



**UNITINGCARE NETWORK SUBMISSION**

**to the**

**PRODUCTIVITY COMMISSION  
PUBLIC INQUIRY**

**into**

**THE CARE OF OLDER AUSTRALIANS**

**Contact:**  
Susan Helyar  
National Director  
UnitingCare Australia

02 6249 6717



## INTRODUCTION

Agencies in the UnitingCare network provide services and supports in all states and territories to older Australians, their carers and families through a wide range of programs and initiatives in community based and facility-based care. We welcome the opportunity to make a submission to the Productivity Commission's Inquiry into Caring for Older Australians. As a member of the Campaign for the Care of Older Australians, UnitingCare Australia has said this Inquiry must lead to action and a plan for renewal that can commence in the next term of government. It must prioritise the well being and independence of older people within the health and community care systems and adopt a universal entitlement approach to aged care services.

We acknowledge the complex task before the Commission. Key incremental changes will need to occur over time to ensure that growth in demand for aged care services that is projected for the next 30 to 40 years will be met by an adequately resourced community care and health system. There will need to be a number of key transition periods every 5 to 10 years as systems develop and offer time for reviewing achievement of outcomes.

We are pleased to note that the community and key decision-makers share UnitingCare Australia's view that major reform of aged care is long overdue. This consensus has been built through numerous Inquiries, reviews and research projects that have outlined broad principles and specific recommendations for reform.

Over the past three years UnitingCare and individual UnitingCare agencies have contributed to these national reform discussions via the following submissions and advocacy material:

UnitingCare Australia submission to the *Inquiry into Planning Options and Services for People Ageing with a Disability* - 2 June 2010 + cover letter

UnitingCare Australia submission to the *Review of the Aged Care Funding Instrument* - 11 March 2010

UnitingCare Australia response to the Aged Care Recommendations in the *Productivity Commission Draft Research Report 'Annual Review of Regulatory Burdens on Business: Social and Economic Infrastructure Services' [June 2009]* - July 2009 + cover letter - 31 July 2009

UnitingCare Australia submission to the *Senate Inquiry into Residential and Community Aged Care in Australia* - December 2008

UnitingCare Australia submission to the *Pension Review* - 26 September 2008 + cover letter

*A Health Reform advocacy pack* for agencies to talk to their local Federal ALP MPs and Senators about the National Health and Hospital Reform Commission's Report, 21 August 2009

UnitingCare Australia submission to the Minister for Ageing, reporting on *social inclusion and wellbeing projects implemented by UnitingCare agencies using Social Inclusion grants since June 2008*, 31 July 2009

*UnitingCare Australia submission to the Australian Senate Inquiry into Residential and Community Aged Care in Australia* - December 2008

UnitingCare Network submission to *Conditional Adjustment Payment Review* - October 2008

*Bleak House: Threats to sustainability and equity in residential care for older Australians* UnitingCare Australia Aged Care Issues Paper, produced by the Allen Consulting Group - January 2008

UnitingCare Australia believes the Productivity Commission's Issues Paper delivered in June this year is cause for optimism ahead of this Inquiry. We welcome the Commission's request for detailed evidence and advice that will build on agreed principles for reform and previous recommendations.

With demand on services predicted to at least double in the next twenty years, urgent attention is needed now to decide on the actions that will be taken by governments, working in partnership with consumers, carers, communities and service providers to establish person-centred, wellness promoting, optimal care and sustainable services. These actions are needed so Australia can renew the service delivery, funding and regulatory framework so it fits with 21<sup>st</sup> Century needs, expectations and operating environment.

## EXECUTIVE SUMMARY

The current service model is a legacy of past policies and funding settings – none of which are appropriate in the current environment nor will they be able to meet older people's needs in the context of population ageing, changing family and community structures and the increasing incidence of chronic diseases. Current policies and funding arrangements related to health care, housing, urban design and community engagement do not support healthy ageing, social inclusion or continuity of care as people's care needs increase, especially for people who are disadvantaged and vulnerable, and those living in rural and remote locations.

The following key drivers of demand, expectations and factors affecting capacity need to be considered as a new approach to meeting the needs of older people evolves:

- Models of care – access to services when needed and in preferred settings, alignment with consumer needs and expectations, impact on workforce attraction and retention;
- Funding – sources, sustainability and equity;
- Demographic change – structural ageing, family and community changes, increasing incidence of chronic disease;
- Quality and safety – ensuring these whilst maintaining choice and dignity
- Regulatory burden – impact on costs of services and workforce;
- Workforce – skills shortages and gaps, remuneration, flexible working arrangements, increasing scope of practice, access to team-based work and support, professional development and renewal, safety;
- Importance of the interface with the general health sector – hospital-home links, hospital–care, primary health care, workforce and carer understanding of the ageing process, family support needs, continuity of care across ageing and systems, supporting healthy ageing/health promotion

Many commentators, policy makers and decision-makers in the Parliament believe a greater emphasis on enabling market forces to shape the aged care system will deliver substantial improvements, and address the current gaps and inefficiencies in the service system. But aged care is a social good that demands a creative response from Government and the community to supporting older Australians in their efforts to remain as healthy as possible for as long as possible, and providing a range of options for care when the time comes. This paper includes critical reflections on the capacity of older people to exercise consumer power at vital points in the ageing process.

This submission provides UnitingCare Australia input on a number of big picture issues. Specific detail on challenges in the current service system and alternative service models have been provided by UnitingCare agencies providing aged care services, namely:

- Joint Submission by ECH Inc, Eldercare Inc and Resthaven Inc (South Australia – submission 100)
- Helping Hand Aged Care (South Australia - submission 196)
- UnitingCare Community Options (Victoria – submission 152)
- BlueCare (Queensland – submission 254)
- Frontier Services (Regional and Remote Australia – submission 323)
- UnitingCare Ageing NSW/ACT

This Inquiry provides a unique opportunity to bring together knowledge, experience and advice from all sources and sectors and produce a report and recommendations that provides:

1. A meta-analysis of current activity in the aged-care sector, noting any duplication and gaps, and examining whether our aging population is being provided with services that are comprehensive, high quality, adequate, appropriate and accessible. This analysis would also examine where growth is expected and what services are needed for the future.
2. A summary of promising approaches and best practice.
3. An analysis of the cost of optimal care across the range of services people require.
4. A transition plan that ensures ongoing supply, equity of access, improved service options and a sustainable service system.
5. Detailed feasibility and equity analysis of market mechanisms for improving access to high quality services, optimising care outcomes, improving choice in and sustainability of services.

**CONTENTS**

INTRODUCTION .....	2
EXECUTIVE SUMMARY .....	3
UNITINGCARE AUSTRALIA .....	6
CURRENT CHALLENGES .....	7
VISION STATEMENT REGARDING OLDER AUSTRALIANS .....	8
ACHIEVING THIS VISION .....	9
REFORM OPTIONS AND TRANSITIONAL ARRANGEMENTS .....	10
Priorities for reform .....	10
Sequencing .....	10
SERVICE REFORM CHALLENGES AND ISSUES.....	12
Increasing Flexibility and Innovation .....	12
Community Based Alternatives to Residential Care .....	12
Continuum of Care .....	13
Information Technology .....	13
Reform of Assessment Functions .....	14
Models of Sub-Acute, Chronic Health and Primary Care Services .....	15
Improving the interface between health and aged care services .....	16
IMPROVING CHOICE FOR CONSUMERS AND COMMUNITIES .....	17
Consumer Directed Care .....	17
Dementia Care .....	18
Respite Care .....	19
IMPROVING HOUSING OPTIONS .....	20
Retirement Villages .....	20
Interaction with aged care.....	21
Regulatory issues .....	21
Other Affordable Housing Options for Older People .....	22
FUNDING ARRANGEMENTS .....	23
A Sustainable Funding Environment.....	23
Parity of Subsidies and Funding .....	24
Reforms of the Aged Care Funding Instrument (ACFI).....	25
Casemix Funding Approaches .....	26
MARKET ANALYSIS .....	27
Equity of Access .....	27
Market Mechanisms .....	28
Issues Regarding Operation of the Aged Care “Market” .....	28
REGULATORY ARRANGEMENTS .....	30
Government role in regulation.....	30
Specific issues in aged care settings .....	31
Current challenges .....	32
WORKFORCE REQUIREMENTS .....	34
Staff Recruitment and retention .....	34
Assistive Technologies .....	36
REFERENCES .....	37

## UNITINGCARE AUSTRALIA

UnitingCare Australia is an agency of the National Assembly of the Uniting Church in Australia. We represent the Uniting Church's network of UnitingCare community services of which there are over 1,300 service delivery sites nationwide.

The UnitingCare network is one of the largest providers of community services in Australia, providing services and supports to more than 2 million Australians each year, employing 35,000 staff with the support of 24,000 volunteers. We provide services to older Australians, children, young people and families, Indigenous Australians, people with disabilities, the poor and disadvantaged, people from culturally diverse backgrounds and older Australians in urban, rural and remote communities.

