

Aged Care Program Redesign: Services for the Future

UnitingCare Australia response to Consultation Paper 1

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About UnitingCare Australia

UnitingCare Australia is the national body for the Uniting Church's community services network and is an agency of the Assembly of the Uniting Church in Australia.

We give voice to the Uniting Church's commitment to social justice through advocacy and by strengthening community service provision.

We are the largest network of social service providers in Australia, supporting 1.4 million people every year across urban, rural and remote communities.

We focus on articulating and meeting the needs of people at all stages of life and

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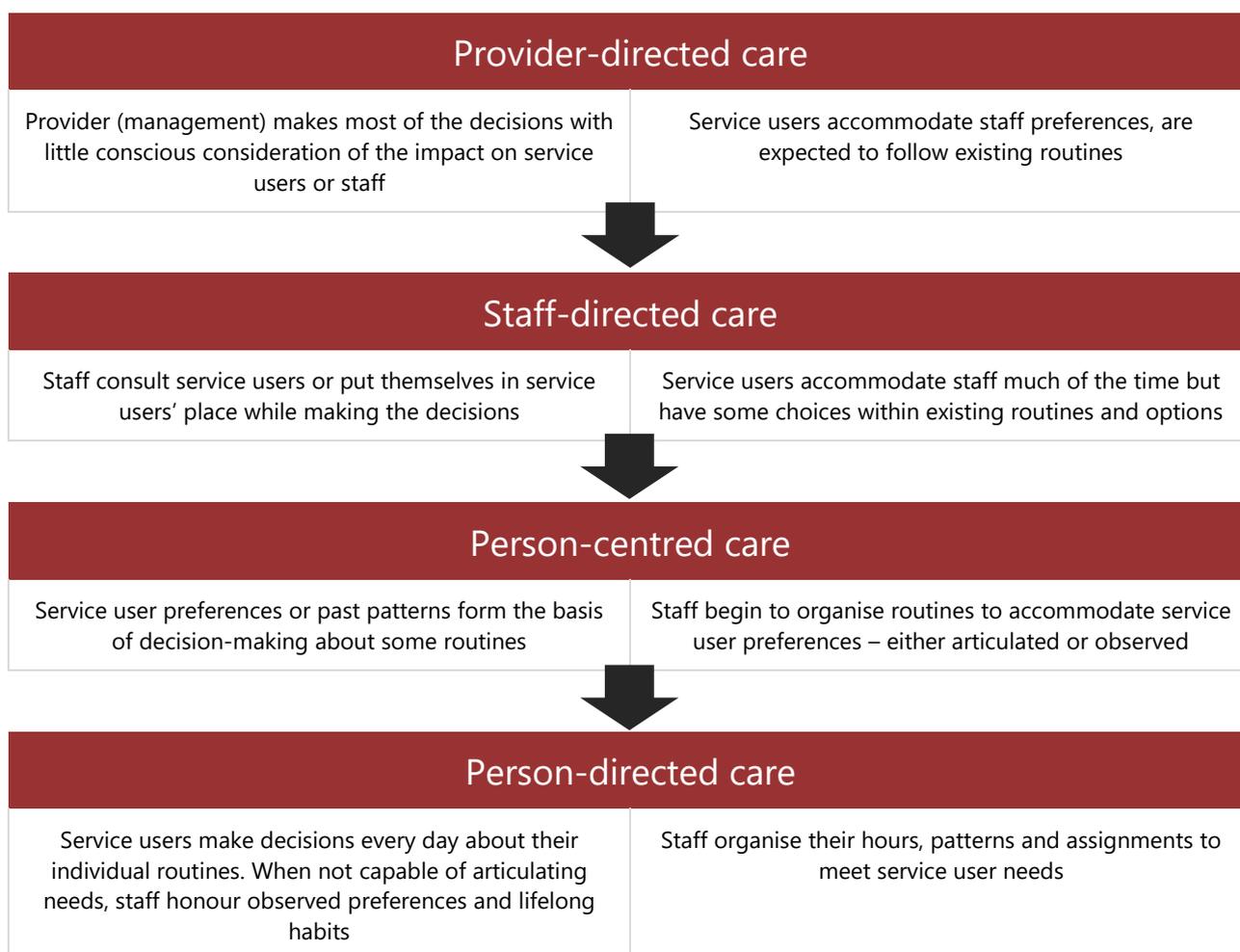
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Introduction

UnitingCare Australia has provided our ‘future vision’ document Ageing to our Full Potential¹ to the Royal Commission. Ageing to our Full Potential represents the collective thinking of the organisations of the Uniting Church in Australia that are providers of aged care.

This response to the Royal Commission’s Consultation Paper 1 complements – and should be read together with – Ageing to our Full Potential. The main body of this response to the Royal Commission’s paper expands on the conditions we believe are necessary to enable providers to change the way they do the ‘business’ of aged care. The key message that we would like to convey to the Royal Commission is that to create ‘the best possible program, structures and system overall’ we need a paradigm shift. We need to recognise that social change and reform are needed to overcome the inertia which keeps the ‘aged care system’ from becoming a fully ‘person directed services’ system. The figure below represents how we see a continuum of models from provider directed care to person directed services.

