

Ageing well in Australia: Time for a rethink

Submission to the Productivity Commission Caring for Older Australians Inquiry

The Benevolent Society

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1. Introduction

The Benevolent Society appreciates the opportunity to make a submission to the Commission's Inquiry into Caring for Older Australians. We are aware that this Inquiry follows a number of other major inquiries and reform processes proposing future directions for the care of older Australians. While some important reforms have been made over the last decade, other reform processes have stalled and are long overdue.

Our submission focuses on support and care of older people living in the community, rather than on residential aged care. It also recognises the critical factors which underpin social inclusion and wellbeing in older age – adequate financial resources; appropriate, affordable and secure housing; a supportive built environment; good quality and timely health services, access to transport; community attitudes of respect and acceptance; and opportunities to participate in family and community life.

Our submission argues for:

- a fundamental rethink about the options available to people in later life, especially in relation to models of housing, care and support
- a paradigm shift in the way we think about and support older people in the community, and the way in which we provide community-based care
- consideration of the design, funding and delivery of aged care services to be underpinned by a clear understanding of older people's wellbeing and the factors that contribute to it
- a greater focus on evaluating and measuring the impact of community care services, and on supporting the implementation of evidence-based practice.

1.1. Summary of key principles and directions for reform

1. Any consideration of the design, funding and delivery of services for older people must be underpinned by a clear understanding of older people's wellbeing and the factors that contribute to it.
2. Fundamentally, care services should be about enabling older people to live as full a life as possible. Care services should be provided in ways that support and encourage self-reliance.
3. Research and evaluation of community aged care needs to be better supported and funded, and the results shared. Data collection, monitoring and accountability to funders should have a greater focus on outcomes. The Benevolent Society supports the establishment of a Centre for Community Service Effectiveness.

4. New models of housing, care and support (or service-integrated housing) such as the Apartments for Life project are needed.
5. Government funding is required to enable the inclusion of subsidised rental and shared equity affordable housing for low income older people in service-integrated housing. This could be achieved through social housing funding and by broadening the National Rental Affordability Scheme to suit older people's circumstances (or introduction of a similar scheme that targets older people). This could be implemented initially on a pilot basis through a number of demonstration projects.
6. A broader national older persons' housing strategy is overdue, to increase the stock of housing suited to an ageing population and address affordability issues.
7. A paradigm shift is needed in the way we think about and support older people in the community, and the way in which we provide community care services. Programs for older people and their carers should be oriented to focus on people's goals, strengths and abilities, in order to avoid unnecessary dependency. Programs and service providers should support consumers to be more actively involved in deciding the care services they need and how they will be delivered.
8. Restorative models of care should be given greater prominence. However, long term care will always be required for people whose health and other circumstances are such that becoming completely independent again of formal care services is unrealistic.
9. The Benevolent Society supports the consolidation of community care funding programs under one Commonwealth Government program. It should provide for people to receive flexible care based on their needs, circumstances and preferences, and be able to adapt as these change. Programs should enable services to be flexible enough to be able to provide intensive restorative care e.g. after periods of ill health, major life changes or to see if a person can regain functions, as well as to provide ongoing long term care and care for people who are dying.
10. Funding for community care programs should be increased to address unmet needs, enable a more appropriate level of care to be offered to existing clients, expand the availability of key services such as allied health services and home maintenance and modification services.
11. More funding for higher level community care packages (Extended Care at Home, EACH) is required. An intermediate level of packaged care between Community Aged Care Packages and EACH packages and would relieve pressure on demand for EACH packages.

12. Older people and their families should have greater choice of type of services, who provides them and when and where they are received – whether in a residential aged care home or in their own home.
13. The Benevolent Society supports there being a range of forms of consumer-directed care, to suit people's different circumstances, needs and preferences.
14. Government funding guidelines should allow for the diversity of caring relationships. Service providers should allow those who approach them for assistance to define the nature of their own caring relationships. Support of carers and the person they are caring for should work seamlessly together.
15. Community care recipients need better access to good health care, including to GP services (with home visits), allied health care, mental health services, chronic disease management, and health promotion strategies such as falls prevention programs, medication management programs, nutrition and exercise.
16. Better links between hospital services and community care services are required, including better discharge planning and increased availability of post acute care.
17. Good links between GPs and care service information/advice points are vital. Carelink centres could be much more effective with better resourcing and with better links to and from GPs.
18. Additional policy and community responses are needed to address social isolation among older people.
19. Governments need to play a greater role in regulating and monitoring the quality of privately run and financed services.
20. A range of strategies are needed to support the uptake of evidence-based practice in community care. The Benevolent Society supports the development of mechanisms to enhance collaboration between researchers, policy makers and practitioners in ageing/caring for older people. The Australian Research Alliance for Children and Youth (ARACY) is a useful model.
21. Greater clarity is needed about people's rights or entitlements to aged care services, what people can expect to receive and what they will be expected to pay.

1.2. About The Benevolent Society

The Benevolent Society is Australia's first charity. For almost 200 years we have been leaders in identifying the evolving needs of the community and in pioneering vital social reforms and services.

The Benevolent Society's purpose is to create caring and inclusive communities and a just society. We deliver leading edge programs and services, find innovative solutions to complex social issues and advocate for a more just society. We believe that building stronger communities will lead to a more inclusive Australia. We take pride in delivering effective services and are constantly looking for better ways of working. We help the most vulnerable people in society, and support people from all backgrounds including Indigenous Australians and people from culturally and linguistically diverse communities.

Snapshot of The Benevolent Society

- TBS is a secular, not-for-profit organisation. It is a company limited by guarantee with an independent Board.
- Our 700 staff and 600 volunteers support more than 17,550 children and adults each year in New South Wales and in Queensland.
- We deliver 124 programs in 48 locations with financial support from federal, state and local government departments, businesses, community partners, trusts and foundations.
- Our revenue in 2009 was \$59.8 million. Approximately 85% is spent directly on our services. A further 8% is spent on our leadership, social initiatives and research.
- In 2009, 73% of our income came from government sources. Fundraising, trust and foundation grants provided another 5%, client fees generated 12% and our investment portfolio contributed a further 10%.

1.3. The Benevolent Society's interest in older people and in aged care

The Benevolent Society has provided support to older people since the beginnings of the organisation in the early 19th century. At the turn of the 20th century the Society was instrumental in the introduction of an age pension, although during much of the 20th century the Society's focus turned to women's health, emergency relief and services for children. In the 1960s and 1970s the Society again started to expand its services for older people, supporting older people through low cost housing and in the 1980s through residential aged care. The Society began providing community-based services for older people in their own homes in the 1980s and this is now the largest area of the Society's work with older people.

Today, we support older people primarily through:

- community care services for frail older people and those with disabling health conditions who need assistance with activities of daily living
- services for carers¹ of older people (many of whom are older people themselves), carer education and training
- supported housing for older people on low incomes
- community development, information services and education
- social re-engagement projects (often involving volunteers)
- research, evaluation and advocacy.

Over the last 5 years the Society has deliberately moved way from running residential aged care services. We are currently developing a flagship project of a new model of supported housing with care, Apartments for Life, described later in this submission.

Our community care programs for older people operate in Sydney and neighbouring areas, and are funded through several federal and state government programs:

Program	Funded by
Packaged care - Extended Aged Care at Home (EACH) Extended Aged Care at Home-Dementia (EACH-D) Community Aged Care Packages (CACP), providing coordinated services tailored to the individual such as case management, personal care, nursing care, meals, nutrition, medication monitoring, domestic assistance, garden/house maintenance, appointments, social activities, rehabilitation, continence management and respite.	Australian Department of Health and Ageing
Home and Community Care (HACC) funded-services: domestic assistance, respite care, food services, centre-based day care, case managed brokered services (Community Options).	Ageing, Disability and Home Care NSW, jointly funded Australian Department of Health and Ageing
ComPacks and Healthy at Home: Post acute care services for older people after leaving hospital; and to older people at risk of imminent but avoidable hospitalisation.	NSW Health
Commonwealth Respite and Carelink Centre that serves southern and eastern Sydney and run a number of carer programs.	Australian Department of Health and Ageing
ACHA Program: Assistance for older people who are homeless or in insecure housing.	Australian Department of Health and Ageing
Carer programs which support older people directly and/or indirectly, funded through the National Respite for Carers Program.	Australian Department of Health and Ageing

We have many years in-depth experience of supporting older people in a wide range of different circumstances – those requiring low key occasional support, those requiring support for a period

¹ In this submission, we use the term ‘carer’ to mean informal carers such as spouses, other family members and friends.

while they rebuild or recover, through to people with complex multiple health and other difficulties, those who need long term care over many years, and people in the terminal phase of life.