UnitingCare Australia works with and on behalf of the UnitingCare network to advocate for policies and programs that will improve people's quality of life. UnitingCare Australia is committed to speaking with and on behalf of those who are the most vulnerable and disadvantaged for the common good.

UnitingCare Australia believes that all people have the right to access a decent standard of living. This includes access to:

- Appropriate food, clothing, housing and health care;
- Meaningful work, education, rest and recreation;
- The opportunity to meaningfully express and explore spiritual needs; and
- The opportunity to participate in and contribute to communities.

UnitingCare Australia believes that belonging in community is fundamental to people's well being. We value an inclusive community that strives to remove all barriers that prevent people from belonging and participating as fully as they wish and are able.

UnitingCare Australia affirms that all people have intrinsic value, and that older people have social, spiritual and physical needs, and a just claim to be heard.

Older people have and continue to contribute to society and have the right to participate in community as fully as they wish and are able to, and the right to opportunities to enhance their life chances and quality of life.

We recognise that older Australians may require assistance and care as they age. We also recognise that many older Australians provide care in the community for their family, friends and others. Whether people are cared for or are carers or volunteers, our vision is that older people should have the chance to share justly in the abundant resources of our nation.

UnitingCare agencies manage 12 per cent of all residential aged care places in Australia and are a major provider of community-based services used by older people. We have the experience and knowledge to understand the trends and pressures in both residential and community aged care — and propose actions to address them.

We seek a total re-think of how we support our older citizens in Australia. We acknowledge that the aged care service system is part of a broader environment that is increasingly focussing on the individual, the market and users paying for services. We believe however that the aged care system needs to be built on an entitlement to care when and where it is needed, and embedded in community.

## CURRENT CHALLENGES

For some time, the Uniting Church in Australia has been concerned about the viability and sustainability of aged care services and the appropriateness of the social and community infrastructure available to people as they get older. The current service system is not working in the best interests of older people or their families and carers. New human and physical infrastructure is needed to meet the challenges we face and a new service system paradigm is required.

UnitingCare is committed to serving the needs of older people, and we will honour our current commitments in the area of residential care. The future development of residential services will not be possible unless a more sustainable funding system and model of care is developed. Increasingly our focus will be on community-based care options, supporting development of appropriate and affordable housing and enhancing the capacity of older people to remain in their homes and communities as they become more frail both physically and cognitively. We need to retain current infrastructure as we reform the wider system to make it more sustainable and responsive to community preferences and expectations. But we also need new investment and new thinking to deliver choice and dignity as people get older. As part of this shift, the aged care sector needs to embrace available technology that helps older Australians remain more independent for longer.

The current service system does not provide equitable access to the services and supports that older people need. Many older people do not get timely access to the supports they need to stay living in their own home. While consumer directed care packages are being trialled that provide flexibility within the community packaged care framework, more needs to be done to make the Home and Community Care (HACC) program more flexible. In residential care, lack of access to capital funding is caused by the limitations imposed by government funding instruments, inability to access contributions from residents in high care who have the capacity to pay, the return on capital investment being lower than the interest rate on loans and reduced returns on private sources of funds in the wake of the Global Financial Crisis. An urgent injection to the capital shortfall in aged care is needed.

## VISION STATEMENT REGARDING OLDER AUSTRALIANS

*Imagine.... an Australian community where older people are valued and included in community life, enabled to maintain health & independence, are able to contribute their talents and wisdom, pursue their interests, nurture relationships, maintain their culture and spirituality and be in control of their future. Imagine if those who need support can receive it in a way that supports the above, and is provided with dignity and respect.*

Our vision is one that begins with a person and family centred approach, enabling people to continue to live a full life as they age, and providing support when people can no longer be fully independent. This support must be delivered in a way considered appropriate for citizens of any age, and in the context of a supportive community.

The UnitingCare network aims to preserve the dignity and independence of all people who need support, whilst also recognising that we are all interdependent and value our friendships and community networks. Services for older people should support individuals and their families and communities to maximise their health and wellbeing and ability to participate in the community. Government, communities, families and individuals must work together to achieve this vision.



## ACHIEVING THIS VISION

A policy environment that supported healthy ageing in inclusive communities would include the following elements:

- Older people would be able to remain connected or become re-connected with their passions, interests and relationships and supported to share their skills, knowledge and wisdom with the community;
- Housing and urban environments would: facilitate ageing in place; enable timely and smooth transitions to more congregate housing when people choose; and support access to clinically and socially appropriate housing as people become more physically frail and/or cognitively impaired;
- Regardless of housing type older people would be able to continue to contribute to and participate in their families and communities;
- Active co-ordination and alignment of health and community policies to facilitate early and effective interventions to reduce the incidence and impact of chronic diseases; and accessible, affordable and effective services to address the needs of people living with chronic disease;
- Explicit consideration of the impacts of a broad scope of policy decisions on healthy ageing and continued engagement of older people in family and community life - especially health, social services, housing, urban design and transport.

A service system that better reflected the expectations and needs of older people in the 21<sup>st</sup> Century would provide:

- Equitable access to services that promote the dignity and choice of all people regardless of their ability to pay for services;
- The separation of accommodation and care in funding packages, which provides Consumers with access to meaningful choices in the services they receive and the settings for the services;
- Appropriate remuneration and training to the aged care workforce (which would need to be reflected in funding levels);
- Integrated, localised and progressive assessments that feed into care planning;
- A primary point of care that is community-based;
- Supported care settings of a size and design that optimise clinical and social outcomes.

## REFORM OPTIONS AND TRANSITIONAL ARRANGEMENTS

UnitingCare Australia recommends the following priorities for and sequencing of implementation of health, aged care and community care system reforms that will enable better and more sustainable care for older Australians:

### *Priorities for reform*

- Alignment of the price paid for aged care services with the real cost of providing these services.
- Consolidation of aged care policy and funding under the responsibility of the Australian Government.
- Increased sources of funding, capital investment and improved recurrent funding and indexation.
- Reduced regulation and compliance burden in the service system
- Opening up the market to increase the supply of services is essential. However, there will be no gain for the aged community of Australia if an open competitive market means that only the high end for profit market can compete ultimately resulting in a reduced provider pool with reduced choice to the consumer and reduced capacity to support the breadth of demand.
- Removing the division between community and residential care. That is, enabling a care recipient assessed as requiring care to determine their preferred environment for that care (i.e. accommodation choice)

### *Sequencing*

The sequencing and incremental improvements in services and supports for older people will be required to respond to the growth in aged care services in the next 30 to 40 years and will not be fully implemented in the next five years –our first steps should set the base from which future improvements can be made.

The first step in implementing reforms should be to increase access to additional resources for aged care, with the de-regulation of places to follow after the existing service sector has been able to establish sustainable funding arrangements.

We see the first five years will focus on the following system development attributes

- Residential care based on an allocation formula similar to that which now applies
- establish entitlement to community care for all people assessed as requiring and choosing such a care option hence no artificial limit of supply by way of a population formula as currently applies (service providers being required to be approved service providers within the system defined)
- Further supply flexibility within residential care by allowing services of approved levels within the allocation formula to attract up to 10% additional places by way of individuals transferring their community entitlement in such an option if that is their choice

Any change in planning ratios needs to be after sustainability of service models and funding has been improved.

Increased access to data, information, advice and advocacy needs to follow access for all older people, regardless of their financial status, to meaningful choice about the services and supports they use.

The Campaign for the Care of Older Australians has outlined short and long term actions that need to be taken as the aged care system undergoes a necessary transformation:

Short term actions:

- An independent cost of care study to determine pricing and indexation structures that work. The NHHRC recognised the need for care subsidies to be periodically reviewed.
- In the interim, funding for both residential and community care should be increased by restoring and extending the CAP (or a similar mechanism) which is indexed until the long term reforms are finalised and implemented.
- Flexible payment options for accommodation, which could be at no cost to Government, including refundable accommodation deposits for high care:
- Removal of the distinction between high and low care, which could be at no cost to Government;
- An increase in the daily accommodation charge for people who can afford to pay to match the cost of housing, which could be at no cost to Government;
- Linking government payments (the accommodation subsidy) for concessional residents to the real costs of providing accommodation.
- The creation of one community care program to provide a range of flexible funding levels to meet individual, and changing, client needs.
- Workforce issues must be addressed. The NHHRC report recognised the critical role of the workforce in a reformed health and aged care system and outlined proposals to create a modern, learning and supported workforce.

Longer term actions:

- Ensuring an entitlement based on assessed need
- Demand driven, rather than supply driven, services
- Readily available access
- Consumer choice in services, (including health and disability support, housing, and community and residential aged care), and who delivers them
- Flexibility in price and payment methods
- Promoting independence and wellness

## SERVICE REFORM CHALLENGES AND ISSUES

### *Increasing Flexibility and Innovation*

There are significant barriers to innovation in delivery of services to older people, including those imposed by both funding and regulation. These issues are discussed in more detail below. In simple terms, the price paid for services for older people does not match the cost of providing high quality sustainable services, program guidelines limit the diversity of services able to be provided and demand for aged care outstrips supply. In this environment, services are extremely constrained in their ability to develop and deliver a more diverse range of models of care.

