SUBMISSION TO THE SENATE COMMUNITY AFFAIRS REFERENCES COMMITTEE

INQUIRY INTO AGED CARE

Aged and Community Services Australia (ACSA) is the national peak body for not-for-profit church, charitable and community providers of aged and community care services. ACSA's 1400 member organisations provide residential and community care services to over 200,000 older people throughout Australia.

Aged and Community Services Australia

Level 1, 36 Albert Road, South Melbourne, Victoria 3205

Telephone: (03) 9686 3460 Fax: (03) 9686 3453
Website: www.agedcare.org.au

SENATE COMMUNITY AFFAIRS REFERENCES COMMITTEE
INQUIRY INTO AGED CARE

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

The Government announced a number of welcome education and training initiatives in the 2004–2005 budget (which are outlined in the attached separate paper The Hogan Review and the Budget) in response to the recommendations from The Hogan Review. However, these responses fell short of the Review's recommendations. The Government has also already commenced the development of a National Aged Care Workforce Strategy.

All of these initiatives are useful in their own right but they tend to focus on the residential aged care workforce and do not tackle the strategic issues confronting the whole sector. Community care workforce issues in particular merit further attention.

There is a worldwide shortage of registered nurses which would have to be resolved before its impact on aged care could be negated. Given that the shortage is unlikely to be resolved in the near future, models of care which are not so strongly predicated on the availability of nurses must be considered.

The provision of more nursing degree places will not ensure graduates choose an aged care career over acute or other health areas.

The Budget also provided a welcome increase in the subsidies paid for residential aged care with a supplement of 1.75% being added to the care subsidies for the next four years. This will generally not be sufficient to enable aged care employers to pay wages that are competitive with the public hospital sector. Until this is addressed it will remain very difficult for the current workforce issues in residential aged care to be effectively dealt with.

What Else Needs to be Done?

Plans must be put in place to ensure that there is a flexible and growing workforce able to deliver residential and community care services. Co-ordination of efforts of State, Commonwealth and Industry – leading to the development of an industry wide (residential and community) workforce plan is urgently required.

The current National Aged Care Workforce Strategy effort needs to be continued and:

- reflect the changing nature of the workforce with less availability of nurses requiring more strategic use of their time;
- deal with community care workforce demands and issues;
- expand the availability of traineeships for personal care workers entering either residential or community aged care and progressing to higher levels;
- pay special attention to developing innovative approaches to promoting aged care careers, particularly among young people; and
- address a number of, mainly state-based, regulatory barriers to the efficient and flexible deployment of existing staff which inhibit the provision of safe, economical and genuinely person-centred care.

Aged care providers must be funded to a level which enables them to pay wages that are competitive with the public hospital sector. This would best be achieved by linking aged and community care subsidies to an appropriate index of health sector wages. Alternatively a higher supplementary payment than that provided to residential services in the 2004–2005 budget should be made. No such payment was provided for community care services but should be if an alternative index is not used.

(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.

It is ACSA's view that the current structure of the aged care accreditation system - a single stand-alone process applying to only one of the many programs in the aged care field and a single agency with a monopoly on accreditation service provision - is less than optimal and inhibits its overall effectiveness.

There are three main issues relating to the current provision of accreditation services and one relating to the Agency's role in education and training. The three issues concerning accreditation are:

- The lack of exposure of the Agency to price and quality pressures;
- The inability of the Agency to respond to the whole range of accreditation needs of aged care providers. Many of our members are involved in providing services to older people under a number of different government programs, or directly to older people themselves, and are therefore compelled to participate in multiple accreditation systems to cover the whole scope of their activities. This could be addressed if a market in the provision of accreditation services were to be allowed to develop and to respond to the industry's accreditation needs.
- The fact that a market exists for the provision of accreditation services to other industries, including other parts of the health and care system, and that this market is regulated under the Joint Accreditation System for Australia and New Zealand (JAS-ANZ).

The JAS-ANZ Framework

The industry has had long standing concerns with the internal quality control procedures in place in the Agency around such issues as consistency and objectivity. The existence of an overarching and active quality control framework in JAS-ANZ guards against this.[1]

JAS-ANZ accredits accreditation bodies and subjects them to the same type of scrutiny that the accreditation processes apply to services. In so doing it provides for a regulated marketplace of accreditation providers who are able to tailor the range of areas in which they are certified to meet the needs of their customers.

