



# **Aged Care Queensland Inc**

Submission to the  
Productivity Commission Inquiry into Caring for Older Australians

July 2010

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## Introduction

In response to the Productivity Commission's Inquiry into Caring for Older Australians, Aged Care Queensland has engaged with three significant association committees, the residential care, community care and retirement living committees, as well as other special interest groups. This submission represents the distilled thinking of these groups.

Aged Care Queensland and its members have developed 8 principles that represent the critical success factors needed for an effective and viable aged accommodation, service and care delivery industry.

- 1. A streamlined, integrated accommodation, care and support service system for older Australians**
- 2. A funding regime that reflects the true cost of care**
- 3. Consistent assessment and universal access to care and support**
- 4. A consistent and equitable fees structure for aged and community care**
- 5. A compliance system that is fair and equitable**
- 6. A quality framework that supports better performance and continuous improvement**
- 7. A Retirement Village Sector with capacity to grow**
- 8. A well resourced and sustainable workforce**

This paper will outline the key issues and opportunities within each of these principles and provides recommendations for the Productivity Commission to consider as part of the review process. A summary of these recommendations is provided below. ACQ and its members would welcome further opportunities for dialogue with the Productivity Commission regarding any aspect or issue raised in this paper.

Aged Care Queensland also acknowledges and has contributed to the submissions of the two national aged care associations of Aged Care Association Australia and Aged & Community Services Australia.

## Summary of Recommendations

### 1. A streamlined, integrated accommodation, care and support service system for older Australians

#### Recommendations

- ACQ recommends the separation of accommodation, care and support services to ensure the “right care at the right time, in the right place”.
- ACQ recommends the program barriers between HACC, CACP, EACH and EACHD are removed so that the level of care an individual can receive is not restricted by program boundaries.
- ACQ recommends aged care places be calculated based on the ratio of per 1000 persons aged 85 years and over.
- ACQ recommends consumer choice be a foundational principle of the Australian aged care system.
- ACQ recommends the exploration of consumer directed care models that are not restricted by current funded program boundaries.
- ACQ recommends that all future aged care systems and services recognise the particular needs of Aboriginal and Torres Strait Islander people, people from Culturally and Linguistically Diverse backgrounds, people living in rural and remote locations, people who are homeless and other special needs groups not recognised under the *Aged Care Act 1997*.

### 2. A funding regime that reflects the true cost of care

#### Recommendations

- ACQ recommends a new methodology be developed to determine annual indexation on all aged care funding and in the interim the greater of the CPI or PBLCI be used to determine indexation percentages.
- ACQ recommends research be undertaken to identify the true cost of providing care and support across residential and community care settings.
- ACQ recommends that the Productivity Commission review the effectiveness of linking aged care funding in high care to a proposed fair price authority for the acute care sector.
- ACQ recommends the creation and adoption of a sustainable capital raising system for residential aged care.
- ACQ recommends the continued and expanded investment by the Commonwealth Government in relevant capital infrastructure for community care.
- ACQ recommends Day Therapy Centres receive an expanded and guaranteed role through the provision of ongoing, sustainable funding.
- ACQ recommends greater utilisation of the existing aged care system in the funding and provision of Transition Care and Sub-Acute Care programs.
- ACQ recommends all DoHA funding agreements be for a minimum three year period with appropriate timeframes for renewal as required.

### **3. Consistent assessment and universal access to care and support**

#### **Recommendations**

- ACQ recommends a review of the current ACAT model and the exploration of new approaches to timely and consistent assessment.
- ACQ recommends the development and validation of a nationally consistent suite of assessment tools to determine eligibility and access to services.
- ACQ recommends that the role of ACAT be solely to assess a person's needs and approve eligibility for government funded aged care.
- ACQ supports the creation of "One-Stop Shops" as an identifiable but not exclusive entry point into the aged care system. ACQ recommends that the establishment of "One-Stop Shops" be supported by significant government investment to ensure a diversity of service models, appropriate geographic coverage, effective information management systems, and a skilled workforce.
- ACQ recommends the involvement of the aged care sector and consumers in the design and establishment of the "One-Stop Shops".

### **4. A consistent and equitable fees structure for aged and community care**

#### **Recommendations**

- ACQ recommends the implementation of a National Community Care Consumer Fees Policy & Framework, encapsulating all government funded community care service provision, with principles, guidelines and upper limits, whilst allowing each provider to determine their schedule of rates dependent on service models, location and target groups.
- ACQ recommends the deregulation of systems to accommodate for consumer choice and user pays.
- ACQ recommends that restrictions of retention amounts from accommodation bonds be relaxed.
- ACQ recommends a simple online assessment tool for community care providers to consistently determine financial disadvantage or hardship.
- ACQ recommends additional funding supplements for provision of community care services to persons from socially and financially disadvantaged groups.
- ACQ recommends that the concessional ratios be reviewed to more adequately reflect the socio-economic status of communities.
- ACQ recommends that concessional supplements for residential care be reviewed to ensure better alignment with bond and charges.

### **5. A compliance system that is fair and equitable**

#### **Recommendations**

- ACQ recommends a new approach to complaints management and investigation be adopted with a greater emphasis on conciliation, mediation and resolution at the local level.
- ACQ recommends the separation of compliance, complaints investigation and quality assurance in the management of all aged care funding, especially residential care.

## **6. A quality framework that supports better performance and continuous improvement**

### **Recommendations**

- ACQ recommends the adoption of a new quality auditing process for both residential and community care that draws on a competitive market of certified accreditation agencies, independent of government.
- ACQ recommends appropriate support and funding be provided to community care providers to transition to the new Community Care Common Standards.

## **7. A Retirement Village Sector with capacity to grow**

### **Recommendation**

- ACQ recommends an industry driven accreditation scheme for Retirement Villages be established.

## **8. A well resourced and sustainable workforce**

### **Recommendations**

- ACQ recommends reforming the funding regime for aged care to enable greater wage parity with the healthcare sector.
- ACQ recommends a continued investment by government in training and skills development across all professions and work groups relevant to aged care.
- ACQ recommends that more funding be allocated to leadership and management to assist emerging leaders in the industry.
- ACQ recommends a review of the current certificate level course delivery by Registered Training Organisations (RTOs) to ensure sufficient emphasis is placed on practical experience and “work readiness” for the aged care industry.
- ACQ recommends a greater emphasis and exploration of new and emerging service models and technologies that help alleviate the impact of workforce shortages.

