Tasmanian Government Submission to the Inquiry into Residential and Community Aged Care in Australia

Tasmanian Government
February 2009

Tasmania
Explore the possibilities

EXECTUTIVE SUMMARY

- Tasmania has the fastest ageing population and has experienced substantial growth in demand for aged care services.

- There are 86 residential aged care providers in Tasmania providing 2324 high care and 2179 low care beds.

- Current provision of places does not meet the demand and providers are not able to invest in and plan sustainable services with the current funding model.

- The availability of packaged care is inadequate to meet demand – especially in rural and remote areas.

- Shortfalls in both residential and packaged care are placing increasing pressure on public hospitals – with prolonged hospital stay for older people costing $13.4m in 2007-08 and projected to be $14.5m in 2008-09.

- The Tasmanian Government considers that reforms to community aged services are needed to ensure a sustainable, equitable and quality aged care system in the future. In summary, these reforms involve:

  – A complete and thorough review of the strategy for planning, funding and allocation of community and residential aged care funding across the complete care continuum for the older person including residential and aged care packages; acute rehabilitation and sub acute rehabilitation, primary health. This to take place with the involvement of States and Territories.

  – An improved funding formula base and unit pricing and allocation of services which recognises increasing complexity. The funding model would include appropriate indexation, capital investment strategies; weightings and equitable consistent consumer fees.

  – Improved targeting of existing services and reduced gaps and overlaps in existing services

  – Continuity of care models that facilitate the transition of clients between services (in accordance with their needs)

  – Increased use of case management and service brokerage for clients who have a high or complex level of need.

  – Models of care that restore health and prevent ill health.

  – Funding that allows flexible service delivery for all areas and especially in rural and remote communities.

  – A streamlined administration and reporting system that reduces the burden on service providers while focusing on the usefulness of data collected.

– Information technology that eases reporting burden and supports information sharing.

TASMANIAN CONTEXT

TASMANIA'S AGEING POPULATION

Over the last decade Tasmania's population has experienced both growth and decline. Current predictions suggest that the size of the population overall will increase slightly over the next 20 years, but its composition will change as the age of the average Tasmanian increases.

This is due in part to the conventional causes of population ageing experienced right across Australia (ie low birth rates and increased life expectancy), but is exaggerated by large numbers of older migrants entering the state, coupled with many younger people moving interstate or overseas.[1]

The dependency ratio[a] in Tasmania is projected to increase substantially over the next 40 years due to the ageing of the population.[2] Over this time, the number of Tasmanians aged 65 years and over is anticipated to more than double and the number aged 80 years and over is set to more than treble. Meanwhile, the number of Tasmanians in younger age groups is already in decline. Tasmania will find it increasingly difficult to adequately support its ageing population.

Table 1: Tasmania population growth 2007/2018

State population		**Population by region**		
	Tasmania	**South**	**North**	**North West**
2007	493 371	243 820	139 466	110 085
2018 projected	528 556	264 122	149 509	114 925

In line with these projections, it is anticipated that future demand for aged care services will increase at a significantly faster rate than planned increases in the supply of aged care services. A shortfall is likely to arise as Australian Government aged care funding is currently allocated on the basis of the number of people aged 70 years and over in a population. People aged 80 years and over comprise the most rapidly increasing service group in Tasmania.[3]

Table 2: Tasmanian Population, by region, age 70+ and 80+

Population	**Pop 70-100 by region**			**Pop 80-100 by region**		
	South	**North**	**North West**	**South**	**North**	**North West**

[a]The 'dependency ratio' is a measure of the number of people in a population who are outside the traditional working age, compared to the number of people who are within it. It is used to measure the capacity of a population to support itself within its available workforce.

2007	24 624	14 781	11 941	9 649	5 627	4 517
2018 projected	32 724	20 244	16 651	11 616	7 200	5 972

An increase in the number of older people living with dementia is also likely to place particular strain on aged care service providers. It is well documented that the incidence of dementia in the community will continue to increase in Tasmania given the demographic profile: two per cent of the population aged 60-65 has dementia and the incidence doubles for each five year cohort increase. Currently there are over 5 000 people with dementia in Tasmania. It is estimated that this will increase to 14 340 by 2050.[4]

RESIDENTIAL AGED CARE IN TASMANIA

There is a mix of 86 residential care providers in Tasmania including both profit and not for profit organisations.