Continuum of person-directed culture



¹ <https://unitingcare.org.au/wp-content/uploads/2019/10/Ageing-to-our-full-potential-FINAL.pdf>

Fortunately provider-directed care is a thing of the past, and most services aspire – as do the aged care quality standards – to a system which delivers person-directed services. We believe, however, that a range of impediments – many related to the way in which services are funded – prevent us from progressing from person-centred to fully person-directed services. We consider it possible for any type of service to be person directed. Indeed it is impossible to imagine commercially available personal services – from hairdressing to wedding planning – *not* being person directed. The critical element relates to recognising the person as the ‘expert’ in their own life – consistent with the approach that has become the norm in the recovery model of mental health service design.²

We also believe that the future system must overcome the tendency in the current system to ‘manage’ demand. By starting with affordability for the government – itself a contestable idea³ – the individual is already relegated to a secondary role in decision making. Service models develop to meet the needs and specifications of the funder, rather than the end user. Other sectors that provide essential services – such as power generators and water utilities – have been encouraged to be innovative in moving from ‘supply driven’ to ‘demand driven’ models of delivery as a way of increasing efficiency.

Ageing to our Full Potential identifies key areas in which government/sector/community action is needed to realise the vision of a system in which person-directed service is the norm. The following sections expand on these and link them to principles of system design. This does not represent a comprehensive ‘roadmap’ to a consumer-directed service system. The sector has been journeying towards a consumer-directed system for many years and understands transformation takes time. Considerable improvement has been made, in terms of increased person-centredness, openness to market direction, and consumer skills and knowledge building. Although our long-term view represents a significant departure from the current system, there are elements of the current system which, with adequate resourcing, should be retained.

Ageing to our Full Potential offered a ‘three horizon’ proposal to build from the existing base towards a system which ensures **quality care and support for all people, as they age, to live lives to their full potential and with dignity**. We envisage

- changes to the system to increase flexibility and responsiveness, achieved over a two year period;
- the shift to an integrated, outcomes-based system that fosters real innovation and investment (similar in many ways to the model proposed in Consultation Paper 1), implemented by 2025; and

² Australian Government. National framework for recovery-oriented mental health services. 2014. Available from: <http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-recovfra>

³ We are not aware of any study that has rigorously assessed the costs and benefits of current arrangements, the savings to be made by more effective, preventive approaches (although the study by Ansell Strategic commissioned by UnitingCare Australia demonstrated considerable savings purely by reducing the number of entries to residential care, which is internationally high) or the costs of underservicing of many communities, for example avoidable hospital admissions. The Commonwealth has a responsibility to ensure the equitable distribution of resources regardless of locality, and as the nation state, to uphold human rights of the individual.

- a fully integrated, referral-based health/aged care system, based in the community and enabling a genuine continuum of care, to be achieved by 2040. [refer to Ageing to our Full Potential, page 3, 6-8]

This approach depends on agreeing upon what we are aiming for as the third horizon, as the changes that are needed to get there must start now. Social, political, and financial systems will evolve along with health and community services as the population changes and grows over the next twenty years. This submission reflects the direction that UnitingCare Australia believes must be taken, to position communities and services to respond to community needs. Technology and health sciences will also evolve over that time, so we cannot predict what will be possible or what will be considered 'best practice' in 2040. We are confident however that by maintaining the vision of a person-directed services system, we can be prepared for whatever eventuates.

Leadership commitment

Consultation Paper 1 refers to the relevance of most of the challenges identified in previous reviews of the aged care system. While we agree there is truth in this, a key element that has never been tested is the commitment at all levels of government to a system in which the needs of every individual are met. UnitingCare Australia considers that there is a fundamental failure of leadership that has played out in the way in which governments have attempted to draw lines around accountability for the experiences of individuals as they age.

At the national level, the Australian Government has tried to create an institutional 'system' to manage a subset of the health sector, which does not reflect any aspect of systems thinking – the intersections between the health needs of older individuals and their needs for social services, housing, financial stability. As a result, those with the least resources are most impacted by geographical, cultural and social issues. What should be complementary elements of systems are managed by different levels of government, independently. Outcomes therefore vary widely based on factors that should be 'irrelevant' such as jurisdiction.

Adequacy of health and community services should never be about politics, yet there can be media statements about aged care facilities 'dumping' residents on the health system⁴ as though the issue was about cost shifting not the capacity of the aged care system to function as it should – in the best interests of the individual. Providers must meet state and local regulatory requirements in addition to national standards, however there is little evidence of cooperation in ensuring that individual components of the 'systems' are compatible and/or complementary. Nor is funding consistent. As a result, in a situation such as that revealed through the Oakden inquiries, there is a blurring of lines of accountability (for example between specialist dementia care and mental health care) and ultimately a risk of individuals receiving inappropriate or inadequate care. Arguably Oakden was a case of the state 'dumping' residents into the aged care system.

⁴ <https://www.sbs.com.au/news/aged-care-homes-accused-of-dumping-elderly>

To a degree the apparent failure of governments to learn from issues or to implement adaptations in response to failures is a by-product of discontinuities and ambiguities in the respective responsibilities of different levels of government. Discussion Paper 1 refers to 'an uneasy mixture of complex programs operating under a range of different guiding principles, within a structural framework that was not designed for those programs to operate together with optimal efficiency and effect'. An additional inference is that the basis on which aged care has been funded ensures suboptimal effect: the starting point has been to allocate and manage limited budgets rather than to calculate and provide the resources required to meet the needs of all service users.

Local government plays a role in how well community infrastructure supports older people in the community. Yet many local councils focus on what EveryAGE Counts refers to as the 'burden narrative' that views older people as an economic and social drain on society.⁵ Instead of taking up the challenge of harnessing the benefits of longer lives, for example by 'mainstreaming' ageing and building on the strengths of their community, they may look for strategies to 'reverse the deterioration in the dependency ratio'⁶. Ageism, not evidence, often drives policy at the level of government with the greatest potential to make a real difference in the way in which individuals and populations respond to converging demographic and economic change.

