CATHOLIC HEALTH AUSTRALIA

SENATE COMMUNITY AFFAIRS REFERENCES COMMITTEE

INQUIRY INTO AGED CARE

6 AUGUST 2004

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The Secretary
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The Catholic health, aged and community care sector

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Dear Secretary

Please find attached Catholic Health Australia's submission to the Inquiry into Aged Care.

CHA has responded to several aged care inquiries over recent years which also address our position on these issues. As this Inquiry was limited to a few select terms of reference, this submission is not a definitive position from CHA on aged care issues. As such, CHA would welcome the opportunity to appear before the Committee to discuss aged care issues in more detail. Inquiries about this submission are welcome and may be directed to Margaret Deerain, Manager Policy and Research at:

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Yours sincerely

FRANCIS SULLIVAN
Chief Executive Officer

Catholic Health Australia – Background

Catholic Health Australia (CHA) is the largest non-government provider grouping of health, community and aged care services in Australia, nationally representing Catholic health care sponsors, systems, facilities, and related organisations and services.

The sector comprises providers of the highest quality care in a network of services ranging from acute care to community based services. These services have been developed throughout the course of Australia's development in response to community needs. The service providers carry on centuries-old traditions of bringing Christ's healing ministry to those who suffer – the ill, the disabled, the elderly, the disadvantaged, the marginalised, the poor, serving those that others with a profit motive do not. The services return the benefits derived from their businesses to their services and to the community; they do not operate for profit; they are church and charitable organisations.

The Catholic health and aged care ministry is broad, encompassing many aspects of human services. Services cover aged care, disability services, family services, paediatric, children and youth services, mental health services, palliative care, alcohol and drug services, veterans' health, primary care, acute care, non acute care, step down transitional, rehabilitation, diagnostics, preventive public health, medical and bioethics research institutes.

The Sector Snapshot

Over 17,500 residential aged care beds
5326 independent living and retirement units
over 8,000 community care packages (CACP, HACC and EACH)
65 hospitals
9,000 hospital beds
45 privately funded hospitals
20 publicly funded hospitals
7 teaching hospitals
8 dedicated hospices and palliative care services
17 rural and regional hospitals
157 rural and regional aged care services

The Catholic health, community and aged care ministry is defined by these interrelated foundational principles:

Dignity: Each person has an intrinsic value and inalienable right to life. Everyone has a right to essential comprehensive health care.
Respect for Human Life: From the moment of conception to natural death, each person has inherent dignity and a right to life consistent with that dignity.
Human Equality: Equality of all persons comes from their essential dignity. While differences are part of God's plan, social and cultural discrimination in fundamental rights are not part of God's design.
Service: Health care is a social good. It is a service, not a commodity used for maximising profit.
Common Good: Social conditions should allow people to reach their full human potential and to realise their human dignity. Equitable access to care, developing research and training, and conducting professional inquiry into the social, ethical and cultural aspects of health, builds social conditions and communities that respect human life and allow people to realise their potential.
Association: Every person is both sacred and special. How we organise society – in economics, politics, law and policy – directly affects human dignity and the capacity of individuals to grow in community.

Preference for the Poor: Priority must be given to the needs and opportunities of the poor and disadvantaged. This encompasses economic, cultural and individual notions of poverty and disadvantage.
Stewardship: Health resources should be prudently developed, maintained and shared in the interests of the community as a whole and balanced with resources needed for essential human services.
Subsidiarity: The identified needs of individuals and the community are best addressed at the level where responses and resources are available, appropriate and effective.

The Terms of Reference for the Senate Community Affairs References Committee Inquiry into Aged Care are outlined below.

(a) The adequacy of current proposals, including those in the 2004 Budget, in overcoming aged care workforce shortages and training.

CHA is aware of several recent initiatives which go some way to address workforce shortages and training needs in the aged care sector. In particular, the 2004-05 Federal Budget included a $101.4 million package over four years for:

- 400 additional undergraduate higher education places in nursing in 2004-05 (growing to 1,094 places over four years), allowing 1,600 more students to commence nursing studies over the next four years;
- up to 15,750 aged care workers over the next four years to obtain or upgrade their qualifications, up to Enrolled Nurse level;
- up to 5,250 Enrolled Nurses over the next four years to obtain training in medication management; and
- up to 8,000 more aged care workers over the next four years to be assisted through the Workplace English Language and Literacy (WELL) program to improve their literacy and language skills.