We have considerable experience in working with people from a wide range of culturally and linguistically diverse backgrounds, people with dementia, mental illness, public housing residents and others on very low incomes, and people who are very socially isolated.

Our approach depends on the needs of the clients and their family members and the particular program's guidelines. However it is characterised by a focus on people's strengths (building on what they can do, rather than what they cannot) and on the outcomes we are aiming, with the client, to achieve. In our services, this means:

- holistic assessment in consultation with clients and carers and family members so that the services we provide are responsive to their needs and preferences
- addressing clients' social wellbeing, as well as their physical and mental/emotional wellbeing
- building carers' resilience to continue as carers, by looking after their needs as well those of the person they are caring for
- being as flexible as possible in what we offer, and allowing for services to change over time
- stability of staff/client relationships, where possible
- training and supervision of staff to ensure they are fully equipped to support clients
- assisting clients to obtain other services and support and, if the time comes that we are no longer able to provide the level of care they need, assisting them to obtain help elsewhere.

2. Understanding older people's wellbeing

There is a substantial body of research on quality of life in old age. Drawing on this research and on its work with older people, The Benevolent Society sees successful ageing – or having 'a good life' in older age – as one in which people have access to adequate resources and are active agents in managing their own lives, continuing to prioritise and make choices, adapt to changing personal circumstances, and participate as full members of the community.

Adequate resources means sufficient financial resources; appropriate, affordable and secure housing; access to good quality and timely health services and to transport. Other structural underpinnings include a supportive built environment; community attitudes of respect and acceptance; and opportunities to participate in family and community life.

Any consideration of the design, funding and delivery of aged care services, such as is being undertaken through this Inquiry, must be underpinned by a clear understanding of older people's wellbeing and the factors that contribute to it.

Fundamentally, care services should be about enabling older people to live as full a life as possible. They should be provided in ways that support, build and rebuild people's abilities to do things for themselves irrespective of their stage of life and state of health.

It is important for governments and service providers to understand the factors that contribute to the wellbeing of older people receiving community care, to ensure that

- services meet clients' holistic needs, and
- funding is used in a way that maximises positive client outcomes and minimises unnecessary dependency on an over-stretched service system.

Currently, research evidence of the impact of community care services on older people's wellbeing is limited. The evidence that exists has tended to focus on measures of client satisfaction, physical and mental health outcomes and some elements of quality of life. Social and emotional wellbeing outcomes have rarely been the focus of research into community care services.

Wellbeing is not simply about the absence of disease or disability, although this may certainly be desirable. People with objectively assessed poor health may report high levels of wellbeing. Health is an important contributor to older people's quality of life, but it is seen as a means to an end – to be able to do things and be independent – rather than an end in itself.

The ability to remain 'independent' is valued very highly by older people. What this means and the weight attached to different components of 'independence' reflect personal circumstances, values and perspectives and changes over the ageing process. Independence may, for example, mean quite different things to people in their early 60s to those in their late 80s; and similarly to people in different cultural groups. Independence is also not an absolute concept; inter-dependence and reciprocity are also key values.²

However, consistently mentioned by older people as important are:

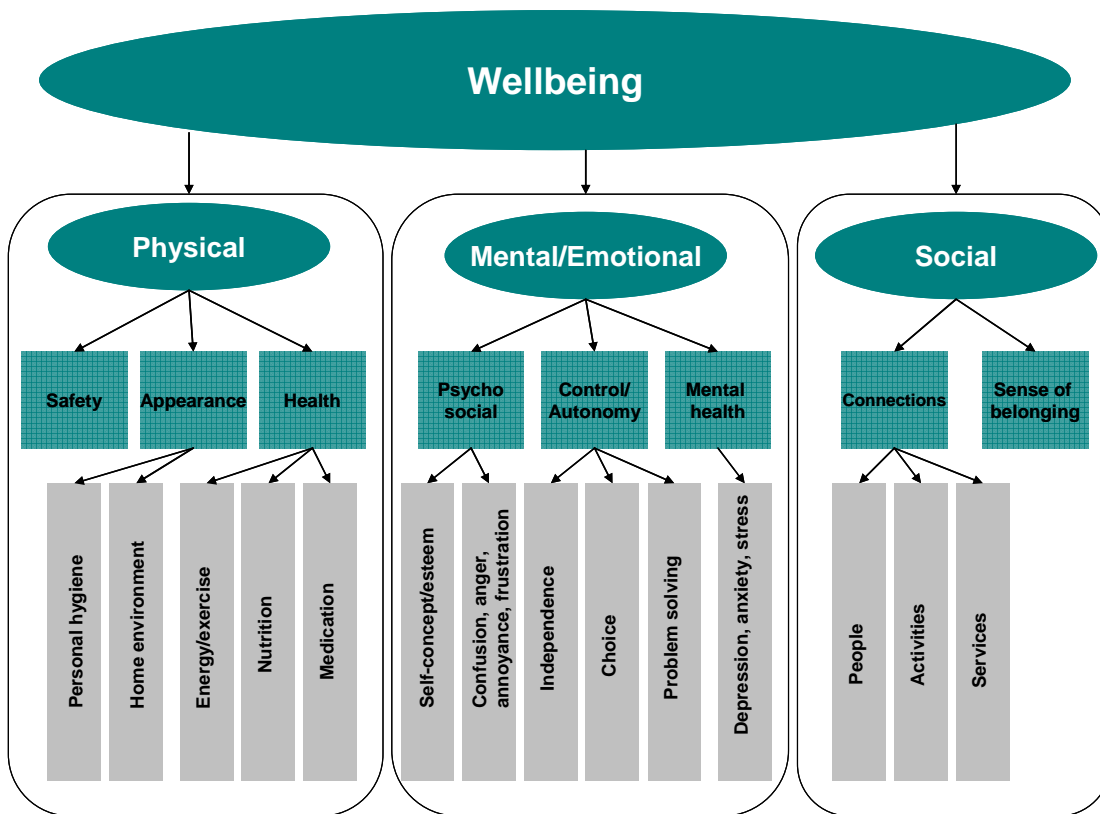
- the opportunity to make choices, the freedom to do things of interest to them
- social connections, companionship, love and, if possible, intimacy
- having a meaningful role and opportunity to do something worthwhile
- a sense of pleasure and enjoyment in life
- a sense of belonging
- being treated with dignity and respect
- feeling safe
- being able to reciprocate, not being 'a burden' on others
- being able to contribute to future generations.

Older people who receive community care services are – by definition – people who need assistance with one or more aspects of daily living because of ill-health or disability. The Benevolent Society uses the following framework to guide its provision of services to its community

² Godfrey M, Prevention and promoting wellbeing, 2008. Available at <http://www.dadhc.nsw.gov.au/NR/rdonlyres/30BBE880-23D4-4F0B-A38130B72B097A69/3424/MaryGodfreypresentation.pdf>

care clients and evaluation of their impact. It captures key elements of wellbeing from the research literature and as expressed by older people themselves.

As mentioned earlier, access to sufficient financial resources, appropriate and affordable housing, transport and a supportive built environment underpin these aspects of wellbeing.



2.1. Evaluation and measurement of wellbeing

The Benevolent Society is currently undertaking a pilot evaluation of its community care programs to:

- better understand and measure levels of social and emotional wellbeing of its clients
- explore the potential of its community care services to have a greater impact on these aspects of wellbeing, and
- identify areas for practice improvement, innovation and policy development.

Early results from the evaluation of new³ community care clients have, for example, identified considerable levels of social isolation (as assessed by our practitioners) among clients over the age of 65. There are also indications that mental and emotional distress is high. Fifty percent of an initial small sample⁴ of clients of Community Aged Care packages and HACC-funded Community Options services who were interviewed using a standardised tool, indicated either anxiety or mood disorder or serious psychological distress.

³ People who became clients within the previous 6 months. Total sample 204 people.

⁴ 18 people.

Over time we are aiming to show reductions in levels of social isolation among clients. Early results from the evaluation also suggest that outcome measurement can bring direct benefits to individual clients. The use of tools to measure aspects of wellbeing when clients first start receiving a service and at review points, can lead to a better dialogue with clients and therefore greater understanding of their needs and perspectives. It give clients greater opportunity to have a genuine say in important decisions affecting them.

The Benevolent Society is using evaluation and associated tools such as program logic⁵ and biennial client satisfactions surveys, as key drivers to promote practice innovation and change within our services.

Research and evaluation of community aged care needs to be better supported and funded, and the results shared. The Benevolent Society supports the recommendation of the Productivity Commission that a Centre for Community Service Effectiveness⁶ be established.

