of their choice. For some clients the choice is always to return home quickly with the services they need in their own home, for others it is a chance to regain their strength, courage and independence in a supportive residential care environment.

Our palliative care services will respect choice and are designed to assist people to live as they want for as long as possible and to die with dignity in the environment of their choosing.

Benetas will have a strong research focus and a system to easily translate research findings into useful material for service practitioners, thus helping to improve service delivery. We will have a culture of innovation based on a top-down vision and bottom-up imagination where our people are encouraged to bring their ideas to the attention of our researchers and actively participate in projects that will continue to shape our future service experience.

We will be a positive and effective advocate in promoting the voice of older people and encouraging a society and system which respects, includes and values older people through active community engagement and participation programs. Our strong Anglican heritage and commitment to provide care and services in accordance with Christian values will be evident through our partnerships with Anglican parishes and communities particularly in rural communities, and communities of need. Our pastoral care services will provide general spiritual support as well as valuing other faiths.

Our housing initiative will be designed to support the diverse needs of an ageing population. This initiative will encompass a range of accommodation options and support services, enabling older people with a variety of financial means to live full and independent lives in secure, environmentally-friendly homes which adapt to meet their changing needs. The concept that every Australian's home is his/her castle will be alive and well in Benetas communities.

Through our collaborative work with Governments, universities and other agencies Benetas will raise the standards of those employed in aged care, and proactively look at alternatives in an age where workforce management requires flexibility and sensitivity to attract quality staff. Central to our success is our focus on engaging people who embody our values of respect, responsibility, community and spirit and are truly passionate about working with older people. Benetas will offer rewarding career paths, flexible working conditions and a supportive environment which values the individual and encourages innovation. Our volunteer base in the community will have grown exponentially. Benetas will have community champions or 'ambassadors' to provide much-needed social engagement activities and help introduce older people to new life skills including use of the internet.

Distinguishing Benetas from other providers will be the personal connection we make at each point of service – whether the first telephone call to our advisory centre, a visit to our website or an in-home assessment for our services. Consumers feel welcome, respected and heard “yes, we can” in all avenues of contact. Our belief is that each person deserves a first-class ageing experience provided by a passionate community of caring people who are doing a job they love in an environment which supports and encourages them to enrich the lives of the people in our care.

3. Research and development

Service delivery improvements and development of new services must be based on strong evidence provided by rigorous research projects and evaluation. Benetas has demonstrated its commitment to this area by creating a new full-time position for a Research and Development Manager, and is currently involved in a number of research projects with major universities. A research and advocacy plan has been developed which sets the directions for Benetas' future involvement in this area. This plan has identified three primary areas of focus – Inequality and Disadvantage; Dementia Care: and Consumer Choice and Participation; and three supplementary areas – Working with CALD Communities, Engaging in Partnerships with Rural Communities; and Positive, Active and Healthy Ageing.

While research into the care of older people is already underway, much of it is focuses on physical health and clinical care. While this type of research needs to continue, there should also be a greater emphasis on research which examines a more holistic view of wellbeing of older people and their quality of life. Older people may receive the best practice medical and clinical care but have little life satisfaction. In caring for older people, services must take into account the needs of the whole person – physical, emotional, psychological and spiritual. To assist service providers in this work, research has to be undertaken to provide evidence for what is best practice in enhancing the quality of life of older people under their care.

Benetas is currently involved in a number of these projects. We are working with Melbourne University to develop user-friendly technology specifically designed to ameliorate social isolation in older people. In another project we are working with Deakin University to assist staff in residential aged care facilities to recognise depression and refer residents for treatment. Benetas has also partnered with Deakin University in a project to enhance the dining experience of older people with dementia living in residential aged care.

At Benetas we believe that service providers need to be involved in research so they can impart their knowledge to inform the research, and in turn improve their services as a result of the findings. Benetas has made a substantial financial investment into its research and advocacy activities and this funding comes entirely from its own internal resources. However, to really develop the research area for service provider involvement, government funding is required and investigations should be undertaken about establishing a research funding stream for service providers and researchers.

In addition to the actual research, there needs to be a focus on the transfer of the knowledge gained from findings to service delivery providers and consumers. In our experience, a large amount of research is being undertaken by tertiary institutions and others, but the knowledge gained from the results of this research is not being disseminated in a fashion that is readily available to the aged care industry and consumers. While research findings are made accessible through websites, journal articles and conference presentations, they are often presented in an academic framework using language and concepts that make it difficult for service providers to convert the results to care practices.

An action research program is currently operating in Canada in which groups of service practitioners, professionals, researchers and consumers have been formed with the express purpose of translating specific research findings into an easy-to-read format which can be utilised by care providers. These groups produce checklists, information sheets, pamphlets and brochures which are distributed to aged care providers, consumers, health professionals and others. The program is funded by the Canadian Government and is called the *National Initiative for the Care of the Elderly (NICE)*. Further information can be found on <http://www.nicenet.ca>.

A similar program could be developed in Australia and links with the Canadian program could be established, especially as the Canadian program is keen to forge international ties. Funding from an existing program, such as the aged care innovative pool could be utilised to establish a pilot program with an evaluation framework and an aim to develop it as a sustainable program if the results are positive.

Recommendation: consideration is given to establishing a research funding stream for service providers to work with researchers on projects to improve services to older people.

Recommendation: funding be utilised from an existing program to pilot a program for translating research findings into an easy-to-read format for aged care providers based on the Canadian program National Initiative for the Care of the Elderly (NICE).

4. Consumer choice and participation

Greater choice for older people accessing aged care services needs to be closely aligned with a greater participation by older people in aged care services planning, delivery and evaluation. Aged care legislation in Australia acknowledges the right of individuals to participate in decisions affecting their lives. However, there is still a need to strengthen the voice of service users to allow them to influence aged care service delivery.

Studies of the healthcare industry have shown that consumers with active levels of participation in the decision-making process enjoy greater improvements in healthcare outcomes. Active consumer participation also leads to more accessible and effective healthcare services. A number of documents have been released in the general health and mental health fields providing guidelines, action plans and standards for a more active involvement by service users in the services provided to them. However aged care is a notable absentee in this area and there is a clear need for the development of national policies, action plans and guidelines to assist aged care service providers to increase the participation of clients and residents in decisions affecting all aspects of their care.

