ACSA
Aged & Community Services Australia

ROYAL COMMISSION INTO AGED CARE QUALITY AND SAFETY

AGED CARE PROGRAM REDESIGN: SERVICES FOR THE FUTURE

Submission

January 2020

ABOUT ACSA

Aged & Community Services Australia (ACSA) is the leading aged care peak body supporting church, charitable and community-based, not-for-profit organisations. Not-for-profit organisations provide care and accommodation services to about one million older Australians.[1]

ACSA represents, leads and supports its members to achieve excellence in providing quality affordable housing and community and residential care services for older Australians.

Aged care providers make a significant $17.6 billion economic contribution to Australia, representing 1.1% of GDP by producing outputs, employing people and through buying goods and services. The direct economic component is akin to the contribution made by the residential building construction and sheep, grains, beef and dairy cattle industries.[2]

ACSA members are important to the community and the people they serve and are passionate about the quality and value of the services they provide, irrespective of their size, service mix or location.

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[1] Australian Government, Department of Health, Report on the Operation of the *Aged Care Act 1997*, December 2016.
[2] Deloitte Access Economics, Australia's aged care sector: economic contribution and future directions, Aged Care Guild, June 2016, page 24.

AGED CARE PROGRAM RESDESIGN: SERVICES FOR THE FUTURE

BACKGROUND

On the 6 December the Royal Commission into Aged Care Quality and Safety (the Commission) invited submissions on the future design of the aged care system.

A consultation paper (the Paper) was released that explores options for future design of aged care programs. The Paper poses some key questions, along with underpinning 'principles'.

The Commission hearings held throughout 2019 identified a range of regulatory, care and system failures in aged care which are not acceptable and need to be acknowledged and addressed.

The Commission's Interim Report titled *Neglect* was released in October stating 'a fundamental overhaul of the design, objectives, regulation and funding of aged care in Australia is required – not merely patching up[3]'.

In response to the release of the Interim Report ACSA CEO Patricia Sparrow said "The Royal Commission has been important to expose significant problems and challenges. We can do better, and we will do better".

As the peak body for not-for-profit aged care providers we are therefore pleased to respond to this Paper. Our submission responds to the questions and ideas put forward by the Commission. We have not sought to re-explain system issues or evidence, taking these as a given, to facilitate a clear and simple response to the Commission's ideas.

ACSA is separately developing its broader reform and design vision for aged care and will make that available to the Commission, and publicly, as soon as it is available.

[3] About the Interim Report, Royal Commission into Aged Care Quality and Safety, Thursday 31 October 2019

RESPONSE TO DESIGN QUESTIONS

Q1 / WHAT ARE YOUR VIEWS ON THE PRINCIPLES FOR A NEW SYSTEM, SET OUT ON PAGE 4 OF THE CONSULTATION PAPER?

ACSA broadly supports all of the principles espoused on page 4 of the consultation paper. We particularly think the inclusion of principles on the right to a good death and equity of access are very important to improve the quality of service delivery and system operation. The below comments are focussed on the principles we think need to be fleshed out further or incorporate other elements to be meaningful and drive reform.

Be underpinned by respect and support for the rights, choices and dignity of older people

This effectively describes a human rights approach but doesn't clearly articulate that. ACSA supports a clear human rights approach to aged care. It is one of the founding principles that must be embedded in service provision as we prepare for aged care reforms for the future. Aged care legislation must support a human rights approach, or more specifically legislation must promote 'outcomes' that are consistent with a human rights approach.

A human rights approach will provide baseline protections for older people who need aged care and provide a framework to guide decision making[4]. Aged care services must be non-discriminatory, promote equality, services must be available, accessible, appropriate and of good quality[5].

The human rights approach is often taken to mean the rights of an individual above all else. ACSA's view is that while the rights of the individual are central, there must also be balance with the rights of the those around them or the community of people they interact with. This is to say an individual's rights must be exercised giving consideration to the welfare and wellbeing of others, or to put it yet another way individual rights should never be considered in isolation, they cannot be absolute. This is particularly pertinent in communal living environments such as residential aged care, where we need to consider everyone not just the individual, including providers having a responsibility to protect employees through the provision of a safe work environment.

Compassion and respectful relationships[6] must be embedded within the principles, covering consumer to consumer and consumer/staff relationships.

In addition, it will be important for an aged care system of the future to invest in building community as well as supporting individuals. This is equally important for people living at home and for those living in residential care. Community focus and social infrastructure also ultimately assist in meeting needs of individuals and this shouldn't be overlooked.

[4] A human rights approach for ageing and health – Respect and choice: home based and residential care for older people, Australian Human Rights Commission, 2012, Executive Summary, 2012

[55] Ibid

[6] Respectful relationships are also referenced in the Charter of Aged Care Rights, see here

Be transparent, easy to understand and navigate

Transparency, in relation to the use of Government funds and aged care operations, has been a key feature throughout the Commission hearings. It is a key principle in increasing trust in the aged care system and in individual providers.

ACSA has consistently advocated that services must be transparent in the information they provide to consumers (including financial information, terms and conditions of contracts etc.) and in the quality and outcomes of their services. In addition, consumers must be able to readily compare like services against each other to better enable them to make informed decisions about the services they are considering.

Both transparency and comparability are paramount to consumers having confidence in the sector. Both elements should be incorporated into the principles.

Maximising independence, function and quality of life

ACSA supports an increased focus in maximising these three outcomes as a system bedrock from assessment through to service provision. This needs to be underpinned by an approach to funding that enables these outcomes to be achieved.

Greater coordination needs to occur between acute and primary health services and aged care, to ensure that older Australians that require rehabilitation have access to rehabilitation services. Timely access provides a greater likelihood that people requiring short term inputs stand a greater chance of being able to remain living in the location of their choice, minimising the risk of premature transition to more intensive support services.

Linking and agreeing this principle across systems, including health, will be important in giving effect to this principle.

(We address independence and function in more detail in Q5, see page 11).

(We address quality of life outcomes in more detail in Q10, see page 26).

Recruitment and retention of a skilled, professional and caring workforce

Workforce is one of the most pressing issues for the sector. Securing a 'right-fit' workforce for the future is vital and should be incorporated, along with ensuring people have the right skills[7]. You can train for skills and qualifications, but ensuring staff have the right attitudes and attributes to be a compassionate and successful worker is significantly harder.

The need to recruit and support right-fit workers should be incorporated into the principle.

Support effective interfaces with related systems, particularly health and disability

Greater coordination between aged care, primary care services, acute health, community health (including community pharmacies) and disability services is required. Cross

[7] 'Right fit' referring to workforce that has the right attitude, approach, skills and knowledge to enable the delivery of quality services to older Australians

jurisdictional connections need to be strong to ensure older Australians receive consistent care when moving between these different components of health and aged care.

At the individual level, access to high quality transitional care is important for older Australians with multiple chronic conditions and complex therapeutic regimes[8]. At a systems level, good interaction between different jurisdictions (Commonwealth/State/Territory) is required to coordinate funding and programs to ensure older people receive the care and services they require.

This should be seamless and behind the scenes so that it does not impact on the individual.

Interface between aged care and disability is one that requires ongoing development, particularly post-introduction of NDIS where people younger than 65 years of age are able to receive NDIS funding (significantly greater than that available in aged care) but those diagnosed with a disability who are over the age of 65 are not.

