BlueCross
community & residential services

Dear Commissioner Fitzgerald,

Re: Blue Cross recommendations to the Productivity Commission

In collating a response for the Productivity Commission, Blue Cross considered alternatives for composition. It was decided to create a 3 part submission:

- Part 1 - ***Aged Care Solutions***, focuses on the immediate imperatives and is aimed at providing workable solutions to address the current funding and service constraints which are placing significant and unnecessary strain on the industry. In some ways this becomes the Executive Summary for the Blue Cross submission.

- Part 2 - ***The future of Aged Care is in dispute. Background research on Current approaches and possible future alternative for Aged Care***, focuses on background items under all four headings of Service delivery framework, Government roles and responsibilities, Funding and regulatory arrangements and Workforce requirements.

- Part 3 - ***A précis of findings and suggestions*** is in table format for ease of reference and collates items referred to in the earlier two parts plus other dot points of relevance again under the same four headings.

  Attached after Part 3 is a draft Aged Care Transition Management tool, which is an example of how Quality of Life indicators may be used as triggers for transfer between care modalities.

We would like to acknowledge the opportunity to make this contribution and are hopeful that the strong views which will emerge from the industry will have an impact and improve the way Aged Care is delivered in Australia and in the future.

Yours sincerely,

David Eccles,
Managing Director.

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enriching *lives*

Part 1. Aged Care Solutions.

The Government has recognised the critical importance of aged care services and the need to reform them as part of its broader health and hospitals agenda. The Third Intergenerational Report reinforces that, with a growing aged population and decreasing tax base, reform is essential. If aged care is operating effectively, public expenditure on more intensive and expensive health services can be contained or even decreased. The Productivity Commission has been requested to develop detailed options for redesigning Australia's aged care system to ensure it can meet the challenges facing it in coming decades. There are significant issues that must be addressed to ensure a robust and sustainable aged care sector which effectively supports older people.

Blue Cross Community Care Service Group operates 1400 bed licences and supports1000 community care clients. Our experience has shown that the system is reasonably effective in delivering a high quality service however the current recurring funding shortfall is placing significant stress on the services that are being delivered. Critically, the best operators are achieving very poor overall investment returns whilst the majority of operators are actually losing money. This financial situation makes it very difficult to attract investment capital and is a major impediment to the future growth of the industry and the construction of new aged care facilities (and especially for high care beds). This paper provides solutions which go a significant way toward addressing this problem. If the funding shortfall is addressed we believe that the industry itself will deliver the long term solutions for our ageing community and providing Government is prepared to maintain the appropriate indexation on its funding subsidies into the future.

We are particularly concerned that the Productivity Commission's recommendations will take many years to implement and even then there is no certainty that Government will actually adopt any of the recommended initiatives. The industry requires changes to be made **NOW** which will address the financial difficulties faced by aged care operators. We strongly recommend that short term initiatives be undertaken, as summarised herein, which will provide Government and Operators with the necessary time to then introduce the appropriate longer term changes to place the industry on a stronger, sustainable footing.

The following are the key reform agenda which we believe need to be addressed as a matter of urgency:

- adequate indexation against the real costs of delivering quality care;
- capital funding initiatives which enable the building of new aged care facilities or upgrading/replacing of existing facilities to meet the ongoing demand for residential care;
- ability to provide community care hours which *adequately* support older people who choose to continue to live at home;
- initiatives to attract and retain staff – particularly nurses and care workers – to deliver care to older Australians;
- adequate technology infrastructure to take advantage of the emerging e-health system which stands to improve both productivity and clinical care for older people; and
- the move to a Social Wellness model that enhances the quality of life of clients using both community and residential service options and including services and treatment centres for clients living with dementia.

As a result of the current funding constraints, the industry is being forced to curtail important services to continue operations while still trying to provide the level of care older Australians deserve and require. Significant issues exist as follows:

- **Inadequate funding of high care residents in residential aged care.** Even after the funding review and the introduction of the Aged Care Funding Instrument (ACFI) to support people with high care needs, the subsidy/revenue has simply not matched the cost of delivering the intensive care that is needed.
- **Declining operating/investment returns, especially in residential high care.** Inadequate return to Operators means less investment is being directed to the industry and thus future older people requiring high care will not be able to find a place. Nearly 2000 residential care places were

not taken up in 2009-10 and 786 bed licences were handed back, in the two years prior, because aged care providers can't justify the financial commitment to build.

- **Declining funding in Community Aged Care.** Funding has continued to fall in real terms and this has forced operators to curtail the level of services provided. According to ACCV, on average Community Aged Care packages (CACP) previously provided 7 hours or more of support each week, but now deliver only 5 hours, despite people having increasingly higher levels of need.

Without the Government addressing these issues older people's access to these essential care services will be ever more limited. A failure to address these issues has further reaching impact on the health system and especially on the demand for hospital beds.

BLUE CROSS RECOMMENDATIONS

It is imperative to increase the overall inadequate returns to Operators to reverse the lack of new capital being attracted to the industry. If this situation persists there will be a chronic shortage of private capital funding which will have a detrimental impact on the level and availability of aged care services in the future. This is already evident in the diminished construction of high care facilities (where the community needs for residential care are the greatest).