While there is a gap in this area, some initiatives are leading the way for further development of consumer choice and participation. For example the recently announced Consumer Directed Care program is a step in the right direction, but it needs to be expanded and an emphasis placed on building the capacity of older people and their carers to make informed decisions about the care provided – rather than just handing over funds and then expecting clients to know what they want to do with the money.

Best practice methods of transitioning consumers into directed care need to be captured and documented. Discussion and consideration about potential deregulation approaches, which attach the funding to the client and not the service provider, must focus on outcomes and not just hours of care.

Marginalised groups need extra focus too. These groups usually have difficulty accessing services, let alone participating in service decision-making. These groups such as those from culturally and linguistically diverse backgrounds (CALD), those with dementia and those with mental health problems need extra assistance to take an active role in this area.

As a service provider Benetas has developed some initiatives such as inviting consumers to be key note speakers at some of our staff training seminars. We've also developed programs in residential aged care where residents have a real say in the services being offered, and consumers have been actively involved in our evaluation and research projects. However, we would like to expand these activities particularly to assist clients/residents and their carers to develop the capacities to take a more active role in service choice and provision. Great work is also being done by organisations such as National Seniors and COTA in this area, and it needs to be acknowledged.

To effectively provide clients, residents and families with greater choice and participation, a specific program and funding stream needs to be established, as has occurred for consumer directed care. This program could initially operate as a pilot, testing some specific innovations and initiatives that have been put forward by service providers. For example, the model for resident wellness which has been implemented by the ACH Aged Care Group at its Highcombe Home in Hope Valley, Adelaide.

Recommendation: flexible pool funding be made available to pilot some specific innovations and initiatives that have been put forward by service providers to enhance consumer choice and participation.

5. Interface with acute and sub-acute health

The move to place aged care, acute and sub-acute health services under one government body is a welcome initiative. However, these services still receive separate funding and have their own information systems as well as assessments, care/treatment plans and discharge procedures. They operate in distinct silos, and making connections between them is often difficult and complex. As a result older people have to fit into the different service systems rather than services being provided to meet the individual needs of older people.

A much closer relationship between these services would provide service users with a continuum of care across a seamless range of systems. For example, older people ready to leave hospital should be offered a service which includes residential or community aged care, rehabilitation, primary care and allied health. Transitional care packages are a step in the right direction but they don't necessarily lead to breaking down of the separate service silos.

The National Health and Hospital Reform Commission recognised the issues around segregated services and made a number of recommendations to integrate service delivery. These recommendations include:

- The widespread establishment of Comprehensive Primary Health Care Centres and Services
- The development and introduction of streamlined, consistent assessment for eligibility for care across all aged care programs
- That there be a more flexible range of care subsidies for people receiving community care packages, determined in a way that is compatible with care subsidies for residential care
- Flexible funding arrangements are required to reconfigure health service delivery to achieve the best outcomes for the community.

In its report, the Commission made clear that it believed the implementation of these recommendations would assist in keeping people from being inappropriately admitted to hospital or being kept in hospital when they are eligible to be discharged.

Building on these recommendations, a solution to this problem could be to develop a comprehensive assessment process which expands the current ACAT assessment to include assessment for rehabilitation services, palliative care, transition care and other allied health services. This assessment could be undertaken by a team composed of aged care and sub-acute care professionals, and an integrated assessment form could be developed and tested.

The next reform that would need to occur is to align the care subsidies and user payments right across residential and community aged care and all sub-acute care services. This would entail separating care from accommodation costs in residential aged care. Older people would then be given greater scope to choose for themselves between using their care subsidies for residential or community aged care, and choosing their sub-acute care provider and services.

Clearly this a major reform, however a cross-discipline team with appropriate representatives from government service providers and external 'experts' could be established to plan the process with a view to developing a draft assessment document for testing.

In undertaking this reform, existing networks could be used such as the Victoria Primary Care Partnerships, or the proposed Medicare Locals which are currently being explored. These partnerships have the potential to involve all of the above programs and provide opportunities to develop systems to smooth the pathways between the services. New policy and program development and appropriate funding could be utilised to establish these networks across the nation, implementing the initiatives arising from the proposed reforms.

A vastly improved system across these services will result in real financial savings as older people would not have to stay in hospitals needlessly but could leave as appropriate and receive the services they require elsewhere. In this way inappropriate admissions back into hospital could also be prevented. Hospital discharge planning for all elective/planned admissions should occur in primary care prior to the patient being admitted and as soon as admitted for all acute episodes.

Older people need to be funded according to their assessed needs, not as dictated by a service delivery system.

Recommendation: a streamlined comprehensive assessment process is developed for eligibility for care across all aged care and sub acute programs. This should include:

- developing new assessment tools; and
- developing networks based on the Victorian Primary Care Partnerships and Medicare Locals to smooth the pathways between the programs

Recommendation: care subsidies and user payments be aligned across residential and community aged care and all sub-acute care services.

Recommendation: costs for care and accommodation in residential care are separated.

6. Positive ageing

A number of recent reports, such as the Intergenerational Report 2010, have identified the impending growth in the number of older Australians and the impact this will have on services such as health care and the overall economy. Most of these reports have been interpreted in a negative way, identifying this growth in the ageing population as a future burden on our society. It will result in a declining portion of the population in the workforce and a greater demand on publicly-funded services, especially health. The positive contribution made by our older people to our society, such as through volunteer work, is often overlooked and rarely mentioned.

In partnership with Deakin University Benetas recently released a report *Respect in an ageing society* which discussed the findings of a research project on respect for older people. These findings indicate a general societal view that older people are unproductive, lack ambition post retirement and are fragile. This ageist viewpoint is reinforced by the media portraying older people as forgetful, lacking physical coordination, in poor health and senile.

In response to the findings from the *Respect in an ageing society* research project Benetas prepared a policy paper which included a range of actions to promote positive ageing, address social inclusion and increase consumer choice and participation. This paper was presented to representatives from peak bodies, Governments and industry organisations to support a public launch of the research findings. The Minister for Ageing, Justine Elliot unveiled the findings and her advisors were present. The launch was supported by a media strategy which generated interviews on radio, articles in the daily papers and articles in industry journals.

As further follow up, Benetas is partnering with the Lord Mayor's Charitable Foundation to hold a public debate in the Melbourne Town Hall as part of the Victorian Seniors Festival. The debate will focus on respect for older people. In addition, a major article based on the research findings is being prepared for publication in Anglicare's *State of the Family* magazine. Other strategies in regard to intergenerational activities in our services are also being planned, such as a recent ball at one of our facilities where younger people from local schools were invited and mixed freely with residents.