More flexible funding and care arrangements will facilitate adoption of the models of care that older people prefer - including models that focus efforts on maintaining function in a person's own home, sustaining the capacity of informal carers and networks and improving continuity of care across the ageing process. More flexible funding will also provide older people with better access to the resources and skills needed to address sub-acute and palliative care needs in a more timely and targeted way than is currently possible. Such a model should strengthen the individual's capacity to look after themselves, and assist family and community to provide support, with third party formal support (both volunteer and paid services) supporting and enabling the overall process, meeting client needs as and where needed.

A long term desirable outcome is to implement person-centred planning by allocating funding for care and support needs more flexibly, with older people and their carers being able to determine the preferred type of services offered and the setting for delivery of these services. This will require implementation of more flexible funding arrangements, including pooling of funds from different programs and consumer directed funding mechanisms, similar to those utilised in the disability field.

The idea of person centered planning is not to replace services that are directed at 'support and maintenance', but to provide enhanced services earlier to promote independence, so as to reduce the need for ongoing support in the future. This would be highly valued by clients, who want to receive assistance before they reach a crisis point. It may also help to contain the future cost of care by facilitating more timely and effective interventions in the course of the ageing process, reducing the number of clients with ongoing care needs, and possibly decreasing the average intensity of service provision per client.

### *Community Based Alternatives to Residential Care*

An increased focus on rehabilitation and restorative services, especially at critical times in the ageing process would facilitate improved quality of life, reduce frailty and enhance people's capacity to remain living in their own home. A critical shift in aged care services is needed, with increased investment in community-based care so the tipping point into residential care is reached later in the course of ageing.

In the future residential care should focus primarily on supporting people with dementia who cannot be safely cared for in community-based settings as those requiring palliative care or constant 24 hour nursing care. Currently, residential care provides needed support for a broad range of problems, such as loneliness and alcohol addiction – these issues need to be better identified and accommodated within community-based care settings. People need to be able to choose to live in residential care, but accessible services need to be available to encourage and enable them to choose to remain in community settings.

UnitingCare Australia recommends the following:

Maintain or hold residential care supply constant within a planning allocation similar to that which now applies on the 88/1000 place population formula;

Establish entitlement to community care for all people assessed as requiring and choosing such a care option, with no artificial limit to supply by way of a population formula as currently applies;

Enable individuals with community care approval to move their community entitlement to a provider of choice (being an approved provider under the Act) which may include a residential care provider (who is already operating residential care under an allocated number of places but has excess places for people making a choice to move their community subsidy to their residential care).

Further deregulation of supply in residential care could be considered at a future time when an incremental review of the system is undertaken and the outcomes expected in the entitlement system in community can be evaluated.

This follows the premise that a community care entitlement model will decrease demand for residential care as those who can select to remain outside residential care are able to do so. This will increase relative supply of residential care within the current ratio and contribute to a more competitive environment, as argued by the NHHRC and Productivity Commission in previous reports.

### ***Continuum of Care***

There is a critical need to improve the continuum of care across the ageing process and the service system. This could be facilitated by:

- Adoption of e-records across the health, community and aged care systems
- Parity of subsidies and funding regardless of setting (workforce remuneration, care funding in different residential settings)
- Reform of assessment functions (development of agreed tools, improved access to self-assessment tools, increasing evidence base of who is able to assess, when to assess, and how assessment processes influence demand and supply)
- Developing models of sub-acute, chronic health and primary care service that can be delivered directly via the aged and community care system
- A systematic review of state and territory regulations and legislation that need to be amended and aligned to ensure smooth transition to a wholly Commonwealth Government-managed aged care system

### ***Information Technology***

Unlike other areas of the health and care system, aged care has had very little investment by Government in information technology. Information technology could play a vital role in revolutionising the lives of people who are ageing, but in Australia it is under-utilised.

E-health monitoring and support and single health records would streamline processes and help reduce red tape and ultimately ensure a higher level of care through more accurate record keeping. There are numerous examples of agencies investing in new IT health management systems – for example UnitingCare agencies in NSW and Tasmania are trialling “iCare” systems. It needs to be acknowledged that such systems are expensive to develop, and may not be cost-saving in the first instance, so Government investment in

identifying, designing and evaluating such systems may be necessary to jump-start the uptake of such technologies.

In community settings the technology is available to create virtual support communities and chronic disease management. Australia lags far behind other developed nations, for example virtual communities in USA exist and are extensively utilised to enable older people to support independence, increase community connection and self manage chronic disease. BlueCare Queensland has piloted an "IT house" to encouraged older people living in their homes to access such support communities online.

### ***Reform of Assessment Functions***

The ACAT teams were established to provide individuals with advice, guidance and referrals, but in reality ACAT staff often simply complete the ACAT assessment form and provide basic information such as lists of residential care providers in the area.

Individuals should only require one ACAT assessment, once admitted to the care service system (whether it be community or residential). Such assessments could be undertaken by service providers, within a process where regular auditing takes place (similar to existing processed to undertake ACFI assessments). The level of care subsidy could then be defined by way of the funding tool adopted, removing the need for further ACAT review and assessments to generate the level of subsidy assessed as appropriate on the funding tool or move between residential or community.

There is a need to move to more self-assessment of needs, especially at lower levels of need, so that highly skilled clinical staff are primarily used for more complex assessment processes.

## ***Models of Sub-Acute, Chronic Health and Primary Care Services***

### **Leading the fight against chronic disease**

Blue Care's partnership in an Australian-first chronic disease program will help set health industry benchmarks in the way chronic illness is managed now and in the future.

The Linking Chronic Disease Services program, launched in January 2010, is a partnership between Blue Care, GP Connections (Toowoomba and Darling Downs Division of General Practice), RHealth (South East Queensland Rural Division of General Practice) and Queensland Health.

The program aims to improve the quality of life and reduce the need for hospital-based care for people with Chronic Obstructive Pulmonary Disease (COPD), Chronic Heart Failure and Type II Diabetes.

The Linking Chronic Disease Services program is a coordinated approach to helping people who may be having trouble managing their chronic disease.

About 75 per cent of Blue Care's community clients suffer from three or more chronic conditions at any one time and with this percentage expected to increase, so does the need for community coordinated programs like this one.

The program is the first time health professionals and clients have come together to provide integrated care for people with chronic disease in hospital and at home.

The biggest benefit will be for Blue Care's clients who will be able to access a coordinated approach to the management of their health care and hopefully decrease the level of stress for themselves and their carers.

"Down the track we hope the benefits of the program will extend beyond our local clients with chronic diseases and can be used as a model that could be adopted by other communities elsewhere in Australia."

This program is demonstrating that genuine multi-disciplinary, cross agency partnerships can be established and can reduce inappropriate hospital admissions.

The program has been funded over two years from the Queensland Strategy for Chronic Disease through the Toowoomba and Darling Downs Primary Health Care Partnership Council.

### **Transition Care**

Uniting Aged Care Vic Tas currently provides bed based transition care within two of their residential facilities. They are contracted by state health services to provide these services and transition care is an important sub-acute service which they are ideally placed to provide.

Their delivery of transition care would be enhanced by being directly contracted by the Commonwealth to provide Transition Care. Currently the State takes a "slice" of transition care funding and insists on providing some of the services e.g. allied health from the acute health system. If agencies were fully contracted to provide all Transition Care services the benefits would be: lower costs or increased services, and improved integrated planning of services both for each person and also for the system of integration with other aged care services.

### *Improving the interface between health and aged care services*

There are significant opportunities for improving the interface between health care and aged care services. UnitingCare Australia has previously made comment on this. Our submission to the NHHRC inquiry, and response to the NHHRC recommendations can be found at [http://unitingcare.org.au/images/stories/submissions/090428\\_ua\\_response\\_nhhrc\\_interim\\_report.pdf](http://unitingcare.org.au/images/stories/submissions/090428_ua_response_nhhrc_interim_report.pdf)

Key recommendations coming from our analysis include the need for:

- Earlier assessment and delivery of service and support needs, and simplified processes for assessment, through use of self screening tools, better targeting of the use of the limited supply of highly qualified clinical assessment staff and early access to small amounts of services before needs are higher and family carer supports have been exhausted.
- More finely grained increases in funding as people's needs change and increase, including higher levels of funding for EACH to reduce the need to move into residential care and access to episodes of more intensive care (e.g. in sub-acute settings) to sustain ageing in the community.
- Improved clinical knowledge and skills about the ageing process and access to services in the broader health and community workforce including medical specialists involved in the care of older people in residential care, and better access for older people in residential and community settings to primary care, allied health workers, mental health care, palliative care, pharmacy support and dental care.
- Continued Implementation and evaluation of trials of Consumer Directed Care (e.g. respite care services), that in addition to individualised budgets also include consumer involvement in overall system and service design, access to independent advice about care options and planning support, and the opportunity to choose when and how to access informal and professional services sometimes concurrently. Training and support to consumers, families and service delivery staff is also a critical component of effective implementation of CDC.
- Advanced care planning needs to be part of earlier and better informed planning for ageing across the broad range of needs, including access to planning advice and support regarding both care needs and financial issues. Implementation needs to include staff training, access to additional staff time, engagement of families and carers as well as the older person, and access to specialised advice and advocacy.
- Improved support for carers via increased funding and infrastructure for carer respite, counselling, education, training and advocacy. Improved access to sub-acute and rehabilitation services will reduce the risk of community-based care being used to compensate for a lack of appropriate medical intervention, or failing as a result of unreasonable demands being placed on informal carer, or from services not being equipped to manage more complex health care needs.