We also recognise that implementation of practice change requires considerable and sustained investment on several fronts if the new practices are to become fully embedded in services. This is discussed further under Workforce Issues at Section 8.

2.2. Data collection and quality improvement

At present, government-funded community care service providers are largely accountable to government on *outputs* (e.g. client numbers, service duration and intensity) and *processes* (e.g. service accessibility, responsiveness of services). While these contribute to giving a picture of the quality of services, government funders do not currently require that service providers collect data on wellbeing *outcomes*.

Revisions need to be made to the types of data which are provided to government and how they are used. Service providers commonly experience the “black hole” phenomenon whereby data is submitted to government and then is never seen again in a format that is useful to the service provider.

Developing an outcomes approach, combined with a better use of mandatory data reporting, is a practical strategy for quality improvement. It could bring a better understanding of the needs of clients, of gaps in funding or services, and of the impact on wellbeing of clients with different socio-economic characteristics or service dosage/type.

The data collection requirements of the Department of Health and Ageing (DoHA) and the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) to monitor and understand the performance of service providers running community care programs are, in our view, much more meaningful and useful for quality improvement purposes than those

⁵ A program logic describes, usually schematically, the logic behind a program i.e. why it exist, the inputs or resources used, activities and processes, target group, outputs, outcomes (short term, long term, goals) and the theory of change / assumptions / rationale. It ensures there is an evidence based rationale behind a program, its practices and processes.

⁶ Productivity Commission, Contribution of the Not-for Profit Sector Research Report, January 2010

used by NSW Ageing, Disability and Home Care (ADHC) to monitor the performance of HACC-funded services. HACC-funded services in NSW are required only to provide information about outputs, such as the number of clients that have received a service.

A focus on outputs has the effect of elevating efficiency over quality when in reality both are important. It also has the effect of limiting the responsiveness and flexibility of services to clients. For example, in NSW the HACC Program funds service providers to provide domestic assistance⁷ to clients, rather than to support clients to learn or relearn the skills and confidence to undertake some or all domestic assistance tasks themselves or to find new ways of dealing with them.

DoHA and FAHCSIA's approach, while much more time-consuming, requires services to provide data that gives a much fuller picture of the quality of the service provided, the extent to which it responds to local needs and circumstances, the clients supported and (to an extent) the results achieved for those clients.

Services are required to provide an annual plan based on continuous improvement. It must include practice goals, client outcomes sought, regional trends, outreach and community development plans and information about infrastructure and compliance. Six monthly reports against this annual plan allow for more meaningful reporting and a more constructive relationship between service provider and funding body, and the opportunity to explore innovation and service development in partnership.

2.3. Social inclusion and older people

The terms "social inclusion" and "social exclusion" are key themes in social policy and in the Federal Government's approach to addressing disadvantage.⁸

Under the Federal Government's social inclusion strategy, being socially included means people must be given the opportunity to

- secure a job
- access services
- connect with family, friends work, personal interests and the community
- deal with personal crisis, and
- have their voice heard.⁹

While the social inclusion framework is potentially very relevant to older people (with the exception, for most, of having access to a paid job), the Federal Government's current social inclusion priorities focus on families with children and people of working age.

⁷ Standard Service Type Description: Domestic Assistance refers to assistance with domestic chores, including assistance with cleaning, dishwashing, clothes washing and ironing, shopping and bill paying for a safe secure healthy environment.
http://www.dadhc.nsw.gov.au/dadhc/Doing+business+with+us/service_type_descriptions.htm

⁸ For example, see Australia's Social Inclusion agenda at <http://www.socialinclusion.gov.au/AusGov/Pages/default.aspx> and follow link to list of current initiatives.

⁹ Aust Govt A Stronger Fairer Australia, 2009

In older age social exclusion can result in poor quality of life, avoidable illness and disability, higher rates of hospitalisation, premature institutionalisation and premature death. Sections of the older population most vulnerable to social exclusion include:

- renters
- older people who depend wholly on the pension, that is, on very low incomes
- older people who are carers of, for example, a spouse in poor health, an adult child with a disability or grandchildren
- people with mental health conditions
- people with long-term disabilities who are ageing

3. Need for new models of housing, support and care

The Commission has invited comments on the strengths and weaknesses of the current system of aged care services. Before going on to issues relating to community care services – see Section 4 below – we believe that there needs to be a fundamental rethink about the options available to people in later life.

Most older people want to live as independently as possible, continuing to do the things they enjoy and staying connected to their community. Yet current housing and care options to enable them to do this are very limited because:

- there is a shortage of housing stock that is suitable for older people's circumstances, especially older people on low incomes who have no or modest assets
- there is a lack of options that integrate housing, care and support and take account of the fact that over time people will probably require more care and support.

Unsuitable housing can increase the costs of caring for older people and contributes to premature and unnecessary moves to nursing homes and hostels. Conversely, we know that appropriate housing and social supports can enhance older people's self reliance and quality of life and reduce their need for aged care services. The challenge is to develop new forms of housing – with care when needed – that:

- enable people to remain in their own homes and communities
- encourage older people to be as self-reliant as possible
- offer more cost effective ways of supporting frail older people, and
- enhance older people's participation in the community.

If given the choice, the majority of older people would prefer to live in their own home throughout older age and, when their health declines, be supported by family and community care rather than move to a nursing home or hostel.

While residential aged care plays an essential role, it is highly regulated and it is difficult for facilities to be truly 'homelike' and to offer residents genuine control and choice. Older people typically

describe the difference by saying that staying in their own home allows them to ‘maintain their dignity’.

The economics of residential aged care also means that the average size of facilities is increasing, the reverse trend to virtually every other area of human services. Nursing homes are also an expensive option for the taxpayer and for individuals.

The purpose-built retirement housing section of the Australian housing market is small and has a number of limitations. Many retirement village operators have built their financial models on the expectation that residents will move on to an aged care facility when their care needs increase, at a time of life when moving home is difficult and destabilising. Some villages also operate as ‘gated communities’ with residents having minimal interaction with others in the community. This is particularly so for villages located on the urban fringes with poor transport links.

The Benevolent Society has drawn on Australian and overseas experience (especially the Humanitas Foundation’s Apartments for Life¹⁰ in the Netherlands) to develop a new model of housing, care and support for older people. As its name suggests, a key feature of the model is that it offers older people a chance to remain in their own home – in this case an apartment – throughout older age and to avoid having to move home when their health declines and they require increasing levels of care and support. The Apartments for Life model challenges the oft-held assumption of the inevitability of a move to a nursing home in later old age.

Apartments for Life can be described as a form of ‘service-integrated housing’, defined by Jones¹¹ et al as

‘All forms of housing for people in later life where the housing provider deliberately makes available or arranges for one or more types of support and care in conjunction with the housing provision’

However, the Apartments for Life model is about more than just enabling older people to live in the one place until the end of life. It is about supporting older people’s control over their own lives and their continued activity and participation in community life.

The Apartments for Life Project is being trialled by the Society in Bondi in Sydney. It offers a new concept in retirement living and aged care – a place where older people can live in their own homes throughout the changes and challenges of later life, with a sense of autonomy and purpose and fully connected to their local community.

The key features of the model are:

- design that encourages ‘active ageing’, social interaction and autonomy and includes a high level of adaptability to residents’ changing needs

¹⁰ The Benevolent Society, Apartments for Life in Australia, Lessons from Humanitas in The Netherlands, 2009. www.bensoc.org.au

¹¹ A.Jones, A.Howe, C.Tilse, H.Bartlett, B.Stimson, Service integrated housing for Australians in later life AHURI Final Report 141, Jan. 2010

- access to care services from local care providers when needed; a care advisor to assist residents to connect with the particular type of care that they need and negotiate with providers on their behalf; and to monitor residents' wellbeing
- the inclusion of social and affordable housing, so that residents' socio-economic diversity reflects that of the local area
- a location close to shops, transport and services, plus on-site services and facilities open for use by the local community as well as residents
- social activities and community engagement, to foster integration with the local community, older people's participation in the community and minimise loneliness and depression
- a philosophy of respect for residents' individuality and autonomy
- evaluation and research so that others can learn from, replicate and adapt the model.

The model's benefits and value for money from the perspectives of residents, developers and governments have been assessed by consultants ACIL Tasman¹². They noted that it offers:

- reductions in need for high level aged care facilities
- increases in the efficiency of the formal care services, especially via reductions in travel times, better time utilisation of skilled (and scarce) care staff
- design and support features that support a range of health cost savings
- substantial freeing up of other housing, in general better suited to families
- increased affordable housing and opportunities for delivering more cost effective affordable housing
- environmental advantages.