In this role as an influential provider Benetas has developed four pathways to promote a healthy, positive experience of ageing for older people:

- a) Improvement of its own services, internally through staff meetings, staff training and development and information sent to service users.
- b) Improvement of the standard of service in the aged care industry through engagement with peak bodies, articles in industry journals and network meetings.
- c) Increasing public awareness of ageing issues and strategies that need to be undertaken to address these issues through media exposure such as radio interviews, articles and opinion pieces in newspapers and television coverage.
- d) Influencing Government policy on ageing and aged care services by meeting with Ministers and advisors and local members of parliament, and forming partnerships with peak bodies and other organisations to operate specific campaigns.

It is clear that a range of strategies need to be established to counteract the ageist viewpoint that is so prevalent in our society. Initiatives such as an active media campaign, similar to Aged and Community Services Australia's current *Can't do it without you* social media campaign, could be developed and implemented, and the government's policy approach to *Active Ageing* for Home and Community Care services be further developed and expanded into other areas of aged care.

Wonderful stories abound of how older people have made valuable contributions to their community. For example, in 1984 a group of parishioners from St John's Anglican Church in Croydon, Victoria identified the need for a nursing home to be built to meet the growing needs of older people within the local community. The group, many in retirement or close to retirement, set themselves a challenging task – to raise enough funds to build a low-care hostel.

The parishioners decided to open and run an opportunity shop to raise money. Anglican Aged Care Services Group (now trading as Benetas) paid for the building of a shed on land owned by the group in Mooroolbark to give the volunteers a suitable space to run the 'op shop'. Proceeds from the Shed, along with a variety of additional events and fundraising activities, saw the volunteers raise over \$300,000 to build a 20-bed nursing home. Construction went ahead and the doors opened at the St John's Park Hostel in 1992. When Benetas took over the management of the hostel, the St John's Park Auxiliary was officially formed.

Over 60 volunteers have been part of the St John's Park Auxiliary since it was formed. In 2010, there are currently 10 committed volunteers who donate their time to the Shed each week and in voluntary time alone, members of the Auxiliary donate well over 3,720 hours each year. The majority of these volunteers are well into their retirement and since 1984 they have raised and donated \$1.5 million to Benetas' services in the local community.

This is an extraordinary contribution and achievement by a group of older people, many who have been involved in the Auxiliary since its inception. Stories like these present a stark contrast to the often ageist attitudes held by some members of the public about the contribution of older people. They also demonstrate a strong argument against the view that our ageing population is a burden on Australian society.

Many local governments have developed their own range of positive ageing plans and programs for their municipalities. The benefits of these programs should be widely disseminated.

Recommendation: consideration be given to developing a range of initiatives to raise the status of older people and counteract ageist attitudes, such as local government taking on the role of publicising the benefits of their positive ageing programs.

7. Community Care issues

This section outlines current issues in Community Care through case studies, paired with possible solutions to these problems areas. A particular focus is on inequities in the funding and assessment system and the impact this is having, the special needs of rural/remote clients which are not being recognised in the current supplement system, and the special needs of homeless and ATSI groups for an extended assessment period. Some of the case studies clearly demonstrate the risks of social isolation and increased health problems some clients face when they cannot access all services necessary to fulfill their care needs.

7.1. Funding and assessment system

A major issues for the community services area is the large gap between the Community Aged Care Packages (CACP) subsidy (\$36.05 per day) and the Extended Aged Care at Home (EACH) subsidy (\$120.50 per day). People who fall into the 'gap' between high care and low care (and have been assessed as low care) are missing out on services as they are not eligible for EACH subsidies. This is at odds with the gradational system used in residential care where there are four funding categories under low care.

Examples of the impact this is having on service users are given below in two case studies.

Case study one:

- *J is a 78-year-old woman who lives alone in an independent living unit. J worked as a psychotherapist, she is a writer and has performed on stage. She had a heart attack six years ago and has significant expressive dysphagia, confusion and short term memory loss. J experiences significant frustration with her word finding difficulties and her independence is compromised by her memory loss and problems arising from her accessing the community independently. J's family has been involved but this has reduced in recent months.*

- *J was assessed as eligible for a CACP and currently receives the maximum her CACP budget will allow – fortnightly home care and weekly shopping assistance. J has attended a writing group for many years but is no longer able to attend because of her inability to use public transport safely. She attends a weekly dinner at the retirement village but J does not attend any other group and has few other supports. J rarely leaves her home.*
- *J has been offered a vacancy in a weekly local therapeutic activity group but is unable to meet the cost of attendance and transport and the cost will not fit within the CACP. The CACP is unable to fund the cost of transport to her writing group. J does not require the level of support provided by an EACH package but is not having her needs met by a CACP and consequently is at real risk of social isolation.*

Case study two:

- *CACP recipient is an 80-year-old male living alone. His wife passed away five years ago and he suffers from significant financial hardship/stress/abuse. For example he gave his credit card details to an online 'lonely-hearts' club and had nearly \$5000 charged to his card. He has a history of a high number of falls and has depression and limited mobility. He wants to stay in his own home but the house is in very poor condition and is really not liveable.*
- *An injection of funds was required (above and beyond weekly budget) to improve his quality of life, reduce his falls risk, improve his nutrition and skin integrity and to undertake the following:*
 - *Heavy duty carpet clean*
 - *Industrial house clean – six hours*
 - *Clean-up of yard (rubbish removal, lawn mowing)*
 - *Gutter clean/window clean*
 - *Personal alarm*
 - *Purchase of a new refrigerator*
 - *Occupational therapist assessment and purchase*
 - *Continence assessment and purchase of products*
 - *Building works for installation of ramp to enable safer access to his front door*
 - *Ongoing home-care and transport to medical appointments*
 - *Purchase of skin care products*
- *We have spent an average of \$250 per week since his commencement on the package in April 2010, and we are now focusing on meeting his ongoing needs including socialisation and maintaining his standard of living. As a charitable organisation we deemed this client to be seriously at risk and we have put in the extra funds needed to be able to assist this client. However if another service provider without access to extra funds had him as a client we believe his basic living needs would have been largely unmet.*

In a similar vein there is a real need for clients on the EACH program to have access to a higher level of funding on a par with the highest level of funding for high care in a residential setting which is currently \$162.89 per day compared to the EACH subsidy of \$120.50 per day.

Examples of the impact this has on service users are outlined below.