Blue Cross believes there are a number of changes that can be undertaken immediately which will address the key problems outlined above. The main solution to the problem is to change aspects of the current funding model with the increased funding burden being directed to the Care Recipient while the Government would provide a safety net to those who don't have the financial capacity to pay for the services.

Operators must have the ability to charge Care Recipients higher fees if they have the capacity to pay for the services being offered. We believe the consumer already has significant choice of aged care services (including opting for care at home) which ensures active competition between Operators that will deliver a competitive and acceptable care fee structure. An illustration of the effectiveness of the competition that already exists is the way accommodation bonds are negotiated between the Care Recipient and the Operator without the need for a Government imposed cap on these bonds.

The biggest impediments to the industry are the current cap that exists on care fees (charged to Care Recipients), the inability to charge bonds in high care and the subsidy indexation which is consistently lower than the real cost of delivering the care services.

1. Residential Aged Care

We believe it is imperative to look at the integrated approach to residential aged care however the Productivity Commission have been requested to consider the issues relating to the delivery of ***CARE SERVICES*** and the provision of ***ACCOMMODATION***. The following provides an overview of the key issues and our recommendations on how to address the current funding shortfalls which are holding back the industry:

(i) DIRECT CARE

Direct Care services in a residential setting can be defined as the services that must be delivered in accordance with the Aged Care Act 1997, and can be broadly categorised as follows:

- ***Care Staff*** including wages, superannuation, leave entitlements, payroll tax, WorkCover, training, education, etc;
- ***Allied Health Services*** such as physiotherapy, podiatry, dietary, etc;
- ***Health Products*** such as continence aids, medical aids, lifting machines, etc;
- ***Hospitality Services*** including activities, catering, cleaning and laundry;
- ***Occupancy*** related services such as water, power, heating, maintenance, gardening, rent, ROI, property, etc; and
- ***Support Services*** including management, finance and administration.

The following provides a summary of the changes to the care subsidies which Blue Cross believes will deliver immediate financial respite to Operators and enable an increase the level of services (in keeping with those demanded from the Care Recipients).

Daily Care fee :

We recommend the following changes be undertaken to the daily care fees:
Pensioner fee maintain at current level of 82.5% of pension;
Non-pensioner fee ***Uncap*** to allow negotiation between the Care Recipient and the Operator.

Strengthening a user pays system where this cap is removed could be achieved through an extension of the same model which has already been established effectively with accommodation bonds (being negotiated between the Care Recipient and the Operator). Adoption of this principal alone would move the industry to greater sustainability and has no burden on the Government at all.

The same principles of capacity to pay and significant existing consumer choice of aged care service options (including remaining at home) will ensure active competition across the industry so that an acceptable care fee structure is maintained. Pensioners can be protected through the requirement for Operators to maintain the regional/location based ratios for pensioner/supported residents. Thus, Operators will ensure a minimum number of beds are allocated to supported residents. Ongoing concessional rates will ensure equity for those not able to take up this option and maintain social justice values within the system.

This recommendation does not require any increased funding from the Government.

Government Subsidy (ACFI) :

We recommend that ACFI be retained, but there is a need to increase the funding across each of the HIGH subsidy rates so that the maximum rate is increased to match similar service provision rates charged in acute health (the current $162.89/day is well short of returns for similar services). An immediate reform to approximately $200 would deliver greater services instantaneously.

The single biggest impediment to the provision of high care is the return in employing Division 1 nurses. The increase in funding for the highest care residents will ensure Operators allocate additional resources to the provision of specialised high care services (such as palliative care). The increased funding will allow Operators to expand their services by increasing their staff rosters, attract new staff by offering higher pay rates and undertake additional training opportunities for all staff.

This recommendation requires increased funding from the Government but solely across the three levels - ADL, BEH and CHC - HIGH subsidy rate.

Indexation:

The current COPO indexation has consistently eroded, in real terms, the funding to the industry. A new indexation methodology MUST be introduced which funds the real costs of care and is applied to all aged and community care services.

An important observation is that wage expenses (Care Staff, Allied Health, Hospitality and Support Services) comprise approximately 92% of total expenses for Blue Cross residential aged care services. Based on historical operating cost data across all its residential facilities over the past 5 years, the Blue Cross breakdown of the cost to income ratio for each of the cost categories is:

- Care Staff expenses 64.0%
- Allied Health expenses 1.0%
- Health Product expenses 1.5%
- Hospitality expenses 14.5%
- Occupancy expenses 6.5%
- Support Services expenses 12.5%

Accordingly, we recommend that all future funding indexation be linked to a wage-based index (inclusive of wage increases, superannuation, WorkCover, leave entitlements, staff-related insurance and payroll tax).

It is suggested that during design of such a methodology, an interim measure of utilizing the greater of the Consumer Price Index (CPI) or the All Groups Pensioner and Beneficiary Living Cost Index (PBLCI) to index the Federal Government's aged care subsidies be introduced.

This recommendation requires increased funding from the Government as COPO (of 1.7% for 2010/11) is significantly below the wage based cost index which, for Blue Cross, will be approximately 4.6% for 2010/11.