There is considerable interest in the Apartments for Life model among older people's organisations and the aged care and retirement housing sectors. More importantly there is a very high level of support for it among the population as a whole, as evidenced by recent polling¹³ for The Benevolent Society.

The polling found that 92% of respondents support the Apartments for Life model, including 56% who strongly support it. Support is high among all age groups, not just those aged 50 and over. The benefits of the model were recognised, with the principle ones being ability to maintain independence, easy access to health care services and proximity to family and friends. People aged over 50 years, the ones for whom this type of accommodation is most relevant, put greater emphasis on remaining close to friends and being able to stay within their neighbourhood.

¹² ACIL Tasman, The 'Apartments for Life' Housing, Care & Support Concept for Older People, An assessment of economic and budgetary implications, July 2009

<http://www.bensoc.org.au/director/whatwedo/olderpeople/oceanstsite.cfm>

¹³ See www.bensoc.org.au for media release and report

This polling also found very high levels of community concern about access to affordable housing as people get older. The inclusion of affordable housing in the Apartments for Life is considered quite important by 90%, including 47% who consider it very important.

The Benevolent Society would be pleased to provide a more detailed briefing about the Apartments for Life project. More information is also available at www.bensoc.org.au.

3.1. Government support for new models of housing, care and support

Support by governments will be important if new models of housing, care and support (or service integrated housing) such as Apartment for Life are to be developed and become widespread.

A key feature of Apartments for Life is the inclusion of affordable housing – both for older people with low incomes and no assets (ie social housing) and for older people on low incomes with some assets. These two groups of older people have very limited housing options when their health or mobility declines and may be forced to relocate to a new area thus jeopardising their social networks, sources of social support and access to familiar services.

Clearly, low income older renters are the most vulnerable. They typically pay a high proportion of their income in rent and/or may live in very poor housing. Financial pressures may force them to relocate frequently.

However, low income older people who own a modest asset also face an affordability challenge, as the value of their asset may not allow them to relocate *and* stay within their local community. These are typically people who own a dwelling below the median value for the area (for example, people who own a modest home unit in a small block with no lift, who can no longer manage the stairs) and people with a modest lump sum.

The National Rental Affordability Scheme (NRAS) recognises that there is a section of the working age population that does not qualify for social housing but their modest income does not allow them to purchase. Among older people, the equivalent group is more likely to be in the reverse financial situation – to have some assets but little income. However, they do not qualify for NRAS if already homeowners. The present NRAS regulations do not allow an older person to make a capital contribution and achieve a share of the equity in a retirement unit. NRAS also has a 10 year rental subsidy limit which is reasonable for working age people who may eventually be able to purchase, but which is a problem for low income older people already in retirement.

The inclusion of subsidised rental and shared equity affordable housing in service-integrated housing for older people requires a broadening of the NRAS scheme (or introduction of a similar scheme) targeted to older people's financial circumstances, and provision of upfront capital funding and/or ongoing subsidies. In the first instance this could be done on a pilot basis through a number of demonstration projects.

Partnerships and projects involving public housing authorities, community housing sector and aged and community service providers, could increase the availability of 'service integrated housing' for low income older people without assets.

The Apartments for Life project will also require the development of partnerships with governments and with local service providers to forge new policies and models of services delivery. Proposals, if implemented, to separate subsidies for housing and subsidies for care (so that a person approved for high level nursing home care could receive the equivalent subsidy and services in the setting of their choosing) would assist in enabling residents with complex health difficulties to remain in their apartment until the end of life.

Support for research and evaluation in order to quantify the social and economic outcomes is also required.

3.2. Older people's housing strategy

The Benevolent Society also believes that a broader national older persons' housing strategy is overdue, to increase the stock of housing suited to an ageing population and address affordability issues. This should involve federal, state and territory governments.

The strategy should be aimed at enabling older people to make housing choices that allow them to maintain a high quality of life as they age and maintain their social networks and potential sources of informal care.

Its elements would include:

- introduction of universal design standards (the recent Liveable Homes initiative for new dwellings is an extremely positive move in this direction)
- review of planning controls to encourage the conversion of existing housing to age-friendly smaller units, construction of 'granny flats' and dwellings that cater for multi-generation households, incorporation of more smaller dwellings into new developments, and flexible housing designs that can adapt to changing household composition and ages
- strategies to make it easier for older owner occupiers to downsize to housing that is more suited to their changing needs, including easier access to independent information and advice on housing, finances and care services and help to navigate the complex interaction between pension, tax and residential aged care rules
- enhancing older people's access to home maintenance and modification, by improving access to reliable independent information and advice and access to recommended tradespersons; and by increased expenditure on subsidised home maintenance and modification schemes
- greater investment in social housing for older people, including in 'independent living units'.

4. The current service system

While there has been enormous growth and development in community care services over the last 25 years, the system is creaking at the joints and is not sustainable in its current form. Moreover,

we believe that a paradigm shift is needed in the way we think about and support older people in the community, and the way in which we provide community-based care.

4.1. New approaches to community care

Fundamentally, care services should be about enabling older people who cannot do so without some help, to live as full a life as possible. Care services should be provided in ways that support, build and rebuild people's abilities to do things for themselves irrespective of their state of health.

The role of formal care service providers should be to work with (or 'walk along side') older people and their carers/family members to provide advice and guidance about possible ways of achieving their goals and of dealing with the aspects of life they are currently finding difficult or are unable to manage. If needed and agreed upon, services to help them meet their goals should then be organised and/or provided. These may be formal services or informal support (through family, friends or neighbours) or a combination. Under this approach many people will require care services on an episodic basis, not ongoing. Importantly, under this scenario, older people will also need to be confident that care services will be available to them again in the future, if needed.

One of the critical steps is to ask the right questions when people first ask for, or are referred to, a service for support, and at the assessment stage. The tendency is for assessors to be constrained by the services they know to be available in the area, rather than to really explore in what ways the person's difficulties could be addressed with or without the assistance of formal care services, and so that the person (or their advocate) can make an informed choice.

Community care services have much to learn from the philosophy and models of 'case management' in other areas of social policy especially disability services, rehabilitation services and employment services, where the focus is on client-led assessment and planning.

The distinction between three tiers of care, as outlined in *The Way Forward*,¹⁴ remains useful:

- information and advice about services, assistance, benefits, devices and equipment for people to act upon themselves, provided through *highly visible* adequately resourced local centres in the community, in places where older people already go; and via user friendly, easily searchable and accurate websites
- guided access to basic services that offer low level assistance; plus follow up to make sure that it was successful and the services useful; and
- assessment and access to packaged services; coordinated, advocated for and organised by a case manager for those that need it.

The current system is difficult to navigate – for experts, let alone for older people and their family members. It relies heavily on people knowing that assistance exists, knowing how to access it and

¹⁴ Australian Government, Department of Health and Ageing, *The Way Forward: A New Strategy for Community Care*, 2004 edition.

then taking the onus of doing so. One result is that many people only get assistance *after* a health crisis has occurred, and opportunities have been lost for them to obtain low key inexpensive forms of assistance that could have prevented the crisis.

The increasing number of older people from culturally and linguistically diverse backgrounds is likely to exacerbate the inaccessibility of the system unless it is energetically addressed. This would need to take into account not only language, but also cultural factors which influence attitudes towards ill-health, the coping strategies people use and willingness to seek help.

Good links between GPs and care service information/advice points are vital. Carelink centres could be much more effective with better resourcing and with better links to and from GPs. Incentives for GPs to make better use of Carelink and to make referrals to Carelink, rather than to ACATs (unless it is clear that an in-depth geriatric assessment is required), could be explored, perhaps in conjunction with Medicare-funded assessments for people 75 and over. Links between health services and the care system are discussed further below at 4.8

4.2. Assessment

Currently, as people's circumstances change, they typically need to transfer to a different program, and often to a different agency. This may then mean another wait to be formally assessed, and another wait for a 'package' or service to become available in their area. They then have to get used to a completely new set of people coming to their home (coordinators and care workers) with new questions, forms and routines.

Assessment processes tend to focus on people's deficits rather than on their goals and strengths, are inconsistently administered and the results are not shared across the system. The latter leads to unnecessary duplication and confusion for the client having to repeatedly tell their story.

Carers are frequently not sufficiently included in the assessment process, either in relation to their own needs or to those of the person they are caring for.

The Benevolent Society would support the introduction of new approaches to assessment.

4.3. Maintaining/ rebuilding independence

The Benevolent Society believes there is insufficient focus on restorative care and rehabilitation – that is, forms of support that can actively help older people to gain or regain skills and confidence, and so reduce their dependence on ongoing care.