The Commonwealth has also been developing a National Aged Care Workforce Strategy.

CHA has welcomed these initiatives as they demonstrate that there has been a recognition of the potential crisis in the aged care workforce and some priority given to putting in places strategies and measures that will go some way to addressing aged care workforce issues.

In Professor Warren Hogan's *Pricing Review of Residential Aged Care*, it was acknowledged that the residential aged care sector faces significant workforce issues that need to be addressed as a matter of priority. The *Pricing Review* identified:

- The general shortage of trained nursing staff, which is greater in the residential aged care sector than in other areas of the health system;
- Specific barriers to recruitment, retention, and re-entry to the aged care workforce (which include wage parity, working conditions, lack of education and career opportunities, poor image and lack of appreciation of skills);
- The ageing of the aged care nursing workforce;

- Differences between the states and territories in the regulatory frameworks governing training, medication management and employment conditions; and
- The changing profile of consumers of residential aged care services, with its implications for the nature and extent of the demand for future services and the composition and skills mix of the workforce.[1]

As part of the overall recommendations made in the *Pricing Review*, the specific workforce recommendations included:

- The Government should increase the number of registered nurse places at Australian universities by 2,700 over the next three years, with 1,000 first-year places commencing in the 2005 academic year.

- The Australian Government should support aged care providers to assist at least 12,000 enrolled nurses to complete medication management training, 6,000 aged care workers to complete a Certificate Level IV qualification and 24,000 aged care workers to complete a Certificate Level III qualification by 2007-08.

Clearly the Government has chosen to adopt some components of the Hogan recommendations and expand on them while others have not been addressed to the same level as was recommended in the *Review of Pricing Arrangements in Residential Aged Care.*

While CHA has welcomed the Budget measures to improve the capacity to train and increase the skills of the existing and potential workforce, CHA remains concerned that the recurrent funding subsidy in aged care is not keeping up with the real costs of providing quality care. It is this issue which is the major structural impediment to addressing aged care workforce shortage issues. CHA's submission to the *Review of Pricing Arrangements in Residential Aged Care* stated:

> Quality aged care services can only be achieved through adequate funding that provides for quality staffing. The Commonwealth government must develop a model of funding (mutually agreed by all stakeholders) that reflects the real costs of recruiting, training and maintaining sufficient staff to achieve quality outcomes). The issues of achieving and maintaining wage parity for all staff working in aged care with their public hospitals counterparts must be urgently addressed. The increasingly complex care needs of residents requires skilled nursing staff. The shortage of registered nurses in aged care is exacerbated by the wage differential. Residential aged care facilities located near acute hospitals are especially disadvantaged by the differential.[2]

The issue of adequate funding in the sector to meet these real costs of recruitment, training and maintaining staff remains an issue of concern. In fact, the increased availability of training options, while having significant benefits, may also have the effect of increasing costs to providers as they back-fill positions while people are in training. This is particularly an issue for providers in rural and regional Australia. While CHA

[1] Hogan, W.P. (2004) *Review of Pricing Arrangements in Residential Aged Care*, chapter 11.
[2] Catholic Health Australia, (2003) *Submission to the Residential Aged Care Pricing Review.* P 15.

welcomes the 2004-05 Budget initiative to fund a "conditional adjustment payment" of 1.75% in addition to the Commonwealth Own Purpose Outlay (COPO), this increase does not address the costs associated with training and maintaining high quality staff. The wages gap between nurses working in aged care and their public hospital colleagues for example is currently about $170.00 per week.[3] It is clear that the conditional adjustment payment will not be adequate to address wage parity issues.