Principle 1

Governments at all levels must lead a bipartisan process to agree on objectives – defined in terms of outcomes not outputs – of the service arrangements that reflect community expectations

Principle 2

Governments must commit jointly to providing adequate resources to ensure that individuals – regardless of their age – achieve the greatest possible quality of life and care outcomes

⁵ https://d3n8a8pro7vhm.cloudfront.net/benevolent/pages/392/attachments/original/1564966888/FINAL_EveryAGE_Counts_Submission_to_Royal_Commission_on_Aged_Care_Quality_and_Safety_020819.pdf?1564966888

⁶ This line is from a local council submission but reflects what appears to be a general lack of consideration of the opportunities from growth in community and social services; by way of further example, see the terms of reference for the 'Jobs for the Future in Regional Areas' inquiry, which make no reference to the potential for positive impact of population change due to increased longevity.

https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Jobs_for_the_Future_in_Regional_Areas/Job_sRegionalAreas

Consumer and community involvement

The point that the aged care sector 'is not, and is unlikely to ever be, a fully efficient market' is well made in Consultation Paper 1. By definition, an efficient market excludes those who are unwilling or unable to pay the 'market price' for services, and subsidies to correct market failure may simply be inflationary. In many regional and remote areas, there are limited or no aged care and disability services provided commercially, as the cost of provision exceeds the capacity of local residents to pay.

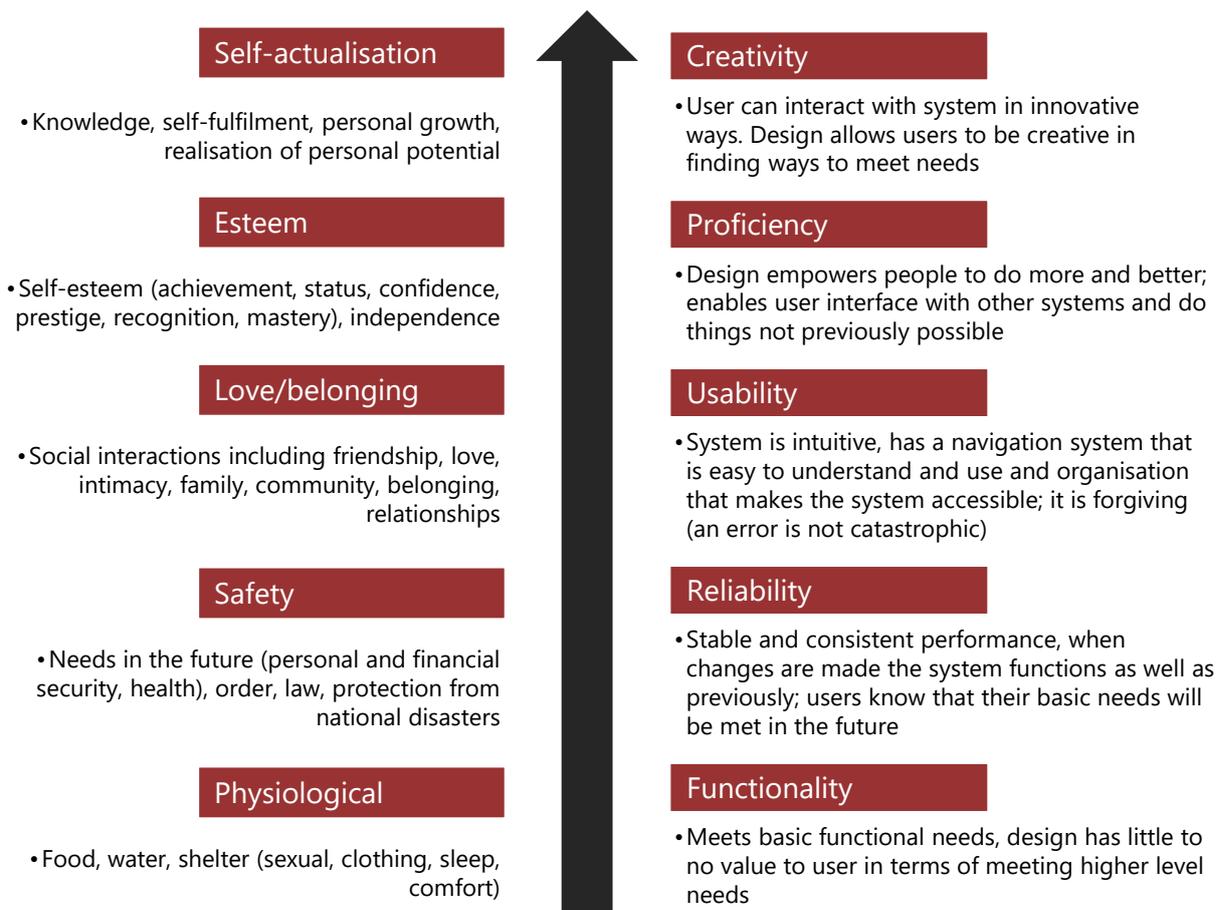
Not only are there 'market failures' in the provision of aged care services as a whole, many of the human needs that are not met through the current aged care system are not able to be commodified. There is not, nor can there be a 'market' for social engagement, interpersonal relationships, or personal growth. To conceptualise such a market would imply the possibility of defining, putting a price on, and creating scarcity of relational aspects of care. The preference to remain in one's home, in one's community for as long as possible is a reflection of the fact that these 'free' services exist and are most accessible at home and in the community where a person has a network of supports. These 'services' are for the most part irreplaceable and unsubstitutable, although in the right environment individuals can establish new and valued relationships.