Community care programs such as HACC and Commonwealth-funded packaged care were essentially designed as programs of long term care for older people for the rest of their lives or until they enter residential aged care. They were not designed to provide services quickly when older people need immediate, relatively intensive but short term assistance. Nor were they designed to rebuild older people's capacity to live without formal support, where possible. A culture of dependency has been inadvertently created.

The ageing process usually does not mean a linear decline but is more usually characterised by periods of ill health and losses (including major life events like bereavement), alternating with recovery or partial recovery, and continued growth and change. However, it is also true that frail

older people's health can deteriorate quickly if relatively minor health issues are not tackled actively and promptly, leading to cascading problems and eventually hospitalisation.

Moreover, post acute care was specifically excluded from the HACC program in order to avoid cost-shifting from state hospital budgets. Post acute care requires quick access to short term services provided in close cooperation with health services and with a focus on restoration of function and/or avoidance of unnecessary deterioration and dependence.

A number of such programs exist, such as transition care and, in NSW, the ComPacks program and Healthy at Home Program. There are signs that these can be very effective but access to them is patchy and inconsistent. In NSW ComPacks provides up to 6 weeks community care for a person after an episode in hospital and Healthy at Home similarly provide up to 6 weeks care but is aimed at keeping older people whose health is deteriorating out of hospital in the first place (but only operates in a few parts of NSW). The Benevolent Society has contracts to run these services in southern Sydney.

Key features of Healthy at Home, as run by The Benevolent Society, which distinguish it from how community care service provision is more typically organised include:

- clients are assessed jointly within 48 hours (if the service has capacity to accept them), in the client's home
- this assessment must be undertaken jointly by the community care service provider (case manager) *and* the hospital geriatric assessment centre (usually by a registered nurse)
- regular meetings are also held to discuss what is going well, what could be done differently, what is not working well
- working with clients to build their confidence and knowledge around how to obtain support themselves, when they need it in future
- being careful to ensure that careworkers do not do any tasks that the client can do themselves.

Encouragingly, there is an increasing focus on capacity building and restorative approach to community care called variously in different states 'Impact'¹⁵, 'active service models', 're-ablement', or 'wellness' approaches. There is increasing evidence of their potential to make a difference to people's lives and for cost effectiveness.

Wider implementation of these approaches will require improved access to allied health services such as physiotherapy and occupational therapy that can be very important in enabling people to regain functional skills. Recent UK research suggests prompt supply of equipment and independent living aids and staff (re)training and supervision are also vital.¹⁶

The physical environment in which people live has a huge impact on their need for community care. Improving the use of home maintenance and modification services to make older people's homes suitable for their changed circumstances and to remove hazards, would also be a very strategic

¹⁵ See <http://www.agedservices.asn.au/products-services/community-care/impact>

¹⁶ Rabiee R and Glendenning C, 2010, The organisation and content of home care re-ablement services. Research Works No. 2010 -01, Social Policy Research Unit, The University of York

approach towards enhancing and rebuilding older people's independence and towards reducing unnecessary dependence on aged care services.

Restorative models of care should be given greater prominence. However, long term care will always be required for people whose health and other circumstances are such that becoming completely independent again of formal care services is unrealistic.

4.4. Flexibility of services

There is insufficient focus on supporting older clients in *whatever* way will have the greatest impact on their wellbeing and achieve the best results. Instead, service providers are constrained by innumerable guidelines and the services provided tend to be inflexible. Rather than being client-focused, the norm is that clients are offered a narrowly defined set of services irrespective of what would suit them best in their circumstances. While some service providers, including The Benevolent Society, try hard to bend and stretch the rules to provide truly client-centred services, this is not always possible.

In NSW, In-Home Respite Care (part of the HACC program) is an extreme example. This is intended to provide support in the form of respite to carers¹⁷. Organisations with contracts to provide in-home respite services, and which follow the program guidelines, can only provide a worker to sit with the person in their home while their carer goes out. The worker cannot do anything useful around the house at the same time, such as ironing, cleaning or making a meal, that would provide some practical assistance to the carer. Nor can they take the person out for a change of scenery or a social activity and give them some support as well as respite for the carer. The carer is also literally expected to go out while the worker is present. The carer cannot stay at home and get some respite from being on duty as a carer.

By contrast, Disability Support Program (DSP) Community Access in NSW, which funds service providers to support younger people with disabilities, allows service providers much greater flexibility in *how* the services are provided in order to meet clients' needs in ways that suit their personal goals, preferences, cultural background, family situation and so on. DSP funded services for ageing carers of people with a disability (usually an adult son or daughter) are similarly much more flexible than comparable HACC-funded services.

The Benevolent Society recognises that this inflexibility is partly a reflection of unnecessarily rigid and detailed government program and sub-program guidelines, but also of the culture of many service providers. An aversion to risk among funders also has a tendency to create conservative programs with unimaginative goals.

The complexity of the current service system also leads to inefficiency and waste, access barriers and inequity in access to services.

For example, while the growth of programs and services specifically for carers has been positive in many ways, program boundaries and guidelines and rigid interpretations as to who is, or is not, a carer, and what forms of support carers can receive can also lead to nonsensical situations,

¹⁷ Informal carers such as spouses, other family members and friends

especially affecting older couples who in effect are carers of each other. An example will illustrate this:

The son of a couple in their 80s approached a carer service. His mother had been in reasonably good health and his father had early dementia. There was a mutually supportive relationship and as is common with many couples of this age, housekeeping and meals etc were largely the responsibility of his mother.

When the son called, his mother required immediate short-term assistance with personal care to enable her to continue in her role, within the couple's mutually supportive relationship. She had a broken arm which had led to an unplanned episode in hospital. She had just been discharged and it was a Friday.

The carer service declined to provide personal care for the wife on the grounds that she was not a 'carer' and encouraged the son to contact the equivalent carer service in his area (he lived in a different area to that of his parents), having made the assumption that the son was or should be their 'carer'. On reconsideration, the original carer service did agree that the wife could be considered a carer but they could not provide her with direct support (in this case, personal care for herself), they could only provide *indirect* support such as respite which was not what the couple needed or wanted at that time. (In the end, the second carer service decided to organise short term personal care for the wife in technical contravention of their funding agreement).

In this example it was obvious that the couple needed immediate short-term community care assistance. Unnecessary difficulties arose because of:

- tight definitions imposed by program guidelines as to who is and is not a carer, that may exclude older couples in mutually supportive relationships, or assume that a person must be wholly 'well' in order to be considered a carer
- wrong and/or unhelpful assumptions made about caring relationships and responsibilities
- lack of availability of quick response community care services for people other than 'carers'
- the apparent absence of adequate discharge planning by the hospital, and failure to organise short term post-acute care community assistance through NSW ComPacks.

To provide people with the most appropriate service, service providers should allow those who approach them for assistance to define the nature of their own caring relationships and government guidelines should allow for the diversity of caring relationships.

Other examples:

- One member of an elderly couple was receiving a Community Aged Care Package (CACP) from one agency and the other was receiving carer support through a carer program run by a different agency; a more sensible approach would have been for the couple's needs to be

assessed as a whole and for them to receive support from one agency (or at least organised through the one agency). This would have meant one contact point for the couple, less paperwork and assessment, and fewer different caseworkers coming to their house each week.

- A woman from Victoria flew to Sydney to be with her elderly father while he was in hospital. He was discharged from hospital without the personal care service he would require (short-term) during his recovery period in order to transition back to living independently at home. He was discharged without any community support being arranged as it was assumed that his daughter was his 'carer' and would take care of this need.

On the other hand, The Benevolent Society is also aware of examples of imaginative good practice in support of an older person and family members/ carers. This case study demonstrates that carers are experts in their own lives and can and should be consulted regarding individualised meaningful outcomes.

- A kinship network was supporting an elderly Aboriginal family member who was dying and receiving community care. The role of the kinship network in supporting the person and the importance of 'connection to place' was recognised by the carer service. At the request of the family, the carer services assisted a family member and the person to travel to the person's place of origin (travel and direct assistance) so that the person could live out their days in their country.

4.5. Community care reform

Many of these service delivery issues have been recognised for some time, but progress in tackling them has been very slow and leadership by governments lacking. In 2002, the federal government initiated a review of community care programs that 'would simplify and streamline current arrangements for the administration and delivery of community care services'. Its focus was to 'ensure that it will be easier for people to access the care that they need and that community care programs are well aligned and are interlinked, offering an appropriate continuum of care in the community that is of high quality, affordable and accessible.'¹⁸ These goals remain relevant eight years later.