Case study three:

- *Mrs G resides in her family home in with her husband/primary carer. Mrs G has been diagnosed with Alzheimer's disease and Lewy Bodies dementia (parkinsonian symptoms). Mrs G sustained a fall in February 2010 and fractured her right hip requiring hospitalisation for several weeks. Mrs G's needs are classified as high care due to her cognitive impairment. Mrs G was offered an EACH package which the family accepted, as it was their firm belief that Mrs G would be happier at home in her familiar environment.*
- *The case manager met with the client, her husband, daughter and staff of the nursing home, where Mrs G was receiving respite services, to discuss the range of services required to enable Mrs G to return home. Two weeks after assessment and discussion, Mrs G was able to return home with an extensive range of support services for herself and her husband. The Benetas EACH package commenced at an exceptionally high level to enable the client to settle at home. Personal care was provided for seven days per week morning and afternoons, domestic assistance once per week and once weekly respite shift to allow Mrs G's husband to attend social events and go shopping. The case manager arranged for an occupational therapist to review and recommend appropriate equipment which was then purchased/ hired, and training arranged for carers to enable them to attend to their duties as per OH&S guidelines. This equipment was assessed and was placed in the home within one day of the OT visit.*
- *Staff required training in the use of the hoist lift to be able to attend to the client. Prior to the client being at home she was not communicating verbally and was quite restless. However since returning home her wellbeing has vastly improved, and her family is relieved that Mrs G's wish of remaining at home has been met. This has also improved the family's wellbeing, and reduced the stress levels of all concerned.*
- *The cost of providing this high level of care and extra resources is well above the current EACH funding and these extra costs have been met by Benetas and the family. These extra costings average around \$165 per week.*

Case study four:

- *A 78-year-old male had a stroke and came onto an EACH package in July 2009. Throughout this time the client attended physiotherapy via the Community Rehabilitation program but this ceased in October 2009. The client sought assistance with private physiotherapy but was unable to afford the cost. The client began attending a Day Therapy Centre for strength training. He also participated in a hydrotherapy group and received physiotherapy but this could not be maintained as the client required one-on one care which could not be provided by the package funding. EACH funding only allowed him to attend the Day Therapy for group strength training sessions.*
- *The client was referred to a private Neurolink physiotherapy in April 2010 with his main concerns being left shoulder pain and decreased mobility, By 1 June 2010 the client had attended six visits with the treatment focused on improving hip and shoulder alignment, facilitating sit to stand and gait as well as other treatment.*
- *The client has shown real improvement since commencing physio and both the client and his wife have noticed changes which include greater flexibility and mobility as well as decreased pain. The plan is to continue with physiotherapy for this client on a twice weekly basis over the next six months. However the services for the client now exceed the EACH budget, but his physical condition will deteriorate if exercise and physiotherapy is reduced and his wife may not be able to manage him at home*
- *The extra funding required for these services are being met by Benetas, which is averaging at around \$100 per week, and his family is also contributing extra funding, but it is uncertain how long this can continue. If the extra funding ceases he will have to move into a high care facility and most probably receive the highest level of funding. So why can't this highest level of funding be provided in a community setting so that he can remain in his home which is what he wishes?*

The above examples show there is a clear need to establish a funding system for community care which is similar to residential aged care funding. Community Care clients should be funded for their individual care needs as occurs in residential aged care and not lumped into one single funding category.

Recommendation: a funding system which has similar principles to that used by residential aged care is implemented for Community Care in order to align funding with the care needs of the person.

7.2. Special needs of rural/remote clients

The special needs of community care clients living in rural/remote areas need to be recognised and funding allocations for metropolitan and rural areas should be calculated on different scales. At present the Community Aged Care Viability Supplement (ARIA) does not provide any funding to clients living in rural townships, such as Lakes Entrance and Wonthaggi in Victoria. However, Benetas has clients living in these townships who have to travel from 30 minutes to several hours to attend appointments as public transport is not available, and in some cases these trips are needed three or more times each week. An example of the impact this has on clients is outlined:

Case study:

- *Mr R lives in Lakes Entrance, a town in East Gippsland over 400 kilometres from Melbourne. Mr R commenced on an EACH package with Benetas in July 2005. Mr R's diagnosed conditions are Muscular Dystrophy and Asthma. Mr R was dairy farmer and an active member of the local branch Masonic Lodge (Freemason – lifetime member for 50 years). Mr R was the Grand Master, providing assistance to many members in the local community. Mr R was also heavily involved in initiating and maintaining community events such as a pony club. During the progression of his disease, Mr R and his wife were required to modify their home to accommodate the ever-changing equipment to support him living at home. The local community, including the hospital, the Rotary Club, the Masonic Lodge as well as local businesses, all assisted the family in providing funding and experienced tradespeople to refurbish the home and external environment.*
- *Mrs R maintained a routine of travelling a round trip of 100 kilometres three times per week to take her husband to hydrotherapy. Mrs R was an instigator of the installation of an all abilities hoist chair at the swimming pool to allow people with disabilities ease of access into the pool. Mrs R also purchased a spa and ensured the highest level of physiotherapy, exercise and social interaction to maintain Mr R's range of movement in his muscles. Mr R also attended the local men's shed for social interaction, and to continue his community support.*
- *Benetas initially provided domestic and morning personal care assistance. These services progressed from morning personal care, to morning and evening personal care, respite care and home care. Mr R's health declined, requiring respite care in the hospital setting rather than a respite facility. Benetas provided support in the hospital/respite setting to assist Mr R with meals (eating with dignity – not rushed), and exercise routines to keep his muscles moving and reduce the muscle contractures – this also ensures Mr R can be dressed with dignity and limited pain involved.*

- *Mrs R required a hip replacement, and although not requiring the services of a package, during her recuperation additional services were required. Mrs R attended hydrotherapy and therefore additional respite care of three to five hours was required for Mr R. Shopping trips took longer due to the Mr R's slower-paced movement, and the distances needed to be travelled in the rural area to attend follow-up medical appointments, shopping and hydrotherapy all added additional cost to services.*
- *Mr R's health has deteriorated and he is now unable to attend many activities in his local community. However, the visits to the hydrotherapy service remain important for his mobility. Also, the progression of his disease requires a high level of nursing visits for continence support, and monitoring health status. Benetas continues to support this client to remain living in his home, providing a high level of support above and beyond the funding provided by the EACH package. However it is uncertain how long this will continue. Mr and Mrs R are fully aware that permanent care is the only other (and highly undesirable) option.*

Mr R does not receive ARIA funding even though he has additional needs due to living in a rural environment, particularly the long distances required to attend hydrotherapy services. Rural townships rarely provide specialised care services and clients have to travel for long periods of time to access these services. At present ARIA scoring is based purely on location which is scored on its apparent access to services. Work needs to occur to devise a new formula for the Viability Supplement which takes into account the needs of particular individuals, rather than the specific location. Again the present system is a case of individuals having to fit into a closed system which suits the funding body rather than the funding system being designed to meet the particular needs of the client.