The key principle for access to any service is that similar/same needs are met (funded) in the same way, regardless of their age (whether under or over 65 years of age) or where they live (in their own home, in aged care or in disability accommodation). This will remove discrimination (in terms of funding differences and therefore care outcomes) between people and should be enshrined in the principles.

Consideration needs to be given to how these principles can be given life and apply equally across all relevant related systems.

Be affordable and sustainable, both for individuals and the broader community

Aged care must remain available to all older Australians regardless of means. ACSA advocates that those who can afford to contribute to their care should be required to do so, and those who cannot must be subsidised by Government.

Protections must be in place for services operating in 'thin markets' as well as for older Australians with special needs. Australia must guard against any slide towards a two-tier care system.

This principle also needs to recognise that services need to be sustainable for the provider to deliver. This is currently not the case. Funding must be adequate and support providers to deliver care and services that meet community expectations and that provides for sector sustainability over the long-term.

(We address affordability and sustainability in more detail in Q9, see page 20).

These principles appear across multiple questions responded to below; when the characteristics of a principle (for example 'access' or 'sustainability') are described by us, every subsequent reference to the principle should be read to espouse the characteristics of that principle.

[8] Transitional Care: Moving patients from one care setting to another, Naylor M. & Keating S., NHS Public Access Author Manuscript, USA.

Q2 / HOW COULD WE ENSURE THAT ANY REDESIGN OF THE AGED CARE SYSTEM MAKES IT SIMPLER FOR OLDER PEOPLE TO FIND AND RECEIVE THE CARE THAT THEY NEED?

The Commission has clearly articulated the shortcomings of the current entry and access point to the aged care system.

The 2011 Productivity Commission report[9] recognised that consumers had difficulties accessing the aged care system. The Report proposed an entry point that provided easily understood information, included an assessment component (of both support need and financial status), entitlement to approved aged care services and for care coordination – all available locally. My Aged Care (MAC) was subsequently established.

What was implemented fell short of the original proposal and MAC has not reached its full potential. It has, in fact, created some other access issues which now need to be addressed.

Future reform could build on and improve MAC or create a new front end to the system. The system must be designed to provide support and respond positively to the most vulnerable people in our community. This includes homeless people, people with cognitive impairment and those who speak other languages or have communication difficulties. If this is achieved it is likely the system will respond well to all older people.

Regardless of which option proceeds the entry and access point needs to be provided online, through a call centre and face-to-face support including:

- Case-management and system navigation support, this is particularly important for people with special needs such as respite, Culturally and Linguistically Diverse (CALD), Aboriginal and Torres Strait Islander people (ATSI), homeless, and those with complex needs etc.;
- Personal support to navigate the system, where possible, to be provided through regionally based service outlets. Where face-to-face is not practicable, say for example in remote locations or communities, suitable on-line/video support should be an option, or alternatively provided through local health services or health professionals who are credentialed to provide navigation and assessment supports;
- Readily available information in a variety of formats (on-line, in written or video form, formats for people with hearing loss and/or visual impairment, community languages and for people with limited literacy etc.); and
- Supports to people while they are waiting for their assessment and then until such time as the service/s starts to be delivered.

[9] Caring for Older Australians Productivity Commission Inquiry Report Overview, no. 53, Productivity Commission, Australian Government. June 2011, pxxviii

Q3 / INFORMATION, ASSESSMENT AND SYSTEM NAVIGATION – WHAT IS THE BEST MODEL FOR DELIVERY OF THE SERVICES AT THE ENTRY POINT TO THE AGED CARE SYSTEM – CONSIDERING THE IMPORTANCE OF THE FIRST CONTACT THAT OLDER PEOPLE HAVE WITH THE SYSTEM? THIS INCLUDES LOOKING AT SERVICES PROVIDED BY PHONE AND WEBSITE AS WELL AS FACE-TO-FACE SERVICES.

Very few people plan ahead for their aged care needs. This can result in people having to navigate a complex environment and make significant decisions, often under stress following health events or an increase in their (or their loved one's) support needs. This is particularly true for those with higher care or support requirements.

The older person may not be well placed to navigate the complex system including organising an assessment and then identifying the right service provider/s to meet their needs. Conversely, the older person may have simple support needs but still have to navigate a complex system to get access to low levels of support.

This challenge may be exacerbated for the older person who may be experiencing hearing loss or vision impairment, they may be computer illiterate or have poor access to online services. Compounding these challenges, they may lack family or social supports to help them and/or their support people may also find the system difficult to navigate.

The need for supports for individuals and their support people facing a complex and confusing aged care system has been widely recognised [10].

In relation to system navigation, future age care requires:

- Easily understandable information in a variety of formats from a central point (an improved My Aged Care[11]);
- A simple assessment for people with low level support needs, referring on for more complex assessments should that be required; and
- Implementation of a network of regional aged care navigation services able to provide face-to-face support, including to vulnerable people[12] through registration, assessment, and finding the right provider, right up until service delivery commences.

The assessment service accessed through the gateway will:

- Provide accurate, timely, responsive, free and independent assessments that are easy for consumers to understand and use to access the services they need;

[10] The Productivity Commission Review Caring for Older Australians: Overview, Report No. 53, Final Inquiry Report, Canberra 2011 and the Legislated Review of Aged Care 2017, Tune D., Commonwealth of Australia, Department of Health 2017.

[11] There is evidence that community awareness of My Aged Care is low and that this reduces the effectiveness of aged care planning (Legislated Review of Aged Care 2017, Tune D., Commonwealth of Australia Department of Health, 2017, p11)

[12] There are currently a range of trial programs being trialed across Australia. These trials aim to ensure that more senior Australians can access support and information about aged care services that meet their needs. The programs are said to offer new ways for consumers who face barriers to access or who are 'vulnerable', to find support. These trials are being led by COTA. Trials of information hubs, community hubs and specialist support workers are occurring. The Aged Care Navigator pilot is funded to mid-2020.

- Be undertaken by an integrated and independent assessment workforce able to assess all aged care programs (in-home care and residential care) and provide referral to mainstream services the older person is entitled to receive (including health, dental etc.), be multi-disciplinary in makeup, correctly resourced, well trained and culturally aware/competent and cognisant of special needs groups[13] (e.g. ATSI, CALD, LGBTIQ and homeless);
- Take a wellness and reablement approach, including offering short-term services prior to determining and providing ongoing services, to ensure the right level is made available and that independence is supported and maximised;
- Supported by an assessment tool that is valid in whatever environment it is used (hospital, the consumer's home etc.), with a robust design for inter-user reliability with consistent application of the tool by assessors across states and territories (free of vested/conflicts of interest);
- Resourced and equipped to provide timely services including to individuals needing services in regional, rural and remote (RRR) areas (which may require credentialing use of local services or professionals to undertake assessment and provide navigation support) as well as timely review and reassessment;
- Technology is well utilised to support assessments occurring in rural and remote locations, particularly where there are no locally based assessors. This provides for timely and efficient access to assessments and subsequently service support;
- That are evidence based (algorithm-driven) and provide appropriate prioritisation of assessments ensuring people that require urgent support are addressed; and
- The system has a mechanism to provide interim, time-limited supports to people who require it while they are waiting.

[13] The navigator trials have identified a range of vulnerable consumers including; those who live in regional and remote locations; CALD; those with limited access to the internet; those who identify as gender diverse, homeless, those with cognitive impairment; hose with mental health; and those unlikely to seek aged care support without getting assistance from others.