## **A streamlined, integrated accommodation, care and support services system for older Australians**

### Separation of accommodation, care and service

To ensure the “right care at the right time, in the right place” accommodation, care and services should be separated. A consumer should be allocated funding based on their assessed care needs and then decide the setting where they would like to receive their care i.e. in their own home, retirement village, or residential care setting.

The cost of accommodation will require a separate funding model from the funding model for care. For those unable to fund their own accommodation, the Government will need to provide a safety net. This new system would provide consumers with flexibility wherever they choose to reside. Implicit in this model is the notion that they will receive the same level of funding for their care irrespective of the location that it is provided.

ACQ notes a de-facto splitting of accommodation and care is already a reality in the Queensland market, with retirement villages openly working in conjunction with community care providers or in their own right to provide subsidized care services in their village. In this scenario the resident pays for their accommodation and is able to access funded care to match their needs.

As a person’s care needs increase to the point that they can no longer be cared for adequately in their own home or if the risk of remaining generally unsupervised is too great, residential care options should be available and the transition made more efficient by the transfer of accurate and specific care documentation.

### Streamlined programs

Within the current aged care system there are too many programs, each with their own objectives, regulations, and funding models. The system has become complex and is confusing for clients, families and providers. This is particularly evident in the provision of community care programs.

The level of funding and support provided to people receiving services in the community is segregated by the existence of more than 15 different program structures with the most prominent being : Home and Community Care (HACC), Community Aged Care Packages (CACP), Extended Aged Care at Home (EACH), Extended Aged Care At Home Dementia (EACHD), and National Respite for Carers (NRCP). The Department of Veteran’s Affairs also funds a wide spectrum of support and assistance to eligible Veterans including Veteran’s Home Care that complement this system. According to government policy, HACC represents the lower end of the spectrum whilst EACH and EACHD are seen to be equivalent to high level residential care. The interface between these packages is complicated by a number of factors including subsidy rates, client fees, eligibility and service scope.

This complexity gives rise to a number of anomalies, for example, the interface between HACC and CACP is currently constrained by the client’s perception of value for money. The HACC program currently offers more service types than a CACP, similar and sometimes greater hours of care and a

fee that is considerably lower for the consumer. The service scope of a CACP is so narrow that it is not unusual for a client progressing to a CACP to draw on HACC services such as allied health, nursing and centre based respite care to supplement their care requirements. These factors make clients reluctant to progress from a HACC package to a CACP despite the increasing complexity of their needs.

The interface between CACP and EACH/EACHD also present challenges. The CACP program delivers a low level care in the community with an average subsidy of \$12, 684 per person/per annum. The EACH/EACHD delivers a high level of care in the community with an average subsidy of \$42,000 per person, per annum. The difference in subsidy levels is substantial and no middle tiers of funding are made available for people requiring more than a CACP but less than an EACH.

If the barriers between HACC, CACP, EACH and EACHD were removed consumers could move through the system seamlessly with their level of care increasing incrementally as their needs increased. They would not be faced with difficulties in receiving the level of care they require because of restrictions in program parameters and they would not be forced to leave their preferred provider simply because that provider is not funded to provide a particular program.

#### Updated approach to Planning

The government tightly regulates the supply of aged care places through a complex set of planning ratios that determine a target level and mix of aged care services. The current planning ratio target equates to 113 operational places per 1000 persons aged 70 years and over. The process of calculating places per 1000 persons aged 70 years and over was adopted as the basis for planning in the mid 1980s (DOHA, 2008). The National Health and Hospital Reform Commission (NHHRC) recommendation (42) acknowledges that this process is now out of date and does not reflect the growing number of people aged 85 and over who require care. The results of this shortcoming mean that the supply of aged care places is limited and waiting lists for care provision are a common occurrence.

The supply of aged care places is distributed amongst approved aged care providers who deliver services and support to those who are assessed as requiring care. Places are distributed regionally through the competitive tender process known as the Aged Care Approval Round. There are constraints on the number of aged care places a provider can receive through the ACAR process (these constraints align with defects in the planning process) and as a result the consumer is not always able to access care from the provider of their choice. ACQ would support government funding subsidies for aged care more directly linked to people rather than places.

#### Offering choice and a continuum of care

Consumer directed care is an area that has been receiving increased attention. The NHHRC made a recommendation in their report *A Healthier Future for all Australians* that people receiving care in the community be provided with greater choice in how their resources are allocated. Following this recommendation the Australian Government released a tender for the piloting of 1200 consumer directed care places.

ACQ have advocated for the introduction of consumer directed care for a number of years and are pleased to see the recent developments in this area. The introduction of consumer directed care has



the potential to support the provision of more flexible and innovative services that are tailored to the need of the individual, and incorporate models of care which are restorative and make use of new technologies.

Whilst there is evident enthusiasm around the trial of the consumer directed care model, ACQ believes that consumer directed care should never completely replace current models of care but rather sit alongside them as an available alternative. In saying this, the trial of true consumer directed care should not look like packaged care re-badged as is the case in the current trial.

Aged and Community Services Australia have developed a Consumer Directed Care Position Paper which presents a number of guiding principles for the consumer directed care in the community (Refer to [Appendix 1- Consumer Directed Care Position Paper April 2010](#) ). ACQ encourages the Productivity Commission to review this paper when considering the implementation of consumer directed care models.

#### A flexible system to address diversity and gaps in accommodation, care and support services

In developing a simplified and streamlined aged care system, resources for people within the most marginalised groups must not be forgotten. The provision of a quality aged care system must have flexibility and safeguards to ensure persons from a variety of backgrounds can access and receive appropriate support and care. This diversity includes those from special needs groups formally recognised in the *Aged Care Act 1997* such as people from Aboriginal and Torres Strait Islander (ATSI) backgrounds, people from Culturally and Linguistically Diverse (CALD) Backgrounds and people living in rural and remote areas. Recommendations on how to enhance service delivery to these groups are provided in the following pages. ACQ believes all funded aged care providers should be culturally competent in the delivery of services however this should not replace the need and importance of specialist Indigenous and CALD organisations.