Table 3: Operational bed volumes in Tasmania: aged residential care as at January 2009

Level of care	**High care Residential**	**Low care residential**
Number of Places	**2324**	**2177**

In recent years these providers have found it increasingly difficult to remain financially viable.

PACKAGED CARE IN TASMANIA

The report *Aged care packages in the community 2006-07, A statistical overview*, stated there were 37 997 operational Community Aged Care Packages (CACPs) offered across Australia during 2006-07, with 34 867 individuals receiving assistance at 30 June 2007.[5] At 30 June 2007, the majority of recipients were in New South Wales and Victoria (34 per cent and 26 per cent respectively). Queenslanders comprised 16 per cent of recipients, followed by South Australians (nine per cent) and Western Australians (nine per cent). Tasmanian recipients comprised three per cent of all recipients at 30 June 2007, equating to **953 CACPs.**

The distribution of the 2,999 Extended Aged Care at Home (EACH) package recipients at 30 June 2007 was similar – New South Wales had 32 per cent, Victoria 28 per cent, Queensland 16 per cent, South Australia nine per cent, Western Australia eight per cent, the Australian Capital Territory and Tasmania three per cent and the Northern Territory two per cent. This translates to just **75 EACH packages** for Tasmania, giving a **combined total of 1028 Australian Government funded aged care packages** in the state at 30 June 2007.

The small number of EACH packages means that clients living in rural and remote communities have very limited or nil access to an EACH package. This severely limits client options for remaining in their community with appropriate levels of service and significantly increases their risk of entering institutional settings – namely, acute hospitals and residential care.

The above report showed that Tasmania had the 'oldest age profile' of CACP package recipients in Australia. Ninety four percent of Tasmanians receiving a CACP package were aged 70 years and over – this compared to the national average of 89 per cent. This trend reflects Tasmania's faster rate of growth in the 85 years and over age group.

TERMS OF REFERENCE

(a) Whether current funding levels are sufficient to meet the expected quality service provision outcomes

(b) How appropriate the current indexation formula is in recognising the actual costs of pricing aged care services to meet the expected level of and quality of such services

(c) Measures that can be taken to address regional variations in the cost of service delivery and the construction of aged care facilities

(d) Whether there is an inequity in user payments between different groups of aged care consumers and, if so, how the inequity can be addressed

(e) Whether the current planning ratio between community, high- and low- care places is appropriate

(f) The impact of current and future residential places allocation and funding on the number and provision of community care places.

The Tasmanian Government response to each of the Inquiry Terms of Reference follows:

(a) Whether current funding levels are sufficient to meet the expected quality service provision outcomes

Tasmania has a small, dispersed population with little scope to gain economies of scale in service provision. This creates access problems especially for the population living outside the main urban centres. Small facility size creates problems of financial viability unless adequate weightings are applied in the residential aged care funding model. The funding model does not adequately take this issue into account. Please also see section (c) below.

The residential aged care industry has expressed significant and increasing concern over recent years about the inadequacy of the funding model. Tasmania's Department of Health and Human Services (DHHS) has recently obtained independent advice that modelled residential aged care facilities and demonstrated that a minimum of 55 to 60 places were required to be

viable. At least two Tasmanian residential homes have closed during the past year and at least two more have reduced beds in an attempt to remain in operation.

DHHS operates a small number of residential aged care services in rural and remote areas. It has been required to provide substantial additional funding to these services because of the shortfall in Commonwealth funding. These State supports include Rural & Remote Allowance, District Allowance, Island Airfare Agreement, Training and Clinical Support, Medical / Clinical Support, Rural Medical Management and Agency Nurse Support. The additional costs, predominantly incurred to ensure safe staffing levels and to ensure appropriate quality and safety support, add an additional cost equivalent to 12.8 per cent of nurse salaries over a similar service in a metropolitan area.

The Tasmanian Government is deeply concerned that small residential aged care services – in particular rural services – are already not viable. This raises concerns regarding the adequacy of care being provided and the future of such services as well as limiting the potential for clients to remain in a location close to their family and community.

Recruitment and retention of skilled staff is also a significant issue and represents a major risk to the ongoing sustainability of rural services and the level and quality of care that can be provided.

Reduced Administrative and Reporting Burden

In the AIHW report, *Cutting the Red Tape,* a National Community Services Data Committee examined the problem of multiple reporting by providers of community services.[6] The findings in this report demonstrate that community service providers are experiencing an increased data collection and reporting workload because of:

- the requirement of program-centred reporting for service providers to use separate, program provided data collection forms and/or software resulting in recording and reporting on the same client on multiple occasions; and

- the lack of electronic data capture, storage and reporting systems in the community services sector which would give providers the capacity to record data once, from which multiple reporting could then occur.