Q4 / ENTRY LEVEL SUPPORT SYSTEM – AS PEOPLE AGE AND NEED SUPPORT WITH EVERYDAY LIVING ACTIVITIES, HOW SHOULD GOVERNMENT SUPPORT PEOPLE TO MEET THESE DOMESTIC AND SOCIAL NEEDS?

Older people need to be able to access mainstream health and other services as well as aged care specific supports. Some may need to be available to all and are part of social and community infrastructure (such as community transport, social support, senior citizens centres (or equivalent)) while others may only be provided on the basis of an assessed need.

Universal services

Government to provide a range of universal services at no (or minimal) cost to older Australians, these services designed to provide information and educate on matters/services relevant to older people (health related, legal, service finding etc.); provide social supports that help people remain connected to their community; transport services; support with meals etc. These services may be provided in conjunction with local government authorities, service bodies, not-for-profit agencies and others.

Services based on assessed need

Where there is an assessed need, services are provided through a combination of taxpayer funding and individual contributions where people have the financial means to do so. Age is only part of the considerations in determining need and there may be some instances (e.g. domestic assistance) where the individual is eligible, but sources and pays for the service separate to any government supports. This includes funding for 'entry-level' supports such as gardening, maintenance and domestic supports.

Funding for this level of service support should occur where it can be demonstrated that the support will assist the person to remain living in their home for longer.

Government funding should act as a safety net.

In relation to entry level supports, future aged care requires:

- An integrated in-home support program which recognises the importance of time limited services, entry/low level services as well as providing for higher levels of support to those who need it;
- That those people who need immediate support can gain a level of interim support during the period they are being assessed by My Aged Care, undergoing assets and means testing and searching for a service provider;
- A reablement approach applied to service delivery; and
- A consistent approach to means-testing and fees structure[14] for all people receiving funding to remain living in their own home.

[14] ACSA recommends the adoption of means testing and consumer contribution related recommendations of the Tune Review (Recommendations 12, 15 and 16). (Legislated Review of Aged Care, Tune D., Commonwealth of Australia, Department of Health, 2017)

Q5 / INVESTMENT STREAM – THE BENEFITS FROM REGULAR AND PLANNED RESPITE, REABLEMENT AND RESTORATIVE CARE ARE WELL DOCUMENTED, BUT THE SERVICES ARE IN SHORT SUPPLY. WHAT INCENTIVES, INCLUDING ADDITIONAL FUNDING, COULD BE INTRODUCED TO ENCOURAGE PROVIDERS TO OFFER GREATER AND MORE FLEXIBLE OPTIONS, INCLUDING MAJOR HOME MODIFICATIONS AND ASSISTIVE TECHNOLOGIES, WHICH MEET THE NEEDS OF THE OLDER PERSON, CARER AND CARING RELATIONSHIP?

Respite care

Having the ability to access respite, as either a planned activity or in emergencies, is vital to ensuring carers are able to care for their loved ones over extended periods. This allows older Australians to remain living at home for as long as practical.

Where respite services[15] are not available there is risk to carer health and wellbeing and of premature admission to residential aged care.

In relation to respite services, future aged care requires:

- A coordinated national approach to funding respite services across both community and residential aged care settings which can be accessed through individualised funding (for those living at home) and a residential approach (including residential aged care and respite cottages etc.) that ensures availability;
- The entry and access point/s (My Aged Care or the Carer Gateway) work seamlessly to support individuals to identify and find the right respite services or combination of services to support them;
- A mix of individual, community and residential respite services are available in all areas around Australia;
- Funding ensures availability by fully funding the cost of delivering respite services in residential care[16];
- Government to address equity of access for special needs groups; and
- Consistency in approach to fees be developed across different programs/service streams including respite care.

Assistive technology

Assistive technology (AT) has the capacity to deliver positive health and wellness outcomes to older Australians[17] and is presently underutilised in aged care service delivery. They need to be a key future service element as an offer to an individual as well as appropriately funded and supported to be part of the service system.

ACSA, as a member, supports and recommends the Commission review the National Aged Care Alliance (NACA) Position Paper *Assistive Technology for Older Australians*[18].

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[15] The Aged Care Financing Authority identified a number of key themes as part of their review of respite services (Report on respite for aged care recipients, Aged Care Financing Authority, Australian Government, October 2018

[16] ACSA intends to discuss this point in more detail in its separate 'design vision' paper referred to in the 'Background' section of this submission

[17] Position Paper Assistive Technology for Older Australians, National Aged Care Alliance, June 2018

[18] Position Paper Assistive Technology for Older Australians, National Aged Care Alliance, Australia, June 2018

Key elements for future program design are:

- Establishment of a national AT program or coordinated funding streams through case management that ensure people have access to AT, regardless of age or disability – this could be established through the Council of Australian Governments and address the sometimes confused/jurisdictional approaches by bringing them together or focusing on wrangling funds that meet an individual's needs;
- Increase investment across home care/residential care;
- Data on outcomes and usage to be collected and monitored to drive investment and program improvements; and
- Increase consumer awareness and literacy on the availability and breadth of AT support.

ACSA also supports the development of technology designed to support older people to maximise function. To this end a new partnership between ACSA, the Aged Care Guild and the Digital Health Cooperative Research Centre will drive technology related innovations and better care for older Australians.

Reablement / Restorative care

Wellness and reablement programs are powerful ways to assist older people to improve their function, independence and quality of life. This is the primary reason why such services need more focus in aged care in the future. In addition, their provision can delay the need for services for a period of time altogether or reduce the level of ongoing support that is required[19] which is important for demand and system management.

- These services therefore need to be an integral component of the future system: the gateway/assessment should recognise where a person has a short term need for reablement services that would allow them to retain or maximise function and remain living in the location of their choice[20] for longer, without support or with a reduced amount of support. The system must provide for the provision of short-term, time-limited interventions, this will require a person to be readily able to flex in/out of the aged care system;
- Commonwealth/State/Territory wellness and reablement programs need to be well coordinated across jurisdictions to ensure older Australians receive the reablement services they require, when and where they require them;
- Access to reablement services must identify and support 'special needs' groups, for example those people with a diagnosis of Motor Neuron disease, enabling people to remain as independent as possible and living in the location of their choosing for as long as practical, reducing the risk of prematurely needing higher level supports;

[19] Silverchain in Western Australia through their Home Independence Program demonstrated considerable benefits to providing reablement approaches for people at an early stage, reducing the need for many to progress to more intensive levels of program support (for example for people at a low service need level who undertook the Silverchain program showed that reablement reduced the need for home care support, with just over half the clients at three months and nearly three quarters at twelve months not using any home care service at all. A further 19 per cent and 14 per cent were using the same or lower level of service at these time points than at baseline, despite having been referred because their needs had increased (The Home Independence Program with non-health professionals as care managers: an evaluation, Lewin G. et al, Clinical Interventions in Aging, 2016, 11: 807-817, June 2016)

[20] The older person, and their desire to remain living in the location of their choice for as long as practical should be the guiding principle of wellness and reablement programs

- A diagnosis of cognitive impairment, or an advanced age, should not, on their own, preclude that person from receiving such a service[21], particularly in circumstances where such support would enable them to continue to live at home[22];
- Funding for wellness and reablement should follow the consumer; and
- That living in a residential aged care service should not preclude an older person from receiving rehabilitation support equivalent to that received by someone living in the broader community. Providers of residential aged care should be in a position to receive short-term additional funding to provide time-limited intensive rehabilitation to a resident following an acute health episode.