Extra Service Fee:

The extra service fee becomes redundant if the current Daily Care Fee cap is lifted and Operators are permitted to negotiate a daily care fee with each Care Recipient based on their capacity to pay for the services that are being offered by that Operator (much the same way that accommodation bonds are negotiated).

This recommendation does not require any increased funding from the Government.

(ii) ACCOMMODATION

The cost of building aged care facilities has almost doubled over the past 5 years in Melbourne. This is a function of increased land acquisition costs, higher construction costs and the compounding effect of higher interest expenses as a result of the higher overall development costs. Despite effective financial management, we have not been able to recoup the gap between increasing costs and decreasing revenue resulting from a capped fee structure and diminishing returns on accommodation bonds that are charged.

Considerable debate surrounds the capacity of Operators to raise capital to fund new building. Despite the ability to receive accommodation bonds in low care facilities, which has been reasonably effective in attracting capital, further amendments need to be undertaken to reverse the erosion in the returns from these bonds. However, the restrictions on accommodation bonds in high care (with the exception of Extra Services facilities) has had a significant negative impact in attracting capital to build new high care facilities.

An important factor which the Productivity Commission must take into consideration is the expected return on investment that investors seek. This is usually between 13-18% depending on the risks attached to an investment. An investment in aged care (given the growth outlook and Government subsidised income flows) would probably be deemed to be of a lower risk profile and accordingly investors would most likely accept the lower end returns of between 13-15%.

If these returns could be delivered by the industry, we would expect a significant inflow of capital, especially from the superannuation industry. Accordingly, all initiatives that are being considered by the Productivity Commission MUST lead to an increase in the return on capital invested in aged care facilities.

Blue Cross recommends the creation and adoption of a sustainable capital raising system be introduced that will attract capital from investors to the industry. The following integrated package measures should be considered:

High Care Accommodation Bonds

We strongly recommend the removal of the distinction between high and low care so that accommodation bonds can be charged across ALL levels of care (low care AND high care).

This recommendation does not require any increased funding from the Government.

Accommodation Bonds

The current system of charging accommodation bonds in low care is a well proven and effective system and we recommend that this be extended to high care as well. An important consideration is that Care Recipients have significant choice and this market competition is already delivering an accepted accommodation bond amount in low care and extra service high care facilities based on the location, age and type of facility as well as the services that are offered. There is no evidence to suggest that standard high care recipients will be disadvantaged if accommodation bonds are introduced in high care. On the contrary, we believe Operators will refocus on high care services.

There are two key components to accommodation bonds that MUST be modified to ensure the charge provides an acceptable rate of return on the cost of the accommodation. We believe the following will address the current poor returns being achieved:

(a) Permissible Interest Rate On Accommodation Bonds

The Government sets a maximum rate each quarter and it fluctuates depending on the Treasury Yield. The current rate is 8.80%, set for the period 1 Jul - 30Sep 2010. This rate is well below the rate of return expected by investors.

We recommend that the rate is fixed at 13%. This ensures the bonds deliver the desired investment return and also eliminates the volatility in earnings from the periodic payments.

This recommendation does not require any increased funding from the Government.

(b) Accommodation Bond Retentions

The Accommodation Bond retention amount is set annually by the Government and is currently $307.50/mth for 2010/11. The set retention increases have simply not matched the increase in capital costs over the past ten years. Based on an average accommodation bond of $200,000 and the annual retention amount of $3,690 this equates to a return of just 1.8%. If we assume that the Operator offsets their debt (at an average interest rate of 8.5%) from the bond proceeds then the effective return on the bonds is about 10.3%. The overall return must approach 13%.

We recommend that the retention amount be increased from $307.50 to $700/mth to catch up on the reductions that have occurred since accommodation bonds were introduced.

This recommendation does not require any increased funding from the Government.

Accommodation subsidy

We recommend that accommodation bonds be permitted in high care and thus accommodation subsidies would only apply to pensioners and supported residents who are unable to pay an accommodation bond.

Currently, the $26.88 daily charge equates to an annual return of $9,811. The current average cost to build in Melbourne (for Blue Cross) is approximately $250,000/bed. Thus, this annual fee return of just 3.92% pa equates to less than what is currently available in short term investment *doing nothing*. This is grossly inadequate and the most compelling reason why investment in high care facilities has virtually frozen.

We recommend the daily accommodation subsidy MUST increase to a minimum of $65/day to reflect the cost of accommodation for concessional and supported residents. Without an alignment between the user pays system and a subsidy payment, a sustainable balance will not be maintained. Furthermore, we recommend linking the government accommodation subsidy payment to the average cost of building residential aged care.

This recommendation does require a significant increase in funding from the Government for this component of their subsidy funding. However, on average this equates to approximately 20% of total residents in residential aged care with the remainder of residents funding their share of accommodation costs.

In conclusion, we believe these recommendations will deliver significant capital inflows to the aged care industry. Once a healthy financial return is in place, the superannuation industry will take a very positive and active investment approach to aged care, which will place far less financial strain on the Government in the future. The vast majority of the funding obligations will reside with the Care Recipient whilst the Government will provide the safety net for pensioners.

We believe that in the light of these suggested financial reforms, the industry itself will be able to deliver the care and accommodation that our communities require and are able to pay for. Importantly, these changes to the funding system will provide the impetus for Operators and Government to review the overall model of care delivery into the future. At the very least, the industry will be placed on a sounder financial footing.