In Tasmania, community aged care service providers commonly report these kinds of difficulties. Peak bodies in the aged and community care sector argue that the various community care programs have created separate reporting requirements and different eligibility rules.[7] Organisations that provide a mix of community care programs must complete multiple sets of very similar information in order to satisfy the reporting requirements of their various funding bodies. These requirements duplicate administrative costs, taking funding away from direct service provision and therefore hands on service, which in turn threatens the provision of quality services.

The Tasmanian Government considers the levels of reporting to be undertaken to be onerous. For example, the Conditional Adjustment Payment requires that an independent audit be carried out on aged care sites in Tasmania, even though all accommodation bonds and the viability of sites is guaranteed by the State Government.

Consistent reporting requirements should be agreed between Commonwealth, States and Territories including a common reporting framework for community care. For example, aged care workers argue that a framework in line with the Home and Community Care (HACC) Standards could assist those providers who need to report on a mix of Commonwealth and HACC funded programs. HACC reporting uses a more rigorous approach than the quality reporting process for packaged care and clearly identifies expectations and benchmarks. The Community Care Review initiated by the Australian Government in 2004 and involving all States and Territories is developing common standards for Community Care – particularly HACC, CACP and EACH – and this work should be picked up and expanded across the aged care sector.

A standardised information system could be used to reduce the number of times the same data are provided, entered and reported on by service providers. Integration of data systems across the aged care sector: residential, community; primary health, sub acute and acute services would assist to reduce duplicated effort and the administrative burden as well as increase the opportunity for service continuity. In Tasmania, the Department of Health and Human Services has recognised the need to invest in this area. Improved IT infrastructure would not only ease the reporting burden in but also facilitate better communication between service providers and funders. Improved data collection would also enable a more strategic approach to planning for the future delivery of services.

(b) How appropriate the current indexation formula is in recognising the actual cost of pricing aged care services to meet the expected level and quality of such services;

There has been concern expressed by the aged care residential sector at the adequacy of both the core funding and indexation models for several years. In the case of DHHS programs, the Australian Government's indexation model for residential aged care has resulted in the Department receiving growth of close to two per cent while it has needed to deal with a Consumer Price index at over three per cent, health inflation close to six per cent and wage increases projected to be more than ten per cent.

The subsidy increase is based on the combination of CPI and the Safety Net adjustment. This does not reflect the increase in cost to the industry, whose business costs are highly weighted towards wages and will not be able to gain the level of efficiencies in production costs to which other industries have access.

Therapy services, diversional programs and equipment are meant to be provided as part of general services in aged care residential facilities but funding restrictions through inadequate indexation and increased staffing and operational costs has led to these core services increasingly being unable to be funded through the Aged Care Residential payment. An alternative funding source has therefore been required and inevitably costs are shifted to state governments.

Modelling the input costs of residential aged care is required as a basis for long term sustainability – including appropriate indexation. A larger crucial piece of work needs to be undertaken to establish true costs of service delivery so that a transparent pricing model can be developed. This should occur with a rationalisation of client payments so that these are

equitable and transparent. This work is required for both the residential and community care sectors.

(c) Measures that can be taken to address regional variations in the cost of service delivery and the construction of aged care facilities

Unlike most mainland States and Territories where populations tend to be most concentrated in capital cities, Tasmanian's population is spread right across the state. In fact, Tasmania has the highest percentage of people living outside its capital city of any State in Australia, with 59 per cent of the population living outside of Hobart.[8] Major population concentrations are in the South (Hobart and surrounding regions), North (Launceston and surrounding regions) and North-West (Burnie and Devonport regions).[9]

Where population growth or redistribution is occurring, this is also mostly outside of Hobart. The largest percentage increases have occurred in rural and remote areas. This dispersion of the population has a number of implications for access to health and aged care services. Outside the major centres of Hobart and Launceston the provision of many health services is more costly. Rural and remote clients often have to travel to access services or wait for health professionals to provide outreach services.

Tasmania has special needs that arise from its rural and remote status and the geographical spread of its population. Clients living in rural areas simply do not have access to the same range of services and numbers of skilled staff as their metropolitan counterparts

Some particular barriers reported by aged care workers in rural and remote Tasmania are as follows:

- Older people and their carers often have very limited choice in the services available to them. There is a clear lack of CACP and EACH packages in rural areas, which often results in admission to an aged care facility distant from their community being the only care option available. Access to allied health professionals is also very limited.