[21] Anecdotally ACSA is aware of examples of where an older person would benefit from rehabilitation following a medical event, to enable them to remain living at home, but has not received such support because of an underlying cognitive impairment. Older people with cognitive impairment should be recognised as a special needs group who require access to reablement programs.

[22] Health professionals with appropriate qualifications/skills in gerontology/rehabilitation must be charged with determining appropriateness of an older person being provide rehabilitation services. Rehabilitation services should be universally available to all older Australians.

Q6 / CARE STREAM – AS PEOPLE'S NEEDS INCREASE AND GO BEYOND WHAT CAN BE MANAGED WITH ENTRY LEVEL SUPPORT OR WITH THEIR CARER, THEY MAY NEED CARE SERVICES – PERSONAL CARE, AS WELL AS NURSING AND ALLIED HEALTH. WHAT ARE THE ADVANTAGES AND DISADVANTAGES OF DEVELOPING A CARE STREAM, INDEPENDENT OF SETTING?

ACSA supports an approach that identifies and funds the provision of care services to individuals, including funding 'following' the individual. Government should fund assessed care needs regardless of where the consumer lives or through which program they receive support.

This is easier to achieve in home care than in residential care and much more thought and discussion is needed if this is to be the recommended reform. The NDIS has blazed a trail and there have been successes but also issues which we need to understand and learn from before moving down this path, noting that disability is also the subject of a Royal Commission at this time.

Currently in residential care, accommodation costs and care costs are separated:

- Care is subsidised by government through the Aged Care Funding Instrument (ACFI) on assessed need, and related supplements (for example for oxygen therapy);
- 'Hotel services' costs are funded through resident fees[23]; and
- And accommodation charges cover the cost of occupying a room[24].

So, in one sense the residential care stream is already funded separately from accommodation. The Paper is proposing combining this with care provided to people living in their own homes to create one care stream of funding. This could be done with pricing that acknowledges the cost variances of care based on the location of delivery or recognising that you may be able to buy less in one setting than another and that is a choice point for individuals.

There are efficiencies of scale gained in residential care when providing care to multiple residents through the pooling of care income (ACFI and subsidies). For example, it supports collective programs, such as activities programs, to be made available for everyone. This is much harder to achieve if there are only individual budgets.

It will be important to analyse this approach throughout the various Royal Commission forums to determine whether this reform is the right approach that will deliver quality of care to older Australians.

[23] Hotel services costs are defined as day-to-day living costs covering meals/laundry/cleaning/utility costs. These are funded through the resident 'basic daily fee' and where means tested as applying, the 'means tested care fee'.

[24] The amount due depending on assessed income and assets.

Q7 / SPECIALIST AND IN-REACH SERVICES – HOW COULD THE AGED CARE AND HEALTH SYSTEMS WORK TOGETHER TO DELIVER CARE WHICH BETTER MEETS THE COMPLEX HEALTH NEEDS OF OLDER PEOPLE, INCLUDING DEMENTIA CARE AS WELL AS PALLIATIVE AND END OF LIFE CARE? WHAT ARE THE BEST MODELS FOR THESE FORMS OF CARE?

The provision of quality contemporary palliative/end of life care services to older Australians receiving aged care services, whether in their own home or in a residential aged care facility, is integral to service quality. There needs to be a variety of models that meet different circumstances and location including:

- In the person's home if they are receiving a high-level home care package;
- In a residential aged care facility if the person resides there; or
- In an acute health setting or palliative care centre.

ACSA advocates for the provision of palliative care in-reach services for people requiring palliative care whether this is in their own home or in a residential aged care facility, such a service could incorporate an advisory service, direct care support and staff education.

In some instances, a particular setting will be preferred or required based on the level of need or the individual's wishes. Adequate funding[25] needs to be made available for palliative/end of life care based on the individual's needs and staffing requirements regardless of the location of the delivery. For example, if a residential aged care home is providing the same level of care as that in an acute setting the funding should be the same.

In addition, it needs to be acknowledged that both the health and aged care systems play a role in ensuring a person has a good death in aged care service. The systems need to work together to ensure that outcome, and the program design needs to support this occurring.

[25] The Productivity Commission report of 2011 recommended that 'Government should ensure that residential and community care providers receive appropriate payments for delivering palliative and end-of-life care'. The report stating that the appropriate payment to providers should be determined by Government in consultation with the National Hospital Pricing Authority (Caring for Older Australians Productivity Commission Inquiry Report Overview, No. 53, Productivity Commission, Australian Government, June 2011.

Q8 / DESIGNING FOR DIVERSITY AND IN REGIONAL AND REMOTE – CARING FOR PEOPLE WITH DIVERSE NEEDS AND IN ALL PARTS OF AUSTRALIA HAS TO BE CORE BUSINESS, NOT AN AFTERTHOUGHT. HOW SHOULD THE DESIGN OF THE FUTURE AGED CARE SYSTEM TAKE INTO ACCOUNT THE NEEDS OF DIVERSE GROUPS AND IN REGIONAL AND REMOTE LOCATIONS?

"Australia is a diverse nation, and older people display the same diversity of characteristics and life experiences as the broader population[26]"

ACSA advocates for an aged care system that provides equitable access and appropriate care for people from diverse backgrounds. Many ACSA members are not-for-profit organisations founded to deliver appropriate and safe care to people of diverse backgrounds and in diverse locations.

ACSA supports the use of appropriate aged care diversity frameworks to guide practice[27].

Older Australians must have access to aged care services that are 'culturally safe'.

In relation to diversity, future aged care requires:

- The system must be designed to provide support and respond positively to the most vulnerable people in our community, including those with diverse needs;
- Appropriate action as recommended earlier regarding easy to access information in a variety of formats;
- The provision of case management and system navigation support (particularly important for people from culturally and linguistically diverse backgrounds, people from a homeless background, indigenous Australians, and other people with special needs);
- Inclusion of specialist services and knowledge in assessments for better outcomes for diverse needs, including for example vision impairment and disability for younger people;
- A coordinated approach to the numerous programs that support the sector address diversity, including the PICAC program;
- Development of national 'e-interpreting' services to assist diverse cohorts to access information about aged care services and to assist with aged care assessment support; and
- Associated costs, including providing ongoing and comprehensive language services for clients from CALD communities, needs to be built into funding and service models to ensure equity of access.[28].

[26] Aged Care Diversity Framework, Aged Care Sector Committee Diversity Sub-group, Department of Health December 2017, p2

[27] The Aged Care Sector Committee Diversity Sub-group provided advise to Government in the development of diversity guidelines, in February 2019 a range of guidelines were developed to assist the sector to provide informed support to diverse client/resident cohorts who receive aged care services: The Guides can be found here

[28] This is consistent with recommendations in the 2011 Productivity Commission report (Caring for Older Australians Productivity Commission Inquiry Report Overview, No. 53, Productivity Commission, Australian Government, June 2011)

Supporting Services for the Homeless

Homeless older Australians are a special needs group that have particular characteristics which creates difficulties for them in accessing and utilising main stream aged care services. It is vital that aged care of the future is designed to respond flexibly and compassionately to their particular needs. Some key points ACSA would make are:

- Homeless individuals are supported by specialist providers while they wait to secure a home care package, this will help to address where an individual is transient;
- That the additional costs[29] associated with providing (often extensive) support to homeless people must be adequately funded[30]; and
- Providing capital for homeless providers who are unable to raise such funds independently.