If such a framework were to be adopted for the aged care sector in Australia, ACSA believes it would confer the following advantages:

1. It would enhance the credibility of the residential aged care accreditation process by providing for ongoing and regular scrutiny of the systems and processes employed by accrediting bodies. The Federal Government would retain responsibility for setting the standards against which services are assessed, though this should be done with input from stakeholders including providers, staff and consumers.

[1] The Agency is understood to be currently seeking accreditation from Standards Australia International. This is a positive move which would in fact go some way to equipping the Agency to compete in an accreditation market place though its legislative base may still be an obstacle.

2. It would provide for greatly reduced duplication of effort in circumstances where an increasing proportion of our members provide a range of services, more than just residential aged care, to frail older people and currently are subject to a different accreditation process for each one.

   Providers of community care services suffer similarly - one ACSA member reported to a 2003 national Community Care Forum of having to comply with eight different accountability regimes for its total funding of $250,000!

   The open structure of the JAS-ANZ framework would facilitate a common approach to accreditation regardless of the funding source, though some additional work may also be required on the Standards themselves. This, in turn would promote the continuity and consistency of care for older people across their whole range of needs.

3. The JAS-ANZ framework is premised on the principle of continuous improvement both for the industry in question and its accreditation bodies.

4. The independence of the accreditation process would be assured, further enhancing its credibility.

5. Because accrediting bodies are able, under JAS-ANZ arrangements, to spread their fixed costs over a much broader range of clients and industry sectors they are in principle more economical.

6. One of the keys to the robustness of the JAS-ANZ arrangements is that they provide for contestable service provision. This is not about shopping around for a 'soft' auditor - the rigour of JAS-ANZ accreditation militates against this- but it is a powerful mechanism to ensure responsiveness to client needs, in terms for example of the range of services covered, and for continuous improvement.

The demonstrated effectiveness of the Agency in ensuring improved quality for residents was questioned in a report last year by the Australian National Audit Office[2], and the subsequent findings of the parliamentary Joint Committee of Public Accounts and Audit[3], on the management of the residential care accreditation process. ACSA members experience of accreditation is that it is a paperwork driven and resource intensive system which doesn’t necessarily improve the quality of care for residents. Any accreditation system in a human services context should have the prime outcome of improving the quality of care for consumers.

While it is generally acknowledged in the aged care industry that the accreditation process has represented a step forward, it remains ACSA's view that better outcomes would be achieved if competitive service provision and quality control under the JAS-ANZ framework were to be introduced.

Education & Training

The Agency has always had a legitimate role in ensuring that the aged care industry is informed about the Agency and the accreditation system. Recently the Agency has started to provide training seminars and forums, such as a series of Best Practice seminars. Service providers have stated that they feel they must attend such events because they are run by the Agency which is the only accrediting body for aged care.

It is ACSA’s view that while the Agency operates as a monopoly it would be better to confine its education and training role to ensuring that the aged care industry is fully informed and educated about the accreditation system and its operation.

---

[2] *Report No 42 of 2003*

[3] *Review of Auditor-General's Reports 2002-03: Fourth Quarter*

(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;

(i) Young People with Disabilities in Residential Aged Care

Residential aged care is not the best place for younger people with disabilities to live. The aged care industry supports the call for appropriate accommodation options for younger people.

Aged care organisations provide care to assist younger people and their families where there are no alternative support options available. Residential aged care funding is insufficient to meet the needs of younger people, which are often very high, and services do the best they can with the funding available. At the highest need level residential aged care attracts significantly lower funding per annum for each resident than disability accommodation services receive. The availability of alternative accommodation options would ensure appropriate support for younger people themselves and free up beds currently being used (approximately 6,000) for older people.

Many older people have to wait to enter residential care. Sometimes they wait in hospital, at significant cost to the health system and sometimes they remain at home alone, or with carers, in untenable situations. Access problems for older people are not only, or even mainly due to the fact that there are younger people in the aged care system but the existence of alternative accommodation for younger people with disabilities would free up those resources for use by older people.

Commonwealth and State Governments must accept the responsibility and care of both older people and younger people with disabilities. The needs of each group should be considered in their own right and not through a trade off of services. It is not satisfactory when the accommodation option for many younger people with disabilities is inappropriate for their needs and diverts scarce resources away from aged care.