## IMPROVING CHOICE FOR CONSUMERS AND COMMUNITIES

UnitingCare Australia advocates for older people and their families to be able to exercise more choice in when and how they access support and services, and who provides these.

The principles that UnitingCare Australia believe should guide provision of care in the community are articulated at

[http://unitingcare.org.au/images/stories/resources/2008april\\_community\\_care\\_principles.pdf](http://unitingcare.org.au/images/stories/resources/2008april_community_care_principles.pdf)

Below are a number of examples of practice models that provide flexibility and choice for individuals:

### *Consumer Directed Care*

UnitingCare Australia supports Consumer Directed Care and believes that the recently released pilot CDC places will be a great opportunity for older people and the provider system to test out the philosophy of consumer controlled approaches within the current standards framework for packaged care.

An example of 'what works' comes from the *People at Centre Stage* project, UnitingCare Community Options, Victoria

#### **The Assisted Independence Model (AIM)**

How it works: The 'assisted independence' model is based on the belief that people often require some level of assistance to make good decisions and that people value, and often need, assistance to maintain independence and autonomy when faced with reduced ability associated with old age. Our resources – such as skills, access to information, health and material resources - profoundly affect our ability to shape our lives. This model focuses on the information, skills and resources people need to lead a fulfilled and autonomous life and how peers, families and communities can become crucial assets in this quest. The model also includes support services that seek to restore or maintain the cognitive, physical, and social capabilities of a person. In addition, the AIM model makes available necessary information in the form of facilitated peer support groups as well as a web-based support network to assist participants to make informed decisions.

The AIM model takes into account that services provided by institutions can reduce older people's decision making capacity and choice, narrowing clients' choices and cultivating dependency. The AIM model returns power to individuals by providing older people and their carers with greater self-direction possibilities and enabling them to once again choose their own paths through life. The model offers participants the opportunity to influence and shape their care arrangements at all stages starting with their relationship with their case managers to the way they interact with care provider agencies. While participants can elect to take on the responsibilities for organising and coordinating most of their own care arrangements, they will always have some support of a case/care manager.

Participants will have a sliding scale of self-direction options. Typically, participants will be introduced to self-direction at a low level and have the option to take on more responsibility as they become comfortable with the aged care system. At the highest level of self-direction, participants take on extensive responsibilities in the domains of care planning, care coordination, budgeting and financial responsibilities.

The model is designed to enable participants to make informed choices about the care they receive, and to assist them in taking on the level of control and direction of services that they choose and feel comfortable with.

**People at Centre Stage service model: key features:**

- Sliding Scale of Self-Direction Options focusing on all aspects of social care, including case/care management that ranges from zero (full case management) to a maximum.
- Participants are able to take on care planning, budgeting, care coordination, and financial responsibilities, supported by a care manager
- More flexible financial and budgetary arrangements through use of discretionary fund to be spent within framework of existing guidelines.
- Negotiated role of case/care manager
- Negotiated care planning, monitoring and oversight
- Transparent processes and procedures
- Transparent financial arrangements
- Assisted independence approach with focus on healthy eating, exercise, medication management, social engagement and restorative approaches utilising motivational goal setting.
- Case manager focus/emphasis on identifying and/or removing obstacles to participants around their decision making capacity
- Retention of core case management services such as monitoring and review.

Enhanced person-centred practice taking into account intrinsic power imbalances, including:

- Goal setting approach finding personal motivators for people to stay as independent as they can.
- Enabling approach assisting and encouraging people to self-direct their care arrangements.
- Focus on social inclusion, peer support and community options strategies.
- Closer co-operation between case/care managers, clients and brokered care and health services aiming to maximise flexibility and quality outcomes, and to actively involve provider agencies and care workers in assisting clients to achieve their personal goals.

***Dementia Care***

There is a need to explore models in the community that meet high care needs. This includes a different approach to dementia care and working towards service and funding models that enable care to be provided in domestic scale settings of fewer than 10 people in care. The current situation where large numbers of people needing dementia care live in the same environment might be financially viable, but it falls short of meeting the care needs of this vulnerable group.

Uniting Aged Care Vic/Tas provides a continuum of dementia care in the Hawthorn area.

On one site they provide day programs for people for dementia, day respite and a 13 bed residential dementia unit. These services are located in a residential area, are accessible by public transport and all have a welcoming "homely feel". Clients who attend day programs and those in residential care often participate in joint activities and carers develop a relationship with staff across the continuum of care.

The residential unit runs at a loss due to its poor economy of scale. However, the client/family satisfaction Press Ganey data demonstrates a very high level of client

satisfaction with this domestic scale of residential domestic care. The satisfaction is far higher than in our larger residential settings which have dementia units.

Further, staff turnover is low thus staff skills in dementia care are maintained and importantly so are relationships with clients and families.

This unit is similar to dementia units in the Netherlands. The Dutch Govt has a policy of no dementia unit being larger than 9 residents and they are in local community settings and integrated within communities. The difference between this and our Australian institutionalisation of people with dementia is HUGE.

A new dementia care program is providing Blue Care staff with a framework for the care of people living in the community with dementia.

Launched in December 2009, the program aims to support staff in quality service delivery through all the stages of dementia management. In addition, Blue Care has adopted the Queensland University of Technology (QUT) research publication *Clinical Practice Guidelines and Care Pathways for people with dementia living in the community*.

Every Blue Care Community Care centre has been provided with a copy of the program as well as the guidelines and its corresponding education programs for health professionals and care workers.

The program will provide staff across all disciplines within the organisation with a platform to support best practice in dementia care services, now and into the future.

The program promotes a holistic, person-centred approach to care and encourages spontaneity and innovative resourcefulness in service delivery.

Staff are encouraged to utilise a range of flexible service options that provide responsive choices in care delivery, to ensure people with dementia maintain a high level of dignity, independence and quality of life.

### ***Respite Care***

Respite Care is a highly valued part of the care system, but recent research by Yvonne Wells of the Lincoln Centre for Research on Ageing (Latrobe University, [http://www.latrobe.edu.au/aipc/aipc\\_staff/y.wells.htm](http://www.latrobe.edu.au/aipc/aipc_staff/y.wells.htm)) has indicated there are not lasting benefits from these periods of respite. There is a need to re-imagine respite care and re-engineer funding arrangements so that there is more flexibility in how the respite time and resources can be used. There is also a need to use respite funding more flexibly - for example, during some periods of respite it could be useful to engage with carers on strategies to make their role more sustainable which may result in longer term benefits of respite for carers. Currently the respite funding cannot be used for this purpose.

## IMPROVING HOUSING OPTIONS

### *Retirement Villages*

Building ageing friendly communities with appropriate infrastructure – housing, transport, security, opportunities for community engagement and maintenance of physical activity, and small amounts of community-based assistance early in ageing process – can provide residents with the supports and services they require to allow them to remain in these communities. Higher support facilities can be incorporated into these communities to allow residents to remain within their communities even when their care needs grow.

#### **Retirement Living Example (Blue Care, Queensland )**

Tenure in a retirement village is the right to occupy a unit, apartment or villa and to use available services. The typical types of tenure in retirement villages are:

**Loan and licence agreements:** Where the village operator retains ownership of the village accommodation units and the resident pays an ingoing contribution before occupying a unit. This ingoing contribution is characterised under the Retirement Villages Act (RVA) as a loan. The operator will typically charge a departure fee (or deferred management fee as it is known in Queensland (DMF)) and may share in any capital gain. The DMF may be calculated as a percentage of the ingoing contribution or the exit value.

The DMF is often deducted over a period of about 10 years. An example for a new village is 6% per annum over 5 years and then 1% per annum for the remaining 5 years (based on the ingoing amount). The DMF provides the investment return for the operator. DMF is used by operators to pay for the cost of new and replacement capital which is fully the responsibility of the operator. Residents incur no direct cost for new and replacement capital for the village.

**Leaseholds:** The operator grants the resident a lifetime lease of their accommodation unit for which the resident pays the initial price of the unit. The initial price is made up of prepaid rent and a refundable loan, thus making this form of tenure similar to a loan and licence structure.

#### **The main barrier to older Australians accessing retirement living options are:**

- a) Their ability to pay an ingoing contribution. Generally, to pay an entry contribution and gain access to a modern integrated community or a supported living environment, a resident would have to own and be able to realise an existing property
- b) Reticence to incur the deferred management fee.

Industry participants acknowledge that the retirement village industry has not communicated the benefits of retirement living as effectively as it could, nor has it demystified the financial arrangements.