ACQ also encourages the Productivity Commission to consider the needs of other groups which are not specifically covered in this submission including:

- People with a Mental Health diagnosis including depression, post traumatic syndrome, substance abuse and psychosis. The challenge of mainstream services to provide appropriate responses to many people with these diagnoses should not be underestimated. In both the community and residential care setting there is a need for specialist mental health diagnostic services to assist with diagnosis and ongoing case management.
- Older homeless people – the Queensland HACC Program has successfully provided a responsive Homeless Outreach Program through targeted funding and flexible service models that enable clients to access a range of support services. Such programs should not be lost in any transition of responsibility to the Commonwealth Government and must be embedded in a case management framework.
- Younger People including those with early onset dementia, those requiring palliative care and those who are unable to be supported through State disability system.
- People who identify as Lesbian, Gay, Bisexual or Transgender.

### Aboriginal and Torres Strait Islander Persons

Aged Care Queensland facilitates the Queensland Aboriginal and Torres Islander Aged Care Network (QATSIACN). This network consists of over 40 Indigenous specific service providers operating across the state in rural, regional and metropolitan locations. Participants in this network deliver Home and Community Care Programs, Community Packaged Care, residential care and Flexible Aged Care services. This group meets every 6 weeks via a telelink which is funded by the Department of Health and Ageing. The telelink provides participants with an opportunity to share information network and to address Indigenous specific service delivery issues.

The Queensland Aboriginal and Torres Strait Islander Aged Care Network have prepared a separate paper highlighting some of the key areas where reform could enhance Indigenous service delivery (Refer to [Appendix 2- Aboriginal and Torres Strait Islander Aged Care Reference](#)). Suggestions for reform include:

- Support for Indigenous specific organisation to prepare funding applications, including advice on calculating unit costs and training on how to write funding submissions;
- Direct allocations to Indigenous specific service providers through the Aged Care Approval Round;
- The implementation of regional Aboriginal and Torres Strait Islander Aged Care Liaison Officers;
- Quality outcomes for Indigenous service providers that encompass holistic and sustainable community development principles and align with current government initiatives such as the Closing the Gap Initiative;
- Regular and ongoing support to assist services to meet quality outcomes; and
- The development of a National Aboriginal and Torres Strait Islander Aged Care Reference Group which encompasses all aged and community care programs.

### People from Culturally and Linguistically Diverse Backgrounds

ACQ acknowledges the value of programs such as Partners in Culturally Appropriate Care (PICAC) and the Community Partners Program (CPP). These programs provide information and advice about aged care services and how to access them, foster links between communities and aged care providers and liaise with aged care providers about how to meet the special needs of CALD clients. ACQ encourages the government to continue supporting programs such as these but also calls for the provision of appropriate funding for CALD specific aged and community care service providers.

Providing services that are culturally appropriate for people from a CALD background can be time consuming and costly. Many CALD specific services match clients with workers from an appropriate cultural background. In community care the process of matching clients with workers can result in increased travel costs as often the most culturally appropriate worker is not always the most geographically appropriate worker. Activities such as conducting assessments and developing a care plan can also take longer as often these activities require face to face contact with the client and the support of an interpreter.

The importance of interpreters in delivering responsive care to people from CALD backgrounds is currently not being recognised and supported by the Department of Health and Ageing. The Department of Health and Ageing provides no funding for interpreters in residential care or community packaged care. In Queensland, HACC service providers can currently access free translating and interpreting services. Providers are concerned that this funding will disappear completely once HACC is transferred to the Commonwealth. Further to this, the current supply of interpreters that are available to the industry have a limited knowledge of aged and community care and this often makes interpretation of key messages difficult.

#### People in Rural and Remote Areas

Queensland is one of the most decentralised states, making the provision of sustainable aged and community care services in rural and remote locations a real challenge. Financial viability is one of the biggest challenges for these providers as often they are faced with higher costs that are not adequately compensated by the current viability supplement. ACQ have identified that the trend towards larger organisations auspicing small standalone rural and remote services is no longer occurring as these arrangements are not financially viable.

There is a need to recognise the diversity of needs within rural, regional and remote areas of Queensland. While there is some commonality in the challenges and issues faced, the scale of impact should not be underestimated. For example, access to adequate primary and acute health care services may be an issue for a person living 1-2 hours drive from Brisbane but is even more costly and difficult to achieve for a person who is located more than 500km away from their nearest major facilities. It is important to have strong and effective interface with the new Local Hospital Networks and Medicare Locals (Primary Health Care Organisations).

Maintaining a local focus and encouraging opportunities to collaborate and consolidate government funded service provision across community care, residential care, primary health care and acute care services, needs to be a focus of the Department of Health and Ageing through the COAG Reforms process. The Multi-Purpose Health Service model can provide efficiencies and effective integration providing it is not totally controlled by the State Health Department or local hospital/health service district. Performance measures and monitoring needs to be well established to ensure funding is not solely directed to the acute care system at the expense of the ongoing aged care components. Currently in Queensland only one of the twenty MPS centres is provided by a non-government organisation.

Attracting, retaining and supporting the workforce in rural, regional and remote centres remains a very real problem for many aged care providers. Many providers in Queensland sight ongoing difficulties in recruiting and retaining qualified allied health and nursing staff outside of the major metropolitan centres. Government funded workforce initiatives need to be expanded to include emerging roles such as allied health assistants that work within a care framework developed by the relevant allied health professional. The ability to backfill staff attending training should also be funded as part of developing the workforce.

Advancements in technology offer new ways of providing care and support that can help address issues regarding workforce shortages. Funding to enable rural, regional and remote providers to trial and purchase the latest available technology is required (Note: the Department of Health &

Ageing Technology in Aged Care Budget Initiative of 2007-08 was ceased in 2009 without any real investment made by the department). In community care, technology offers new equipment that can provide a level of healthcare monitoring and social interaction via the internet thereby reducing the amount of travel and number of staff required to support people in their own homes. This of course is dependent on reliable access to broadband internet, which for many areas of Queensland is still not a reality.

#### Recommendations

- **ACQ recommends the separation of accommodation, care and support services to ensure the “right care at the right time, in the right place”.**
- **ACQ recommends the program barriers between HACC, CACP, EACH and EACHD are removed so that the level of care an individual can receive is not restricted by program boundaries.**
- **ACQ recommends aged care places be calculated based on the ratio of per 1000 persons aged 85 years and over.**
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- **ACQ recommends that all future aged care systems and services recognise the particular needs of Aboriginal and Torres Strait Islander people, people from Culturally and Linguistically Diverse backgrounds, people living in rural and remote locations, people who are homeless and other special needs groups not recognised under the *Aged Care Act 1997*.**

## A funding regime that reflects the true cost of care

### Adequate indexation

The annual indexation for residential aged and community care programs has been too low for too long yet aged care providers are still expected to meet the rising costs in providing care and support such as water, electricity, food and petrol.