Recommendation: the current Community Aged Care Viability Supplement be reviewed with the purpose of developing a new formula which takes into account the individual needs of clients.

7.3. Special needs groups

Prior to providing services to people with special needs, such as those with a homelessness background or people from Aboriginal and Torres Strait Islanders (ATSI) groups, a great deal of time has to be spent developing a rapport and building trust. In most cases these people do not have a history of positive engagement with mainstream services and they are reluctant to be involved in programs such as Community Aged Care. Consequently, after receiving the referral care managers have to arrange a number of meetings with the prospective clients to introduce themselves, talk about the program and try to develop a relationship of trust.

These pre-service delivery meetings usually occur where the prospective client feels safest and this could be on the street, in a park or in a crisis centre, and it can take up to five or six meetings or longer before the prospective client agrees to receive the service. At present there is no funding for this important pre-service work, and given the special needs of this group this type of engagement is essential to bring the person onto the program. If a person from these special needs groups are provided with services before this trust is established then inevitably the person will drop out of the program.

This work of building trust should be regarded as an integral part of service delivery and needs funding. A flexible funding pool could be established for care managers to use in these special circumstances where lengthy assessments are required.

Recommendation: a flexible funding pool is established to be used by care managers when working with special needs groups such as people with a homelessness background or people from ATSI groups.

8. Residential Care issues

8.1 Supported Residents in Low Care facilities

Under the Aged Care Funding Instrument (ACFI) there is little incentive to admit people into residential low care facilities who cannot pay a bond and who do not have significant care needs. Usually these people have mainly behavioural problems and behaviour supplement payments under the ACFI are extremely low. Organisations have to be financially sustainable and to do this they have to admit people who can make a reasonable financial contribution, either personally or through care services subsidies. This places pressure on charitable organisations such as Benetas who wish to admit needy people but in order to continue to operate we have to make enough money to cover our costs. An example of this is problem is outlined below:

Case study:

We recently had enquiries from an older woman seeking admission to one of our facilities. She has been assessed as requiring residential low care and she lives with her daughter, who has been providing her with care for some time. Her residence was within easy walking distance from the facility. The daughter had health issues of her own, and was awaiting surgery. The daughter did not have fulltime access to a car. The facility was ideal for the woman and her family. However, while she was assessed as requiring low care, she could not afford a bond and did not meet the criteria for high care admission. The facility had already filled its required supported places, and so could not admit the woman. As a result she had to go on a waiting list, and then had to start looking for another placement further away from her family.

The income derived from a supported payment is currently estimated to be around \$9,500 per annum, and this is well below the estimated conservative figure of around \$13,000 per annum, allowing for a five per cent interest on investment, which Benetas currently receives from an average bond of \$200,000. Clearly this is a disincentive for facilities if they already have more than 40 per cent of their residents as supported clients. A number of facilities have worked out that it is now more financially advantageous to have a few supported residents and fill their facilities with bond-paying residents.

This discrimination against older people with few assets and little income is concerning. Benetas is keen to find a solution. Clearly a substantial increase in supported payments would help alleviate the problem but we believe a more considered approach needs to occur. In particular the current supported payment system needs to be reviewed so that incentives are offered to providers who admit large numbers of supported residents. For example, a graduated additional supplement could be provided when a facility has over 50 per cent, 60 per cent and 70 per cent of its residents as supported residents to offset revenue gained from bond payments.

Recommendation: a full review of the supported payment system is undertaken with a view to offering incentives to low care facilities which have a high number of supported residents, such as graduated additional supplements.

Recommendation: the Behaviour Supplement payments are reviewed with the intention of increasing them so that people with mainly behavioural problems will not be excluded from residential aged care.

8.2 Residents with challenging behaviours

Benetas residential care facilities pride themselves on their abilities to meet the care needs of all residents. However, occasionally situations arise where the particular behaviours of a resident cannot be managed by our staff. One such example is given below:

Case study:

One of our facilities was home to a male resident with dementia and alcohol addiction. This resident was quite active and mobile, and frequently verbalised his intent to leave the residential facility to get a drink. One evening at around 5pm he did leave the facility and arrived at his very elderly mother's home, drunk and disorientated at 3am the following morning. This situation had occurred on a number of previous occasions, and was clearly upsetting to his mother and Benetas staff. Whilst the staff were extremely pleased that he was safe and well, it was clear that the facility was not able to meet his care needs and he was returned to hospital for reassessment and to try and find him a more suitable place to reside.

This story illustrates the cost associated with moving and reassessing the person across the acute, rehabilitation and aged care sectors, the emotional strain on the person themselves and their families in not knowing where they are going to live, the inappropriate care arrangements the person endured while waiting for placement, and the overall stress on the staff of the facility.

The facility in question received little support from other agencies. As it was not considered a mental health problem the psychogeriatric team would not intervene, and it was difficult to get assistance from a drug and alcohol agency as older people did not seem to be an important focus, especially as the person had dementia.

If older people such as the gentleman in the case study are to access and remain in residential aged care then specialised resourcing and support need to be provided to facility staff. Mental health, drug and alcohol services need to be better integrated so there are no gaps. These services need to be available for access on a seven day, 24-hour basis and should provide training and information sessions to residential aged care staff. Consideration needs to be given to establishing a system whereby when a facility admits a person with very challenging behaviours, meetings are arranged with suitable agencies to ensure facilities receive the support they need. These arrangements can then be documented in the person's care plans.

Recommendation: consideration be given to establishing a process whereby when a facility admits a person with a history of challenging behaviours suitable agencies are required to attend the assessment to ensure facilities receive the support they need.

8.3 Wandering residents

A major problem for residential aged care staff is the resident who continually wanders and leaves the facility without notifying staff. A number of these residents have dementia but the disease is not advanced enough for them to be admitted to a dementia secure unit. An example is outlined below:

Case study:

A woman with dementia was staying at a Benetas residential facility for respite and left the facility at 11am and answered her phone at her own home at 5pm that evening, when staff rang trying to locate her. She told the facility manager that she had had a lovely day shopping. The problem was that no one knew where she was, and she was not aware that she should have told anyone where she was going. She did not seem aware that she should have returned to the facility at the end of the day.