Significant reforms of, and investment in, community care are required to meet the needs of today's and future generations of older people. Doing so is needed in order to reduce demand for more expensive services such as residential and acute care, reduce interminable inter-government and inter- departmental debates and cost shifting and, mostly importantly, help foster older people's independence and self-reliance in line with what most people want for themselves and/or their family members.

The recent decision by COAG to move responsibility to the Commonwealth for the funding and administration of the HACC program for people aged 65 and over (or 50 and over if indigenous)

¹⁸ The Way Forward: A New Strategy for Community Care, 2004 edition.

represents an opportunity to revitalise community care. The Benevolent Society strongly supports this decision.

4.6. Gaps in services and unmet needs

Methods of rationing of services are sometimes very crude. In NSW for example, agencies such as the Home Care Service of NSW (the main source of personal care and domestic assistance) sometimes closes its books. As it does not keep waiting lists, callers are told to call again unless their situation is already urgent. This practice also has the result of masking the true level of demand for services and hinders service system planning.

Community Aged Care Packages (CACPs) typically offer an average of 5 hours per week of support. As people's needs increase and when this becomes insufficient, CACP providers are unable to respond. People's choices for staying at home are then few as EACH packages that can provide a higher level of care are very limited in availability. Waiting times for EACH packages in Sydney can be two years (after assessment) by which time it is often too late and the person will have had to move into residential aged care.

The gap in level of service between CACPs and EACH packages is considerable and The Benevolent Society would recommend the introduction of an intermediate level, which would relieve pressure on EACH packages and be cheaper.

In the absence of an intermediate level, clients are sometimes transferred instead to other HACC funded services not intended for this purpose, such as the Home Care Service 'high needs' pool (a limited source of funding for people with high needs) or Community Options. For the client this generally means having to get used to completely new service provider(s) and careworkers.

This situation also highlights the need for rationalisation of the number of different community care programs. The Benevolent Society also recommends increasing the availability of higher level community care such as EACH packages.

In NSW the planning of HACC services tends to be based around existing service types and configurations, resulting in lost opportunities to address unmet needs in different and perhaps cheaper ways. For example, unmet needs for community transport are considerable. Whereas some of this unmet need could be addressed by, for example, assisting older people to become confident in using public transport, the service type description for transport¹⁹ is confined to group and individual transport services.

4.7. A renewed focus on social connections

Failure to understand and address social isolation has serious implications for older people's psychological and physical wellbeing, which in turn has ramifications for future health and community care costs.

¹⁹ http://www.dadhc.nsw.gov.au/dadhc/Doing+business+with+us/service_type_descriptions.htm

It is well established that certain groups of older people are at higher risk of social isolation, and certain life events can trigger social isolation (especially if experienced cumulatively).²⁰

This suggests that support and interventions soon after a critical event or early during life transitions can help to prevent social isolation, especially among already vulnerable older people.

While most older people do not report social isolation or loneliness, it is also well established that social isolation or loneliness is associated with poorer health. As has been said so succinctly:

“People should not have to move permanently to residential care because they are lonely, bored, not eating well – and as a result get sick.”²¹

Community care services are intended address the social needs of older clients. However, in practice, current home-based service delivery styles do little to counteract loneliness and social isolation of older people who live alone.²²

The Benevolent Society’s own experience as a provider of community care services is that clients’ social isolation has typically not been systematically assessed (either by referring agencies or our own services). Recent research with clients has revealed that staff may be unaware of the extent of clients’ loneliness.

While The Benevolent Society is attempting to address this more systematically through training and supervision, these are often difficult or confronting questions for staff to ask and they have limited resources at their disposal with which to attempt to address isolation and loneliness. Addressing barriers to social engagement such as lack of confidence and mobility issues may not be straightforward and can require significant time and skill.

Services providing ‘social support’ are funded through the HACC program although they comprise a very small component of HACC services. Packaged care offers flexibility in what and how services are provided although, in practice, funding levels often do not permit the service provider to offer more than services to meet the functional needs associated with daily living.

Day centres are also intended to provide a social outlet but have limited appeal for many older people. Many only offer a limited range of structured activities with little variation and are inappropriate for older people from differing cultural backgrounds. Older men often find that activities on offer are tailored primarily to women’s interests. Insufficient resources limit day centres’ ability to offer enjoyable and meaningful activities.

The social contact provided by careworkers’ visits to clients is often highly valued by clients, but it is invariably limited by time pressures, and cannot substitute for broader social contacts and community connections.

The Benevolent Society is currently exploring a range of ways of utilising volunteers to help reduce social isolation and loneliness among our community care clients. This includes strategies that enable clients to support each other (for example, over the phone). While using volunteers is a less

²⁰ Queensland Government Department of Communities

²¹ Jane Musared, ACH Group, Service for Good Lives in ACS Update December 2009

²² AIHW 2007 Australia’s Welfare

expensive options than using paid workers, it does have costs associated with it as volunteers also need training and support and their travel cost paid for.

Additional policy and community responses are needed to address social isolation among older people, including;

- developing prevention strategies, programs and services that address the needs of sub-groups of older people likely to be at risk
- identifying individuals who have lost or are losing their social connections and proactively supporting them to (re)build them.

4.8. Service interfaces with wider health and social services systems

The example of the Healthy at Home program (section 4.3 above) also highlights the benefits of better interfaces between community care services and the health system.

Weaknesses in the health system undermine the provision of good quality care to older people. Community aged care cannot compensate for, and should not be expected to compensate for, poor health services.

Older people (community care recipients and potential recipients) need better access to good primary health care, specifically

- a GP who does home visits
- a GP who will refer them to Carelink
- better access to other health services, especially to allied health care, to mental health services, with chronic disease management and to strategic health services such as cataract surgery and hearing services that can reduce dependence on care services
- health promotion strategies such as falls prevention programs, medication management programs such as Home Medicine Reviews and dose administration aids.

It is well established that frail older people, especially those with dementia, do not fare well in hospital. It is in everyone's interest that they receive better primary health care and appropriate specialised services so that avoidable hospital admissions are reduced.

However our experience is of:

- some older people still being discharged from hospital (especially private hospitals) with no or inadequate discharge planning; apparent failure to refer older people in hospital to a social worker for an initial discussion and assessment to occur about whether community care services will be needed after discharge; failure to refer older patients to ComPacks (a NSW program);

- inadequate discharge planning for older people from CALD and indigenous backgrounds; in our experience their high levels of anxiety while in hospital may not be appreciated and they are viewed as uncooperative
- lack of follow-up in the few days after leaving hospital, important as older people themselves may underestimate their ability to cope in the immediate period after an episode in hospital
- incorrect assumptions made by hospitals about the ability of family members to act as carers; or about carers' ability to cope without information, advice and support
- unwillingness of GPs to make home visits
- failure by GPs to refer to or activate community care services for older patients who would benefit from them, *prior* to a crisis
- inadequate access to community-based mental health services
- sub-optimal management of chronic conditions that cause avoidable hospital admissions
- lack of access to allied health services and poor use of Medicare-funded allied health services.

4.9. Consumer directed care

In its September 2008 Research Paper; Trends in Aged Care Services, the Commission reviewed mechanisms to promote more consumer centred care and choice and the issues for consideration.

As the Commission has noted, consumer directed care can take many forms ranging from reforming existing services to encouraging more consumer engagement in choices about what services they receive; through to budget holder arrangements, individualised funding and payment by vouchers or cash.

The Benevolent Society supports having a range of forms of consumer-directed care, to suit people's different circumstances, needs and preferences. No one model will suit all.

Clients and their families/carers should be able to nominate what level of involvement they are interested in. For some, this may mean taking on full responsibility for deciding the form of support and for organising and monitoring it. Others may not want to take on this responsibility.

There is certainly considerable scope for increasing consumer engagement within the existing service system. While there are signs that this is occurring, as evidenced by interest in the Impact and other similar models mentioned earlier, much more could be done. The rhetoric of consumer focused care is easy and almost all services would claim to be doing it; much harder are the sustained cultural changes to make it a reality.

4.10. Specific groups

The Benevolent Society would like to highlight some issues affecting particular sections of the older population.

People with more difficult needs

The Benevolent Society has observed that some agencies (often privately run ones but occasionally not-for-profit ones) with contracts to provide CACPs, 'cherry pick' easier and therefore less expensive clients. They turn away people with more complex and expensive needs, referring them instead to agencies such as The Benevolent Society. Note that all agencies with CACP contracts receive the same amount of funding per person/package. This suggests a lack of appropriate accountability to and monitoring by funders, and possibly the need for mandated levels of service for disadvantaged and low socio-economic older people.

Older people with mental health conditions²³

The Benevolent Society is seeing more community care clients with mental health conditions than previously, possibly because of the lessening of stigma attached to mental illness and greater awareness of it.