This does not mean, however, that the concept of a market is not important to achieving person directed services. Ageing to our Full Potential identifies the need to ensure that individuals, families and communities are continuously involved in decision-making and co-design of care solutions that are tailored towards consumer needs and desires. UnitingCare Australia believes this is consistent with the Aged Care Roadmap proposal for a single aged care and support system that is market based and consumer driven, with access based on assessed need. **This proposal was predicated on the system incorporating a safety net whereby governments would ensure comprehensive service coverage.** The shift to a model that delivers against consumer direction has been hindered by unwillingness on the part of government to fully deregulate the number and distribution of services, and to resource the system according to need. Budget constraints and inflexibility in the funding model have meant the market has not been enabled to work with consumers and communities. Service providers will respond to consumer demand but the system of providing subsidies must be fit for purpose – service innovation is dependent upon funding adequacy and flexibility.

The figure below juxtaposes a version of Maslow’s hierarchy of needs⁷ against a hierarchical representation of system designs⁸. At the apex is a system design that supports users to be creative in finding their own ways to meet personal needs. UnitingCare Australia believes that the ultimate purpose of social and community services is to support individuals to realise their personal potential, therefore the system through which services are provided must be genuinely consumer and community driven, with the latter achieved through authentic engagement and embeddedness of services in the community.

Maslow’s Hierarchy of Needs

Hierarchical representation of system designs



UnitingCare Australia notes that individualised funding is not the same as consumer choice, though it can play an important part in supporting individual autonomy, discrimination, and choice to participate in the market. We believe that the current system gives insufficient attention to the impact of aged care on the degree to which an individual can meet the full suite of needs i.e. needs

⁷ Use of Maslow’s hierarchy here is for illustrative purposes and does not suggest that this is the best/only way of describing human needs, or that needs must be met in a ‘stepwise’ fashion.

⁸ Credit to Steven Bradley whose article Designing For A Hierarchy Of Needs inspired this figure

<https://www.smashingmagazine.com/2010/04/designing-for-a-hierarchy-of-needs/>

that cannot be met within the system. The importance of funding flexibility – particularly to support community-initiated structures that meet specific cultural or social needs – is discussed further in the next section.

Principle 3

The system must recognise individuals, their carers, supporters and communities as experts in identifying ways to meet their needs and knowing when support is needed

Encourage innovation

UnitingCare Australia believes that clear, measurable outcome benchmarks and best practice risk management approaches for services are central to enabling a culture that supports innovation, whilst also mitigating unacceptable levels of risk to individuals.

Policy change in several other areas is also necessary.

Flexibility for individuals to draw on different types of service

Segmenting services into modes of care (e.g. residential care, community care and home care), levels of care, or even 'streams' as described in Consultation Paper 1 is, we believe, inconsistent with genuine consumer-directed care, and with innovation in service offering. Generalising payments maintains the process of 'allocating' individuals to a class of services. A system that is based on self-identified need and problem solving is inconsistent with making category-based eligibility the first step in accessing services.

UnitingCare Australia considers the existence of artificial boundaries between modes of care is a key contributor to complexity and failure of the existing system to meet the needs of individuals and their carers/families. This is particularly true of the cut off points for home care package levels, particularly the 'gap' between the allocation to HCP level 4 and payments for residential care. This system can also create an 'entitlement' to a level of care that reduces the incentive for reablement and reduction in service use.

Flexibility of funding

Funding models will need to be 'fit for purpose' to transition to consumer directed care. Subsidies based on the resources required to meet individual needs, rather than being paid according to a service type, are an important way in which services can be enabled to work with individuals to

reduce and/or defer their reliance on long-term aged care, home care and health services. Outcomes-based funding is consistent with the idea that the consumer is the expert on identifying how to meet their personal need.

Importantly, however, funding should not be restricted to individualised funding. Community-based or place-based responses to need could be provided where a collective response is desired or is the most effective and efficient way to meet needs in the community.

Flexible regulation

Regulatory changes would be required to enable funding allocations directly to individuals, in order to support place-based service provision models, and the types of services/funding arrangements noted above. Some models of care may be better enabled by 'program' style delivery rather than the current model.

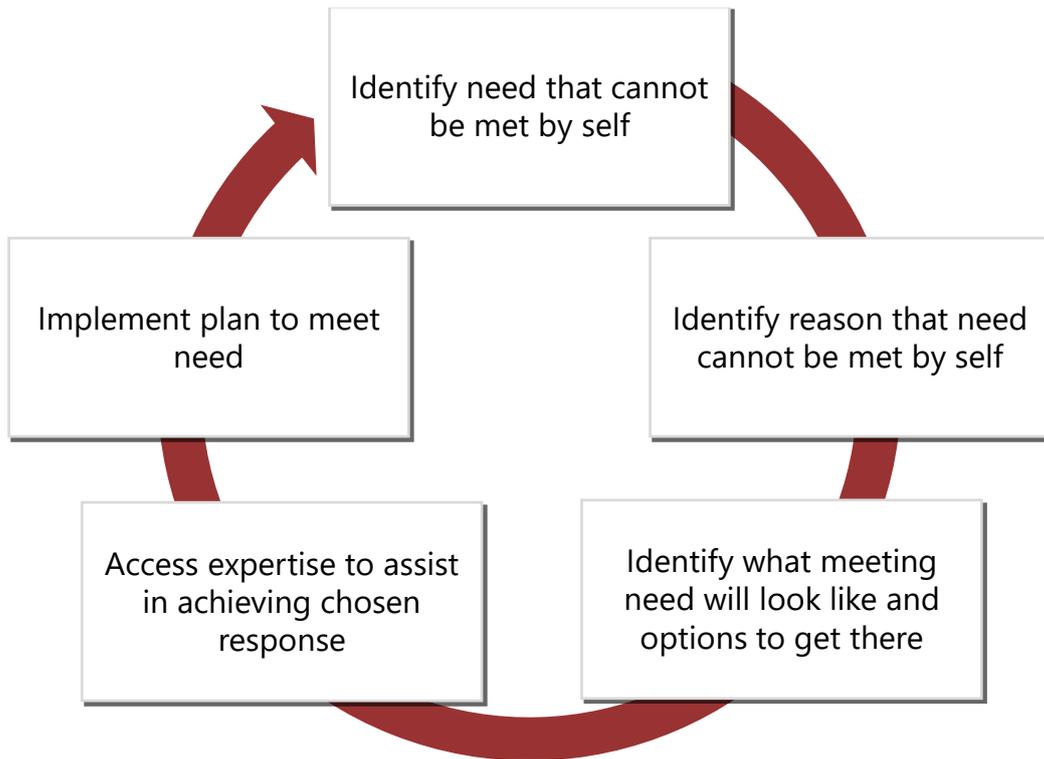
Flexible access

UnitingCare Australia believes that the concept of 'aged care' unintentionally perpetuates ageist stereotypes and promotes tensions between generations about access to scarce public resources.