It will also not be adequate to meet general wage increases. As an example, in Queensland, Award wages are set to increase by an average of 3.5% (4.2% for those on the minimum wage) on 1 September 2004. Given that 80% of Aged Care Provider costs are staff costs, the additional funding will quickly be absorbed by basic wage rises. It becomes very apparent that the conditional adjustment payment, while welcome, it not going to give aged care providers the capacity to provide real additional financial incentives for their care and nursing staff to remain in the sector.

CHA also remains concerned that most of the measures to address workforce and skill shortages have concentrated on the residential aged care sector and little attention has been given to the growing area of community care. CHA believes there would be greater merit in bringing together the strategic workforce issues affecting all aspects of aged care. this would provide a more comprehensive and coordinated response which would address residential and community care together with geriatric care in the acute sector.

Recommendations

1. That recurrent funding in aged care include an indexation factor which recognises the real costs of providing care and enables wage parity in the sector; and

2. That a more comprehensive and coordinated response be developed by the Government to address the strategic workforce issues across residential, community care and with geriatric care in the acute sector.

[3] Australian Nursing Federation, 2004, *Nurses Paycheck,* 3(3) June-August 2004.

(b) The performance and effectiveness of the Aged Care Standards and Accreditation Agency in:

- **(i) assessing and monitoring care, health and safety,**
- **(ii) identifying best practice and providing information, education and training to aged care facilities, and**
- **(iii) implementing and monitoring accreditation in a manner which reduces the administrative and paperwork demands on staff.**

The Aged Care Act 1997, Part 5.4 is about making accreditation grants. Section 80-1 provides for the Commonwealth to enter into a written agreement with a body corporate under which the Commonwealth makes grants of money for that body to undertake accreditation of residential care services in accordance with the Accreditation Grant Principles and any other purposes specified.

The Accreditation Grant Principles identify the Aged Care Standards and Accreditation Agency as the body corporate to whom the accreditation grant is paid to carry out the following functions:

(a) managing the accreditation process using the Accreditation Standards; and
(b) promoting high quality care, and helping industry to improve service quality, by identifying best practices and providing information, education and training to industry; and
(c) assessing, and strategically managing, services working towards accreditation; and
(d) liaising with the Department of Health and Ageing about services that do not comply with the standards applicable to them.

The Accreditation Standards are set in Schedule 2 of the Quality of Care Principles 1997. The Standards are set out in four parts and 44 Expected Outcomes:

- Part I - Management Systems, staffing and organisational development. This Part contains nine Expected Outcomes; and
- Part 2 – Health and personal care; 17 Expected Outcomes; and
- Part 3 – Resident lifestyle; 10 Expected Outcomes; and
- Part 4 – Physical environment and safe systems; eight Expected Outcomes.

Three of the 44 Expected Outcomes are identical across all four principal standards, these are:

- Continuous improvement; and
- Regulatory compliance; and
- Education and staff training.

The Accreditation Grant Principles set out that all residential care services must be accredited against, and monitored for compliance with the Accreditation Standards. The key roles of the Agency with respect to its performance of this part of its charter are to accredit and monitor compliance with the standards not "assess and monitor care, health and safety."

Due to the more rigorous requirement in round two for Assessors to have evidence of Non Compliance, services found that the process was fairer and more balanced. The Agency's approach is one of principally focusing on examining the systems and processes that each approved service has in place to demonstrate that they meet each of the Expected Outcomes. As these Outcomes are expressed in generalised terms, assessment of compliance must, as a requisite, involve subjective elements of judgement.

Herein lies the fundamental foundation for a lack of consistency of judgements made by different teams of assessors and the decisions made by the Agency. It also highlights the difficulty faced by the Agency when it can, on one day, find compliance by an approved service with all 44 Outcomes and within a matter of weeks find substantial Non Compliance when a Review Audit takes place as a result of an adverse event.

The introduction of accreditation in 1999-00 in order for approved services to be accredited by 1 January 2001 did impose an additional administrative and paperwork demand on the sector. Facilities needed to be able to demonstrate that they had the systems, processes, policies and procedures in place to meet the Standards. Continuous improvement was for the first time a legislated requirement.