Access in regional and remote locations

Access can be impacted by:

- The 'tyranny of distance', the challenge of geographically distant communities and services (that are often distant from where the consumer lives) creates very real challenges in accessing services;
- IT limitations create access challenges, as does IT literacy for may CALD consumers and those older Australians in very remote communities;
- Transportation and travel challenges, including significant cost burdens associated with travel (for both the consumer and service provider), compound access challenges; and
- Access to health practitioners (nursing, medical, allied health etc.).

ACSA has consistently voiced concerns about the difficulties faced by providers seeking to deliver care to older Australians living in rural and remote areas. It is worth noting that most providers operating in these areas are not-for-profit organisations.

Equitable access should be achieved through 'in person' support visits by health professionals whenever possible, or alternatively through access to reliable telehealth and on-line services[31].

Different funding and service models (including acknowledgement that market-based approaches are ineffective in many rural and remote communities) are needed to improve access to services in such locations. Block funding – whether that be a straight grant, or a proportion of funding as proposed in the AN-ACC[32] model or funding based on bed numbers

[29] Additional costs may include assisting to negotiate rents or find alternate accommodation, taking a client to a health or specialist appointment, purchasing clothing, assisting with disputes with neighbours or helping to escape violent or abusive situations.

[30] Homeless supplement for aged care, see here

[31] While people living, or services operating, in rural and remote areas are technically able to access such services there are not always the resources to support face to face or telehealth provision, which is ideal for the type of personal and clinical support offered.

[32] The proposed residential aged care funding tool (AN-ACC) developed as part of the Resource Utilisation and Classification Study proposes a 'weighted' component of funding for providers in rural and remote settings to recognise the cost burden these providers experience in providing services where they are located. A similar approach in the Home Care Package program could be implemented, whereby the cost burden of providing services to very remote communities could be addressed, making the cost of delivering these services viable (ACSA is aware of a provider in Western Australia who cross-subsidises the cost of providing services to remote areas through other parts of its business).

rather than occupancy for residential aged care - is likely to provide a better outcome for services that by their nature operate as a more place based than individually based model. This should include capital grants for rural, regional and remote residential aged care providers to build or upgrade facilities given their often more limited access to capital funding[33].

As part of this the mechanisms used to determine differential funding (such as the Modified Monash Model[34] (MMM)) need to be reviewed and/or amended to ensure they identify and direct additional financial support to the priority areas.

There are also additional costs in delivery of services at home that need to be recognised including for example transport. If these are not properly recognised the level of service provided to an individual is inevitably reduced.

Delivering aged care services to regional and remote ATSI communities

Many indigenous services are geographically remote and small in size with low population densities, complicating service delivery and impacting directly on the cost of service delivery[35]. Funding to such services must address the cost burdens of delivering these services, with funding adequately addressing care recipient needs. As the financial situation of providers continue to worsen, so too will their ability to cross subsidise services[36].

Aged care services which deliver care and services to indigenous Australians must be designed to deliver these services in a culturally appropriate manner[37] by staff that are skilled and equipped to understand the specific needs of older Indigenous Australians[38].

Additionally, these services should ideally be in locales that allow older Indigenous Australians to remain in their community[39] (place-based) to minimise social and cultural dislocation from family.

ACSA supports the concluding remarks of the Royal Commission regarding aged care services for Aboriginal and Torres Strait Islander peoples[40].

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[33] Capital grants are funded from the Rural, Regional and Other Special Needs Building Fund, see here

[34] https://www.health.gov.au/health-workforce/health-workforce-classifications/modified-monash-model

[35] Royal Commission into Aged Care Quality and Safety, Interim Report Neglect Volume 1, p184

[36] Ibid, pp184-185

[37] The Royal Commission into Aged Care Quality and Safety indicated that evidence presented at multiple Hearings 'reinforced the importance of cultural safety and its consideration in the provision of aged care services'. A culturally safe environment being described as a place where 'people feel safe and secure in their identity culture and community'. Most importantly, 'the care recipient, not the provider, determines if cultural safety is achieved'. (Royal Commission into Aged Care Quality and Safety, Interim Report Neglect Volume 1, p175)

[38] David Tune noted in his 2017 report that NATSIFACP program had been generally well received by stakeholders but there was still a need to expand the program further into rural and remote locations (Recommendation 31) (Legislated review of Aged Care 2017, Tune D., Commonwealth of Australia, Department of Health, 2017)

[39] The Royal Commission into Aged Care Quality and Safety describes Aboriginal and Torres Strait Islander people having a 'strong preference to receive care in their community and to stay on Country'. (Royal Commission into Aged Care Quality and Safety, Interim Report Neglect Volume 1, p177)

[40] Concluding remarks on aged care services included listing key features: a/Providing accessible aged care assessment pathways; b/Integrating aged care with other services; c/Devising culturally appropriate assessment processes; d/Facilitating aged care provision on Country and 'return to Country; e/Greater provision for Aboriginal and Torres Strait Islander specific services in cities and regional

ACSA suggests the following actions to address the delivery of services to ATSI peoples:

- Barriers to securing 'right fit' workforce in remote communities are identified (housing, security, transport and remuneration, limited local education opportunities, lack of infrastructure etc.[41]), and strategies to address these barriers developed and implemented;
- Partnerships between indigenous and non-indigenous organisations to support cultural safety using the guiding principles as described in the Aged Care Sector Committee Diversity Sub-group[42] guide *Actions to support older Aboriginal and Torres Strait islander people, A guide for aged care providers*;
- Services are 'place-based'[43] and supported by flexible funding programs[44];
- Government to expand the National Aboriginal and Torres Strait Islander Flexible Aged Care Program and funding, to better recognise the additional costs of delivering services in small, remote communities;
- Government address core issues facing Indigenous Australians throughout their life journey (employment, housing, health, education et al) understanding this will positively impact these peoples as they age; and
- Indigenous health workers to be integrated into local service delivery programs.

areas; and f/Providing easier access to respite care. (Royal Commission into Aged Care Quality and Safety, Interim Report Neglect Volume 1, p19)

[41]Addressing Aged Care Workforce Issues in Rural and Remote Australia Report, Australian Association of Gerontology Regional, Rural and remote Special Interest Group, July 2019, p11

[42] The guide for aged care providers, produced by the Aged Care Sector Committee Diversity Sub-group to address their cultural needs outlines 6 outcomes for consumers covering: 1/Making informed choices; 2/Adopting systematic approaches to planning and implementation; 3/Accessible care and support; 4/A proactive and flexible aged care system; 5/Respectful and inclusive services; and 6/Meeting the needs of the most vulnerable. (Actions to support older Aboriginal and Torres Strait islander people, A guide for aged care providers, Aged Care Sector Committee Diversity Sub-group, 2019)

[43] Place based initiatives are programs designed and delivered with the intention of targeting a specific geographical location and particular population group in order to respond to complex social problems. https://aifs.gov.au/publications/commonwealth-place-based-service-delivery-initiatives

[44] An example of Home Care services being delivered in local communities is the APY Lands Commonwealth Home Support Program auspiced by Aboriginal Elders & Community Care Services in South Australia. www.aboriginalcs.org.au

Q9 / FINANCING AGED CARE – WHAT ARE THE STRENGTHS AND WEAKNESSES OF THE CURRENT FINANCING ARRANGEMENTS AND ANY ALTERNATE OPTIONS THAT EXIST TO BETTER PREPARE AUSTRALIA AND OLDER AUSTRALIANS FOR THE INCREASING COST OF AGED CARE?