Removing different types of social and community service from bureaucratic silos such as aged care, disability services, health care, primary care and housing would be a primary enabler of genuine 'whole of person' services and ideally a 'lifecourse' approach that acknowledges ageing as a process that starts before birth.

The current aged care system does not 'foster the provision of services that work effectively with related systems, particularly health and disability' because aged care services are health, disability and in some cases housing services artificially separated from the broader program areas for reasons that do not relate to improving outcomes for older people.

A system that took an approach similar to the model depicted below would be more consistent with the recognition that consumers take different pathways and interact differently with the system. Intermittent use of services (whether community-based, residential or both) is associated with a preventive/restorative approach to age-related health issues, but is not well supported in the current system. For example, a person (regardless of age, general health or living arrangements) may need housekeeping assistance when they are coping with an acute health episode. Under the current system a younger person is not eligible for financial assistance while the older will receive this assistance permanently, even if their need reduces. Aside from the inequity of this outcome, it provides a perverse disincentive to reablement and, for younger individuals, may represent a forgone opportunity to improve future outcomes.



Principle 4

Elements of the system must be flexible, so that providers can innovate and offer genuinely consumer-directed services – services that support the individual to be creative in finding their own ways to meet personal needs

Care Sector Partnership

Re-shaping the way in which older people are supported to achieve their full potential in life is a shared responsibility. All levels of government, consumer advocacy bodies, health and community service stakeholders and service provider peaks must all be involved in, and be committed to, systemic change. Partnerships between local communities and service providers (across health and social services) may well be the only way in which the needs of individuals in smaller populations can be met effectively.

Ageing to our Full Potential touches on the role of health and community services in community building.

A good support system empowers older people, families and carers, service staff, volunteers and the broader community to live and work together in communities where they experience relationships, joy and hope. People of all ages have a valued place in their communities. Older people enjoy respect and dignity, can exercise their rights, and continue to live and grow to their full potential across all of the dimensions of their humanity. Where people are vulnerable, care and support systems reach out to them in partnership with their communities and are tailored deliberately to meet their needs, preferences and aspirations. [Ageing to our Full Potential, page 3]

Service provider organisations are generally sophisticated businesses, yet aged care is often seen as a 'closed' system – rights and responsibilities relate to interactions within an organisation. There may be value in applying principles of corporate social responsibility (CSR) – which require companies to meet 'within reason, the expectations of all societal stakeholders **to maximize the company's positive impact on its social and physical environment**, while providing a competitive return to its financial stakeholders' – to aged care. This view of CSR incorporates the idea of shared value: an approach to business that starts with the intention to 'expand the total pool of economic and social value'⁹.

Starting from a shared value approach when considering the challenges of delivering services in regional and remote communities, or for marginalised groups, can reshape the conversation. Instead of seeing affordability and sustainability in terms of the greatly inflated cost of delivering mainstream models of service that cater to special needs groups, it becomes possible to see sustainability in the economic and social returns on investment in communities.

Principle 5

Ageing must be 'mainstreamed' in recognition that creating communities in which all people are able to fully participate is everyone's responsibility. We cannot plan ahead for our future selves without playing a part in creating our future communities

⁹ Michael Porter and Mark Kramer, Harvard Business Review, Feb 2011

New program design: Design questions

What are your views on the principles for a new system?

UnitingCare Australia has two key points to make in relation to the principles:

Firstly, the principles are aimed at addressing the worst outcomes of the aged care system, and do not recognise that most organisations would assert that their services are already designed according to those same ideas. With respect, the Royal Commission's reliance on the statement that '[f]ormal compliance with poorly described and limited formal standards appears to be the objective' is at odds with the single quality standards development process, which has genuinely shifted the standards away from a format driving a 'compliance mentality', towards a consumer-outcomes-based approach.

One of the greatest challenges currently confronting the sector is the increasing cost of meeting compliance requirements. The experience of providers is of the new Quality and Safety Commission representatives increasingly approaching audits with expectations of how the standards will be met on the ground. This is at odds with the concept of risk management, quality assurance and continuous improvement being recognised as aspects of good governance. It is also at odds with the concept that expertise in meeting the needs of older individuals resides in the sector, and that it is the role of providers to work with individuals to find the best ways of meeting their needs safely, while maintaining their rights and dignity. At the same time, we are not aware of any evidence that this approach has or will improve outcomes for individuals.

Secondly, we have made the case above for the importance of partnerships in creating a 'system' that ensures older people who need support can access it when and where it will be most beneficial. The proposed principles do not make clear which actors in the system are responsible. The following version of the proposed principles therefore seek to better reflect the roles that we believe different actors carry in relation to services.