Maintenance of these administrative requirements has meant more administrative resources, particularly with a focus on improving quality through continuous improvement and trend data collection and analysis. The sector has had to come from a low systems base similar to that of other 'cottage' type industries.

CHA does not dispute and supports the need for accreditation. CHA recognises the lift in overall quality of care standards across the industry as a whole. The question is: "Is the current accreditation process the best way to achieve the objectives set for it?"

The Agency currently has three functions, that of accreditation, compliance monitoring and education and training. Should the Agency have all of these functions?

Should all of the 44 Expected Outcomes be assessed as a part of legislated compliance?

Currently all 44 Expected Outcomes have equal importance but commonsense would indicate that those set out in Standards Parts 2 and 3 should have greater weight than those in Parts 1 and 4. The quality of resident care and resident lifestyle are what really matters to residents and their families, not the management systems.

The act of accreditation is a means by which the Agency assesses compliance. Compliance could be monitored through 'spot checks' and Review Audits. If this was to be the case then the health, personal care and resident lifestyle Expected Outcomes set out in Standards Part 2 and 3 could be the responsibility of the Agency.

Accreditation against either ISO and or industry established standards for management systems, staffing, organisational development, physical environment and safe systems, could be handled by JAZ – ANZ accredited certifying organisations approved for this purpose.

The downside of this approach for providers would be the dealing with another party in the accreditation/compliance processes with possible greater intrusion and disruption to staff time and their caring role, not to mention a possible increase in the costs when two agencies have responsibility for two separate accrediting/compliance monitoring tasks.

Allowing a number of accredited certifying organisations to compete to provide accreditation of an approved service and have responsibility to the Government for compliance would result in even less consistency of assessments and decisions. CHA considers that neither consumers nor the community would accept this approach and cannot support it.

Education and training is a legitimate role for the Agency. Taking on a purely 'policeman' role would create a 'them and us' situation between the Agency and the industry which would be counter-productive. The Agency gains a significant amount of information from the auditing and compliance processes. Sharing this information is a valuable way for the industry to learn about 'best practice' in quality management and to gain from their peers.

In preparing for this submission, CHA asked its members to rate the performance and effectiveness of the Aged Care Standards and Accreditation Agency in:

a) identifying best practice
b) providing information
c) education and training to aged care facilities
d) implementing and monitoring accreditation in a manner which reduces the administrative demands on staff
e) implementing and monitoring accreditation in a manner which reduces the paperwork demands on staff.

The results from our respondents were as follows:

	Excellent	Good	Average	Poor	Don't know
a)best practice	5.6%	50.7%	26.8%	14.1%	1.4%
b)information	9.9%	45.1%	28.2%	14.1%	0.0%
c)education and training	4.2%	18.3%	38.0%	32.4%	4.2%
d)reducing administration	2.8%	8.5%	33.8%	45.1%	2.8%
e)reducing paperwork	1.4%	7.0%	23.9%	57.7%	2.8%

Note: Due to non-responses for some questions, results do not add up to 100%

The following is a summary of the qualitative comments received.

Positive comments

The second round of Accreditation has certainly been a more transparent process and more resident focused. Assessors generally are more positive in their feedback of continuous improvement activities and maintained a professional approach and attitude whist on-site throughout the accreditation audit and ongoing support contact visits.

The support material provided is good. The "Best Practice" Conference was excellent. There has been an improvement in the competency of assessors as the process has developed from its implementation.

The accreditation process does encourage better nursing practice, and facilitate optimal outcomes for residents.

Areas for improvement

Some services found the actual site audit a positive experience, but their experience with support visits had not been so positive. There was a general view that support visits have not provided any "support" and in fact hindered processes.

It is up to each facility to find strategies for paperwork or administrative reduction. There was a suggestion that provision of an annual summary of activities to the Agency would reduce the three year "panic" when the audit time comes around again.

It would be helpful from a resource planning perspective to have information on what will be required for the next round of accreditation well in advance.

The Agency could be more flexible with regard to allowing organisations to present their application for accreditation in formats other than that prescribed by the Agency. Problems still exist between assessors and individual interpretation of compliance with outcomes. The process should be a joint venture toward continuous improvement. This does not always occur as some assessors focus on outcomes rather than improvement.