Blue Care has developed a methodology for clearly articulating the DMF arrangements which appears to be successful based on prospective resident feedback.

Many providers offer capital gain sharing which can provide the opportunity for a long staying resident to exit a village with a nominal capital sum that is greater than the ingoing contribution.

Industry operators comment that resident surveys consistently reveal that most residents wished they had moved to a village sooner. It appears, a priori, for most consumers there is a value proposition in retirement village living.

To meet the needs of low income or disadvantaged old Australians, Blue Care has over 350 affordable units where the capital value and hence, the ingoing contribution, is less than \$150,000. Blue Care also offers a pure rental model (under rental tenancies legislation) as well as financial structuring arrangements that enable the ingoing amount to be substantially reduced and the incoming resident the ability to access rent assistance.

### INTERACTION WITH AGED CARE

Retirement living is compatible with an ageing population. It interacts with aged care services through delivery of community aged care packages into villages and the trend towards co-location.

The collective living offered by retirement villages facilitates efficient delivery of care and other support services.

An integrated community (with care options, including residential aged care) is an effective way of assisting residents with social inclusion, lifestyle choices and extending independence.

Retirement village environments support independence, lessening the demand on publicly funded services through:

- Peace of mind for residents knowing that care is available on site
- Safety via a secure gated community

Unlike supported living style communities, a Blue Care integrated community (with a residential aged care facility) does not require residents to move off campus when their care needs advance to the higher end of traditional low care residential status or high care.

Retirement village living is generally **not** the most appropriate place of care for residents who require support in daily life and have complex behaviours and care needs<sup>1</sup>.

### REGULATORY ISSUES

Retirement villages are regulated by state legislation which is aimed primarily at protecting the interests of people living in those villages.

Retirement village residents are distinguished from residents of a residential aged care facility in that they are either living independently or they are supported to some extent.

The Productivity Commission (2009) stated:

The aged care system is characterised by centralised planning processes which result in a heavy regulatory burden on aged care providers.

Extension of the aged care regulatory environment to retirement villages is not appropriate for people living independently or with support. The burden of regulation would add to the cost of retirement living for consumers and may lead to reduced supply.

<sup>1</sup> In other words, residents without a fulltime carer and whose care needs could be categorised at the upper end of low care or high care in a residential aged care setting.

### ***Other Affordable Housing Options for Older People***

The recent Nation building funding for affordable housing is most welcome, and has been used by aged care facilities to build affordable housing for older people, using innovative models and collaboration with other sectors.

For example, Uniting Aged Care VicTas (UACVT) obtained \$10.2 million to build 50 units for older people across Tasmania. These units will be across 5 existing sites and provide a social mix of housing i.e. rental and ingoings on these sites. In addition most sites have residential and community care and can thus support older people in their affordable and accessible housing for the remainder of their life.

In Victoria, UACVT has entered into a partnership with a Housing Association, (with expertise in affordable housing). The Housing Association will develop all the housing on the UACVT site in Bendigo (where there is both residential and community care). Some of these houses will be "given" to UACVT in return for the land. UACVT will lease these units under the Retirement villages Act and the Housing Association will rent the remainder to older people who are economically disadvantaged. Despite different financial models we will operate the whole site as one.

## FUNDING ARRANGEMENTS

### *A Sustainable Funding Environment*

In a sustainable funding environment:

- Funding arrangements would separately consider capital, accommodation options and costs, care and support costs, and funding sources;
- A small amount of funding would be available for use by services to engage local communities in service planning and development;
- Funding from government programs would be able to be pooled to enable tailoring of services and infrastructure (either geographically or demographically) according to identified gaps and needs;
- Sustainable financing would provide adequately for the needs of people unable to contribute to the cost of their housing and/or care, and provide mechanisms and financial instruments through which people who are able to can contribute to the costs of their housing and/or care;
- Aged care services would have access to additional funding streams, for example through insurance schemes and access to superannuation.

It is essential that a more flexible funding model is established that better meets the needs of individuals being cared for in the community as their needs increase. The funding model needs to address the gap between entry thresholds for CACPS and EACH, which are too broad, with individuals falling between the cracks and not necessarily receiving the level of support they need. Furthermore there is an unhelpful overlap between HACC and CACPS that confuses rather than helps consumers.

More adequate financing is needed to ensure: a minimum level of funding is available to support all people living in residential care, recognising the minimum cost of providing accommodation, care and hotel services; and expansion of funding for community-based services to create alternatives to residential care options.

Increasing access to finance could be achieved by enabling people who are able to contribute to the costs of their care to do so through lump sums on entry or exit from a residential care service, by uncapping the accommodation charge or ongoing charges whilst they access services. However, it is our experience that the current suggested charge of 15% of the Aged Pension for community-based services is not able to be paid by full pensioners.

There is also a risk that increasing fees will serve as a disincentive to utilising community services instead of residential care, as people living at home have additional ongoing living costs such as paying for equipment and aids and transport to appointments.

The UnitingCare national position on flexible financing options for funding residential aged care are listed at <http://www.unitingcare.org.au/images/stories/pdfs/future-financing-national-position.pdf>

UnitingCare Australia would make the following recommendations to funding and administration procedures:

1. Community-based funding streams should be consolidated to reduce complexity and improve interface across care continuum;
2. Housing costs should be decoupled from costs of care, and in residential care hotel costs should be separately defined;

3. Community-based planning mechanisms facilitated by funding bodies working in partnership with community leaders should be utilised – eg C4C model

4. Government funding bodies should define the outcomes that funding is supposed to facilitate, and then service providers and consumers can work on how best to deliver these outcomes given individual needs and preference, family capacity and needs, community capacity and local infrastructure.

This could be achieved by:

- getting rid of unnecessary regulation (as per UA response to the PC review of regulatory burden in social services (2009))
- pooling funding on a locational basis (eg YP4 projects in Victoria, Communities for Children program)
- CDC with appropriate operational and managerial support (as outlined above)

### ***Parity of Subsidies and Funding***

Significant material has been written about the complexity and inequity of current funding arrangements. Currently funding for the same level of need can be very different depending on the setting. For example, residential aged care services provide palliative care, but are funded at a lower level than hospice services providing similar levels of care. Funding systems need to be simplified and re-engineered to put a person and their needs at the centre, rather than the setting for care or the pathway to care determining funding levels.

People entering a residential service on “low care”, but due to ageing in place policies (which UnitingCare fully supports) their care needs gradually increase. Low care residents are required to pay for more services than high care residents, which has a significant impact on residents ability to access services.

UnitingCare Australia recommends that:

A review is undertaken by the Department of Health of Ageing to examine the specified care and services in relation to cost impact on approved provider and resident/family as well as the administrative burden that approved providers have to manage when the definition of a “high” care and “low” care resident can be short term, is based on a funding model, and the prevalence of ageing-in-place facilities have moved residential care away from traditional definitions of “nursing home” and “hostel”.

There are two business rules relating to the RCS saved rates that remain in place following the introduction of ACFI which financially disadvantage approved providers and are unreasonable and unfair. These rules require that Medicare reject any ACFI claim that would move the resident from the RCS saved rate to an ACFI claim unless:

- a) The funding differential between the RCS saved rate and the newer ACFI claim is greater than \$15.00; or
- b) There is a two level shift within one domain in the ACFI scheme.

These policies unfairly disadvantage approved providers because the subsidy paid via the Medicare claim is directly attributed to the assessed need for care. There can be a substantial difference between the cost of care and the subsidy paid by the government and approved providers cannot claim this due to the above business rules.

Blue Care has undertaken an analysis of the annualised and aggregated differential between what would be paid with the business rule in place and what is actually paid as a result of the business rule and is able to demonstrate that this contributes to the



inadequate funding of their aged care services by approximately \$3.5 million per annum<sup>2</sup>.

Whilst this unfair anomaly will over the coming years disappear, it is currently having a significant deleterious effect on the funding provided for aged care in the immediate to short term at a time when the industry is also experiencing other financial pressures such as rises in salaries and wages, increases in food, energy and water costs and lower interests rates on the back of the Global Financial Crisis.

Currently, individuals are assessed in the community by an ACAT team, and the classification of individuals is based on the old RCS system. Individuals may enter residential services classified as “high care”, but are then reassessed by providers using the ACFI classifications and assessed as “low care”. This causes significant misunderstanding, frustration and confusion for residents.

UnitingCare Australia recommends:

An urgent review of the current anomalies between the ACAT Assessment and resultant ACCR and the ACFI requirements be undertaken to ensure funding is provided that truly reflects the care needs of residents when and where the care is delivered

### ***Reforms of the Aged Care Funding Instrument (ACFI)***

Our submission to the Senate Inquiry into Residential and Community Aged Care in Australia, provided in December 2008, stated that while ACFI is an evidence-based model to assess need it is a medicalised model that emphasises deficiency and deficit rather than a person-centred and rounded assessment. UnitingCare is concerned that the current ACFI risks destabilising care delivery and its foundations run counter to the trends in care that emphasise outcomes and responding to aspirations of individual older people.