Much has been written about the deteriorating financial status of aged care providers over recent times[45], including by ACSA. We covered sustainability pressures in our Residential Care Submission to the Royal Commission into Aged Care Quality and Safety (see here), as we did in our Witness Statement of CEO Patricia Sparrow (see here).

Currently there is a mix of taxpayer subsidy for all funded services and individual co-contributions based on a form of income or means testing. This can continue with the current approach being reformed or the system could move to a hypothecated tax though a Medicare levy for example.

Australia spends much less of its GDP on aged care services than other countries, such as Denmark or Sweden, who are often cited as exemplars in supporting older people[46].

With increased levels of resident complexity and needs aged care providers must be funded to provide the level of support required and that the community expects. Adequate base level funding accompanied by indexation that matches real growth in costs (ACSA recommends indexation is match to the Wage Price Index[47]) is required. The financial issues being experienced by the sector must be addressed to reverse the current negative trend (with 51 per cent of homes now recording an operating loss[48]) which is a real and present threat to service access, diversity and capacity. Not-for-profit providers exist with the single purpose of delivering high quality care of older Australians, they must be supported to deliver on this purpose.

The historical strengths and weaknesses of the current financing arrangements are summarised below.

[45] Including StewartBrown in their Aged Care Financial Performance Survey Sector Report: Financial year ended 30 June 2019, October 2019, that describes 53% of homes having a negative Aged Care Home result, this rising to 74% for rural and remote providers. The Aged Care Financing Authority (ACFA) in their annual report for the 2017-18 year also described a deteriorating financial status of both residential care and home care providers (Seventh report on the Funding and Financing of the Aged Care Industry, ACFA, Australian Government, July 2019).

[46] The Daily Commission, DCM Media, 24 January 2020, Edition 227

[47] Indexation should be aligned to the wage growth of the health care component of the Wage Price Index

[48] Aged Care Financial Performance Survey Sector Report: Quarter ended 30 September 2019, StewartBrown, January 2020

Historical strengths of the financing arrangements

Residential Care

- Bed licensing arrangements[49] historically provided a measure of service availability in all areas and funding certainty for providers - this funding certainty was viewed positively by banks and other commercial funders;
- Refundable Accommodation Deposits have traditionally provided a source of capital for redevelopments and refurbishments;
- Prior to 2014 the 'retention' model for Accommodation Bonds supported stronger financial position of providers[50];
- Capital grants[51] to assist providers to build/redevelop facilities;
- Government supplements programs[52] (i.e. concessional, respite, accommodation, viability etc.) to ensure access; and
- Provider's ability to 'pool' funding received for all residents, creating efficiencies of scale in delivering a range of services to residents, for example delivering vibrant lifestyle/activities programs[53].

Commonwealth Home Support Program (CHSP)

- Heavily place based subsidised services for domestic and social supports providing relatively universal access.

Home Care Package Program

- Standardised package amounts and regular payments support planning and funding certainty.

[49] A review of the allocation of residential aged care places was recently undertaken, one of the options proposed in that review being the abolition of the Aged Care Approvals Round where licenses are allocated to residential aged care providers. ACSA's submission to that review can be found here. See also Recommendation 3 of the Legislated Review of Aged Care 2017, p13.

[50] The former Accommodation Bond system permitted operators of Low Care residential aged care facilities to deduct and retain from the lump sum amount an audited small amount per month (as an illustrative example - equating to say $331 per month – being $3,972 per annum) over a period of five years from the date of entry of a resident into the hostel. These monthly retention amounts were indexed each year and provided funding for the upgrade of facilities.

[51] Information on Capital Funding can be found here

[52] Information on Government supplements programs can be found here

[53] We note that studies undertaken in the RUCS trial found that close to 50% of staff time was allocated to communal activities that were provided to residents, with the other 50% being individual time spent with residents (Resource Utilisation and Classification Study, University of Wollongong, New South Wales, Australia, 2019)

Historical weaknesses of the financing arrangements

Residential Care

- Inadequate base funding, without a known cost of care, compounded by low indexation[54] to effectively meet the increasingly higher care needs of residents. Inadequate indexation is resulting in annual growth in costs far outstripping growth in funding, this compounding year-on-year;
- Capping of consumer contributions[55], (in 2016-17 consumers of residential care contributed around $4.5 billion) even where an individual could afford to pay a higher proportion of their costs (excluding refundable accommodation deposits)[56]. David Tune stated in his report that Government contributes around three quarters of all aged care funding, with consumers contributing around one quarter, noting 'this is likely unsustainable into the future'[57];
- Aged Care Funding Instrument (ACFI) – results in 'funding volatility' for both funder & providers, requiring 'adjusting the model' by Government to manage budget expenditure; and
- ACFI not 'fit for purpose', it is widely acknowledged that ACFI is no longer 'fit-for-purpose', it does not well align the actual cost of providing care to an individual resident with the funding received for that resident.

Commonwealth Home Support Program

- CHSP has a fees structure that provides an incentive for consumers to remain with this program rather than progress to a lower level home care package (which has a different fee structure) impacting on the number of people able to access entry level care.

Home Care Package Program

- Not enough funding to meet demand for home care packages;
- The level of consumer contribution both through the basic daily fee and the income tested fee is not affected by the level of a home care package[58];

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[54] Commonwealth subsidies and supplements are generally indexed either biannually (accommodation related) or annually (care related). The indexation applied to the basic subsidy for residential care is the Wage Cost Index 9 (WCI–9), which is a composite index constructed by the Department of Finance that comprises a wage cost component (weighted at 75 per cent) and a non-wage cost component (weighted at 25 per cent). For all Wage Cost Indices, the value of the wage cost component is based on the dollar increase in the national minimum wage (as determined annually by the Fair Work Commission) expressed as a percentage of the latest available estimate of average weekly ordinary time earnings (AWOTE) published by the Australian Bureau of Statistics as at November of each year. The value of the non-wage cost component of WCI–9 is based on changes in the Consumer Price Index between March quarters each year. Accommodation related supplements are indexed using the Consumer Price Index (CPI). (Sixth Report on the Funding and Financing of the Aged Care Sector, Aged Care Financing Authority, Australian Government, July 2018)

[55] David Tune in his 2017 made recommendations addressing consumer contributions, see recommendations 14 and 15. (Legislated Review of Aged Care 2017, Tune D., Commonwealth of Australia Department of Health, 2017)

[56] Sixth report on the Funding and Financing of the Aged Care Sector, Aged Care Financing Authority, Australian Government, July 2018, p5

[57] Legislated Review of Aged Care 2017, Tune D., Commonwealth of Australia, Department of Health, 2017, p8

[58] David Tune in his 2017 review recommended making the value of the basic care fee proportionate to the value of the home care package, retaining an upper limit relating to the value of the single aged pension. (Legislated Review of Aged Care 2017, Tune D., Commonwealth of Australia Department of Health, 2017)

- Accuracy of the payments system has become a significant concern to the sector requiring many providers to expend significant administrative resources[59];
- With only four home care package levels there is a significant 'jump' between levels, making it difficult for package recipients with incremental increases in support needs to graduate to a funding level only incrementally greater than what they currently receive. This can mean these people either have to stay on the (now inadequate) funding level or graduate to a funding level that is greater than their support need (not an efficient use of limited taxpayer funds); and
- The year-on-year growth in the national pool of unspent funds held by providers (currently around $750 million) is evidence that the package levels are not working efficiently.