- Transport is a significant issue that impacts upon all community health services provided in rural areas in terms of access and in cost to deliver services. The need for non urgent medical transport is growing right across the State and anecdotal reports suggest that existing service providers are struggling to meet demand. In the case of CACP and EACH packages, it has been suggested that providers might be more willing to take on rural clients if there were additional funding built into the package to allow for extended travel costs.

- Rural clients often do not have an easy point of contact for information about and assistance with available programs. Program outposts in rural areas or service brokers who reside locally would give clients a physical presence in the community, be able to work more closely with local providers and could reduce the cost of travel.

- Access arrangements for residential respite are not flexible. There is a shortfall in respite places in rural areas. Tasmanian aged care clients experience particular problems in access to respite care in the North West region of the State.

To address these types of concerns, it is suggested that future service planning and funding for community aged care services in rural and remote areas is provided in a more flexible manner. In some instances, services need to be designed and implemented locally to meet the specific needs of local communities. Planning at the local level should be based on the whole range of resources available in a given community, and give particular recognition to the high cost of travel between clients in isolated areas. Aged Care Approvals rounds and other planning should be more closely aligned with the HACC planning and growth management process. Silos of funding should not prevent effective cost efficient care – this is true in metropolitan areas, but particularly in Tasmania.

Construction

There is a lack of viable capital funding streams to support the development of aged care facilities to meet the rising quality standards demanded of providers. This lack of support impacts on quality and bed availability, as the providers are unable to improve facilities or expand both to meet need and to ensure the volumes required for ongoing viability.

Raising capital is dependent on accommodation bonds paid by low care residents only – high care residents do not pay this bond and federally-granted license increases. Pressure has increased with recent legislation requiring upgrades in many facilities.

(d) Whether there is an inequity in user payments between different groups of aged care consumers and, if so, how the inequity can be addressed

There is considerable inequity in the current fee arrangements for different groups of aged care clients.

Under the current arrangements the residential aged care sector receives an accommodation bond for low care residents. There is no fixed amount that can be charged, and a bond cannot be charged if it leaves the applicant with less than $35,500 in assets (excluding the family home). Bonds are not payable for high care residents. This bonding arrangement discriminates against people accessing low care places unless they can afford to pay.

For CACP and EACH packages the client may be charged a fee of up to 17.5 per cent of their pension. This is significantly higher then the usual fee regimes in the HACC Program. In Tasmania HACC fees are generally capped at $10.00 per week. In addition services such as community nursing are not available through a CACP and therefore a client may be charged fees under two regimes.

Tests for disadvantage and full or part waiver of fees also vary between programs.

The current application of user-pays can be seen to gear access to early intervention services towards those who can afford them or who are willing to pay, and to provide perverse incentives to seek sub-optimal care until need becomes acute. Those unable or unwilling to pay for higher levels of support that will prevent residential placement or hospital admission, remain with levels of service that are not optimum for their needs. The ensuing deterioration in health and well being is costly – both for the person's welfare and to tax-payer funded services – as the result is often that the wellbeing of the person declines and early or avoidable admissions to hospital beds or to other permanent higher levels of care such as a residential placement occur.

Moving towards a user-pays system can be appropriate if there is equity in the application, with the provision for fee waivers that are compensated for through provider subsidy, for disadvantaged groups. The concern with such an approach in residential aged care maybe that at the high care end of the spectrum, a person who chooses not to pay ends up by default in the State's health system. However this can be mitigated with careful program design.

A single system of funding is required that takes into account weightings for rurality, transport, level of care and client volumes is required that will give the provider the unit cost per day / per hour and the client responsible (with the provision for fee waiver and subsidy to offset the waiver) for the same costs wherever they reside – high, low or in hospital where the person has refused aged care placement. Safeguards are needed to ensure the person is not coerced into unsuitable placements.

(e) Whether the current planning ratio between community, high- and low- care places is appropriate

The Tasmanian Government suggests improved flexibility and cooperative approaches to managing the care of the older persons are needed to ensure the continuum of care truly operates irrespective of funder or program. Funding silos often undermine effectiveness. *Tasmania's Health Plan* is focusing the State's activities on integrated care in response to quality and demographic imperatives. Change to service planning is essential to ensure ongoing viability of both health and aged care initiatives and services. Where waiting lists exist for either high or low care packages the result is deterioration in well-being for the individuals concerned and ultimately excessive and prolonged use of hospital services. Prolonged stay in hospital is detrimental to the older person's level and rate of recovery and leads to increased requirement for higher and / or extended levels of community or residential care.