Recommendations are made in the UnitingCare Australia submission that if adopted would reorient residential aged care funding to focus on promoting and sustaining wellbeing rather than illness management

We have previously noted that ACFI is reducing the size of the pool of eligible people who can be admitted to low care and pay an accommodation bond, which impacts on the viability of low care and high care and on finding low care options for people for whom low care residential services are an appropriate and affordable option for meeting changing housing and support needs. More realistic base levels and indexation of funding so it keeps pace with the growing costs of remunerating the workforce and purchasing the goods and services used by community and residential services is one of the critical first steps in longer term reform of aged care in Australia. The UnitingCare Australia submission can be found in [http://unitingcare.org.au/images/stories/submissions/100311\\_sub\\_acfi\\_review.pdf](http://unitingcare.org.au/images/stories/submissions/100311_sub_acfi_review.pdf)

---

<sup>2</sup> “Bluecare has approximately 364 residents who fall under the \$15 threshold. **This amounts to losses of \$1.02M per year**, (losses of \$7.55 per resident per day = \$2747 per day). **Additionally, Bluecare is losing \$2.5M** because there are 218 saved rate residents who qualify but have not been reclassified (i.e. are over the \$15 threshold) - (218 people, \$32 per day per resident = \$11,710 per person per year)”

### *Casemix Funding Approaches*

Casemix refers to the use of classifications that bundle patient care episodes into clinically coherent and resource homogeneous groups. Casemix commonly means the mix of types of patients treated by a hospital.

Casemix is an information tool that allows policy makers to understand the nature and complexity of healthcare delivery and that enables the measurement of hospital performance, aiming to reward initiatives that increase the efficiency of hospitals.

The core characteristics of casemix approaches to funding of services are:

- Classification of all interventions/treatments as a basis for determining the types and number of services provided by an organization;
- Ascription of all episodes of intervention/treatment to a category within the classification system;
- Predetermined pricing of all types of procedures/interventions within the classification;
- Emphasis on cost efficiency, effectiveness, cost control, and equity in funding amongst service providers.

Such a system aims to achieve more effective assessment of care needs and circumstances and to place greater emphasis on case management and the achievement and measurement of care outcomes.

One of the variants of case mix based funding that is used in Victoria is CRAFT (Casemix Rehabilitation and Funding Tree) and is the funding system for Victoria's Designated Rehabilitation Units with 20 beds or more. This could well lead to an effective model to be considered in the Aged Care environment however, there is no available evidence found at this time to determine whether or not this has been examined.

A well constructed casemix or case-based funding system may well provide incentives and disincentives that, in conjunction with other measures, may achieve the necessary changes to a more equitable and reliable system of funding aged care, based on contemporary research based evidence and quality and safety requirements of a modern and effective system of aged care.

Nevertheless, a number of questions can be asked about the feasibility and desirability of applying casemix technologies to specialist services that work with people with complex needs – including people who have been homeless and people who need significant interventions to manage dementia-related difficult behaviours.

UnitingCare Australia recommends a comprehensive analysis of the feasibility and impact of using a casemix funding model, that considers the following issues:

- Is it possible to 'standardize' residential aged care services to the degree required for casemix funding?
- What measures of care outcomes are appropriate?
- Can casemix funding provide adequate incentives to ensure that services are provided to care recipients with highly complex needs and can the issue of 'creaming' (providing services to clients most likely to have positive outcomes for minimum input) be addressed?
- How will interventions that do not achieve their desired outcomes be treated?
- What would be the overall impact on the funding levels for residential care services?

## MARKET ANALYSIS

### *Equity of Access*

UnitingCare Australia is especially concerned that changes to funding mechanisms in the aged care sector do not reduce access to care for older people on low incomes, including concessional residents of aged care facilities.

Treasury projections indicate the cost of aged care to Australia will rise from 0.8 per cent of GDP in 2006-07 to around 2.0 per cent in 2046-47. This is due largely to increases in spending on residential aged care, which is projected to rise from 0.6 per cent of GDP to around 1.5 per cent in 2046-47 (Treasury, 2007, p. 53 and p. 57).

Australian government spending on health and aged care is projected to grow significantly over the next 40 years, due to the continued development of improved — but more expensive — drugs and medical technologies, with an ageing population also increasing demand for health and aged care spending (Treasury, 2007, p. 77). It will be difficult for government to fund the additional 1.2 per cent of GDP required to meet demand. All indications are that policy will increasingly shift towards self-support for older people in their health and social care, with a greater emphasis on user-pays on the basis of income and assets. However, there appears to be widening gaps between those with access to non-pension income and/or equity and those without.

Through the early years of this century there has been a disproportionate growth in the number of low income households. Vulnerable and marginalised households who, traditionally, have been excluded from home ownership through economic constraints (Yates, 2002, pp. 18-9), may make up a larger and more expensive proportion of those requiring formal care. The Department of Family and Community Services (2003) has estimated the total number of Disability Support Pension (DSP) recipients will increase by 36.1 per cent between 2001 and 2051, with the number of DSP recipients aged between 45 and 64 increasing by 54.6 per cent to 638 500. Further, as over 40 per cent of Parenting Payment customers are currently aged 30 to 40 years, they will be in the later years of their working lives or of Age Pension age when structural ageing places the greatest demand on the social security system. These people will have minimal, if any, retirement savings.

UnitingCare has a real commitment to its services and is making every effort to continue to provide care to older Australians regardless of their financial means. For example, Uniting Aged Care Victoria and Tasmania is examining options to replace facilities in areas of high land value in suburban Melbourne with developments that mix independent living units sold at market rates with care units that can be offered to concessional residents.

There is a risk of an underclass of asset-poor older Australians unable to access quality services. If current trends continue we will begin to see a pattern of older people's care access and outcomes determined by means rather than need. Traditionally, the voluntary and community sector has fulfilled a vital role in providing services to those without the resources to pay for their own care. Current funding settings are threatening the sustainability of this major social service. Privatisation of the aged care market could further increase this divide.

## ***Market Mechanisms***

Deregulation of prices and increased competition as argued by the Productivity Commission needs to be considered within the characteristics of what is the Aged Care market. There are key traits which mitigate the assumption of normal market behaviour. These traits or characteristics of the aged care service market also vary based on the level of care need an individual may require however key traits include:

- low to modest income profile for the great majority of participant in the market –which will effect price elasticity;
- increasingly limited mobility with age and frailty is a key limitation in actively participating in the market;
- limited carer support;
- the observation of the tendency towards not seeking change and remaining in the same service provider network as against change providers ( that is stay with same community provider or residential provider once placed within their program).

UnitingCare Australia recommends that deregulation of price for costs of accommodation needs to be accompanied by:

- Development of more and better financial products that enable people to save for their costs of care as they age;
- Assurance that subsidies for concessional service users keep up with the full costs of accommodation and care;
- Assurance that people will be able to maintain a decent standard of accommodation and care, as well as meet other costs of living, when they are expected to contribute to the costs of their aged care.

Competition is restricted by limited consumer access to income in retirement – 90% of people are pensioners, and there are a growing number of people entering retirement age who have little or no savings and do not own their own home.

## ***Issues Regarding Operation of the Aged Care “Market”***

A market paradigm assumes informed choice – this is not evident in a market where people are accessing services at crisis points, and for people with limited access to diverse service options (especially in rural and remote locations). For example, 50 per cent of people enter the residential care system from an acute crisis – so have almost no time and very limited choice – this reduces their capacity to exercise consumer power in the market. Added to this is the issue of price competition being limited by the low spending power of many older people – 90 per cent of people are pensioners.

Currently, the Government limits supply (including determining number of places in residential and community settings, regulation of extra services) which reduces the capacity of providers to offer and people to access diverse service options.

As noted in discussions above, levels of supply of community care impact on demand for residential care, and changes in either need to be co-ordinated and transition arrangements need to be in place to ensure continuity of care during a move to more market-based approaches.

Price is also currently set by government via the subsidy and regulatory frameworks – which means there is no flexibility for provider to offer or consumer to seek diverse service options or to have flexible arrangements for consumer contributions to accommodation or costs of care.

Such traits are of critical significance to the aged care service market and need strong consideration within the nature of market based strategies that are proposed and presumed to be effective within an aged care service context.

Uniting Aged Care VicTas can only build residential care when it is subsidised by the profits from units. While this is possible in locations where property prices support this model it is not possible where property prices are low or rental rates high. This position is common throughout all states and territories, and for all UnitingCare agencies.

Notably, agencies in certain regions will face deeper constraints due to market pressures from other industries

W.A. is entering its next mining boom which is likely to last for the next 10 to 15 years. Past experience has shown that this activity creates:

- \* A drastic shortfall in available labour as the mining and related industries absorbs available workers.
- \* Rapid growth in average weekly earnings and general labour costs due to the ability of the mining industry to attract scarce labour through price differentiation (semi-skilled workers earning between \$80,000 and \$100,000pa).
- \* Food cost increases at a rate well above inflation.
- \* Utility cost growth due to the weight of demand on scarce resources.
- \* Dramatic housing price growth due to a shortfall in supply.
- \* A significant rise in the general cost of conducting business due to too much work being available and not enough people and resources to adequately service the demand.