1. Human rights do not diminish with age, therefore all those with a role in supporting our elders (governments at all levels, family, communities and service providers) must practice respect and support for the rights, choices and dignity of older people.
2. The system must balance the individual's right to autonomy and to continue to make life choices; regulation must limit choice only where this is the most effective response to risk; the sector must work with regulators to develop consistent, objective measures of individual outcomes as the basis for continuous improvement and best practice identification and management of poor outcomes.
3. Government must ensure that the point of entry to services is accessible to individuals regardless of social or cultural background, means or locality, and services must be sufficiently flexible and inclusive to cater for the range of individual identities, cultural and social safety needs, and clinical needs that present in older individuals.
4. Government must ensure that the interface between the system and individuals/their support people is sufficiently simple and intuitive that they do not need to 'learn' a new system to be able to benefit from services to which they are entitled, and the system should not result in different standards of outcome for people based on literacy, expertise or resources.

5. The system will only work effectively if there is sufficient funding – subsidies and/or co-contributions – and access to services at the point of assessed need, recognising that the system must cater to approximately a 40 year ‘bandwidth’ over which individuals will have multiple trajectories depending on genetics, life experiences and underlying health conditions; the system must have the flexibility to respond at a point in time when the individual needs help, in a way that enables them and their carer/s to live their best life.
6. The system must act as a social safety net, where additional resources or pathways to services are needed, and should incorporate encouragement to plan for the future and potentially the need for early intervention in age-related issues, regardless of age.
7. In considering the needs that the system is designed to meet, governments and service providers must recognise both basic needs – physical and security needs – and higher order needs that enable the individual to thrive – love and belonging, independence and self-actualisation – and how they can best be met, potentially from outside the system.
8. Support individuals to live well, including where necessary and possible taking best practice clinical services and delivery into the community context – at the end of life health care should intrude or disrupt life as little as possible.
9. The system must include services that meet support needs of informal carers – beyond the need for respite – service providers and families must recognise the importance of maintaining relationships and connections to community.
10. Governments at all levels, communities and service providers must work together to ensure that outcomes for individuals and their supporters are not compromised by a lack of funding or sufficiency of skilled, caring professionals with time to meet those people’s needs.
11. Government services at all levels, individuals and communities, family and service providers all have roles in improving the interfaces between parts of the health and disability systems and for creating effective pathways to achieve individual goals.
12. Governments have a responsibility to fully meet the cost of providing services and supports necessary for individuals to thrive, however individuals and the broader community have a responsibility to work with health and social systems to minimise, throughout their lives and to their best capability, reliance on formal services.
13. Governments must work with providers, professionals and researchers to ensure that individuals receive services and supports based on best available evidence and that the outcomes of interventions are being measured and meaningfully benchmarked as part of services’ continuous improvement and risk management strategies.

How could we ensure that any redesign of the aged care system makes it simpler for older people to find and receive the care and supports that they need?

UnitingCare Australia believes that the concept that an individual ‘enters’ the system is flawed. It implies that the system is closed and that it is up to the individual to ‘qualify’ for assistance. This is more than an issue of language, though the language that is used has the potential to influence outcomes.

The system by which individuals are assisted to access services must be shifted as far as possible away from one which limits the range of responses to an individual's need to a 'catalogue' or 'tick a box' approach. As service providers, our organisations have been trying to expand the range of options and the choice of services that individuals have access to. Their efforts are constrained, however, by underfunding, workforce limitations, and the current regulatory environment. Choice should not be about alternative providers offering the same response, but the individual having the opportunity to respond creatively to the challenge that he or she is experiencing.

We believe the Royal Commission has heard and understood the preference of individuals and their supporters to engage with the system 'face to face'. It is clear that this preference relates to the nature of the situation rather than the individual's familiarity with the internet or computer literacy. Internet access will be appropriate medium to support some but not all functions that the system must perform. The way in which information is delivered, or in which individuals engage with the system, must be determined by the nature of the need that is being met.

The model of entry that we have set out in the body of this submission is based on the nature of need not an 'approval' system. It would operate on the basis that individuals use personal, social and community resources available to them before they seek additional assistance. Any 'assessment' role would be focused on problem solving and planning, based on bring to the individual the expertise necessary to assist her or him in achieving a desired outcome, whether that is a social or health care solution.

Thus, referral for assistance may come from primary health or allied health practitioners, social workers, community services, Centrelink or housing providers. The system is based on cooperation and is sufficiently simple that potential referring services/professions can readily understand how the system can assist the individual. Most importantly, there is no need for an individual to master a new system.

There is no assumption of ongoing need for assistance, but there is access to ongoing services and supports to respond to permanent disabilities/increasing acuity of health needs/end of life care where appropriate.

There is funding for community based or other services that cannot operate on a 'per service' basis e.g. homeshare services, community hubs and community visitor and advocacy schemes. There should be an emphasis in building the community structures that are needed to support those without informal carers or strong support networks, to equalise their empowerment to engaged in supported decision making if their capability is impaired.

[refer also to [Ageing to our Full Potential](#), pages 15-18 [Accessibility of services](#)]

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.

One of the critical differences between a social service/health model and the standard personal services business model is that in order to achieve the individual will not always be able to know what options are available – relationships of trust are critical at the point at which a pathway is chosen. Thus strong, trust-based relationships with assessors and ultimately a provider are an essential element of consumer direction and exercise of choice.

As noted above, we believe that there could be many ‘referees’ to the system; what they have in common is that they represent opportunities to build on existing trust-based relationships. We would add to this list of relationships the one built with a service provider once assistance is accessed.

While many of the services needed by older people are ‘transactional’ in nature – for example housecleaning, the system must recognise that even a basic service needs to be delivered in the context of relational needs. For example, the loss of capacity to meet the physical demand required to maintain a home may represent a spiritual, emotional or psychological challenge for an individual. The act of entering a person’s house to clean for the first time represents a risk and an opportunity: a risk of entrenching dependency as well as an opportunity to assist an individual to maintain a life in which their spiritual, social, emotional and psychological needs are met. UnitingCare believes that every interaction with the health/social services context should be seen for the intangible benefits that it can bring in terms of enabling an individual to live well.