The indexation for aged care funding for 2010-11 was just 1.7% at the same time as minimum wages increased by 4.8% and the Consumer Price Index was 2.9%. Unlike other industries, the aged care sector cannot increase financial contributions made by consumers towards the cost of care as this is heavily regulated by legislation. The end result is that without adequate indexation, the diversity and intensity of care and services provided is compromised.

The Conditional Adjustment Payment (CAP) for residential aged care services was introduced in 2004 following the Hogan Report and was used to supplement the inadequate COPO levels. Unfortunately the CAP was never applied to community care and was also discontinued for residential care in the 2009-10 Federal Budget, placing further pressure on providers at a time of significant increases to utility and wage costs.

Further exploration and research needs to be undertaken to develop an appropriate indexation formula that is relevant to the cost drivers within aged and community care. Community Care programs such as the Department of Veterans Affairs, Veteran's Home Care program provide a good example of different and more relevant indexation methodology.

In the interim ACQ supports the Aged Care Industry Council's (ACIC) 2010 Budget proposal of an immediate intervention until a new indexation methodology for aged and community care is developed:

*"...as from 1 July 2010, the greater of the CPI or the All Groups Pensioner and Beneficiary Living Cost Index (PBLCI) for the year ending 31 March 2010, should be used to index the Federal Government's aged care subsidies" (ACIC 2010-11 Federal Budget Submission).*

This proposal needs to be applied across residential aged care and all community care programs including packaged care, Day Therapy Centres and the HACC Program.

### Funding based on the true cost of care

Currently funding is dictated by budget constraints with the majority of growth funding specifically targeted at additional residential or community care places (or outputs in the case of HACC). There is a critical need for research to highlight the true cost of providing care and support across residential and community care. The results of this research would inform the development of a new aged care funding model that had alignment across community and residential care settings.

In residential care applications for high care bed licenses are at an all time low. Profit and not-for-profit providers, state that the prevailing unsustainable financial arrangements mean they will not be applying for those beds. Furthermore, ACQ's submission to the review of the Aged Care Funding Instrument (Refer [Appendix 3- ACQI Submissions to ACFI](#)) identifies our concerns with weightings and funding under the tool.

Care received in high care residential care and acute care is similar but this is not reflected in funding. ACQ notes that in the COAG Health Reform outcomes that there will be the creation of a fair pricing authority to ensure appropriate real pricing for acute care services. ACQ would welcome a Productivity Commission review into the effectiveness of linking aged care funding in high care to a proposed fair price authority for the acute care sector.

In community care, the hours of care being provided to clients have reduced significantly because funding levels no longer cover the true costs of care. The daily funding amounts for CACP's were first determined in the early 1990's and have only been subject to inadequate COPO indexation since that time. As a result CACP providers have gradually been forced to provide less hours of support. The average Community Aged Care Packages previously provided 7 hours or more of support each week but now only delivers only 5 (Report on Government Service Provision, 2009). This has resulted in many older Australians questioning the benefit of the program and choosing to remain receiving HACC services.

#### Supporting capital investment

The current capital raising system for residential aged care is proving totally inadequate for the expansion and maintenance of quality facilities. As evidenced in the 2008-09 Aged Care Approval Rounds, nearly 2000 residential care places were not taken up. In addition, in the previous two years, 786 bed licences were handed back because providers could simply not afford to build facilities to accommodate the beds.

ACQ supports the joint ACIC recommendation that Government create and adopt a sustainable capital raising system to ensure the ongoing provision of high quality residential care services. ACIC (2010) suggest that features of such a system should include:

- Choice for older people and their families as to how they pay their accommodation costs at no cost to Government. This requires the introduction of alternative payment options, including refundable accommodation deposits for high care;
- Removal of the distinction between high and low care at no cost to Government;
- Uncapping of the daily accommodation charge for high income people and increasing it for those on a medium income so it is equivalent to the average building costs of residential care in the relevant region;
- Linking government payments (the accommodation subsidy) for concessional residents to the average cost of building residential aged care; and
- Allowing providers to charge differential room rates based on the quality and type of accommodation at no cost to Government.

Capital infrastructure is also important to the ongoing provision of community care services. Examples of capital infrastructure in the community include respite centres, motor vehicles (cars and buses) and allied health equipment. Currently within the packaged care programs, DoHA provides Community Care and Flexible Care Grants that allow approved providers to apply for a capped amount of funding that can be used to acquire capital items however it is a limited allocation process that is generally prioritised for new providers or those expanding into new areas. In the Queensland HACC Program, service providers have generally had an annual opportunity to seek capital funding through a written application process although the parameters and timeliness of

these require improvement. ACQ recommends any review of funding models must include how capital requirements for community care will be funded into the future.

### Interface with health

The NHHRC recognised the importance of the interface between the aged care and healthcare systems and the need for improvements and new approaches in funding and service models. ACQ members support this notion and are keen to work with both levels of government and the yet to be formed Local Hospital Networks and Medicare Locals, to identify opportunities for better integration.

Residential and community care providers cite the early discharge of older people from hospital as an ongoing tension between the two systems and the perception is that this is primarily a cost shifting exercise. ACQ's ongoing concern is that if the aged care system is to care for people with sub acute needs, the funding needs to be appropriate for the level of care provided.

The expansion of funding in Transition Care and Sub-Acute Care could help address this issue however greater utilisation of the existing workforce and infrastructure within the non-government sector needs to occur first. In Queensland, the Commonwealth has only contracted one provider for the provision of transition care services. This provider is the State Government which contracts out services to the non-government aged care sector at varying levels. Queensland would welcome the opportunity to explore transition care models as seen in other states such as South Australia and Victoria, who appear to more effectively utilise the expertise of the non government sector.

ACQ further notes the under utilisation of Queensland Day Therapy Centres in the provision of transition care. Day Therapy Centres are already successfully providing a range of high quality rehabilitative and therapy services to people in both residential aged care and community settings.