What is needed going forward to adequately finance the sector?

For too long Aged Care – in particular residential care – has been designed and financed as a separate part of Australians' lives instead of as a continuum of the rest of their life.

The same issues apply: where they will live; the healthcare they will need; the services they want and how they will support themselves to provide these for themselves.

The next generation will have accumulated capital in two tax advantaged assets - superannuation and the family home. These need to be interchangeable to allow Australians to provide as much as they can for themselves. Government needs to consider how they can support consumers and remove inequitable hurdles, both real and perceived, to unlock the equity in their home to pay for their ageing. There are opportunities for Governments to support creative usage of superannuation, and the interplay with home equity, to support planning and paying for the supports needed as an individual ages.

Means testing arrangements (both income and assets) should apply consistently for both residential aged care and home care and that all income and all assets should be treated equally. Consumers of aged care services who can afford to contribute to the cost of their care must be required to do so and those people assessed as low-means are provided protections by government. ACSA considers the current means testing arrangements are inequitable and supports the proposals in the 2017 Legislated Review[60] whereby:

- The full value of the owner's home is included in the means test for residential aged care (when there is no protected person in that home);
- Providers are able to charge residents a higher basic daily fee to non-low means residents, with amounts over a stated threshold to be approved by the Aged Care Pricing Commissioner;
- There are no annual and lifetime caps on means-tested fees in residential care with a phased in approach adopted to their removal;
- Providers are required to charge the basic care fee in home care;

[59] The concerns of providers in relation to the current home care payments system is acknowledged in the recently released report by ACFA. (Consideration of the financial impact on home care providers as a result of changes in payment arrangements, Aged Care Funding Authority, Australian Government, December 2019)

[60] Legislated Review of Aged Care 2017, Tune D., Australian Government, Department of Health, 2017

- Providers are required to charge the income tested fee in home care; and
- There are no annual and lifetime caps on income tested fees in home care[61].

It is also important that means testing arrangements are able to be administered efficiently, effectively and consistently so that consumers and providers know in advance what consumers will pay and what subsidies government will pay towards consumers' care.

Workforce issues have been well recognised in the Commission's Hearings. Addressing workforce through the implementation of the strategic actions contained within the Pollaers report is vital, strategic action 13 of the report identifies finding, including staff remuneration as matters to be addressed as part of the approach to attracting and retaining a skilled workforce[62].

It is imperative that there is a clear way forward that compels fundamental reform occurs to ensure availability and affordability for future generations.

ACSA raises the following for consideration by the Commission. Many of these suggestions have already been made to Governments through various reviews without action being taken.

1. Commission to generate a conversation with the broader community to discuss ageing (and the impacts of ageism) and clarify expectations of care and services provided by the sector, including society's willingness to fund to these expectations.

2. Government to undertake a program to educate community on the cost of age care[63], including explanation on the extent of government subsidy, this conversation raising discussion on consumer contributions to the cost of their care, commensurate with their capacity to pay.

3. Exploration of different ways of ensuring adequate financing including continuing and improving the current taxpayer/individual contribution regime or an aged care levy through the tax system.

4. Funding in the future must provide for quality of life outcomes for consumers as well as quality of care outcomes.

5. Review funding models for providers of aged care services in regional, rural and remote regions to ensure they are funded to deliver the aged care services their communities require allowing older Australians to age in place and 'on country'[64].

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[61] Ibid

[62] A Matter of Care Australia's Aged Care Workforce Strategy, Report of the Aged Care Workforce Strategy Taskforce, Department of Health, June 2018, p16

[63] Consistent with Recommendation 17 of the Legislated Review of Aged Care, (Legislated Review of Aged Care 2017, Tune D., Australian Government, Department of Health, 2017 p14)

[64] Funding models should include approaches that fund direct to providers where appropriate, fund direct to consumers where appropriate, block fund where required (for example to very remote services) etc. Funding models need to recognise the cost burden associated with providing services in regional, rural and remote locations. Funding models must recognise the occupancy challenges of rural and remote providers.

Funding to regional, rural and remote community programs need to recognise the tyranny of distance and fund to cover the extensive costs associated with remote area travel.

In relation to Residential aged care:

6. Adequate base funding in residential aged care that is supported by appropriate indexation[65] (that matches revenue (ACFI) growth to real world cost increases that are experienced by providers). ACSA currently recommends indexation of three percent to match annual wage growth of the health care workforce[66].

7. Determining appropriate levels of 'Returns on Investment' (ROI) benchmarks for the aged care industry' including discussions how these are to be achieved, to ensure needed future investment into the sector occurs[67].

   Mechanisms to ensure adequate access to capital to ensure providers can build/redevelop facilities.

8. Clarification of the service Government is purchasing and funding to support providers enhancing service offerings and choice through additional services. Regulatory certainty is required as is adequate consumer rights and protections to ensure that people who cannot afford to pay for additional services continue to have adequate access to quality residential places.[68].

[65] This recommendation is consistent with a comment made in the StewartBrown end of Year June 2019 report where the report's authors called for ACFI indexation to be based on the Wage Price Index rather than COPE and that this would help address sector sustainability. (Aged Care Financial Performance Survey, Aged Care Sector Report for the financial year ended 30 June 2019, StewartBrown, October 2019, p7)

ACFA in their Sixth Report in relation to indexation noted 'the rate of growth in funding needs to move with cost growth' ensuring care 'prices accurately reflect the cost pressures faced by the aged care industry' (Sixth report on the Funding and Financing of the Aged Care Sector, Aged Care Financing Authority, Australian Government, July 2018, p40)

[66] Australian Bureau of Statistics: Media Release 13 November 2019, https://www.abs.gov.au/ausstats/abs@.nsf/lookup/6345.0Media%20Release1Sep%202019

[67] It is estimated that 88,000 new places will be needed over the next decade, along with an estimated capital investment of $54 billion required for redevelopments (Sixth report on the Funding and Financing of the Aged Care Sector, Aged Care Financing Authority, July 2018, pp35-36)

[68] ACSA's submission to the Department of health on Additional Services can be found here

Q10 / QUALITY REGULATION – HOW WOULD THE COMMUNITY BE ASSURED THAT THE SERVICES PROVIDED UNDER THIS MODEL ARE DELIVERED TO A HIGH STANDARD OF QUALITY AND SAFETY?

- **Is there a case for different regulatory approaches based on the nature of the service provided rather than the location in which the service is delivered?**
- **Would the allocation of funds to older people rather than providers change the need for regulation? What kinds of consumer protections would be required?**

Regulation is an integral component of a sound aged care system recognising the market 'is an inadequate mechanism to ensure the safety and wellbeing of highly vulnerable people[69]'. ACSA is committed to providing quality care and supports a firm but fair regulatory system which protects older people while allowing service innovation to flourish.