We believe that a single ‘entry point’ concept is at odds with the model of access (rather than entry) that we are proposing but in any case should be reconsidered. Regardless of the model that is adopted, as the Royal Commission has found a centralised bureaucracy heightens the risk that an individual cannot ‘get through the door’. UnitingCare Australia believes that advocacy – whether formal or informal – must be available to assist in accessing services. For individuals with no informal supports it is incumbent on the government to ensure that formal advocacy is resourced.

Outreach services, whereby ‘hard to reach’ individuals are sought out for assistance, or opportunities to promote or provide health information or early intervention services, are an essential complement to any ‘access’ system.

[refer also to [Ageing to our Full Potential](#), pages 15-18 Accessibility of services]

Entry level support stream

People maintain their homes and gardens, do laundry, cook meals, get themselves to appointments and attend social engagements across their whole adult lives—some people may choose to pay others to do these things—but mostly they handle them with little assistance.

As people age and need support with everyday living activities, how should Government support people to meet these domestic and social needs?

The most important early supports are those that provide a strategy to meet a need identified by the individual that cannot be met without expertise, assistance or advice. The 'tiered' approach to services will not work as it promotes a 'menu driven' approach based on the attributes of the care finder that places them within that tier. If we are seeking a relationship-based system in which an individual seeks assistance to meet a need, it is the role of the relevant allied health professional to work towards an agreed plan to meet that person's goals. Case management should be available across all service types and resourced at the relevant professional level – complex care demands highly professional and engaged case management. There could, however, be equally valid reasons for case management to be continuous with service provision or treated as a separate service: the choice should be available to individuals.

Taking the example of house cleaning, it is a service that may assist when a carer is unwell or receiving respite, when carer who usually cleans is supporting an individual through intensive treatment or rehabilitation, or it may mean the difference, for an individual, between having the energy to attend a social group or not. There is nothing that renders house cleaning inherent to an 'entry level', 'investment' or 'care stream'; nor is government support for housecleaning inherent to a plan to meet a particular need.

UnitingCare Australia considers that preventive and, when needed, restorative approaches specific to older individuals must be at the heart of the social and health support systems. Support to implement preventive and restorative strategies must be readily accessible to an individual when they can be most effective. This point in time cannot be ascribed to a 'phase' or 'stream'. The concept of 'prevention' applies to social and cultural needs as well as health needs.

Services and aids that demonstrably contribute to prevention of 'age related' conditions must be universally available and affordable: this extends to strengthening mental health and housing services, lifetime access to dental, vision and hearing aids and allied health services such as physiotherapy. Active promotion of early intervention opportunities and 'mainstreaming' of ageing at all levels of government is a complementary strategy that is equally important. This might include promoting health and wellbeing literacy and corresponding actions (maintaining physical/social health, modifying home environments, etc.) as well as financial literacy to increase people's 'life planning' capacity and address the tendency to avoid thinking about ageing until middle age or later.

It is important that the method of delivering funds follows the service model. Debit card approaches can add to the level of autonomy that an individual can exercise, however will not be appropriate where the relevant funds are tied to certain aspects of care/service that are needed to meet standards or deliver appropriate clinical care. Identifying funding delivery models that enable increased autonomy (individualised models) alongside models that enable services to invest in

infrastructure and to maintain minimum staffed models (e.g. day centres, small rural/remote services, homeshare) will be critical when the Royal Commission comes to consider sustainability.

At a more detailed level, it is important to resolve tensions around financial responsibility for rehabilitation following exit from the acute health system. Instituting 'portability of resources' across systems may be one strategy to address conflict around presence of older people in the acute health system – for example enabling transfer of funding from hospitals to residential services that may be better equipped to deliver restorative services.

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?

It is essential that the system meets the needs of carers and individuals for both community based (e.g. current cottage-style overnight respite) and residential short term respite. Accessible short-term residential services must be funded for flexibility – to cater for emergency or irregular use – and for specialist restorative or rehabilitative services. Short term residential services are important both to complement increasing levels of care in the home and to increase accessibility of specialist services best delivered in a residential context – for example post-operative rehabilitation, regardless of whether an individual lives in the community or in a long term residential facility.

The concept of 'respite' should be able to evolve alongside other modes of care, encompassing the concept of 'step up step down' care based on identified needs of the individual and their carer/s.

The system must also support a diversity of short-term residential services to better cater for the needs of individuals using these services e.g. individuals of different ages and capabilities, individuals in need of restorative care/rehabilitation services, those living with dementia.

Funding arrangements must reflect the care needs of users as well as the structural cost differences between providing long term and short-term residential services.

As noted above, restorative or rehabilitative services must be universally available as a key element of a 'preventive' and strengths-based approach to meeting the needs of an ageing population. The proposed distinction between an 'investment stream' and 'care' could – unintentionally – exacerbate the sense that aged care services do not seek appropriate health interventions for older people.

This area provides a stark example of the perversity of creating a system that caters for the health needs of the small proportion of the older population that meets the eligibility criteria for 'aged care' separately to other older people and/or others with the same health needs, but who happen to be younger.

The system must address potential perverse incentives arising from the separation of health and aged care systems – differences in funding levels and approaches must be resolved, for example by ensuring that funding follows the individual if they are discharged from hospital before fully rehabilitated.

Access to services should not be based on age but health services must build appropriate geriatric expertise – health workforces must be ‘up-skilled’ to understand best practice in relation to older patients. Older patients should not have a different experience from younger individuals due to receiving services through the ‘aged care’ system.