2. Community Care

Planning arrangements have sought to provide 100 aged-care places for every 1,000 people aged at least 70. In recent years, provision has been expanded to reach 113 aged care places for every 1,000 people aged at least 70 by 2011. According to Department figures, over the last two decades, the planning arrangements have placed greater emphasis on community care. Moreover, all 100 places were originally residential places whereas the current arrangements, 25 out of every 113 places are community care places. Clearly, the emphasis from Government is to offer greater aged care support for people in their homes.

There is no question that care recipients have a preference to remain at home rather than move into a residential aged care home. Also, the provision of care at home reduces the government's overall expenditure as no accommodation charges apply and a lower level of care service is also provided and funded. Under the HACC and CACPs programs, care recipients receive between 1.5 and 5 hours of home care/personal care per week. The level of care is increased with the EACH and EACHD programs.

The HACC and CACPS programs are economically and socially rational whilst the care levels are low, but as the care needs increase in frequency and with the need to provide additional associated services - such as meals, medication management, allied health, community activity assistance, shopping and visit to doctors, etc - then the cost to provide the service becomes prohibitive.

There is a significant gap between funding and care needs for recipients receiving CACP and EACH packages. We would like to suggest a middle layer for people with increasing needs. This would allow for a similar system to, and the same flexibility of, the "ageing in place" model in residential. Inbuilt flexibility of entry to, and exit from, packages would enhance efficiency, effectiveness and appropriateness of care delivery. This is true for level of care as well as age.

In addition, other non-financial issues need to be taken into consideration. The assessment needs vary significantly between programs. We would recommend streamlining and unifying this approach. Expanding the ACAS role may be a way of achieving this, especially if associated with the co-creation of regional hubs for information, assessment and referral.

Community Care Service Provision

The services associated with the delivery of care to a recipient's home are extensive and include the following:

- Case Management
- Care Planning and assessments
- Care provider co-ordination
- Carer services – home, personal, nursing, maintenance, shopping, travel
- Care provider training and education
- Administration
- Financial audit

As the care needs increase, there is also a corresponding increase in case management involvement, care plan assessments and co-ordination of increased staffing resources.

Community care costs are almost exclusively service based including the cost of wages for direct care delivery only. Accordingly, the funding must be aligned to wage cost increases (inclusive of superannuation, leave entitlements, WorkCover, payroll tax, insurance). Unfortunately, the funding has not matched the increases and this has led to a reduction in the direct hours of care services delivered.

We strongly recommend that the current funding acknowledge the infrastructure costs of providing packaged care and be increased by 20% to enable a closer match between funding and the cost of care so that the level of direct care provision better meets existing client needs.

Additionally, we recommend that future funding be increased in line with a wage based cost index.

We also support ACCV's recommendation for the creation of one community care program (through the merger of HACC, CACPs, EACH and EACHD) under the jurisdiction of the Commonwealth Government. We do however feel it is important to note that in so doing, we strongly urge the Government to maintain a balance of allocations of any homogenised funds between the private and public sectors.

3. Other Initiatives

Staffing

The most effective way to increase workforce participation in aged care is to increase the rate of take home pay for all staff. This can be achieved through two means: (1) raising the rate of pay, (2) introducing the same tax savings of salary packaging and payroll tax benefits uniformly across the whole industry. If funding is increased in accordance with recommendations summarised in this paper, aged care operators such as Blue Cross, would be in a position to offer increased effective wage rates to all staff.

Any wage review needs to be coupled with comprehensive education and training programs especially with students and young workers. The hidden costs of recruitment and retention are significant for aged care providers as workers are lost to the industry. Blue Cross recognises the importance of maintaining a skilled and satisfied workforce and although an existing significant education and training program is provided, it is often the case that staff leave having gained these skills, to work in other areas of the industry returning them better pay in their hand.

Increasing staff satisfaction would leave to better retention and a lessening of the current burden of recruitment. This would add a further benefit for the industry, however there is a critical need to attract younger workers into the industry.

Volunteers are sometimes expected to significantly self-fund contributions to providing service. A generous offer to attend a client need, may be associated with costs which are not reimbursed, making the provision of services unattractive and forcing people to retract offers. We would like to recommend consideration of tax breaks, fully funded training, etc to relieve this situation and encourage recruitment in this area.

Technology

The current burden of documentation is significant. The introduction of technology is having a negative effect on the ability to retain workers who are not computer literate. A move to affordable voice activated software, which satisfies legislative requirements, would be of assistance. Undertaking some early work with regard to electronic signatures would better position the industry for further rollout of computerised solutions.

Remote monitoring and review of clients, whilst not replacing direct contact, can provide reassurance and safety. Assistive devices and prompts for clients with dementia, alert buttons which notify ongoing client functioning, or notification of a fall, etc, video surveillance are exciting opportunities for future development.

Government initiatives to review polypharmacy and medication conventions in aged care would have a positive impact in two ways – decrease consumption of the MBS, decrease burden on the medication gap support, decrease time taken by GPs to subscribe and review medication charts and nurses to administer.