(ii) Special Needs such as dementia, mental illness or specific conditions.

Clients with special needs (such as mental health issues), those who have complex care needs and those who live in rural and remote areas often experience more difficulty accessing services than others. While these people are, in principle, able to access services in the same way as anyone else, they may experience extra difficulties in gaining entry to a service (either community or residential) or having their needs met appropriately once they are receiving a service.

Residential Care

Funding for residential care is provided through the Residential Classification System or RCS. This system classifies residents into 8 separate needs levels and provides funding based on that level.

The RCS does not recognise the full range of needs. The acuity level of individuals entering residential care is increasing as people are coming in later with higher, and more complex, needs. The funding provided, even at the top rate, does not adequately assess and financially support the level of care required. This is also true of disadvantaged groups, such as homeless people where social and emotional needs are not adequately recognised.

The RCS does not adequately recognise care needs related to behavioural issues of residents. This is particularly problematic for residents with dementia (which will increase with the predicted growth of the “old old”- those over 85 years of age) or (past) psychiatric issues as not all resulting behaviours are captured in the RCS questions and these residents are effectively ranked as having lower level care needs. This does not support staff managing difficult and resource intensive anti–social behaviours such as public urinating and inappropriate sexual behaviour.

The Hogan Review recommended the extension of funding supplements to three special needs groups: people with short-term medical needs; people with dementia or who have palliative care needs; and people from a disadvantaged background, such as Indigenous people. The Government response in the 2004 – 2005 Budget however only picks up two of these special needs groups and does not address the needs of people from a disadvantaged background. A supplement should be made available for people from disadvantaged groups. These new supplements appear to be funded from existing funds. This means that resources may be diverted from meeting other needs and ACSA does not support this. The use of supplements needs to be reconsidered in conjunction with the overall of design of a funding model.

There are some services which specifically cater for people with dementia and other who provide care for people with dementia as part of a mainstream residential aged care service. ACS supports the provision of more dementia specific services for people with severe behavioural and psychological symptoms of dementia. In addition all mainstream residential aged care providers should be funded to enable training of the workers to provide dementia care.

Community Care

The community care system also supports many people with special needs such as dementia and mental illness. Community Care staff need access to, and support to attend, training on the range of special needs and challenging behaviours they encounter in providing care.

There are older people who are homeless or living in insecure housing. It is important that support is provided to these people to help them obtain appropriate housing and/or support services. The Assistance with Care & Housing for the Aged (ACHA) program has been effective in this area by preventing inappropriate residential care placement. It is currently a very small program and should be expanded.

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

ACSA believes that significant reform is needed to Australia's community care system if it is to meet the expectation placed on it of assuming an increasingly significant role in the future of our care system and if it is to continue to provide high quality care services to older people.[2] To further reform in this area ACSA, with the support of many other groups, [3] has published a *Vision for Community Care.* A copy of this document is provided with this submission.

For two decades governments have encouraged living at home instead of moving to residential care. Provision of informal care by families and formal community care is an essential and effective way to help people to live in their own homes. Increased government funding, particularly over the last 4 years, has resulted in many programs supporting this goal.

However the community care system in Australia is not meeting all the needs of Australians who currently require it. There are inadequate levels of service provision; it is fragmented, services are often difficult to access and they are unevenly distributed across the country.

It is estimated that by 2006, 1,327,100 Australians will have a severe or profound disability. Australia's population is ageing in both actual numbers (with those aged 65 and over increasing from 2.4 million to 4.2 million over the 20 years to 2021) and proportionally with this age group moving from being 12% to 18% of Australia's total population.

This rapid growth in numbers of people needing community care will place increased pressure on both unpaid carers and the formal service system which currently cannot deliver enough community based care to meet existing demand.

Current data from the Home and Community Care Program indicates that:

- the average amount of domestic assistance received by nearly 200,000 HACC clients last year was just 38 minutes per week; and
- 47,000 frailer HACC clients aged over 65 needing help with personal care (help with showering, shaving etc) received just 50 minutes per week on average.[4]

Funding for community care services needs to be increased to ensure that services are available - at appropriate levels when needed. The Home and Community Care (HACC) Program represents the major Government effort in community care and provides services to approximately 700,000 Australians each year. It requires an initial 20% increase ($146m Federal Government and $98m State Government) and at least 6% growth per annum (plus indexation) thereafter.