### Certainty in Funding Arrangements

A sustainable aged care system needs certainty in government funding arrangements. The Department of Health & Ageing (DoHA) provides ongoing funding for residential and community packaged care places, as long as organisations adhere to quality and compliance requirements. However, DoHA also funds other programs such as many of the Dementia and Carers initiatives on three year funding agreements

Day Therapy Centres have been operating for several years on one year funding agreements that have only been renewed in the last few months of the existing contract. This creates an environment of uncertainty for management and staff, which impacts on morale, staff recruitment and retention and investment or leasing of capital infrastructure and therapy equipment. Queensland Day Therapy Centres provide high quality, responsive and diverse allied health and rehabilitative services that benefits individuals within residential care or living in the community. Refer ACSA Paper "Forgotten Services: Day Therapy Centres & The Future" (Refer [Appendix 4- DTC Forgotten Services](#))

Historically in Queensland, HACC service providers have been allocated three year service agreements that have often been extended for only one year at a time. In taking over full responsibility for the HACC Program 65+ years from July 2012, the Commonwealth must provide

longer term certainty to community care providers once the transition has been fully implemented from mid 2015.

#### Recommendations

- ACQ recommends a new methodology be developed to determine annual indexation on all aged care funding and in the interim the greater of the CPI or PBLCI be used to determine indexation percentage.
- ACQ recommends research be undertaken to identify the true cost of providing care and support across residential and community care settings.
- ACQ recommends that the productivity commission review into the effectiveness of linking aged care funding in high care to a proposed fair price authority for the acute care sector.
- ACQ recommends the creation and adoption of a sustainable capital raising system for Residential Aged Care.
- ACQ recommends the continued and expanded investment by the Commonwealth Government in relevant capital infrastructure for Community Care.
- ACQ recommends Day Therapy Centres receive an expanded and guaranteed role through the provision of ongoing, sustainable funding.
- ACQ recommends greater utilisation of the existing aged care system in the funding and provision of Transition Care and Sub-Acute Care programs.
- ACQ recommends all DoHA funding agreements be for a minimum three year period with appropriate timeframes for renewal as required.



## Consistent assessment and universal access to care and support

ACQ members welcome the COAG proposal to transfer total funding and management responsibility for aged care assessments to the Commonwealth Government from mid 2012. Under the National Health and Hospitals Network, the Commonwealth will take responsibility for aged care assessment teams in line with its new responsibilities to deliver a nationally consistent set of services, support, assessment, care and regulation.

There is a perceived lack of consistency between Aged Care Assessment Teams (ACAT) across Queensland. Members advise that ACAT's have different approaches to responding to referrals, managing waiting lists, interpreting ACAT guidelines and assessing clients. Examples of this conduct include

- Not approving for CACP based on the assessor's judgement that the client will receive more through HACC Program and potentially pay more through a CACP
- Encouraging clients to request and expect reductions in the client contribution for packaged care, regardless of their capacity to pay
- Informing clients to request at least 7-8 hrs/week for a CACP
- New providers not receiving any referrals or evidence of ACAT referring to "preferred providers" (usually the largest provider in the region)

This approach encourages clients to establish expectations of service providers that are unrealistic. It also places increased burden on HACC providers who are receiving referrals for clients who have complex care requirements that are beyond on the scope of the program. Recent changes to ACAT legislation reinforces this practice by allowing persons assessed by ACAT as requiring a high level of care (through an EACH package) to be provided with a CACP in circumstances where there are no EACH packages available. This places an increased financial burden on providers and fails to address and reveal the underlying issue, which is the need for more EACH/EACHD packages.

Occupancy and approval data for community packaged care in Queensland also indicates that in some aged care planning regions, ACAT's are adopting an overly stringent gatekeeper function, with the number of approvals not even meeting the number of allocated places, let alone allowing for people moving through programs.

### Nationally consistent assessment tools

A nationally consistent suite of assessment tools needs to be developed and validated. These tools should include a comprehensive base tool that assesses for core functions including activities of daily living, behaviour, complexity of needs, social needs, cognitive function, medical diagnosis and prognosis, care requirements and environmental factors. These tools should also have additional elements, which can ensure factors unique to the individual can be captured (i.e. care setting, informal support).

In addition to the baseline assessment tool there needs to be a range of nationally validated tools appropriate for assessing people from culturally and linguistically diverse and Indigenous backgrounds. Tools that have already been developed in this area such as the Rowland Universal

Dementia Assessment Scale (RUDAS) - a cognitive assessment tool for people from CALD backgrounds and the Kimberley Indigenous Cognitive Assessment (KICA) - a cognitive assessment tool for Indigenous Australians, are not a mandatory requirement.

Assessment tools should also take into account the needs of informal carers, especially where they have an ongoing care responsibility for a person living in the community. Some work has commenced in this area with the development of the Carer Eligibility Needs Assessment (CENA) Tool however it has been limited to organisations with a specific focus on supporting carers. This tool needs to be finalised, nationally validated and incorporated as appropriate within a global comprehensive assessment process.

In Queensland, there is concern amongst the residential care sector that the assessment tools used by ACAT do not align with the assessment tools that the industry is currently required to use to obtain care subsidies. While it is recognised that the purpose of the two assessments is different, the disparity between the tools, creates confusion and anxiety, results in significant financial loss and also leads to lost productivity with either ACAT having to reassess the client or the residential care provider having to justify a different care level through the ACFI. ACQ members have reported that it is not unusual for persons approved by ACAT for low level residential care to be assessed as requiring high care under the ACFI.

#### Universal Access and Coordinated Care

Information is power and an important foundation in any move towards greater consumer choice and involvement by older Australians (and their families/carers) in determining the care, services and accommodation setting they access. Consumers and the general community must be provided with sufficient information, in plain language, on the range of options including government funded and private services without any bias and in a supportive manner, so that they can make informed choices. The Commonwealth Government have committed to establishing "one-stop shops" located across the country, linked with Local Hospital Networks and Medicare local branches. To date DoHA has not provided any further detail regarding this initiative and how it might integrate or potentially replace existing structures. With an implementation date of 1 July 2011, consultation with the aged care sector, the health care sector and the broader community must commence immediately to ensure an effective network is established and the lessons learned from previous or existing initiatives are considered.