We concur with ACCV who recommend further investment in the development and deployment of electronic medication management solutions for aged care, initially targeted to residential care. This would require a total of $59m over the 2010/11 and 2011/12 financial years. Further investment would be required in the following three years.

CONCLUSION

Because of its unique position in providing services in both residential and community aged care, Blue Cross has taken a whole of industry approach to recommendations and initiatives. We have acknowledged that funding and human resources are the items which can undo the industry. We have detailed ideas on combining increasing elements of government funding with user pay contributions.

Fundamental in our argument for residential is the demonstration of improved investment returns. This outcome will strengthen and widen attraction of long term capital by other stakeholders, in the form of superannuation and other wealth products. Review of care services and access to accommodation bond flows will further contribute toward building new residential aged care facilities, with a willingness to adopt a greater focus on high care beds.

Community care requires establishment of a quarantined proportion of care delivery fees to account for the significant infrastructure implicit in planning and delivering care to clients in their homes. The existing gaps between programs need to be re-negotiated to apportion equity. Streamlining of access, assessment and funding streams would enhance access and portability for clients.

Blue Cross is committed to the provision of quality aged care and is hoping that the proposed government reform will deepen involvement by residents, clients and staff in this rewarding industry.

Part 2 - The future of Aged Care is in dispute.
Background research on Current approaches and possible future alternative for Aged Care

Many existing theories are being significantly revised as technology impacts markedly on previously assumed lineal progression. Calculation of quality life years and morbidity of chronic disease are under rapid review. The bell distribution has changed to a "vase" configuration as the proportion of older Australians expands disproportionately to expectations. Age and onset of disability have lengthened in a world rapidly changing in reality.

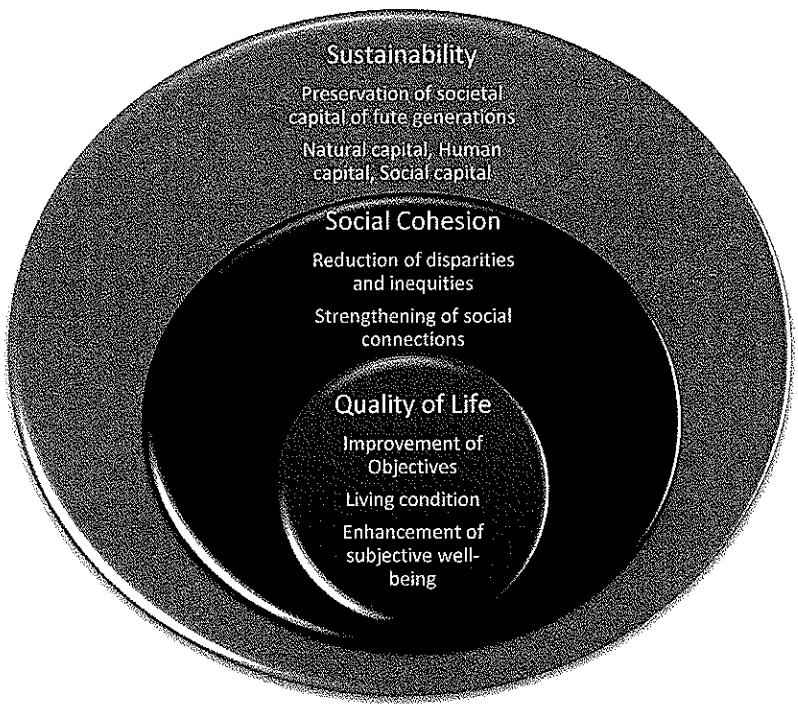
The catch cry of "60 is the new 40" is no more evident than in Aged Care as we have seen a move of entry age. It is anecdotally agreed that typical residents entering residential services are increasingly frail and requiring greater service demand. This move may have been in part created by the general mistrust of the aged care residential industry by the general population (a view that is fuelled by repeated, sensationalized negative media coverage), the recent significant injection of funds to grow and support the community arm of the industry and a culture which struggles with the notion of respect for ageing.

Service delivery framework

Current approach

Most Aged Care organisations are silo-istic in their approach to care delivery. Even those organisations with different arms of service, have difficulty merging the boundaries. Some of these difficulties have been established by competing in the same marketplace, prejudicial community perception, single focus of funding, inability to find staff who can move between genres.

Blue Cross has recently embarked on a "person centred" approach to providing aged care within residential accommodation. This framework includes a holistic approach to gleaning, understanding, honouring and incorporating past life experience and preferences, into current and future life choice options, where individual needs are fully incorporated into service delivery in whatever guise, ensuring quality of life for all involved. Training for key staff has been undertaken and a complete documentation set has been established and is being implemented within an electronic document package (AutumnCare).



Future approach

Although much care is currently delivered in the client's home and is propounded as the way forward, this imposed social isolation has been recognized as a possible contributor to an increase in the onset of depression, increasing frailty and an inability to meet personal survival needs. Division of the elderly to the confines of their own home with only a brief visit daily by a care provider seems to be a narrow approach to future care. As has been proven in research in orphanages, without touch the very young do not survive, is it too much to suggest that without these same social verifications of existence that this phenomenon may also happen in the isolation of living alone as a disempowered aged person?