Some of the respondents had the view that the Agency needs to be more proactive with an education process that reflects the reality of the industry's' issues. They felt that education and training is irregular and not readily accessible. Others considered that the education packages produced by the Agency are comprehensive but an ongoing programme of training in their use may be beneficial. While the packages are available from the website, not everyone has access to the internet and in some cases facilities are unaware of the packages existence.

A major concern that remains is the different expectations of assessors, which translates into marked variation in feedback reports. Also, some assessors are much more open than others in providing information which will benefit individual facilities and resident care.

There was a general view that the time allocation for audits is too brief for the assessors to be able to get a real picture of what is happening and there is a lack of complimentary comments in the reports.

Recommendations

3. That the Agency cease to have an accrediting role. The Agency to have compliance monitoring and education roles funded exclusively by the Australian Government;

4. That existing Accreditation Standards, Part 2 - Health and Personal Care and Part 3 – Resident lifestyle, be the only legislated standards for the Agency to have a compliance monitoring responsibility;

5. That the Agency exercise its compliance monitoring responsibility through approved service spot checks and review audits. Support contact visits would cease;

6. That the Agency, in conjunction with industry stakeholders, develop agreed standard tools to measure standard expected outcomes of care and service delivery for use in assessing compliance and ensuring consistency of assessment and decision making;

7. That the Agency develop a standard evidence based approach to defining what is actually “best practice” in aged care.

8. That Agency education be made available to all approved services through various distribution methods including the internet, satellite television and manuals;

9. That the Agency change its emphasis from the “supervisory” and “regulatory” aspects to a more collaborative and consultative approach and foster with approved services a shared approach to improving quality care standards and service delivery;

10. That approved services be required to be accredited at their own cost for existing Accreditation Standards, Part 1 – Management Systems, staffing and organisational development and Part 4 – Physical environment and safe systems;

(c) The appropriateness of young people with disabilities being accommodated in residential aged care facilities and the extent to which residents with special needs, such as dementia, mental illness or specific conditions are met under current funding arrangements.

Young people in aged care facilities:

There are around 6,000 young people with disabilities residing in residential aged care places. CHA does not consider it appropriate that younger people are placed in these facilities as their physical, emotional, social and spiritual needs are often very different to those of older people. This situation appears to arise out of the different Commonwealth and State Government responsibility and funding arrangements for aged care and disabilities and the classic cost and blame shifting between layers of government that means resident needs are often not the primary focus.

Palliative Care:

In CHA'S submission to the *Review of Pricing Arrangements in Residential Aged Care,* it was argued that residential aged care services need a capital stream to continue to finance the regeneration of the physical fabric of facilities. In particular, CHA views palliative residents as having specific needs. CHA's approach to palliative care is shaped by the following principles:

- Short-stay terminal care residents are receiving palliative care services;
- This interface with the health system means that their care need is not based on the requirement for an alternate accommodation option; and
- As an extension of the health system their care is an essential social service for which the same principles of community responsibility as well as individual responsibility should apply.

Dementia:

In terms of capital funding to meet the costs of providing dementia-specific facilities, CHA has argued that there should be a dementia specific category and it would be reasonable to extend to Dementia Specific and High Care categories the same capital funding arrangements that applies to Low Care. In a similar vein, in our submission to the *Pricing Review*, CHA called for the introduction of a new funding system for aged care based on a defined and properly costed benchmark of care. The Resident Classification Scale (RCS) should be modified specifically to recognise dementia as a separate category.

The recent 2004-05 Federal Budget recognised some of these recommendations particularly the measure to streamline the current eight RCS categories to three (low, medium and high) for introduction in 2006. New supplements will be created for residents with dementia exhibiting difficult behaviours and residents needing complex palliative nursing care. CHA has expressed concern however, that the costs of the new care supplements (dementia and palliative care) are to be absorbed from existing

resources. CHA is concerned that the supplements will not be adequately funded and if they are – this may be at the expense of other important aged care programs.