ACQ believes the universal access and coordination of care must:

- Ensure alignment with existing structures including the network of Commonwealth Respite and Carelink Centres, the Access Point demonstration projects, the Aged Care Australia website, and Aged Care Information Line;
- Ensure adequate coverage of large geographical areas such as regional and remote Queensland – i.e. one shop front in each of the current aged care planning regions is not sufficient coverage;
- Ensure flexibility and local responsiveness in the way they operate to meet the needs of all older Australians in their region - the ability to provide information and support via the telephone, over the internet and in person as appropriate is essential;
- Ensure information is provided in a current and culturally appropriate way;

- Maintain a level of independence from the service provision system;
- Provide information on all aged care options and supports available – i.e. not just limited to government funded support;
- Perform an initial screening or intake assessment to help determine a person's eligibility to the range of government funded support options and refer on for a more comprehensive assessment as appropriate;
- Ensure those people most at risk of falling through the gaps are provided with coordinated care not just a list of agencies and phone numbers.

Any move to one-stop shops must not compromise the existing and effective pathways that many people currently utilise including through Local Councils, General Practitioners, and aged care providers. ACQ supports the creation of one-stop shops as an identifiable but not exclusive entry point into the aged care system.

The creation of one-stop shops requires a significant investment by government including the redirection of funding allocated to existing information services and structures. The Commonwealth Government must provide adequate funding to enable:

- The development or adaptation of existing information management systems that records information and capacity of all aged care services and associated options and allows for relevant government reporting;
- The ability to effectively and securely transfer client records through an e-platform rather than post or fax;
- Appropriate skilling and development of the workforce to undertake all functions of a one-stop shop;
- Information to be made available in clear, simple language and adapted or translated to meet the needs of Indigenous Australians, people from Culturally and Linguistically Diverse backgrounds, people with vision impairment and minimal literacy;
- Timely responses to all enquiries, intake assessment and referral to appropriate options or more comprehensive assessment.

Of course as stated throughout this paper, the aged care system requires reform, less program structures and a more streamlined continuum of care. The provision of easily understood information regarding the government funded aged care system, is impeded unless this streamlining and reform occurs.

**Recommendations**

- ACQ recommends a review of the current ACAT model and explore new approaches to timely and consistent assessment.
- ACQ recommends the development and validation of a nationally consistent suite of assessment tools to determine eligibility and access to services.
- ACQ recommends that the role of ACAT be solely to assess a person's needs and approve eligibility for government funded aged care.
- ACQ supports the creation of "One-Stop Shops" as an identifiable but not exclusive entry point into the aged care system. ACQ recommends that the establishment of "One-Stop Shops" be supported by significant government investment to ensure a diversity of service models, appropriate geographic coverage, effective Information Management systems, and a skilled workforce.
- ACQ recommends the involvement of the aged care sector and consumers in the design and establishment of the "One-Stop Shops".

## A Consistent and Equitable Fees Structure for Aged and Community Care

### National Framework for Community Care Client Fees

One aspect of government funded community care provision that is inconsistent is the charging of consumer co-payments or fees. While packaged care programs have relatively clear guidelines for the maximum amount to be applied based on a person's income status, the HACC Program in Queensland does not provide any guidance beyond broad principles contained within the Draft National HACC Fees Policy.

The development of a National Consumer Fees Framework was a part of the 2004 community care reform strategy *The Way Forward*, which aimed "...to create simple, transparent and nationally consistent ways of determining service fees for clients across community care programs". Significant work was undertaken including a national survey of community care providers and the development of a Fees Purpose Statement and Principles, which was agreed on by all jurisdictions in October 2008. This work has yet to be officially implemented and according to the DoHA website "... the next step is to discuss how to apply the Fees principles across jurisdictions and programs".

The challenges in implementing a consistent approach should not be underestimated and are obviously intrinsically linked to the need to streamline the funding and program structures that exist within community care to ensure a more effective continuum of care. The national survey on fees undertaken by Urbis in 2007 provides useful insight into these challenges and should be considered in any review by the Productivity Commission regarding user contributions for community care. The following statement from Urbis highlights some of the challenges, "Providers themselves say that there are problems with resource pressures, lack of consistency, difficulties with packages and transition between programs, problems with multiple service use, and difficulties with providing services to disadvantaged people in disadvantaged communities" ([Consumer Fees Survey of Service Providers – Summary of Key Results - September 2007](#))

The opportunity to achieve greater consistency must be considered now as part of the Commonwealth Governments move to assume full responsibility for all aged care programs. As the HACC Program is currently administered by State/Territory Governments different practices exist in each jurisdiction with states such as Victoria and Western Australian having very clear fees policies and schedules in place. The Queensland HACC Program has not provided any such guidance however has always promoted the importance of charging a client contribution where possible to support the unit cost of delivering services.

Queensland Health (government department and second largest funded provider of HACC services in Queensland) currently continues to not charge any client contribution for the provision of HACC services which results in higher demand to access and remain receiving their services over other non-government providers and packaged care programs. ACQ does recognise that the health department is proposing the introduction of a HACC fees policy but is concerned that this is subject to normal government endorsement processes and is at risk of not eventuating.

### Deregulate rules around the application of bonds and charges in residential care

Currently constraints exist around user contributions to the cost of accommodation in residential care. The "user pays" system should be encouraged including the ability to charge an

accommodation bond or equivalent e.g. annuities, in high care while maintaining a safety net for those who genuinely are unable to pay for their accommodation. ACQ members believe the restrictions on the retention amounts for accommodation bonds should also be relaxed, for example in some supported living settings, the provider retains up to 40% of the bond/lease amount, an amount significantly above the level available to a residential care provider.

In terms of an accommodation charge versus a bond, members report that residential care families find it difficult to service the accommodation charge. A daily accommodation charge quite often forces families to liquidate their assets. ACQ members report that when explained properly to prospective residents and their families the options of bonds versus charges, they become aware of the minimal reduction on the lump sum bond over a five year period and are comfortable to enter into an agreement. The outcome often is that residents and families can very clearly see the benefits of paying a lump sum bond rather than a daily fee that will continue from admission to death or discharge.

While residential care providers believe the introduction of Extra Service places in high care has promoted greater consumer choice, the differentiation between these places and regular aged care places has blurred. Further, the attractiveness of Extra Service Places has become inextricably linked to the ability to levy accommodation bonds on high care residents. Some ACQ members are reporting that financial institutions state that unless an organization has some Extra Service places to enable them to apply bonds, they are unlikely to be successful with their application for a loan. The banks are only interested in reducing debt and it is not possible to do this without bonds.

#### Financially Disadvantaged Clients

In community care, there are no clear guidelines or consistent practice in the determination of financial hardship to reduce or waive fees as required by program guidelines. While Centrelink is required to undertake a financial assessment for all persons entering residential aged care, they do not perform this for community care programs and there is no clear or consistent tool or process for use by community care providers.