In our experience, often after 3 months of residential care, residents are happier, more socially connected, feel more secure, are in an improved nutritional state and have had the impact of chronic conditions minimized. Stress levels dissipate in a supporting environment focused on wellness, respect and dignity of individual validation. If we agree to consider bringing these positive residential attributes to the provision of community care, we can embrace notions of change in service delivery.

A change in the model of care delivery is required to ensure sustainability into the future. Identification of the need for social interaction and improved physical functioning could therefore benefit by some transactions occurring in a social situation. To support this transition, Blue Cross would like to suggest a "Third Generation Hub model". As sites are re-developed or acquired, it would appear to be advantageous for the co-establishment of

- residential and respite accommodation (catering to the widest population – supported accommodation, low care and high care licences);
- day activity areas for access by those already living on site and in the community who would benefit from this social interaction (it may be possible to add value by including personal care (showers, dressing and laundry assistance, paid for on an as needs basis),
- access to meeting rooms for external groups, gymnasium, – all constructed within a user pays framework.
- kitchen, men's workshop, women's craft area and worship centre, a community hub, short term accommodation for resident's loved ones, hairdressing salon, kiosk, café & bar, private dining room, library, television and video theatre, music lounge, chapel, men's shed, kitchenettes with tea/coffee making facilities, resident laundry, physio room, visiting practitioner's room and activity & function rooms for use by residents, relatives and friends.
- quality allied health services including physiotherapy, massage, podiatry and complimentary therapies, provided by qualified professionals who have a service agreement with Blue Cross.
- strategically placed quiet areas. External features could include a BBQ area, garden walks, vegetable gardens, courtyards, outdoor protected areas and attractive garden seating.
- Location on residential sites ensures the capacity to incorporate dementia friendly principles, which incorporate sensory approach and secure outdoor area, based on a theoretical exploration and research of best practice, evidence based dementia care and building design.

The benefits of moving to this design is immediately obvious for all as it enhances Quality of Life for community members by offering subjective involvement in a supported environment, focussed on improving mental and physical functioning. A "business centre", with access to computers and internet, will facilitate new interests and support life long learning, enhancing mental capabilities.
This model ensures the inclusion of 24 hr on site staffing by a Division One nurse, thereby supporting any required clinical decision making ability.

Blue Cross would propose developing an Aged Care transition measurement tool which contains algorithms and triggers aimed at identifying the path through the maze of aged care. We believe there is a substantail body of knowledge on which to base this tool (A suggested first draft is attached. It is an excel document which would populate with numbers for wellness or incapacity depending on answers. We would be happy to discuss in further detail). It is hoped that this objective approach would take the guessing out of appropriate recommended navigation through each level.

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- access to meeting rooms for external groups, gymnasium, – all constructed within a user pays framework.
- kitchen, men's workshop, women's craft area and worship centre, a community hub, short term accommodation for resident's loved ones, hairdressing salon, kiosk, café & bar, private dining room, library, television and video theatre, music lounge, chapel, men's shed, kitchenettes with tea/coffee making facilities, resident laundry, physio room, visiting practitioner's room and activity & function rooms for use by residents, relatives and friends.
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Blue Cross would propose developing an Aged Care transition measurement tool which contains algorithms and triggers aimed at identifying the path through the maze of aged care. We believe there is a substantail body of knowledge on which to base this tool (A suggested first draft is attached. It is an excel document which would populate with numbers for wellness or incapacity depending on answers. We would be happy to discuss in further detail). It is hoped that this objective approach would take the guessing out of appropriate recommended navigation through each level.

Government funding is currently rigid and program focused. Organisations require complicated finance packages to track and reconcile funding in and out of ledgers. Clients fear ceasing hard won services for fear of loss. Rigid parameters are set with no possibility of negotiation.

Assertions of growing affluence are being disputed by the incongruence of the current level of home ownership against a backdrop acknowledging that Gen Y may be the first generation in Australia where home ownership is not attainable for a growing proportion of that population. Are we making the same misconceptions of extrapolating past trends into a future that is no longer longitudinal in expectation or trend analysis? Are we basing the extension to community service provision on the presumption that the aged will continue to own their own home, thereby establishing infrastructure at no cost to either Government or the industry? What will happen when the growing aged can no longer fund rents which are due to home owners? What are we doing to prepare for a growing number of people with depleted superannuation and personal wealth?

Significant dollars are spent by industry providers to satisfy Accreditation and legislative requirements and ensure compliance. The current system is laborious and microscopic in its approach.

Future approach
Indicators of success are integral to a well balanced, quality system. The industry must mature in its approach to setting standards and ensuring excellence for consumers, however the approach must be simplified.

Funding streams must be broadened to encapsulate resources to meet client and resident need. Some European countries have introduced insurance processes to accumulate funds for the cost of providing accommodation in aged care and maternity leave for pregnant women. With the projected changes on the horizon, these may be new and novel approaches for Australia.

Workforce requirements

Current approach
There is strong competition for health workers from other parts of the health system. The competing arms within the health industry offer enhanced conditions, better pay and are seen as more socially acceptable. The young no longer enter a profession as a long term career. Financial return is an imperative. Engagement in work is now strengthening as a two way street, which requires increasing personal development and a sense of worth from the employer to the worker.