Implications for aged care:

- \* Shortfalls in skilled capable labour is by far the most demanding issue requiring attention. Flexible and creative immigration policies will be essential to supply skilled and unskilled workers in the caring services.
- \* Government policy settings will need to be sufficiently flexible to compensate boom States for cost structures which are well above that being experienced in the majority of States. Otherwise the needs of elderly people in that community cannot be met.
- \* W.A is already behind other States in that 2500 allocated beds have not been taken up by the sector due to the exorbitant building costs and poor income settings. This will grow to well over 3000 beds following the announcements of the current approvals round. **It takes approx 4 years to place a new residential care facility on the ground.**

## REGULATORY ARRANGEMENTS

The need for regulatory controls is not disputed – older Australians who are vulnerable and dependent on others for shelter, care and control of their finances are entitled to the highest levels of security and dignity. The current regulatory system is expensive and cumbersome and has perverse outcomes in terms of quality of life and prioritising staff time and effort. Changes in the regulatory system in the past ten years have diverted significant effort from direct care, to administration and reporting, and have reduced the capacity of services to deliver flexible care that responds to the needs of individual residents. The Regulation Taskforce (2006, p. 33) concluded that some changes to the regulation of residential care since the *Aged Care Act 1997* were ineffective, that the burden of regulation on the industry was excessive, and that duplication appeared unnecessarily costly for both providers and government.

The purpose of a regulatory system is to protect consumers and ensure accountability with minimal disruption to delivery of care. To achieve that purpose the current system requires reform. Sanctions need to be commensurate with any breaches of safety and civil rights, and facilitate improved confidence in the quality of the service system. Most people wish to be in control of their environment and should be able to influence service delivery, enabling some dignity of risk. Consumer choice should be facilitated by encouraging innovation in service provision and by the recognition of an individual's right to determine personal risk.

We note the Productivity Commission has previously considered regulation in the aged care sector in the 2009 Report on Regulatory Burden. Our response to the recommendations from this report are at [http://unitingcare.org.au/images/stories/submissions/sub\\_pc-regreform\\_agedcare\\_jul09.pdf](http://unitingcare.org.au/images/stories/submissions/sub_pc-regreform_agedcare_jul09.pdf)

### *Government role in regulation*

Our vision for regulation, compliance and administrative process reform is for government regulations and processes to support the implementation of quality social services in a cost effective manner, while outcome measures are used to ensure and evaluate the effectiveness of services in increasing quality of life outcomes for citizens.

Regulatory reform that maintains appropriate transparency and reduces the focus on process compliance over consumer outcomes would be very welcome.

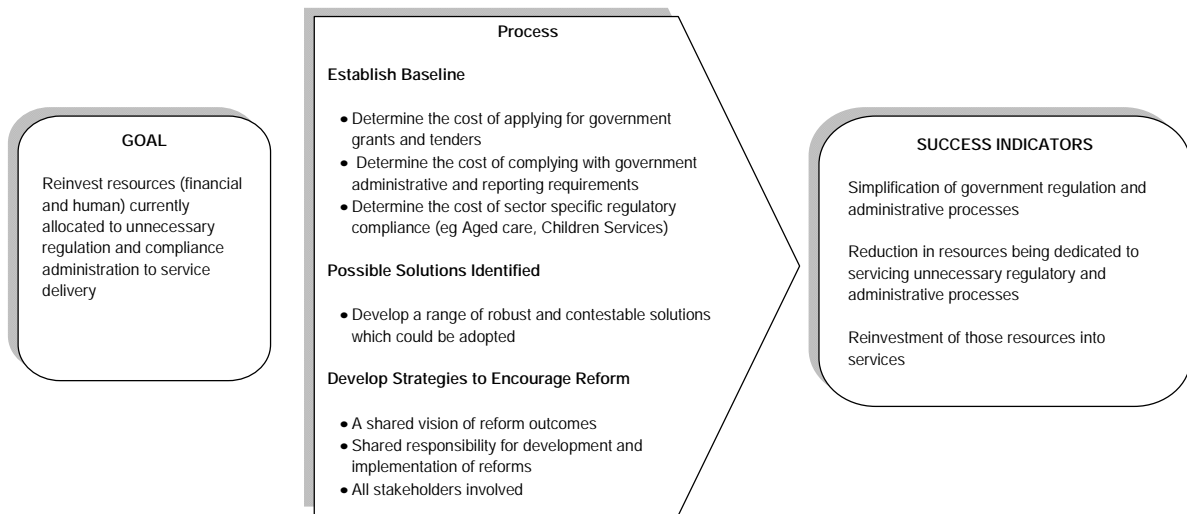
Various regulations/legislation and administrative requirements appear to ignore or underestimate the financial implications relating to the implementation of new regulations and rarely consider the cumulative impact of regulation on social services. Regulation Impact Statements (RIS) were designed to be part of the regulation/legislative development process but have not been utilised for social services. The Office of Best Practice Regulation advised that they do not keep a central Register of RIS and that they are published at the time of tabling in the explanatory materials accompanying documentation to Parliament.

UnitingCare Australia has previously welcomed the Australian Government's commitment to create a central repository, that is publicly accessible, for Regulation Impact Statements.

UnitingCare Australia has also recommended that the:

- RIS process is improved to ensure that the information contained in them explicitly considers the implementation costs on providers (or those being regulated)
- Cumulative impact of new Administrative and Regulatory processes is addressed by sanctioning of government agencies who fail to comply with the requirements of the RIS system
- RIS system be employed as part of the development of new administrative processes before changes those processes are introduced.

Outlined below is a diagram that outlines the key processes to be undertaken to achieve the productivity objective of a regulatory reform agenda.



UnitingCare Australia believes it is critical to improve current inefficient and ineffective government processes and ensure that new and existing regulations are managed in a manner that considers their impact on social service systems, processes and resources prior to implementation. This would enable reinvestment of resources away from unnecessary regulation and compliance administration and into service delivery.

***Specific issues in aged care settings***

When older people or their families complain that they are not being cared for adequately, we need a complaints resolution system that tells services and the community how substantive the problems are and how they are being addressed, and gives evidence that the services have been improved, not just sanctioned.

We need a respectful and co-operative relationship between DOHA and providers – built on recognition of the impacts of regulatory and accreditation system on service delivery and the need for significant reform in the regulatory framework that provides for funding accountability and transparency and the safety and dignity of service users, including residential care residents.

UnitingCare Australia recommends:

- Continuous improvement principles are incorporated into the planning and delivery of services, so that these services are based on sound evidence, and staff are encouraged to participate in research and development activities that seek to optimise the outcomes for older people. A critical component of quality improvement is consumer involvement in the design, management and evaluation of services.
- Services are provided with clear guidelines for identification and management of risks and clear indicators of quality of life
- Accreditation processes incorporate flexibility in compliance regimes so that services that have demonstrated consistent capacity to meet performance measures for high quality care have a level of monitoring that is commensurate with the risk of non-compliance.

The National Aged Care Alliance paper on Complaints policy and regulatory responses articulates how a continuous improvement approach to complaints could enhance service quality, and can be found at <http://www.naca.asn.au/Publications/Complaints.pdf>

UnitingCare Australia also believes that changes in regulatory requirements in other sectors could support innovation in supporting older people in their homes and communities. Two key measures in the housing and construction sector are:

- More innovation in design and improved physical accessibility of domestic accommodation
- Reform the Building Code of Australia) to incorporate the essential building certification standards and therefore eliminate the current certification assessment process

### ***Current challenges***

The workload associated with compliance with accreditation and complaints processes is not commensurate with either the level of risk or resulting improvement in care outcomes.

Accreditation by the Aged Care Standards and Accreditation Agency (ACSAA) can take up to one month to prepare per facility. The process is complicated where facilities share a single site (eg mixed high and low care residential care) where multiple accreditations are required. There are a range of agencies that may undertake unannounced visits including ACSAA, the Office of Quality and Complaints and the Commissioner of Complaints. Inspections are not coordinated and each visit requires significant staff time. For example, unannounced visits by ACSAA require at least two staff to be detached from duties for inspections. There appears to be little flexibility in the practice of scheduling reviews, meaning that senior staff will be required at short notice. There have been reports by care staff of inconsistent evidence requirements, leading to delays and rework.

Complaint resolution managed through Department of Health and Ageing represents a significant workload. For example between July and December 2007 in an organisation within the UnitingCare network that has around 950 residential beds there were:

- Four incidents of alleged abuse that were reported to the Department of Health and Ageing and to the police (who were satisfied with the investigation and processes), and in each of these cases there was no case to progress in their assessment. One hundred and four hours of staff time (at various levels) were required to ensure the organisation was able to report the matters with the appropriate information and within the 24-hour timeline.
- Another 27 matters received detailed internal investigation that identified further reporting was not warranted. These investigations required 80 hours of staff time to review within the 24-hour timeline.