Given that approximately 640,000 older people received support through either HACC or packaged care in 2008-09, to expand the role of Centrelink to perform this would be fraught with issues of timeliness, access and require a significant expansion in the Centrelink workforce to undertake this function. The development of a simple assessment tool available online would allow all funded providers, case managers and other relevant bodies the ability to consistently determine genuine financial hardship and apply relevant reductions or waiving as per the service provider's fees policy. Linked to this issue is the fact that current government funding for community care does not provide any further subsidy or payment for the provision of services to people who are financially disadvantaged and cannot pay a contribution towards the cost of care and support.

In residential care ACQ members call for the removal of artificial targets/cut off points to determine concessional levels in regions. Members report that the socio-economic status of most regions has changed dramatically in the past ten years and some concessional ratios are almost unachievable in this day.

There remains a strong commitment to provide accommodation and care for those who are socially and economically disadvantaged however this cannot be achieved with the current concessional supplement. This supplement is currently grossly inadequate and should be increased to better align with equivalent levels of bonds or charges that residential care providers are receiving from non-concessional residents.

#### Recommendations

- **ACQ recommends the Implementation of a National Community Care Consumer Fees Policy & Framework, encapsulating all government funded community care service provision, with principles, guidelines and upper limits, whilst allowing each provider to determine their schedule of rates dependent on service models, location and target groups.**
- **ACQ recommends the deregulation of systems to accommodate for consumer choice and user pays.**
- **ACQ recommends that restrictions of retention amounts from accommodation bonds be relaxed.**
- **ACQ recommends a simple online assessment tool for community care providers to consistently determine financial disadvantage or hardship.**
- **ACQ recommends additional funding supplements for provision of community care services to persons from socially and financially disadvantaged groups.**
- **ACQ recommends that the concessional ratios be reviewed to more adequately reflect the socio-economic status of communities.**
- **ACQ recommends that concessional supplements fore residential care be reviewed to ensure better alignment with bond and charges.**

## A compliance system that is fair and equitable

### Complaints Investigation Scheme

In the residential aged care industry there is concern that the government has become so risk adverse that everything is viewed through the prism of what regulation should be put in place to cover past problems and minimize risk into the future. ACQ's submission to the Complaints Investigation Scheme (CIS) Review (Refer to [Appendix 5-Final ACQ Submission](#)) highlights the impact that the current complaints investigation procedure is having on the aged care industry. Our members' perceive this scheme as being both adversarial and rigid in approach. ACQ stresses the need for greater conciliation, mediation and encouragement by the CIS for approved providers and complainants to work collaboratively together to resolve an issue.

A full review of all regulatory requirements is necessary to ensure that only one agency handles contentious issues. Presently, if a complaint is made an aged care facility can expect a visit from the accreditation agency, the Department of Health and Ageing, and CIS. A distinction must also be made by CIS between minor and major complaints and allegations to avoid sensationalism and disenfranchisement within the industry. CIS is currently funded by DoHA - it is imperative that an independent and autonomous body governs compliance requirements to ensure a fair and equitable system.

### Separation from Accreditation

The current Aged Care Standards and Accreditation system has a focus on compliance monitoring rather than on the promotion of robust quality systems (Refer [Appendix 6 –ACQ's Submission to Accreditation Review final](#)). The current compliance system of a minimum standard must be changed. ACQ proposes a model where there is a clear division between the function of compliance and accreditation. This would entail the progression from a minimum standard approach to a system that rewards and recognises facilities that strive for best practice and consistent achievement of outcomes. The Aged Care Standards and Accreditation Agency is a government owned company that has a monopoly on the accreditation process for aged care facilities across Australia. ACQ supports a competitive market for accreditation bodies, where accreditation service provision becomes contestable and approved providers have the choice of accreditors.

Consumer driven market forces will ultimately remove 'bad' operators and a move towards deregulation would reduce administration requirements within an already over-stretched sector. The industry accepts that it must be accountable for the money it spends. It is also acknowledged that there must be accountability for providing ongoing quality services. The compliance systems need to be streamlined to ensure a lack of duplication and should be applied in a fair and equitable manner.

#### **Recommendations**

- **ACQ recommends a new approach to complaints management and investigation be adopted with a greater emphasis on conciliation, mediation and resolution at the local level.**
- **ACQ recommends the separation of compliance, complaints investigation and quality assurance in the management of all aged care funding, especially residential care.**



## A quality framework that supports better performance and continuous improvement

### Competitive Market for Accreditation – Independent of Government

ACQ welcomes the development of the Community Care Common Standards. The implementation of these standards will reduce duplication and streamline quality reporting systems, providing a standard approach across HACC and packaged care is adopted. Home and Community Care audits in Queensland are conducted by the external agency Institute for Healthy Communities Australia. The arrangement with this third party agency is generally well received by providers. Quality reporting audits for community packaged care are conducted by Department of Health and Ageing officers. There are a number of concerns associated with this arrangement. Firstly, these officers typically work in other areas of the Department and are put offline to conduct audits. This presents a conflict of interest, as often these are the same officers that are called offline to assess applications for funding through the Aged Care Approval Round. Their perceptions of quality could easily influence their decisions to approve an organisation for funding. Secondly, there is concern many of the auditors have a limited knowledge of community care. In addition to this, these officers rarely have experience or expertise in quality auditing and in Queensland receive very limited training in this area.

Quality auditing processes in both residential and community care need to be reformed. The industry needs to be drawing on a competitive market of certified accreditation agencies to conduct audits and these agencies must be independent from the government. Under this system a report would be provided to the Department outlining that the government standards had been met. This approach would be more efficient and effective and would ensure the separation of quality service delivery and compliance with government funding requirements. The Queensland disability sector provides a good example of this model.

Disability Services Queensland requests that all service providers undertake a service user assessment, a self assessment and external assessment every three years. For most service providers, an independent certification body registered under the Joint Accreditation System of Australia and New Zealand (JAS-ANZ) conducts the external assessment. Providers are able to choose which certification body they would like to contract to undertake their external assessment. All certification bodies follow the JAS-ANZ accredited procedure for external auditing of the Queensland Disability Services Standards. An external audit team appointed by the independent certification body also conducts annual maintenance visits to monitor the progression and outcomes of continuous improvement programs and the provider's process for maintaining its quality management systems. The system has been designed to allow for the diverse range of service delivery models that currently exist in the sector in Queensland.