The facility followed its legislative and moral responsibility and reported the person missing to the police after not being able to locate her for 20 minutes, and notified the next of kin. After one hour, and the person still missing, the facility reported the matter to the Department of Health and Ageing. Staff had to leave their duties and drive around the neighbourhood looking for her. Additional staff had to be brought in to cover for those searching for the missing person, and staff gave up their own time to support the search or to support their colleagues. Clearly this puts staff under extra stress as they worried about the missing resident. Such an exercise is costly at more than one level.

At present Benetas community services are trialling a tracking device which can be fitted to a person with dementia as a waist belt or ankle strap. The device is set with the coordinates corresponding to the geographical area in which the person can move, and once outside this area an alarm is activated and the person can be located. A similar device is also being trialled by Alzheimer's Western Australia. Before trialling our device discussions were held with Carers Victoria and no ethical problems were raised. Rather than being a restraint, the device actually gives the person freedom to move within a certain area. It is envisaged that if this trial in Community Care is successful the device will be trialled in residential aged care. The use of such a device would greatly assist in overcoming problems with wandering residents. Currently the device costs \$430 plus \$10 a week monitoring, although facilities could undertake the monitoring.

Recommendation: consideration is given to establishing a subsidy scheme to provide tracking devices at a reduced price to aged care service providers with wandering residents and clients.

8.4 Palliative care

As residential aged care facilities become more equipped to manage residents in the last stage of their lives, questions are being raised about people's rights to choose the place they wish to end their life. Advance Care Plans are being used by a number of facilities but as they have no standing in law they are often ignored by acute health providers. An example of this occurring is given below:

Case study:

A Benetas facility was recently home to a resident who was seriously ill and he and his family indicated a wish to end his days at the facility. Unfortunately his condition became such that he needed acute medical treatment and he was transferred to a hospital. Whilst there it was determined by hospital staff that active treatment would cease and he would be managed palliatively. The family were not given the option to transfer him back to the residential facility which in effect was his home. He died a week later in hospital.

Benetas staff are skilled, as are many residential aged care staff, in providing a multi-disciplinary palliative approach, including a positive and collegial relationship with clinical staff and pastoral care workers. Such events as described above could be avoided if Advanced Care Plans, as developed by residents of residential aged care facilities and their families, were recognised and accepted by all sectors of the health industry, including general practitioners, para-medical staff and hospitals. If Advanced Care Plans were given a legal basis then this problem could be overcome.

An excellent example of the efficacy of Advanced Care Plans is occurring in the Respecting Patient Choice program which is being operated by Austin Health in Melbourne. This program allows patients and their families to make clear choices about possible future treatments and services. One of the results of this program showed that 85 per cent of aged care residents who completed an Advanced Care Plan died in their aged care facility as they wished, while only 33 per cent of aged care residents who did not complete an Advanced Care Plan died in their aged care facility.

Benetas' Community Care team in Gippsland has received training in assisting clients to develop Advanced Care Plans and this has resulted in real benefits for the clients and their families.

The National Health and Hospital Reform Commission made a number of recommendations regarding Advanced Care Plans relating particularly to funding, education and training and we certainly support these recommendations. However we believe another step is to give Advanced Care Plans supporting legislation on a national level, and this already occurs in some states and territories.

Recommendation: Advanced Care Plans as developed by residents and clients of aged care services and their families be given a legal standing on a national level.

8.5 High/low care distinction

People moving into aged care should receive services appropriate to their needs. To artificially create certain domains on the ACFI which put a person into 'high care' makes no sense. An increasing number of older people are ageing in-place in residential aged care facilities, and low care facilities operating pre-1997 which meet the building codes are accepting an increasing number of high care clients. When residents classified as 'low care' have increased needs, and their ACFI score increases to a stage where they pass the mysterious barrier to 'high care' all of a sudden a whole range of resources have to be provided to them at the cost of the facility. Oddly, if a resident needs these resources, but cannot pay for them, providers are still required to ensure residents receive these resources to meet their duty of care. So why have this barrier?

Difficulties arise when ACAT assesses a person as low care, but the provider's assessment has them as high care. The provider has to source another ACAT assessment, which could take a great deal of time, and there is no guarantee that the ACAT will change its assessment. This means a high level of service and care is being provided to a resident but the subsidy does not recognise this care because of its labelling of 'low care'. If there were just the ACFI domains with 'high care' or 'low care' labelling then subsidies would better reflect the care being given.

Removing the categories of 'high care' and 'low care' would mean all residents would be treated the same financially. All residents with the financial means would therefore be expected to pay an accommodation bond which seems fair, as all are treated equally in a financial sense irrespective of their care needs.

Recommendation: the categories of 'high care' and 'low care' are removed and residents are given the care and resources as assessed to meet their needs.

9. Culturally and Linguistically Diverse (CALD) communities

As is common with many aged care organisations, Benetas has a large proportion of service users from CALD backgrounds. Older people from CALD backgrounds have unique needs requiring special consideration. Many of their needs can be quite different to older people who speak English as their main language. Unfortunately as people from CALD backgrounds do not have information about available services they tend to try and access services only during a crisis. Consequently they are under a great deal of stress and initial contact with service providers is often a difficult process for them, and the care staff involved.

One example of these difficulties surrounds a Russian-speaking woman and her family who approached a Benetas facility about moving in. Facility staff contacted the interpreter service but there were delays and communication problems as the contact was made via the telephone. This served to only increase the stress which is often experienced when a person first enters a residential aged care facility. This situation can also arise when a person first comes into contact with a community aged care service. As a result, it is essential that all aged care providers have access to funded interpreter services. However telephone interpreter services have their limitations – one way to enhance communication would be for the interpreter service to have video links available via programs like Skype or using webcams.

Another problem that arises when trying to make services accessible and culturally appropriate for older people from CALD backgrounds is the lack of data in terms of the requirements of these people, and little research has been done in this area. Benetas has just commenced a project funded through the Victorian Government's Dementia Care Program to identify the meal requirements of older people from Italian and Greek backgrounds who have dementia and are living in their local community. Many more of these types of action research projects need to be funded.