CHA has argued for some time that a much more strategic approach to aged care funding needs to be introduced in Australia that is more person-centred and is consistent regardless of whether a person is receiving care in their own home or in a residential aged care facility. CHA has proposed a possible funding model referred to as an Aged Care Benefits Schedule.

Aged Care Benefits Schedule:

The current care subsidy arrangements, namely the RCS has an objective of placing people in a "category" which does not necessarily take into account their unique care needs. An Aged Care Benefits Schedule would provide a new way of funding aged care services across residential and community care. Individuals would be assessed according to a range of categories (including mobility, challenging behaviour, medication needs, toileting and continence, palliative care needs to name a few) and then would be assessed for eligibility for Aged Care Benefits Schedule Items (similar to the Medicare Benefits Schedule Item numbers) with the appropriate funding attached.

The Aged Care Benefits Schedule would provide a continuum of care payments corresponding to assessed care needs. As an individual's care dependency increases this would be reflected along the payments continuum. The person would be eligible to receive the care that they are entitled to either in their own home or at a residential aged care facility.

The Aged Care Benefits Schedule would to ensure that funding relates more closely to specific care needs and provides an opportunity for separating the care subsidy from the accommodation and hotel costs to enable portability of the subsidy across different accommodation types.

The Aged Care Benefits Schedule would be an ideal model in which to introduce a minimum benchmark of care into the Aged Care Program. The subsidies provided through the Aged Care Benefits Schedule would be linked to this Benchmark or Care.

A copy of the CHA Concept Paper on the Aged Care Benefits Schedule developed in February 2004 is attached to this submission.

Recommendations

11. That the Federal Government make available specific funding to ensure that younger people with disabilities residing in residential aged care have their specific needs met;
12. That residents assessed as needing to enter residential aged care for short stay terminal care and other intense transitional health services be exempt from paying an accommodation payment with the Commonwealth making the payment on their behalf.
13. That the Commonwealth introduce an Aged Care Benefits Schedule.

(d) The adequacy of Home and Community Care programs in meeting the current and projected needs of the elderly.

Provision of high quality community care helps people to live in their own home for longer. This has several advantages:

- Most people prefer to live in their own home rather than moving to a residential aged care facility;
- Community care helps people retain their independence for longer;
- It is the sign of a healthy society to have more assistance provided to keep people living in the general community for as long as possible;
- Provision of high quality community care uses less health and aged care resources as it avoids more costly admission to residential aged care and acute care.

CHA recognises that the Government has increased funding and places to community care over recent budgets. Some measures in the 2004-05 Federal Budget included:

- Formally changing the aged care planning ratio to increase the number of Community Aged Care Packages (CACPs) from 10 per 1,000 people over the age of 70 to 20 per 1,000 people over the age of 70.
- Home and Community Care Funding was increased by 8.12% (2.12% indexation and 6% real growth).

These policy and budgetary changes are supported by CHA. However, the projected increase in the ageing population in Australia causes CHA to question whether the existing policy and funding parameters will be adequate to meet future need. Clearly a major investment will be needed in community care to meet expected demand for services.

In November 2002, CHA released a major paper on community care – *Community Care Services for Older People: Current Issues* which CHA had commissioned La Trobe University to prepare. This paper provided a comprehensive summary of community care issues in Australia. A copy of this paper can be provided to the Senate Committee if required. For the benefit of the Committee, the following is a summary of the Policy Issues identified in the report and the policy options proposed:

Summary of Policy Issues

HACC program issues:

- There is a high demand for HACC services caused by growth in the target population and shifting policies in other sectors which are putting an upward pressure on the program including shorter length of stay in acute and structural reforms in the residential sector. The program is in danger of losing its preventative focus.

- HACC has currently no common framework for targeting levels of service use: There is a need for guidelines which define a set of criteria around the upper limits of service provision. Lower level preventative services need to be quarantined.
- There is currently no mandatory comprehensive assessment for high level HACC users. Some HACC clients may be using high levels of service unnecessarily. Identification of reversible conditions, the potential for rehabilitation and use of aids and equipment would promote independence and may reduce high levels of service use.
- Currently HACC does not provide case management as a general service. This causes a perverse incentive to seek a CACP package when only case management (and perhaps only time limited case management) is required.