Managers have expressed concern that the system is not flexible enough to allow for management of differing severity in complaints. Vexatious complaints are regarded as consuming too much time and the corrective actions required by the Department are viewed as disproportionate, for example:

- A UnitingCare site had had a complaint from a resident who was asked to wait while another resident received care. Despite agreeing at the time the resident later filed a complaint. An investigation (based primarily on discussion with the resident) resulted in the site having to undertake extensive staff training so that residents would not be asked to wait in future. This included all staff attending a one hour meeting and a one hour training session – a significant impact for a single complaint. Following on from this process, the resident was still not satisfied so phone and email updates were being given to the Department twice a week.

Complaints processes also do not allow for individual responses, for example:

- A woman with severe cognitive impairment constantly calls out that she is being molested. These allegations are not made about particular staff but the assessment of this behaviour reveals that it generally occurs following assistance with toileting. The family are aware of these allegations and have been involved in developing care plans to manage the behaviour. These allegations are in a category that can't be excluded from the reporting requirements under the Complaints Investigation Scheme, so the staff are required to make a report to the CIS every time an allegation is made – that is, several times a day. This reporting process takes significant documentation and time, and is a source of significant stress to staff who are the subject of these allegations.

The time taken to report on the outcomes of and finalise an investigation of complaints is unreasonable, and potentially reduces the capacity of a provider to improve their practice, for example:

- An incident occurred on 23 March 2009 and was reported as a complaint in June 2009, and the residential care facility is listed as being non-compliant with the Act. The service provider was advised on 22 July that a complaint investigation would be undertaken. Since then, copious amounts of information have been provided to the investigating office and even by September 2009 no information on the progress or outcome of the investigation had been given to the service provider.

## WORKFORCE REQUIREMENTS

The industry is experiencing increasing difficulties in attracting and retaining all types of staff, particularly nurses and care workers, required to deliver critical services. As part of addressing this issue, the real costs of care, including appropriate wages and conditions for care staff, needs to be established. There is also a need for continuing investment in workplace development.

In the midst of an acute national skills crisis the aged care sector is under particular pressure. It is well documented that aged care staff are paid less than equivalent staff in the acute health sector, resulting in chronic skill shortages. Addressing skills shortages requires creative thinking and long-term planning.

The shortage of care workers is impacting on the ability of consumers to access care workers who will support them to continue living at home. There are locations in major cities and in smaller towns where there are insufficient care workers who live locally who can support the care of those living in the community. Care workers are reluctant to drive long distances to provide care, especially at night and on weekends.

### *Staff Recruitment and retention*

Staff turnover is a long-standing problem with surveys of providers in 2002 identifying it as a key issue (Anglely and Newman 2002). A survey study by Richardson and Martin (2004) identified recruitment and retention as a major challenge facing aged care providers, one that would worsen in a tightening labour market. The results suggested that 25 per cent of personal carers and 20 per cent of nurses have to be replaced each year by their employer and 25 per cent expect to have left aged care employment within three years.

A recent study (Martin, 2007) suggests that job satisfaction is a powerful predictor of aged care workers' expectations about whether they will stay in the sector. He finds that aged care workers are less satisfied than the average worker, particularly on the issue of pay (26 per cent of personal carers and 29 per cent of nurses in the aged care workforce were satisfied with their pay relative to 72 per cent of the average workforce). He also identifies working arrangements (e.g. shift arrangements, opportunities for job autonomy and use of skills) as factors that significantly affect job satisfaction.

There is anecdotal evidence from within the UnitingCare network that employers are having difficulty retaining qualified staff in leadership roles in residential care, due to their reported interactions with the regulatory systems such as accreditation and validation, being a negative and demoralising experience. The extra pressure of spot checks from the agency and the complaints unit is reported to put increased pressure and stress on workers already managing high workloads and expectations and severely reduces job satisfaction.

UnitingCare organisations are attempting to become 'employers of choice' by providing flexible working conditions and a variety of programs to support our staff (e.g., child care).

UnitingCare is also taking a creative approach to training and recruitment, for example

- Uniting Church Homes (WA) is one of a number of partners working with Curtin University and the WA Chamber of Commerce and Industry to provide structured work experience to year 11 and 12 students. Successful completion of the program guarantees the students placement in the Curtin Registered Nurse course. This gives students with weaker academic records the chance to study. For Uniting Church Homes the short term benefit is that many work experience students stay on as part-time care workers during their studies, and in the long term students may chose to work as registered nurses in the aged care sector.
- Blue Care in Queensland is now one of the largest employers of indigenous trainees in the country, employing over 120 trainees.
- Frontier Services has partnered with the Bachelor Institute and the NT Department of Health and Community Services to train Indigenous nursing staff for work in remote communities. Frontier Services and its partners are providing Bachelor of Nursing courses in Tenant Creek, with lecturers coming in from Darwin, and a full time lecturer appointed in June 2007. Frontier Services further supports the initiative by providing flexible rosters and working conditions to allow staff to attend the course.
- UnitingCare Community Options in Victoria has an innovative staff training program that seeks to build the capacity of staff to understand and apply person centred care to support the care of individuals in the home. This training enhances our staff's understanding and application of a restorative approach to maintaining consumers' health and well being at home. Through an ARC funded pilot we are working with service providers, allied health and nursing providers to develop a model of care that applies these principles in practice.

The current supply of registered nurses does not meet demand, and this gap is expected to widen despite measures to increase the size and skills of the nursing workforce. The aged care sector is currently heavily reliant on registered nursing staff. However, nursing staff are comparatively expensive and time-consuming to train. In addition, there are significant challenges in attracting nursing staff to the aged care sector (including poorer pay and more regulated work than acute healthcare). These workforce challenges need to be addressed in and of themselves. However, there is also scope to meet rising demand for care and control costs of delivering care by developing new models of care that are less reliant on registered nursing.

Jurisdictions across Australia have been undertaking pilots of the 'nurse practitioner' role with a national pilot conducted from 2005 (ACT Health, 2005). The case for establishment of nurse practitioners in aged care is clear from the work completed to date. However, the models in the state-based pilots have been different and there is a need for clear national direction to move nurse practitioners from pilot to full implementation. The government should fund a systematic review of the models and evidence gathered to date, with a view to and funding the establishment of national standards and training programs.

There is a strong need for new processes to bring more staff into work and retain them. This will require new models of training that reduce the barriers to entry and allow multiple training paths. The federal government should fund the evaluation of a range of training schemes that aim to increase the number and diversity of people entering the care profession through diverse training pathways, both as registered nurses and as care

workers. The government should also commit to fully funding successful models that emerge from those pilots.

UnitingCare Australia recommends:

- Funding of pilot programmes to evaluate models of residential care that use less expensive models of care and commit to supporting those that work;
- Funding the evaluation of a range training schemes that aim to increase the number and diversity of people entering the care profession, both as registered nurses and as care workers, and .
- In the medium term, ensuring that care funding is increased to allow parity in pay for nurses between aged care and health. .

### ***Assistive Technologies***

Advocates have claimed opportunities exist in use of 'assistive technology' (sometimes referred to as telecare) to drive down the cost of care and develop more creative services. Assistive technology should in theory allow older people to remain independent for longer and reduce their dependency on care staff in residential care (Kings College, 2004, p. 2). However the use of technology in care is in its early development phase and the evidence for its impact is limited (Productivity Commission 2005b, p. 127).

Further, technology may not be available equitably across the population. The Productivity Commission (2005b, p. 163) found evidence that rates of use of some medical technologies were lower for Australians living in more socioeconomically disadvantaged areas (particularly the elderly in these areas), those residing in rural and remote areas and Indigenous people.

Uniting Care recommends that the government should fund research on the impact of assistive technology and the potential for assistive technology to improve access to choice in care settings and improves health and wellbeing outcomes. This research should focus on evaluating equity of access to assistive technologies and equity of outcomes.

## REFERENCES

ACT Health, 2005, *The Aged Care Nurse Practitioner Pilot Project (ACNPPP): Final report to the Australian Government*, ACT Government

Angley, P. and Newman, B., 2002, *Who Will Care? – The Recruitment and Retention of Community Care (Aged and Disability) Workers*, Brotherhood of St Laurence.

King's College London, 2004, *Introducing Assistive Technology into the Existing Homes of Older People: Feasibility, Acceptability, Cost and Outcomes*. Institute of Gerontology, King's College.

Martin, B 2007, 'Good jobs, bad jobs?: Understanding the Quality of Aged Care Jobs, and Why it Matters', *Australian Journal of Social Issues*, vol. 42, no. 2

National Aged Care Alliance, 2009, *Resolving Aged Care Complaints: a continuous improvement orientation for the aged care complaints mechanism*  
<http://www.naca.asn.au/Publications/Complaints.pdf>

Productivity Commission, 2005a, *Australia's Health Workforce*, Commonwealth of Australia.

Productivity Commission, 2005b, *Impacts of advances in medical technology in Australia*, Commonwealth of Australia.

Richardson, S and Martin, B, 2004, *The Care of Older Australians*, National Institute of Labour Studies.