Our experience is that many of the other local care agencies from whom we normally broker or purchase services, will not accept clients with mental health conditions. We note also a shortage of specialist mental health services available to older people.

It is a common misconception that depression is a normal part of ageing, but it should also be recognised that older people may have good reasons to be depressed and anxious in older age. Research commissioned by Beyondblue found that among people 65 and over living in the community, 10% to 15% of experience symptoms of depression (half pre-existing and developed in old age). Similarly, 10% have a diagnosable anxiety disorder.²⁴ The depression rate in older people receiving a high level of support at home is approximately twice as high as less frail community-dwelling older people²⁵.

In 2007-8 about 8% of older men and 11% of the females reported high or very high levels of psychological distress.²⁶

There is a growing recognition of the scale and impact of depression and anxiety among community care clients. Risk factors for depression clearly overlap with risk factors for needing assistance with activities of daily living. Risk factors for depression include increases in physical health problems like heart disease, stroke, chronic pain; losses such as bereavement, loss of independence and mobility; significant change in living arrangements, admission to hospital; special occasions (anniversaries) and the memories they evoke; as well as pre-older age psychological conditions.

²³ This section draws heavily on a presentation by Dr Gerry Naughtin, Chief Executive Mind Australia at ACSA 2010 Community Care Conference.

<http://www.agedcare.org.au/CONFERENCES/Current-and-Previous-ACSA-Conf/2010-Comm-Care-Conf-Speakers-Papers/Gerry%20Naughtin.pdf>

²⁴ Beyondblue Depression in older age: a scoping study. Final Report - National Ageing Research Institute (NARI), September 2009

²⁵ Beyondblue Depression in older age: a scoping study quoting Baldwin, R., Chiu, E., Katona, C., & Graham, N. (2002). Guidelines on depression in older people: Practising the evidence. London: Martin Dunitz Ltd.

²⁶ AIHW, Australia's Health 2010

As mentioned earlier in Section 2, our own pilot evaluation results are indicating higher than expected levels of emotional and mental disorders among clients.

These trends highlight:

- a need for training and development among the community care workforce
- a need for better, more integrated responses involving health services and care services, for example, better collaboration with GPs, mental health practice nurses and specialist mental health agencies and use of Medicare funded to enable clients to have access to psychologists, and a need for specialist mental health programs for older people.

They also add additional weight to the value of placing greater focus on strategies to promote 'active ageing' and to address social isolation and loneliness.

Some promising developments include

- exercise programs
- psycho education programs
- risk profiling for depression
- increasing use of screening and assessment tools
- education of staff on signs symptoms and responses
- stronger focus on carer depression.

Older people with lifelong or long term disabilities

This is a small but increasing section of the older population. A growing issue is that older people with disabilities receiving disability services are expected, at the magical age of 65, to transfer to aged care services. Firstly, this may cause major and unnecessary disruption to their lives. Secondly, few aged care services are well equipped to cater to their needs. While there may be a case for *funding* responsibility to transfer from disability to aged care programs at aged 65, they should be able to continue accessing appropriate services.

Older residents of state-funded services for people with disabilities (such as group homes) should have the same eligibility for receive community aged care services as an older person living in their own home. Without access to community aged care services they can end up having to move prematurely to residential aged care.

Older people and their carers

As the Productivity Commission has noted, 83% of older Australians receiving assistance in the community are supported by informal carers, wholly or partly. They enable many older people to avoid or delay admission to residential care and support people's preference to remain living in the

community.²⁷ Their role is vital but many family carers are under great stress. Their psychological wellbeing is lower than any other group in the community. Carers of a spouse or partner are least likely of all carers to seek help.²⁸ Carers of people with dementia or complex needs are the most vulnerable. At the same time, carers may derive esteem and meaning from their role as carers, particularly those caring for a husband or wife.

Many carers are, of course, older people themselves, usually either carers of a spouse or of an adult son or daughter with a disability.

A comprehensive review in 2007 of carer interventions by Eagar et al²⁹ reported that carer burden scores did not seem to be reducing as a result of current interventions. The authors suggested that while this could be due to a difficulty in distinguishing the effective from the ineffective components of study evaluations, it also suggested that interventions may not be “specific enough to meet carer needs”.

Carers of family members with end stage dementia (often older people themselves) have reported the importance to them of opportunities for intimacy, people to give you support and advice but not take over your life, and understanding of how difficult it is to hand over the care of people you love to strangers.³⁰

The Benevolent Society is currently exploring way of working with carers that build carers’ resilience and ability to continue as carers (if they wish to do so). In contrast to simply offering respite (short breaks from caring), our approach is to work with carers to identify what would be of greatest help to them and to harness carers’ own inherent resources.

Care services for a good life – in a nutshell

- ▶ Give people more choice and control - about what service they receive, who delivers it, when and how it is delivered, and where.
- ▶ Offer community services on the ‘IKEA principle’ – give options for DIY, simple instructions, services that are well designed, click together and are easy to use, and at a good price.
- ▶ Raise the profile and visibility of home care services in local communities, through for example, ‘big, loud inviting resources centres which shout about the possibilities for help at home.’ This would encourage people to make use of services at an early stage and avoid sudden crises.
- ▶ Support older people to manage their health pro-actively, through prevention and health promotion programs (especially focussing on exercise and eating well), recovery programs that help people recover from periods of ill-health, screening to detect problems early, self-management programs for conditions such as arthritis or in the wise use of medicines. Community care services could play a much larger role, working with GPs and other primary health care services, to sponsor such programs and/or to assist older people to access them.

²⁷ AIHW 2009 Australia’s Welfare

²⁸ AIHW 2007 Older Australians at a Glance

²⁹ Eagar, K et al, Effective Caring: a synthesis of the international evidence on carer needs and interventions, Centre for Health Services Development, University of Wollongong, 2007

³⁰ Shanley C, 2009, Presentation to Australian Association of Gerontology Conference

► Pay attention to good service design – by really listening to older people (recipients of services, other older people, family members).

► Look beyond people's functional needs (having a shower, meals, going to the shops) and pay attention to the social context of people's lives.

Adapted from Jane Musared 2009 ACH presentation to HACC Community Care conference Aug 2009

5. Objectives of the aged care system

We look forward to a discussion of the objectives of the aged care system and how it should be paid for in the Productivity Commission's draft report, and to contributing further at that point. However we would point the Commission to the UK Green Paper *Shaping the Future of Care Together* published in July 2009³¹, which identified six key things that everyone should expect from a national care service:

- *Prevention services:* everyone will receive free support to stay as well and as independent as possible; this will include re-ablement (care and support to help people get back on their feet after leaving hospital).
- *National assessment;* wherever you live you will have the right to have your care needs assessed in the same way. And you will have a right to have the same proportion of your costs paid for.
- *A joined up service:* All the services you need will work together smoothly, particularly when your needs are assessed. You will only need to have one assessment of your needs to access a whole range of services.
- *Information and advice:* There will be easy access to information about who to go to, what care you, or the person in need of care, can expect and how quickly the care will be in place.
- *Personalised care and support:* Your care and support will be delivered around your individual needs. You will have much greater choice about how and where you receive support, and the possibility of controlling your budget wherever appropriate.
- *Fair funding:* Everyone who qualifies for care and support from the state will get some help meeting the cost of their care and support needs. Your money will be spend wisely to fund a care system that is fair and sustainable.

6. Paying for aged care services

As pointed out in the UK Green Paper,

³¹ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_102338

'care and support needs in life and old age are inherently uncertain. Two in three women and one in two men³² will develop high care needs during their retirement. But some people will need no care and support at all. The current social care system does very little to help people minimise that uncertainty, with some facing very high costs near the end of their lives and others needing far less care.'

Certainly in the Australian context, greater clarity is needed about people's rights or entitlements to services, what people can expect to receive and what they will be expected to pay. We also caution that while it is certainly true that older people have, on average, greater financial resources than previous generations, this is very unevenly spread and significant sections of the older population have low income and/or low assets. Access to aged care should be equitable and the fees payable take into account ability to pay.

Recent polling³³ for The Benevolent Society shows that there is near universal agreement in the community for governments to do more to introduce strategies to address the expected funding shortfall arising from the worsening in the ratio between numbers of older people and number of taxpayers.

We look forward to further involvement in discussions about future options for paying for the aged care system.

7. Regulation

It is likely that privately-funded services paid for in full by users will play a bigger role in the community care system in future, for those that can afford to pay for them. Currently such services are not subject to any quality control, monitoring or regulation (other than through general consumer protection legislation and regulation of registered health professionals). Government quality assurance mechanisms apply only to those that directly receive government subsidies.