CACP issues

- Many CACP programs have long waiting lists – up to 12 months in some areas.
- Short length of stay on CACPS suggests either people are entering the program 'too late' or the funding levels for packages is insufficient to maintain people at the equivalent of RCS level 6.
- Package funding levels: there are concerns that the funding level of the packages is not keeping pace with the rising cost of service delivery. Some CACP clients are having to pay full cost for all HACC type services and aids and equipment. This means that the amount of services that a CACP client might receive is quite low, sometimes less than basic HACC.
- Is the CACP program promoting and maximising client independence? Can continence aids and mobility aids be purchased through the CACP package? Is the CACPS package funded at a level which recognises the essential partnership between aids and personal assistance? Both are important enablers of independence for older people but it is unclear that the CACPs program can always fund these restorative services.

Respite issues

- Community based respite programs currently overlap State, Commonwealth and joint State/Commonwealth responsibilities.
- Does this program disadvantage frail older people without carers? Are there sufficient resources in the system for older people who do not have carers?
- Improvement to the residential respite program is needed as demand is high but utilisation is low.

System level issues

The following system level issues were identified:

- The projected change in the demographic profile of our older population over the next ten years will mean a rapidly increasing proportion of older people from culturally and linguistically diverse backgrounds and of older people aged 85+.
- There is increasing demand for all three major national programs. One of the flow-on effects of this is a blurring of the distinction between basic HACC and CACPs. This has produced incentives to approve older people for CACP packages who only need basic HACC services.

- Areas of Commonwealth/ State responsibilities for community care provision overlap resulting in fragmented funding arrangements.
- The boundaries between community care and low level residential care have been opened up with trade offs between low level beds and community care packages. To date this has been a highly successful trade off and a popular care option among older people. However there are a number of concerns about this trade off:
    - Can older people whose care needs are equivalent to RCS 6 be adequately maintained in the community for $30 per day?
    - What level of low level residential care must we *maintain* to care for older people who either do not have adequate, secure housing, or who cannot live independently in the community because of emotional/ cognitive problems? Whose responsibility is it to plug the gap left by the reduction of low level care beds?
- Have we got the right mix of services? Four different community service types are identified as providing the essential range of community services. These are: 1) Information, assessment, coordination; 2) supportive services; 3) preventative services and 4) restorative/therapeutic services. Through the HACC program, supportive services have grown substantially over the last 10 years. But have we got the right balance between supportive and restorative/therapeutic service? Are we band-aiding older people with services without first trying to prevent, restore and provide aids to maintain independence?
- Whilst the HACC program has a set of national service standards the mechanism for monitoring, evaluating and reporting on compliance with these standards is still being implemented. A HACC Consumer Survey Instrument is also starting to be used in some areas. Quality standards in the CACPs and respite program have not been developed. The community care sector should be working towards a common Quality Improvement framework which sits over all community programs and which incorporates consumer feedback. *(Note: CHA welcomes the quality measures which were announced in the 2004-05 Budget).*

Long term policy objectives:

- At the national level, there is a need to develop a comprehensive framework for the delivery of community care which outlines
    - An agreed set of principles,
    - An agreed mix of services,
    - Areas of Commonwealth/ State responsibilities for community care provision that reduce areas of overlap and minimise fragmented funding arrangements.
    - A logical progression of tiers or levels of need that can be met in variety of ways either through community based or residential care/supported accommodation. Clear access pathways need to be defined.
    - Within each level there should be an agreed funding system that meets the needs of the particular cohort.
    - A stronger partnership between acute and sub-acute sectors and the community sector to ensure better continuity and coordination of care.
- Funding principles: Explore funding principles which are suitable and relevant to each tier of the system. Funding principles at lower levels should be simple and easy to administer. Funding model that facilitate flexible, substitutable and individualised

service provision for those with higher levels of need to be developed. Options that should be explored include:

- Pooling of funds for example across residential care and community sectors and creating regional fund holders. There are considerable similarities and overlap in the level of disability and dependency between those who receive home based, long term care and those who receive long term care on a residential basis. Issues of parity of funding to care providers and recognition of the economic value of the contribution of carers should be addressed in the development of new funding models and consideration given to principles for the development of a payment model for home based care analogous to the model applying to nursing home care.
- Budget holding: Whereas the dominant model has been to fund providers directly -whether they be in the government, non-government or private sector the option of allocating the funds direct to client or brokers to purchase services on their own behalf should be examined:
- Consumer-directed or self managed approaches: This may involve, where appropriate, an individual accessing an agreed level of funds according to an assessed level of need, to manage and arrange services to be delivered by the care provider of their choice. This approach promotes the notion that many older people with disabilities already manage their own care needs through friends/family and private services, and should be able to access public funds that they are eligible for, to further add to their care plan.

The release by the Commonwealth of its blueprint, *"A New Strategy for Community Care – The Way Forward"* addresses many of these program deficiencies by outlining a series of administrative reform actions.

CHA has welcomed the Commonwealth's recognition in newly released Strategy of the importance of renegotiating the Home and Community Care Agreements with the States and Territories but considers this should be accompanied by a real increase in investment for services. It is important that a more rational distribution of responsibilities between the Commonwealth and States is achieved so that a more seamless system of care services can evolve.

It is crucial that a future community care strategy is national in character and reflects the importance of increased provision of professional care and does not remain reliant on a diminishing number of voluntary carers.

The future of community care services particularly for the elderly, the chronically ill and the socially isolated is directly linked with a sustainable health service and accessible residential and respite care services.

It is essential that a national system be created and there not just be a re-package of a series of disorganised programs which create too many gaps in service delivery, too much confusion and too much wastage through administrative burden.

As mentioned under Term of Reference 1, aged care workforce strategies to date have not adequately addressed future workforce issues for community care and this should be taken up as a priority area.

Recommendations

14. That a clearly defined timetable for implementing all aspects of *A New Strategy for Community Care: A Way Forward* be provided by the Government;
15. That the Government give a commitment to a major injection of resources to meet growing demand for community care into the future as the population ages and people's preference to stay at home increases.
16. That Community Care be given greater prominence in any national strategies to improve workforce planing and skills development in the aged care sector.

(e) The effectiveness of current arrangements for the transition of the elderly from acute hospital settings to aged care settings or back to the community.

As stated in our submission to the *Review of Pricing Arrangements in Residential Aged Care*, consumers can encounter lack of choice when it comes to their interaction with the acute and aged and community care sectors. Moving from the acute setting can result in having to accept inappropriate supportive care modalities, when transitional or rehabilitation prior to going home to receive community care would be the preferred result.

By default, residential aged care is increasingly having residents admitted when a specialised transitional program would enable them to avoid premature admission to long term care.

The current funding for transitional care is somewhat fragmented in the current policy environment. The Commonwealth government contributes funding to:

- The Pathways Home Initiative;
- The Aged Care Innovative Pool funding; and
- A commitment in the 2004-05 Federal Budget to fund on a cost-shared basis with the States and Territories 2000 transitional places over three years.

CHA believes that these disparate arrangements will not be sufficient in the medium to longer-term. Transitional care will need a much more coordinated and strategic policy and funding commitment to meet the needs of older people moving from hospital to aged care settings or the community in the future. To ensure older people receive the health and aged care services they need (and not be subject to missing out on essential services because of cost and blame-shifting between levels of government), a more appropriate response may be for the Commonwealth to take responsibility for all the health and aged care needs of older people.

Recommendations

17. That a specialised transitional program be introduced that would enable consumers to avoid premature admission to long term care.
18. That there be a better integration of aged care and the acute sector to achieve a continuum of care interface to provide the most appropriate and cost effective care, specifically in relation to rehabilitation, psycho geriatric services and other transitional services.
19. That the Commonwealth should take responsibility for the health and care needs of all people over the age of 75.
20. That Commonwealth, State and Territory Health and aged Care Ministers meet regularly to resolve issues of duplication and regulation in order that aged care become a truly national program.