The 20% increase will restore funding levels which were reduced when a fees policy was introduced nationally in the mid 1990s. This policy has not raised the anticipated revenue. Consumers have suffered as a result of this as services have been rationed. This increase will enable more services to be provided.

This shortfall has been compounded by the inadequate Commonwealth Own Purpose Outlays (COPO) indexation method which fails to keep pace with unavoidable rising costs. An increase of 10% on the current prices paid for community care would bring funding and current costs in line.

---

[2] Older people are the largest single group serviced by the community care sector but by no means the only important one. people with disabilities and those suffering from chronic, acute or episodic illness are also very important recipients of community care services.

[4] These figures do not allow for client turnover but the fact remains that services are thinly spread.

In the longer term, community care providers must be funded to a level which supports the actual costs of providing care. This would best be achieved by linking community care funding to an appropriate index of health sector wages. Alternatively a higher supplementary payment – provided for a time limited period to residential services in the 2004 – 2005 budget – should also be made for community care.

Planning for Community Care Services

Residential care is planned and delivered within a planning ratio calculated per 1000 of the population aged over 70 years. Community Aged Care Packages (CACP) and Extended Aged Care at Home (EACH) packages are included in this ratio. In the 2004–2005 Federal Budget the Government increased the number of community package places raising the total number of beds/packages per 1000 people 70 plus to 108. This was a welcome move.

These ratios enable some planning across residential and community care. However planning for the HACC Program and other community programs such as National Respite for Carers, occurs outside of this ratio and is most often unconnected to residential care and community care packages.

A planning ratio which brings together the range of residential and community programs should be developed and would assist in ensuring the full range of care options are available to people in local areas.

The Community Care Coalition

ACSA is a founding member of the National Community Coalition. The Coalition comprises 21 organisations concerned to address the issues facing community care.

The Coalition has produced a document which outlines more fully the importance of community care and the difficulties facing consumers, carers and services providers. A copy of the Coalition's paper *Why Community Care Matters* is attached for your information and consideration.

(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

Quality health and aged care need to be integrally linked. Governments need to act urgently to introduce policies to achieve a system of services where access is determined by the needs of people, rather than the particular point of contact or service setting.

Progress towards a continuum of care for older people requires policies and strategies for the integration of primary care; community care; health promotion and illness prevention; rehabilitation; acute care; sub-acute care; and residential care.

People in residential aged care need more appropriate health care, including effective management of medicines, in the residential setting to avoid unnecessary hospitalisation. In the acute hospital setting, older people need access to specialist geriatric services. Currently their health care needs are not being adequately met in either setting. This unacceptable state of affairs is a result of the fragmentation of health and aged care service.

Older people are often forced to remain in hospital once well enough to leave because appropriate residential or community care is not available for them. Within the acute health system they are disparagingly called "bed blockers". More residential homes and community services are required to enable older Australians to leave hospital safely and securely.

With the lack of resources in the acute sector older Australians are sometimes forced to leave hospital before they are fit enough and/or without appropriate discharge plans. There is substantial anecdotal evidence and many documented stories of inappropriate discharges.

These include people returning home with wounds, which still require medical care and no supports in place for meals, personal care and dressings. Patients are also sometimes sent back to their residential facility without any information about treatment and medication being provided. These types of situations place pressure and stress on the older person, their families and the service providers. It has been argued that poor discharge planning contributes to rehospitalisation and premature admission to residential care. Residential homes and community support services are not able to provide intensive medical treatment.

Acute hospitals need to modify their practices to provide appropriately for the care needs of frail older people. Governments need to agree on how to provide for the care needs of older people who require a level of care that lies between current hospital and residential aged care provision, eg sub-acute', 'transitional', or 'interim' care. A range of successful pilot programs have been funded to assist in addressing these interface issues. These projects need to be included in the care system and receive ongoing funding. Many aged care providers would be well-placed to assist in filling these service gaps if appropriate funding were to be provided.

SUBMISSION ATTACHMENTS
(ACSA Documents published elsewhere)

1. The Hogan Review and the Budget
2. A Vision for Community Care
3. Why Community Care Matters