There are three broad streams to consider in being able to define quality care:

1. Regulation and compliance;
2. Quality of experience; and
3. Transparency.

1/ Regulation and compliance

Australia needs a firm but fair regulatory system that is focussed on outcomes for older people rather than just taking a narrow focus on rules and compliance[70]. An individual's dignity of risk needs to be supported rather than constrained by our regulatory system.

The regulator must be accountable to the community, to government and to the sector for its performance[71].

Is there a case for different regulatory approaches based on the nature of the service provided rather than the location in which the service is delivered?

ACSA supports a proportionate and measured approach to regulation, one that:

- Considers the nature of the service being delivered (i.e. is it a low level CHSP service or is it a more clinically intensive high-level home care package or residential aged care service) and audits/reviews that service accordingly;

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[69] Review of National Aged Care Regulatory Processes, Carnell K., and Paterson R., Australian Government, Department of Health, 2017

[70] Braithwaite refers to the need to focus on outcomes not inputs, where a focus on inputs can lead to what they refer to as 'ritualism' which they describe as 'obsession with means for attaining outcomes that are encouraged by regulators while losing sight of the outcomes themselves'. (Answers to questions by the Commission to John Braithwaite, Valerie Braithwaite and Tom Makkai, Royal Commission into Aged Care Quality and Safety, RCD.9999.0149.0001, 2019)

In their 2007 work Braithwaite (at al) argue that broad-based, outcomes focussed regulation is needed, finding in their investigation of nursing home regulation in the USA, UK and Australia that simply creating new rules about how aged care ought to be provided does little to improve quality', that in fact the risk is the creation of 'regulatory bureaucracies that miss the big picture' (Regulating Aged Care Ritualism and the new pyramid, Braithwaite J. et al. Edwards Elgar Publishing, Cheltenham UK, 2007)

[71] ACSA is receiving feedback from many members expressing concern regarding the 'quality of interactions' between themselves and Aged Care Quality and Safety Commission (the Commission) staff during site audit and review visits. Concerns are also expressed to ACSA regarding perceived inconsistent audit/review outcomes. ACSA continues to directly engage with the Commission regarding these concerns.

- Uses its risk-based approach[72] to determine the level of oversight delivered to individual providers, using a 'lighter touch' for those services with a proven record of performance verses a more intense scrutiny of those services that 'flag risk'. A 'light touch' approach should not be interpreted as meaning a lack of oversight, rather as simply a proportionate oversight[73]; and
- Where consistent sector wide issues are identified by the regulator, all services should be reviewed across these identified areas.

Would the allocation of funds to older people rather than providers change the need for regulation? What kinds of consumer protections would be required?

We do not believe that the allocation of funds to consumers (rather than to providers) changes the need for regulation. It may allow consumers greater ease in changing services (voting with their feet), effectively helping to addressing choice and control for consumers, but independent oversight of providers remains important.

2/ Quality of experience

Ensuring that services are safe is a necessary and essential component of quality service delivery. The real gains that make a difference for older people though is addressing their experience or improving their quality of life.

Boredom, disengagement, loneliness and other maladies must be able to be addressed by services as well as ensuring clinical care and other elements are safely delivered.

Whilst achieving compliance with Aged Care Standards will contribute to sound practices and good quality care, in itself it won't necessarily address quality of life for individuals in aged care services [74].

Many aged care providers are actively addressing or seeking to address QoL/consumer experience, they are addressing this in a variety of ways, some examples being:

- Through service models[75] – introduction of approaches such as the 'house model', Eden approach, Montessori for Elders, Butterfly model are but a few examples;
- Development of dementia friendly facilities, dementia villages etc.;
- Innovative dementia programs;
- Providers partnering with universities to develop Q0L indicators[76].

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[72] Aged Care Quality and Safety Commission discusses risk approach in its Regulatory Bulletins, Issue Number 2019-4.1 and Number 2020-1.0.

[73] J and V Braithwaite discuss proportionate risk in their response to questions put to them by the Royal Commission into Aged Care Quality and Safety where they describe proportionate risk approach as being the allocation of regulatory resources to the cases and contexts where there is the highest risk of abuse, neglect or poor quality care. Where a facility might be viewed as being 'low risk' they caution against 'long periods without inspections for aged care facilities based on risk metrics' (Answers to questions by the Commission to John Braithwaite, Valerie Braithwaite and Tom Makkai, Royal Commission into Aged Care Quality and Safety, RCD.9999.0149.0001, 2019)

[74] When discussing 'quality of life' outcomes it is important to consider the context of the service being provided to consumers of aged care services, for example a CHSP provider who delivers low level services such as periodic gutter cleaning or transport will have a different 'level of investment' (and ability to impact overall) into a consumers QoL outcomes verses the provider of residential aged care services.

[75] Discussion on models of service delivery can be found in ACSA Residential Care Submission to the Royal Commission (which is referenced earlier in this submission.

[76] For example: Flinders University, Caring Futures Institute research, see here

Providers need to be allowed to continue to innovate and get on with this important work, to enable this to happen we need the following:

- Aged Care legislation that allows innovation to thrive;
- An approach to risk by the regulator that takes a measured approach where providers are addressing the dignity of risk (allowing for self-determination, exercise of individual capacity to make choices) against the risk of injury or an adverse outcome[77];
- A transparent and comparable market in which innovative services that meet consumer demand and expectation thrive; and
- Compliance and regulatory approaches that do not stifle or disincentivise innovation.

When these characteristics are in place innovation and change will occur. Innovation must thrive because the environment promotes it, not in spite of the environment.

3/ Transparency

Transparency should be accompanied by comparability. Services must be transparent in the information they provide to consumers (including financial information, terms and conditions of contracts etc.) and in the quality and outcomes of their services. In addition, people must be able to readily compare like services against each other to better enable them to make informed decisions. This is paramount to people having confidence in the sector.

Work is currently occurring to develop Differentiated Performance Ratings which aims to provide transparency and comparability through publication of compliance performance and ultimately also Quality Indicators[78].

ACSA supports this work but highlights that these need to be considered in redesigning system and regulation to ensure there are sophisticated Quality indicator measures in place that give meaningful information about a provider's performance[79] and supports quality care. Therefore, ACSA recommends:

- Quality indicators are reported on, using a casemix-adjusted approach allowing consumers to compare performance outcomes of services with like resident profiles.

[77] The regulator must be able to take a measured approach where a provider is attempting to balance dignity of risk (allowing resident choice – and thereby addressing Standard 1 – where each resident is supported to take risks) versus the potential for injury. Providers should not be penalised for erring on the side of resident self-determination and decision making (where the risk is measured, moderated and 'reasonable').

[78] The use of Quality indicators (for example a falls indicator) must not be allowed to create disincentives to providers (through the public reporting of indicator performance) to implement programs that seek to balance dignity of risk (say promoting a resident to continue to remain ambulant even though they are at risk of falling – due to motor neuron disease as an example) against the risk of injury or incidents.

[79] There are concerns current Quality Indicators do not take into account a provider's particular mix of resident acuity, their size, their service model etc. ACSA advocates for Quality Indicators that compare Indicator outcomes based on a casemix approach to ensure consumers are comparing like-for-like when comparing 'differentiated' performance outcomes between facilities. The risk with the current approach to indicators is that they are not casemix adjusted. So, services with different mixes of resident acuity may be compared against each other without the consumer understanding this.