The Tasmanian Government stresses the importance of slow stream rehabilitation and transitional support to achieve functional improvement alongside enhancement of the person's quality of life. Over time this improvement reduces need for care and the person's funded need will reduce from high to low care – a positive for the client's quality of life as well as for reduced cost and resource utilisation. However, the current system creates disincentives to allow movement between package levels from high to low. Often the client or care professional is unwilling to risk a reduction of care in case need returns and the person is unable to access high care levels again without joining a waiting list.

Tasmania is experiencing an overall increase in the number of people who are waiting in an inappropriate setting for residential aged care. The increase is not only in respect to absolute numbers but also as a percentage of all people with an Aged Care Assessment Team (ACAT) approval waiting on residential placement.

While the majority of aged care type hospital patients are in the public system, a number of people are waiting inappropriately in other State funded specialist residential services and in private hospitals. Private hospital patients whose private insurance cover ceases are often transferred to a public hospital. On occasion, this occurs as an unplanned transfer via the Emergency Services Department.

It is anticipated that pressure on public hospitals to accommodate people awaiting a residential placement will only increase under the current arrangements. A further issue, with similar implications, is the number of hospital beds which are used to support people who are currently waiting on a residential aged care placement and whose current health condition would not normally require acute hospitalisation if they were living within an aged care facility.

People waiting for residential aged care whilst in hospital are competing with all other ACAT approved clients for the available spaces.

The table below shows the cost and volumes for prolonged stay for older people 2007-08 and for the first quarter of 2008-09.

Table 3: Cost of prolonged stay for older people in public hospitals in Tasmania

2007-08					
	1st Quarter	**2nd Quarter**	**3rd Quarter**	**4th Quarter**	**Year Total**
Number of Bed Days (referral to discharge)	7 155	7 793	5 126	6 757	26 831
Cost	$3,577,500	$3,896,500	$2,563,000	$3,378,500	$13,415,500
2008-09					
	1st Quarter	**projected Yr end**			
Number of Bed Days (referral to discharge)	7 034	29 013			
Cost	$3,517,000	$14,506,500			

DHHS Patients awaiting Transfer into Aged Care: figures current to January 2009

The Transitional Care Packages and Long Stay Older Patients programmes are proving effective in improving outcomes for older patients. For example Long Stay Older Patient initiatives have provided diversional services based in the Departments of Emergency Medicine that manage the presentation and admission of elderly clients away from acute settings where possible. Tasmania is also piloting an outreach program to the residents of aged care facilities in order to intervene early and so prevent the need for an acute hospital admission. The Transitional Care Program provides clients with opportunities for intensive rehabilitation placements before they return to their usual place of residence or to an aged care facility. The number of Transitional Care places available is however capped. Rehabilitation and other sub acute programs are essential to individual health outcomes. Good access and adequate staffing is needed for these programs to be fully effective.

The limited number of packages available means that people enter acute care and remain in hospital or awaiting community packages of care. A number of people become so frail, or carer support fails, while waiting for residential aged care in the community, that they are admitted to hospital and remain there until they are placed or die. Recent analysis indicates that the cost to

the Tasmanian Health system in 2007-2008 of older patients occupying beds was $13.4 million. This financial year the cost will be around $14.5 million.[10] More importantly, these aged care type patients occupy beds that could be used for surgery and other acute care services.

The tendency for service gaps and overlaps in the community aged care system - particularly under the HACC, CACP, EACH Package and Veterans Health Care programs - is often noted. In theory, each program has its own discrete role. The HACC program provides basic level support services to maintain an individual's independence. CACP and EACH packages provide a higher level of community care for individuals who would otherwise require low or high level residential aged care. Other Australian Government programs (ie National Respite for Carers (NRCP) and residential respite) then aim to provide separate but complementary services.

However in practice, both anecdotal and formal reports show that service gaps and overlaps are common. The variation in services provided under the various program types is so significant that clients ultimately receive an amount of care that can range from one to 50 hours per week.[11] The gap between funding packages creates problems. The difference in payments between CACP and the EACH package is too large. HACC fills this gap in the absence of a more appropriate intermediate support arrangement.