The same medication and life enhancement technologies which are having an impact on aged care consumers will further extend the quality of lives for staff members and retirement age will increase as wellness and productivity last past historical ages. This same paradigm may have an implication on long service leave and superannuation payments as these workers retire. Consumption of aged care will start later and later in lives and longevity will be accompanied by increasing physical and mental ability.

Future approach
Financial remuneration for aged care workers is reviewed. Aged Care is seen as an industry which makes a difference and contributes to the social health of the community. Fun can become apparent in a workforce focused on improving the quality of life rather than the number of showers to be done this morning.

As an industry, Aged Care moves away from the medical approach of delivering care, to a wellness model where task orientation is replaced by holistic considerations and a focus on recuperative and restorative practices. A path for transitioning skill mix and requirements is set in place to allow more efficient and effective team approaches to delivering care, further supported by care technologies. Clinical supervision is offered remotely by cohesive, well informed staff members.

Current rosters are re-modelled to better deliver care to the wishes of the residents and allow more flexibility for staff, thereby better delivering a work/life balance necessary to sustain meaningful family life.

Part 3 - Précis of Blue Cross Findings and Suggestions

Item	Current approach	Future approach
Service Delivery framework		
Entry Assessment	• Varying assessment requirements between programs.	• Refine method using newly developed Aged Care Transition Measurement Tool (ACTMT) which contains algorithms and triggers to identify an objective path through the transitional maze of aged care.
Ongoing care delivery	• Fragmented. • Often clients hold onto packages for fear of loss if terminated.	• ACTMT identifies changes in care needs and suggests appropriate, objective transition from client perspective. • Streamlined service system to allow improved navigation through the maze
Care packages / licences	• Alignment to geography based on dated assumptions, sometimes out of synch with requirements.	• Flexibility of funding to swap between areas with over or undersupply – programs, geography, acute health/aged.
Funding alignment	• Misalignment between care needs and funding of different programs	• Improvement on residential "ageing in place" model to explore applicability of similar model to community (transfer funding between programs and packages)
Funding appropriateness	• Limitations of program specific services	• Innovation in service delivery – ability to vary purchasing - adding or subtracting modules as required
Location appropriateness (service delivered "at home" or as part of residential suite of service provision	• Clear delineation between community package delivery and residential service provision does not allow for sharing of resources	• Third generation hub around residential services and support of 24 hour on call nursing • Development of more cost effective community focused services at this central location • May include assessment, care planning and innovative program delivery • This model offers wide variety of programs while providing social interactions
Quality of service provision	• Various accreditation bodies	• Development of standardised Key Performance Indicators and reporting requirements across programs

Item	Current approach	Future approach
Community funding	• No recognition for administrative costs implicit in care planning and service delivery (potential to further undermine if move to client held funds with focus only on service delivery costs is introduced) • Anomaly in fees for delivery of like services between programs	• Seamless provider margin is invisible to user by development of appropriate administration cost inbuilt into service provision fees (to ensure ongoing financial viability of service provider and ability to meet documentation requirements) • Fees are reviewed and reasonable rates (see above) are standardised across programs
Government roles and responsibilities		
Funding fragmentation	• Especially in Victoria where local council is fund holder for HACC	• Review and standardization of role of Government in funding, regulation and providing
Building design	• Care at home limited by home access in the community	• Government building regulations suggest preparing for aged care to influence design • Align retirement villages, supported accommodation so that care delivery can be extended to meet needs without change in domestic arrangements.
Alignment of income and expenditure	• No alignment between cross department costs and savings	• Support review of current practices with transfer of funds saved to provide direct aged care service provision. Decrease impact of cost of govt funding of: o medication usage through MBS o acute health hospitalization
Workforce requirements		
Portability of employment	• Division between private and public sector and the anomaly between benefits	• Review the system and offer fair incentives for both arms of the industry – community and residential; private, government and not-for-profit • Suggest portability of employment benefits between all employers
Flexibility of employment	• Predominance of shifts to suit organisations/ established practice	• Review pay rates based on historical hospital system to better meet current move to client/resident focus

Item	Current approach	Future approach
Documentation requirements	• Limited English and computer literacy affect the ability of good workers to provide care documentation	• Fast track review of legislation around data gathering and electronic signature • Establish voice activated/log in codes as suitable signature to allow expansion to new technology • Review breadth of requirements
Role of volunteers (ability to self fund)	• Reducing ability to attract volunteers who have the time and the ability to self fund these positions	• Ability to offset reasonable costs associated with requested service, so that time and labour are the only contributions required of the volunteer
Assistive technology	• Focus on negatives is sometimes seen as an enabler to isolate clients in their own home by providing warnings	• Move to social possibilities of technology and encourage development of free VOIP video/audio links between aged persons and family members/care providers
Reform options and transitional arrangements		
Cultural change	• All incidents seen as negative • Media focus on negatives is punitive and does not show aged care in good light • Little respect paid to the ageing. Focus on eternal youth	• Acceptance of calculated risks for autonomy and expression of choice of healthy ageing • Provide incentive to encourage equal time for good news stories in media • Regard for long life/maturity. Acceptance of death and dying

Attachment: Aged Care Transition Measurement Tool (example only)

This tool is designed around Quality of Life Indicators as an example of an objective evaluation to manage care needs safely. It could be used for all clients seeking care to identify degrees of service provision. The intent is to score functionality across this spectrum of self care and rate according to wellness and capacity.