Governments will need to play a role in monitoring the quality of privately run and financed services to ensure care plans are carried out and to ensure that clients have easy access to an independent voice to communicate their concerns about poor quality service, complaints mechanisms and independent advocates.

In England, for example, the Care Quality Commission regulates all home care service providers, whether run by government, not-for-profit or private agencies and irrespective of whether they or their clients receive subsidised care. Inspection reports and quality ratings (0 – 3 stars) are publicly available.³⁴

We also note the argument that the type of contract between purchasers (e.g. government) and providers of services may have considerable influence on the quality of services and possibly more than agency ownership per se. The funding of packaged care is a case in point. It is on an averaged

³² UK data.

³³ www.bensoc.org.au

³⁴ <http://www.cqc.org.uk/aboutcqc.cfm>

per person basis with agencies allowed to keep any surplus/profit and while this type of contracting encourages agencies to operate efficiently, it may sometime be at the expense of good quality care for individuals.

As mentioned earlier, The Benevolent Society has observed that some privately run agencies (and occasionally some not-for-profit ones) with CACP contracts, 'cherry pick' easier and less expensive CACP clients and turn away CACP clients with more complex and expensive needs, referring them instead to not-for-profits such as The Benevolent Society who are willing to take them. Some researchers have observed that regardless of ownership, recipient of grants for broadly specified services placed lower priority on profit-making than those engaged in contracts for specified services or on a price per case basis.³⁵

The Benevolent Society has also observed a trend among some care agencies, when contacted by an older person looking for subsidised care services, to offer services on a full cost basis instead. In doing so they may be taking advantage of the person's lack of knowledge of other sources of subsidised care available through other local agencies, and their desperation for support.

8. Workforce issues

The Benevolent Society recognises the importance of ongoing strategies to build recruitment, retention and skills among the community care workforce.

In our own organisation, we support staff to undertake training (for example, Certificate 3 or 4) in paid time, through TAFE and through private RTOs (run at our offices). Coordinator/case manager level staff are supported to attend relevant short courses and conferences and through study leave for longer courses. All new careworker and coordinator/case manager level staff undertake a 3 month induction process. Supervision and use of performance development and review (PDR) processes are also important.

The role of the Department of Health and Ageing in funding training for community aged care workers has been valuable. Continuing strategies are needed to attract people to community aged care, including through campaigns to enhance the visibility of the sector and understanding of community care work, scholarships, incentives for mature age workers, traineeships etc.

The Benevolent Society places a strong emphasis on the client relationship aspects of careworkers' role, as well as on the clinical and task-focussed aspects of their work. Our experience is that careworkers' relationships with clients is the most rewarding aspect of their role and is a key factor in staff retention. The importance of careworker-client relationships was highlighted in research conducted by Jane Mears and summarised in a Research to Practice Briefing³⁶ published by The Benevolent Society in conjunction with the Social Policy Research Centre. The research highlighted

³⁵ Meagre and Cortis 2009 Political Economy of For Profit Paid Care in King and Meager (Eds) *Paid Care in Australia*, Sydney University Press

³⁶ <http://www.bensoc.org.au/uploads/documents/research-to-practice-briefing-1-caring-for-older-australians-nov2008.pdf>

the importance of valuing careworkers and their relationship with clients, and of ensuring that organisational policies and procedures support this.

The Research to Practice Briefing is one in a [series](#) developed by The Benevolent Society in partnership with researchers and other practitioners in the sector. The Briefings arose from an observation that although in some areas of human services there are a large number of clearing houses, websites, briefing papers and other forms of communication between researchers and practitioners, this is far less developed in the community aged care sector.

The Briefings were developed as a contribution to filling this gap and to the more systematic implementation of evidence-based practice in community care.

We recognise, though, that other strategies will also be needed to support the uptake of evidence-based practice. Fixsen has noted that across the human services sector, 'research results are not being used with sufficient quantity and quality to impact human services and, therefore, have not provided the intended benefits to consumers and communities'³⁷. Greater focus is needed on 'implementation'.

He also notes that 'to have a useful and significant impact, we must learn how to make use of well-researched programs and practices on a national scale'.

To this end, we support the development in Australia of mechanisms to enhance collaboration between researchers, policy makers and practitioners in ageing/caring for older people.

The Australian Research Alliance for Children and Youth (ARACY)³⁸ is a useful model. ARACY's purpose is to improve the wellbeing of children and young people, by:

'building and supporting collaborations of researchers, policy makers and practitioners across disciplines, to share knowledge and foster new ways of thinking and working. Through these collaborations, and by translating the best evidence into policy and practice, ARACY is helping to prevent problems before they arise, and enhancing the wellbeing of future generations.

ARACY provides neutral space for stimulating and facilitating national collaborative efforts across stakeholders.

³⁷ Dean L. Fixsen, Karen A. Blase, Sandra F. Naoom and Frances Wallace, Core Implementation Components Research on Social Work Practice 2009; 19; 531

³⁸ http://www.aracy.org.au/index.cfm?pageName=ARACY_overview

9. Summary of key principles and directions for reform

1. Any consideration of the design, funding and delivery of services for older people must be underpinned by a clear understanding of older people's wellbeing and the factors that contribute to it.
2. Fundamentally, care services should be about enabling older people to live as full a life as possible. Care services should be provided in ways that support and encourage self-reliance.
3. Research and evaluation of community aged care needs to be better supported and funded, and the results shared. Data collection, monitoring and accountability to funders should have a greater focus on outcomes. The Benevolent Society supports the establishment of a Centre for Community Service Effectiveness.
4. New models of housing, care and support (or service-integrated housing) such as the Apartments for Life project are needed.
5. Government funding is required to enable the inclusion of subsidised rental and shared equity affordable housing for low income older people in service-integrated housing. This could be achieved through social housing funding and by broadening the National Rental Affordability Scheme to suit older people's circumstances (or introduction of a similar scheme that targets older people). This could be implemented initially on a pilot basis through a number of demonstration projects.
6. A broader national older persons' housing strategy is overdue, to increase the stock of housing suited to an ageing population and address affordability issues.
7. A paradigm shift is needed in the way we think about and support older people in the community, and the way in which we provide community care services. Programs for older people and their carers should be oriented to focus on people's goals, strengths and abilities, in order to avoid unnecessary dependency. Programs and service providers should support consumers to be more actively involved in deciding the care services they need and how they will be delivered.
8. Restorative models of care should be given greater prominence. However, long term care will always be required for people whose health and other circumstances are such that becoming completely independent again of formal care services is unrealistic.

9. The Benevolent Society supports the consolidation of community care funding programs under one Commonwealth Government program. It should provide for people to receive flexible care based on their needs, circumstances and preferences, and be able to adapt as these change. Programs should enable services to be flexible enough to be able to provide intensive restorative care e.g. after periods of ill health, major life changes or to see if a person can regain functions, as well as to provide ongoing long term care and care for people who are dying.
10. Funding for community care programs should be increased to address unmet needs, enable a more appropriate level of care to be offered to existing clients, expand the availability of key services such as allied health services and home maintenance and modification services.
11. More funding for higher level community care packages (Extended Care at Home, EACH) is required. An intermediate level of packaged care between Community Aged Care Packages and EACH packages and would relieve pressure on demand for EACH packages.
12. Older people and their families should have greater choice of type of services, who provides them and when and where they are received – whether in a residential aged care home or in their own home.
13. The Benevolent Society supports there being a range of forms of consumer-directed care, to suit people's different circumstances, needs and preferences.
14. Government funding guidelines should allow for the diversity of caring relationships. Service providers should allow those who approach them for assistance to define the nature of their own caring relationships. Support of carers and the person they are caring for should work seamlessly together.
15. Community care recipients need better access to good health care, including to GP services (with home visits), allied health care, mental health services, chronic disease management, and health promotion strategies such as falls prevention programs, medication management programs, nutrition and exercise.
16. Better links between hospital services and community care services are required, including better discharge planning and increased availability of post acute care.
17. Good links between GPs and care service information/advice points are vital. Carelink centres could be much more effective with better resourcing and with better links to and from GPs.

18. Additional policy and community responses are needed to address social isolation among older people.
19. Governments need to play a greater role in regulating and monitoring the quality of privately run and financed services.
20. A range of strategies are needed to support the uptake of evidence-based practice in community care. The Benevolent Society supports the development of mechanisms to enhance collaboration between researchers, policy makers and practitioners in ageing/caring for older people. The Australian Research Alliance for Children and Youth (ARACY) is a useful model.
21. Greater clarity is needed about people's rights or entitlements to aged care services, what people can expect to receive and what they will be expected to pay.