People from CALD backgrounds often have little knowledge of services available to them, and therefore their choice of services is fairly limited. Aged care staff need further training in providing culturally appropriate services which are appropriately publicised so people from CALD backgrounds can make informed choices about the services they wish to use. For example, diversional therapists working in residential aged care facilities need to receive training to ensure they are offering activities which are culturally appropriate.

Unfortunately there is a lack of an overall policy framework at Government level in regards to ascertaining the needs of older people from CALD backgrounds, making services culturally appropriate and ensuring people from CALD backgrounds are aware of these services. It is important that work commences on developing suitable policies in this area.

Recommendation: consideration is given to ensuring all interpreter services are able to be accessed via a video link such as Skype or webcam.

Recommendation: programs such as Partners in Culturally Appropriate Care (PICAC) be appropriately funded to provide suitable training and support for culturally appropriate care to aged care staff.

Recommendation: the Department of Health and Ageing and other Government departments work together to develop appropriate policies for older people from CALD backgrounds and aged care services.

Recommendation: funding be made available for research into the needs of CALD older people so that suitable culturally appropriate services and programs can be provided.

10. Workforce issues

Current research data indicates the aged care industry will face issues relating to reduced workforce growth over the next 10 years. The workforce profile of Benetas is consistent with demographics across many other Australian aged care workplaces reflecting a predominance of workers over the age of 45. Combined with the projected increase in demand for more complex aged care which will require a staff with higher levels of skill and knowledge indicates a strong need for the industry to build a self-driving and sustainable workforce.

To meet this challenge Benetas has undertaken a wide range of initiatives including:

- Investing in traineeships
- Investing in a scholarship which provides up to \$5,000 of financial assistance for fees, materials, travel and accommodation to support staff learning and development
- Sponsoring award programs such as Radio 3AW's Aged Care Nurses Appreciation Awards
- Staff referral program rewarding staff who refer potential employees to Benetas
- Policies and procedures supporting and encouraging women's leadership and work/life balance, such as eight weeks paid maternity and two weeks paternity leave, flexible start and finish times to accommodate child school drop-offs, 48/52 leave arrangement (salary sacrifice for additional leave), ability to use sick leave as carers leave if necessary and a staying connected program for staff on parental leave
- Actively supporting the Commonwealth Government's 'Bringing Nurses Back to the Workforce' program by nominating nurses who are eligible to receive cash bonuses under the program
- Rewarding our Community Care managers with an additional increase in salary.

With 88 per cent of our permanent and casual workforce being female and over 60 per cent of staff working part-time, family-friendly work practices have always been widely supported by Executive and operational managers as a solution to retaining talent.

These initiatives have been recognised with recent awards including a Federal Government citation as an Employer of Choice for Women, and the Fair and Flexible Employer Recognition Award by the Victorian Government.

Our current workforce plan is aimed at developing strategies to manage our ageing workforce and we are investigating trends and organisational case studies such as BMW. This pilot project was developed by BMW to meet the challenges posed by its ageing workforce and involved health care management, enhancing workers' skills, changing the workplace environment, instituting life/work policies and change management processes. Many of the changes were to the physical environment with design and equipment changes, as well as health promotion programs with regular sessions by a physiotherapist. The result was a 7 per cent productivity improvement with an increase in staff morale and a drop in absenteeism from 7 per cent to 2 per cent. A description of the project is given in the article *Defusing the Age Time Bomb*, *Harvard Business Review* March 2010.

A major barrier to recruiting skilled nurses into aged care is the considerable difference in salaries paid in acute health compared to aged care. In some instances acute health pays skilled nurses over 20 per cent more than nurses doing equivalent work in aged care.

The provision of aged care services is becoming more demanding as the needs of older people are becoming more chronic and complex. Access to highly skilled professionals who can advise and train staff is becoming essential. Nurse practitioners are ideal for this role and need to be widely available to aged care staff. A practical way to do this would be to allocate one nurse practitioner to five to 10 residential aged care homes and Community Care packages in these geographical areas covered by the facilities. Clearly there are not enough nurse practitioners to do this at the present time, but it is a key goal as nurse practitioner numbers increase.

Like many other aged care organisations, Benetas is finding it difficult to recruit skilled case managers. One innovation is to have a two-tiered case management system. This involves recruiting people with the skills, but not necessarily with tertiary qualifications, for case management who could come in at a lower level than the tertiary qualified staff. These lower level recruits can follow a career path leading up to the higher level as their experience and skills increase. There are already several organisations interested in this concept which is worth a Commonwealth funded trial. This innovation could lead to more opportunities for skilled people without tertiary qualifications and assist in meeting the case management needs of aged care organisations.

Recommendation: the aged care sector is funded to pay nurses equivalent salaries to those they receive in acute health.

Recommendation: nurse practitioners are made widely available to aged care services.

Recommendation: funding is provided for a pilot scheme to establish a two-tiered case management system and recruit skilled people without tertiary qualifications.

11. Housing and aged care

11.1 Suitable housing for the aged

Residential aged care facilities provide accommodation services as well as care. In our experience it is not unusual for a number of people moving into low care facilities primarily for accommodation, especially those living by themselves in sub-standard accommodation or in homelessness situations. The introduction of the ACFI has resulted in many facilities excluding those with primarily accommodation needs and focussing only on those with care needs. In many cases those with accommodation needs also have care needs but often not high enough to score well on the ACFI and hence find it difficult to access residential aged care. Clearly organisations need to be financially sustainable and providers often cannot afford the loss in income to admit these people.

Older people living in insecure housing often find it difficult to access Community Care. These people are often transient, living in different locations for short periods of time, as they seek permanent accommodation. Consequently Community Care providers have great difficulty in always knowing their whereabouts and where they can deliver their services.

The shortage of affordable housing is well documented, (e.g. studies by Australian Housing Urban Research Institute) despite the introduction of new programs such as the Commonwealth Government's National Rental Affordable Scheme, and older people with accommodation and care needs are falling through the gaps between the housing sector and residential aged care. It is time to consider new models of accommodation for the aged where care can easily be provided.

A step in the right direction has occurred with a recent announcement that universal design for housing will become a standard.

When planning accommodation for the aged, the housing sector needs to involve the aged care sector from the beginning of the process so that care needs are taken into account in the building design. Consideration needs to be given to establishing an aged care advisory body to work with the housing sector in building planning and design. Peak bodies in each state could be resourced to establish these accommodation advisory committees and links established with the state housing sectors.

Recommendation: consideration be given to establishing an aged care advisory body in each state to work with the housing sector in planning and designing housing for the aged.