#### Recommendations

- **ACQ recommends the adoption of a new quality auditing process for both residential and community care that draws on a competitive market of certified accreditation agencies, independent of government.**
- **ACQ recommends appropriate support and funding be provided to community care providers to transition to the new Community Care Common Standards.**

### A Retirement Village sector with capacity to grow

In the near future the retirement village industry will be in a position to cater for a substantial proportion of accommodation, care and support services needs of older Australians. Traditional residential low aged care will move to a semi-independent home service accessed within community or retirement living environments. Residential aged care will essentially be reserved for and will deliver services and care in end of life, severe dementia and cases where personal care needs fall beyond what can be effectively provided at home.

The retirement village industry has matured with its clients and has moved from a lifestyle option to a continuing care model. Market forces have prompted this change and new entrants are now targeting prospects with accommodation and care needs that fall between traditional retirement village and residential aged care.

Regulation of the industry is conducted via state legislation with embedded dispute resolution processes. Consumer groups have emerged as a strong and effective voice for village residents and are forming enduring relationships with industry associations. Most disputes are now resolved easily with few progressing to the courts. Industry and consumer group representation is encouraged to participate in legislative review and change. The predominant motive of the current regulatory framework is to protect consumer interests. In contrast the aged care industry is severely over regulated and under-funded to the extent of creating significant barriers to entry and investment.

The regulatory regime controls inputs and outputs but does little to improve resident outcomes, quality or foster innovation and creates a wedge between providers, their clients and the general community. The system is punitive and ineffective.

To maintain focus on the health, safety and wellbeing needs of older Australians and encourage investment in more broadly based residential models it is essential that the retirement village industry be allowed to develop and self regulate.

[Appendix 7 - Issues facing retirement villages](#) - further explains the industry environment and demonstrates why an industry led accreditation scheme will be the best regulatory option to provide consumer assurance, facilitate government oversight and drive public accountability.

#### Recommendation

- **ACQ recommends an industry driven accreditation scheme for Retirement Villages be established.**

## A well resourced and sustainable workforce

Modelling for the next 15 years indicates that there will be continued growth in community services and health industries. Particularly, there will be an increased demand for service provision within the community. There is a need for a well-resourced and skilled workforce within the aged care sector; however, issues concerning remuneration, training and development, and retention hinder significant development. These issues must be addressed in order to alleviate the growing pressure the ageing population is exerting on the industry.

### Recruitment and Retention

ACQ members believe that the challenges in recruiting and retaining professional staff in the aged care industry can be linked to increased regulation, insufficient resources, and low levels of remuneration.

The low levels of remuneration offered by the aged care industry are a key deterrent for attracting and retaining workers. Currently, the community service and aged care industry sits significantly lower than the earning capacity in public sectors and other related industries. In Queensland, the introduction of a new award for the community service sector recognised this disparity but was not supported by appropriate government funding. Similarly, residential care struggles to meet enterprise bargaining demands without matching increases in subsidy levels. The government must provide additional funding and instigate appropriate reform in order to ensure the continued availability of support and care for older Australians.

ACQ also believes issues of retention are directly linked to the level of regulation the aged care industry is subject to. Current regulation consistently questions the professional integrity of registered staff and exerts significant pressure on the industry ultimately impacting the workforce. Specified care and services, for example, means Registered Nurses must undertake certain tasks, which drives costs upwards. Workplace Health and Safety, Food Safety and Fire Safety regulations all impact staffing and costs, however, none are government funded. Payments for these regulatory requirements can only come from care subsidies

### Education and Training

Education, training and development remain critical. Whilst, ACQ acknowledges the government's commitment to providing a qualified and skilled workforce there is concern that the current outcomes for delivering training are more heavily weighted on numbers rather than quality. ACQ members have reported concerns with fast track training programs, which deliver Certificate III training in less than a month. These programs undervalue the work of the sector, do not effectively link to the work place, and are not conducive to quality training outcomes, placing a burden on organisations to provide additional support and training.

Another pressure experienced by aged care providers is the provision of practical placements to an increasing volume of students. Practical placements require services to invest a significant amount

of time supervising students. Providers receive no financial incentives to offset associated costs. To enhance current programs consideration should be given to financial incentives for approved providers contributing to the practical training placements that are an important part of a complete Certificate III training program.

Government's investment in training and education for the aged care industry must look beyond entry level training. Greater emphasis must be placed on responsive rather than prescriptive strategies for continuing professional education for our clinical leaders. More funding must be allocated in leadership and management to assist emerging leaders in the industry.

From an organizational perspective, sending staff already employed in aged and community care away to access training can mean workers are away from work for a number of days. This places a financial strain on organisations to provide backfill staff. The implementation of any training or professional programs for the existing workforce must consider this influential factor.

#### A Culturally Diverse Workforce

Workforce shortages and increased immigration have resulted in a large number of people from non English speaking countries choosing to work in aged care. Whilst this diversity is supported it presents challenges for aged care providers especially with staff from non English speaking backgrounds that have achieved a nationally recognised qualification but still have limited communication skills. Resources must be allocated to the provision of ongoing support and training for the CALD workforce.

#### New approaches

ACQ proposes several new approaches to address issues relating to the aged care workforce. These approaches include:

- Encouraging nurse practitioners to enter the aged care sector to assist with alleviation of the GP shortages;
- Enhancing assistant roles such as allied health aids to meet the demand for services and allow for a workforce model that maximises the skills of professional staff;
- The provision of government funding for tele-health services in order to ensure all older Australians have access to resources (i.e. psycho-geriatricians and specialist services);
- An increase in e-learning and simulation centres to train staff; and
- The use of new technologies, to monitor and deliver care more effectively, for example, through the use of electronic health records and cares planning.

**Recommendations**

- **ACQ recommends reforming the funding regime for aged care to enable greater wage parity with the healthcare sector.**
- **ACQ recommends a continued investment by government in training and skills development across all professions and work groups relevant to aged care.**
- **ACQ recommends that more funding be allocated to leadership and management to assist emerging leaders in the industry.**
- **ACQ recommends a review of the current certificate level course delivery by Registered Training Organisations (RTOs) to ensure sufficient emphasis is placed on practical experience and “work readiness” for the aged care industry.**
- **ACQ recommends a greater emphasis and exploration of new and emerging service models and technologies that help alleviate the impact of workforce shortages.**