It is proposed that further refinement of a tool based on this premise could deliver percentages of wellness indicating, for example:

>95%	able to self care independently
85 – 95%	able to self care with minimum support (1/2 hr – 1 hr 3 days per week)
75 – 85%	able to self care with medium support (up to 2 hours 7 days per week)
65 – 75%	able to self care with maximum support (more than 2 hours 7 days per week) OR some need for supervision and support (consider ILU)
55 – 65%	need for low level supported residential support (consider low care)
<55%	need for high level supported residential support (consider high care)

Undertaken for:

Score:

on:

Biological factors	Please insert "1" in the appropriate boxes below Yes	No	Wellness / Incapacity Possible score	
Cognition			10	-10
The client had been notified of the meeting			0	0
The client showed readiness for the meeting			5	0
The client is orientated to time			1	-2
The client is orientated to place			1	-2
The client is orientated to person			1	-2
The client exhibits appropriate short term recall			1	-2
The client exhibits appropriate long term recall			1	-2
Functioning			10	-10
On arrival, the client is well dressed and presented			2	-2
There is evidence the client can attend to dressing/undressing care needs			2	-2
There is evidence the client can attend to showering/grooming care needs			2	-2
There is evidence the client can attend to personal hygiene care needs			2	-2
There is evidence the client can attend to food preparation needs			2	-2

Symptoms			**5**	**-5**
The client has no medical condition/s			5	0
The client self-manages medical condition/s			0	-2.5
No functioning is compromised by any medical condition/s			0	-2.5
Treatment			**15**	**-15**
The client requires no access for medical condition/s treatment			5	-5
Accessed treatment is received in a timely manner			5	-5
Accessed treatment improves functioning			5	-5
Self realisation				
Leisure and interests			**20**	**-20**
The client has interests or undertakes leisure activities			5	-10
These interests occur at least daily			5	0
These interests occur between 3 times per week and weekly			4	0
These interests occur between weekly and twice monthly			3	0
These interests occur between twice monthly and monthly			2	0
These interests occur less than monthly			1	0
These interests enhance wellness for this client			5	-5
These interests are pursued outside the abode			3	-5
If yes, the client can access required transport to attend these interests			2	0
Work, contribution to others			**20**	**-20**
The client contributes to the wellness of others			5	-10
This involvement occurs at least daily			5	0
This involvement occurs between 3 times per week and weekly			4	0
This involvement occurs between weekly and twice monthly			3	0
This involvement occurs between twice monthly and monthly			2	0
This involvement occurs less than monthly			1	0
This contribution enhances wellness for this client			5	-5
This contribution is pursued outside the abode			3	-5
If yes, the client can access required transport to attend this contribution			2	0
Family/friend involvement			**15**	**-15**
The client receive visits from family / friends			5	-15
These visits are at least daily			5	0

These visits are between 3 times per week and weekly			4	0
These visits are between weekly and twice monthly			3	0
These visits are between twice monthly and monthly			2	0
These visits are less than monthly			1	0
The average duration of these visits is more than an hour			5	0
The average duration of these visits is between 30 mins and one hour			3	0
The average duration of these visits is less than 30 mins			2	0
Community involvement			**10**	**-10**
The client undertakes outside excursions			5	-10
Outside excursions occur weekly			5	0
Outside excursions occur between weekly and twice monthly			4	0
Outside excursions occur between twice monthly and monthly			3	0
Outside excursions occur less than monthly			2	0
Social support			**10**	**-10**
The client does not require outside support			10	-10
Required outside support is received from family / friends			0	10
Support from family / friends is completely adequate for needs			0	-5
The client demonstrates acceptance of outside service support			0	-5
Emotions			**10**	**-10**
The client can describe a recent happy event			10	0
Unhappy events are mentioned frequently in conversation by the client			0	-10
Spiritual / religious beliefs			**20**	**-20**
The client has a spiritual belief			10	-10
The client has a general belief that all is well			10	-5
The client expresses a distrust of the world			0	-5
Possession				
Shelter			**20**	**-20**
The client lives alone			10	-10
The client owns the abode in full			5	-5
The client is able to fund the abode (rent or mortgage)			5	-5
Environment			**15**	**-15**
The abode is clean and tidy			5	-5

The abode is well maintained	☐	☐	5	-5
Conditions in the abode allow for delivery of current care requirements	☐	☐	5	-5
Suitable heating is available	☐	☐	5	-5
Suitable cooling is available	☐	☐	5	-5
The temperature of the abode is appropriate for the conditions of the day	☐	☐	5	-5
Provisions			**15**	**-15**
Fresh food is available	☐	☐	5	-5
All food items are stored appropriately	☐	☐	5	-5
There is evidence that appropriate food has been consumed recently	☐	☐	5	-5
There is evidence of left overs from a recent meal	☐	☐	5	-5
Finance			**15**	**-15**
There is evidence that the client is financially secure	☐	☐	5	-5
There is evidence of recent purchases - food, toiletries, clothes.	☐	☐	5	-5
Appropriate services are connected to the abode	☐	☐	5	-5