11.2 Partnerships

Benetas has nearly 200 independent living units for older people. However the stock is ageing and poses difficult and costly redevelopment issues. In many cases the land is worth more than the stock. The development of this stock is in the interests of older people and the public purse as most older people wish to live independently and the provision of affordable housing plus access to Community Care services, will enable them to do this and bring down the number of older people who would otherwise fill low care beds. However many not-for-profit organisations (NFP) including Benetas, find it difficult to generate capital, and incentives need to be provided so that NFPs can leverage their land holdings. For example NFPs provide the land and government the construction costs. Partnership projects were previously available where local municipalities provided the land and the state housing authorities the construction costs. Consideration should be given to developing new opportunities for such partnerships between NFPs, local municipalities and housing authorities.

Recommendation: consideration be given to providing new opportunities for partnerships between NFPs, local municipalities and housing authorities to provide housing for older people.

11.3 Access for funding for NFPs

Many NFPs are not in a position to become registered housing providers, but need access for government grants and funding for housing developments for older people. Consideration needs to be given to allow NFPs with land holdings and the ability to develop this land for older person's housing to be given access to government housing grants and funding without become registered housing authorities.

Recommendation: NFPs have access to government housing grants and funding without becoming registered housing authorities.

11.4 Extending the time between when residential aged care places are provisionally allocated and when they become operational

It is clear that being able to purchase a Greenfield site and lodge a development application within six months of being given a provisional allocation is unrealistic. Our experience indicates that an approximate five month period is required to complete the client brief, operational modelling and design stage to 'town planning' standard of a project. This does not take into account the need to source, purchase and settle on appropriate land (which could be complicated by external property market conditions).

At best this process could take between nine to 12 months and at worst, it could take over two years to get to this stage, in particular if the land site being acquired has demolition or contamination (clean up) works associated with it. Most banks will not consider an application or provide finance until a planning permit has been obtained. This process also adds to the time delay in operationalising beds.

Our experience is that even if the local Council issues a permit, aged care developments tend to receive an objection by adjoining and surrounding property owners and are often referred to VCAT for consideration. In general most people don't want an aged care facility next door or in their immediate neighbourhood and they can delay the process by lodging an objection to VCAT at the small cost of a few hundred dollars and often do not even appear at the VCAT hearing to discuss the application.

At the other end of the scale, there have been instances in Victoria where multiple property owners have formed a group, engaged a high profile planning lawyer and argued the case in VCAT and Court.

Although other aspects such as finance and project delivery can be difficult they are certainly under the control and responsibility of the operator. However, it is apparent that the most variable and critical point for any development is obtaining the planning permit. This directly influences the rate at which the design can be completed, financing sought and put in place, construction commenced and bed places commissioned.

Given the planning process is a government controlled process and mainly outside the control and ability to influence of the operator, Government needs to recognise the challenges and somehow streamline or speed up the process (e.g. preferential early listing if referred to VCAT) or recognise these issue in their timelines.

Recommendation: the requirement to operationalise beds within two years of the licences being granted be extended where there are proven cases of lengthy delays because of town planning issues.

12. Recommendations

Research and development

Consideration should be given to establishing a research funding stream for service providers to work with researchers on projects to improve services to older people.

Funding needs to be directed to pilot a program for translating research findings into an easy-to-read format for aged care providers based on the Canadian program National Initiative for the Care of the Elderly (NICE).

Consumer choice and participation

Flexible pool funding should be made available to pilot test some specific innovations and initiatives that have been put forward by service providers to enhance consumer choice and participation.

Interface with acute and sub-acute health

A streamlined comprehensive assessment process should be developed for eligibility for care across all aged care and sub acute programs. This should include:

- developing new assessment tools; and
- developing networks based on the Victorian Primary Care Partnerships to ease the pathways between the programs.

Care subsidies and user payments across residential and community aged care and all sub-acute care services need to be aligned.

Costs for care and accommodation in residential care need to be separated.

Positive ageing

Consideration should be given to developing a range of initiatives to raise the status of older people and counteract the ageist viewpoint so prevalent in our society such as local government taking on the role of publicising the benefits of their positive ageing programs.

Community Care

A funding system which has similar principles to that used by residential aged care be implemented for community care.

The current Community Aged Care Viability Supplement needs to be reviewed with the purpose of developing a new formula which takes into account the individual needs of clients.

A flexible funding pool should be established for use by care managers when working with special needs groups such as people with a homelessness background or people from ATSI groups.

Residential Care

The supported payment system needs to be completely reviewed, looking to offer incentives to low care facilities which have a high number of supported residents, such as graduated additional supplements.

The Behaviour Supplement payments need to be reviewed with the intention of increasing them so that people with mainly behavioural problems will not be excluded from residential aged care.

Consideration must be given to establishing a process whereby when a facility admits a person with a history of challenging behaviours suitable agencies are required to attend the assessment to ensure facilities receive the support they need.

Consideration should be given to establishing a subsidy scheme to provide tracking devices at a reduced price to aged care service providers with wandering residents and clients.

Advanced Care Plans as developed by residents and clients of aged care services and their families should be given a legal standing on a national level.

The categories of 'high care' and 'low care' need to be removed and residents be given the care and resources as assessed to meet their needs.

Culturally and Linguistically Diverse (CALD) communities

Consideration should be given to ensuring all interpreter services are able to be accessed via a video link such as Skype or webcam.

Programs such as Partners in Culturally Appropriate Care (PICAC) need to be appropriately funded to provide suitable training and support for culturally appropriate care to aged care staff.

The Department of Health and Ageing and other Government departments must work together to develop appropriate policies for older people from CALD backgrounds and aged care services.

Funding must be made available for research into the needs of CALD older people so that suitable culturally appropriate services and programs can be provided.

Workforce issues

The aged care sector needs funding to pay nurses equivalent salaries to those they receive in acute health.

Nurse practitioners need to be available to aged care services.

Funding should be provided for a pilot scheme to establish a two-tiered case management system and recruit skilled people without tertiary qualifications.

Housing and aged care

Consideration needs to be given to establishing an aged care advisory body in each state to work with the housing sector in planning and designing housing for the aged.

Providing new opportunities for partnerships between NFP, local municipalities and housing authorities to provide housing for older people needs to be considered

NFPs should be able to access to government housing grants and funding without become registered housing authorities.

Requirements to operationalise beds within two years of the licences being granted need to be extended where there are proven cases of lengthy delays because of town planning issues.



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