The Tasmanian Government suggests the current service model is outmoded, overly complex and ultimately unsustainable and suggests the Australian Government, working in partnership with States and Territories, should move towards seamless transitions rather than persist with a model based on levels of high, low or even intermediate care.

Funding All Levels of Need

In the future, community aged care programs should recognise the value of providing support for people at all levels of need.[12] Funding bodies should ensure that those with less intensive or immediate needs are supported – not just those requiring complex care. As discussed above, there are significant cost benefits in approaches that prevent functional decline at an earlier stage, thereby reducing or delaying the need for acute or residential care.

A possible strategy to ensure appropriate funding is achieved at all levels of need is to develop an overall definition of clients' requirements and establish proportionate allocation of resources to both basic and complex levels of need.

Simplification of Funding Bodies

The multiplicity of programs, funding bodies and service providers does lead to significant confusion not only for consumers but also within the sector. Rationalisation and integration of programs and funding arrangements is increasingly important to simplify access and ensure efficient and effective services.

(f) The impact of current and future residential places allocation and funding on the number and provision of community care places.

The current model of place allocation presents problems because of the difficulties associated with managing an ageing population within the context of the overall system. Package allocation and a focus on levels to fund only deals with part of the issue. It does not factor in the full range of care that is provided to the older person through acute health, primary health, rehabilitation and, later, sub acute rehabilitation. Isolated from wider core system package allocation becomes incidental to outcomes for so many frailer older people who remain stuck in one part of the core pathway. This is not only at a substantial cost to the tax payer – it creates a negative outcome for the older person.

Given the increasingly ageing demographic within Tasmania the problem is of great concern to the Tasmanian Government. Rurality exacerbates the problems experienced as discussed in (c) above, but the issue is not rural alone. For example, in the Southern and most populous region in Tasmania, the waiting lists for ACAT assessed persons to access services currently stands at 189 for residential aged care services and 224 for community packages. The costs created by the consequences of these waiting lists fall to the Tasmanian Government through increased, inappropriate and potentially avoidable use of its hospital system. To the older person for whom prolonged stay in hospital is detrimental to recovery; and ultimately the tax payer who is funding services that are more expensive and less.

Another area of concern to the Tasmanian Government involves the funding of the Tasmanian aged care residential sector. In Tasmania the widely dispersed population base keeps bed volumes in most aged care facilities below the 55-60 required to be viable. This combined with inadequate base funding and allowances and inadequate indexation makes aged care service provision an unattractive business in which to invest. When demand outstrips supply the ability to “cherry pick” increases the difficulties of placement of certain clients and increases cost to the State of alternate care. The Tasmanian Government has been advised anecdotally that the application rate by the Tasmanian residential aged sector for 2009-10 residential placements planning round is inadequate and possibly less than 50 per cent of allocated places. The issue of providers not nominating to take up available places needs careful investigation and analysis. However the issue seems to be related to the points above and the inadequate availability of capital to support building expansion or upgrade. A significant erosion of supply in the Aged Care Residential and Community Packages area will have significant flow on impact throughout the health and community service system, particularly in the area of acute hospital discharge.

While the ongoing development of a more sustainable strategy to manage aged care is being developed by the Australian Government in partnership with States and Territories, it would appear appropriate that the States and the Australian Government have an arrangement to reimburse each other for the costs associated with care of individuals that is the responsibility of the other party. The Tasmanian Government considers that the Australian Government should

reimburse the State for the full cost of providing care to an older person, who has an ACAT approval but is unable to be provided with the approved level of residential or community care and therefore remains in an acute bed or other inappropriate State funded care.

Maintaining the aged care workforce will be a significant limiting resource for the next two decades as baby boomer retirements increase.

The Tasmanian Government supports the types of service made available through the Longer Stay Older Patients and Transitional Care programmes, and the further development of Continuing Care Pathways but suggests that these services are more effectively and efficiently managed closer to communities. A centralised model of package “types” will never meet needs locally and will always result in service and funding silos where funds are expended fully but do not meet the needs of the client base nor achieve outcomes for the client. However centralised regulation, including policy and quality assurance measurements, with States and Territories managing the funding locally and held accountable for outcomes would ensure that client need and outcomes would focus on services rather than package “types”

Managing the ongoing interaction between the demand for aged care and the supply of services in the community sector, the hospital sector and in aged care residences is a complex ongoing task. In addition to longer term strategic national policy models there is a need to provide for local regional operating conditions over a shorter time frame. There are also significant differences in the constraints on supply of services between urban and rural settings, some of which can be alleviated with newer remote technologies.

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