The broader health system also must recognise the long-term impacts and cost implications, as well as lifestyle implications, of underinvestment in rehabilitation and related therapies, for example lack of lifetime access to affordable physiotherapy services.

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?

Needs-based funding should not reflect an assumption of linear/progressive access to services. Individuals should be able to access services as needed, working in cooperation with experts to create appropriate service plans.

Being able to maintain a home and one’s connection to community is a key motivator and linking self-care to enabling this as a choice should be at the core of increasing health literacy and population health. The desired ‘destination’ is a system of services that is genuinely responsive to need, and in which the ‘response’ to need is co-created with the individual. In practical terms, this means a system in which responses are adapted to every individual. Currently, ‘choice’ is between providers of home care and providers of residential care: by definition it is limiting. Australians are more likely to enter permanent long term care than residents of comparable countries, and the decision to enter a residential care facility is likely to be seen as a last resort: when care needs reach a certain point, those without considerable personal resources do not have a choice.

Rather than representing a ‘gatekeeper’ that awards entitlement to ongoing services, as noted above, a responsive system that assists individuals to implement their own solutions to challenges associated with ageing maintains autonomy and independence. Acceptance and adaptation to the changes that come with ageing is a very personal process that each individual will approach differently.

UnitingCare Australia believes that, as is the case elsewhere in the health and social services systems, services providers are trusted to provide services as needed and should be reasonably compensated for services and outcomes delivered. We therefore support government policy and program approaches that do not discriminate against alternatives to traditional large-scale facilities where there is demand from consumers for smaller, community based/‘home like’ or specialist care

environments. We also support a continuum of care which maximises time that individuals can remain in their own home.

One of the key innovations that we believe is required to achieve these outcomes is the facilitation of appropriate and affordable accommodation options, where individuals can receive high quality aged care and end of life services. A second is the separation, as recommended by the Productivity Commission, of provision of accommodation and provision of care. The obvious impediment to residential facilities 'becom[ing] an accommodation choice, rather than a 'compulsory extra' provided in tandem with particular types of care' is the hard separation of funding between home care packages and residential care funding. A consideration for this model to work in practice is, however, the availability of affordable housing and availability of technology and funding to support individuals with high, 24/7 care needs.

As noted in the body of our submission, increased regulatory and funding flexibility is necessary if the system is to generate a greater range of appropriate (in terms of design, affordability and locality) accommodation options in the community, including for younger people and those with specific needs that render 'institutional' options unsuitable, for example 'care' leavers or others who have experienced trauma during their lives. We recognise however that increasing flexibility potentially demands augmentation of the current protections for consumers, for example further consideration of how to ensure community expectations of safety are met in non-traditional accommodation options.

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?

UnitingCare Australia concurs with the points in Consultation Paper 1 relating to specialist advice and services, particularly to the extent that they recognise the importance of an individual receiving clinical care without unnecessary disruption to their life. As far as possible, the very high care needs of those residing in specialist facilities should be able to be met in those facilities, avoiding transfer to hospital.

Conversely, however, older people with health issues or life-limiting conditions who have managed those conditions through the health system should not have to access a separate system to receive support. As a wealthy nation, age should not determine the extent to which health and social supports extend to individuals with needs that cannot be met within their own social or financial resources.

The system should support improved integration of health care and residential services where there are opportunities to reduce presentations to the acute system. Mobile imaging services or dialysis equipment could, for example, be accessed in residential facilities.

There is a misapprehension that specialist expertise flows from the health to the aged care system, which fails to recognise and take advantage of the expertise that resides in the sector. In the area

of BPSD for example, staff in residential facilities can (and often do) have greater expertise than is available in the health system however under current arrangements these services do not have the resources to support individuals with extreme BPSD safely.

Designing for diversity

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?

Designing a system in which the individual is able to create their own 'solutions' is inherently more respectful of diversity.

It is important to acknowledge, however, the often complex needs or additional burden of ill-health of those who belong to special needs groups. UnitingCare Australia supports a system of services that would support further embedding of reablement approaches and preventive attitudes in the model of services for older people. This might include systemic incentives for uptake of preventive or rehabilitation services by individuals, support for integration of short term and rehabilitation services with longer term care services, as well as interventions in health and wellbeing well before individuals are eligible for 'aged care'—with a particular focus on groups in the community at risk of premature ageing.

We note that there are a number of valuable resources available to assist assessors and workers in aged care services to sensitively identify and support members of special needs groups (for example care leavers). More needs to be done however to recognise the impacts of trauma and to respond with trauma-informed services.

Importantly, the current system does not ensure access to or viability of services in regional and remote areas, or for special needs groups whose needs cannot be met in 'mainstream' services (for example people who are homeless or at risk of homelessness). There are many regions that are currently underserved in terms of places¹⁰ or in which the range of services is restricted. Access to specialists (particularly geriatricians), allied health and other services is often very difficult or on a 'fly in fly out' basis, even in major regional centres. There is insufficient funding to acknowledge the cost variance for distances travelled in rural and remote areas (to deliver home care as well as for staff travelling to and from services) or the cost of interpreting services where required for people of CALD background.

The negative attitudes that Every Age Counts identifies as the 'burden of ageing' paradigm is particularly problematic in communities where population ageing is accelerated due to higher mobility of younger people. The system must enable 'place-based' models not only for Aboriginal and Torres Strait Islander communities, but also for regional and remote communities where

¹⁰ see for example the Ansell Strategic study commissioned by UnitingCare Australia that was tabled to the Royal Commission by Ms Claerwen Little on 20 February 2019:

<https://agedcare.royalcommission.gov.au/hearings/Documents/exhibits-2019/20-february/UCH.500.001.0201.pdf>

duplication of social and health services such as disability, health and aged care results in inefficiency and poor outcomes.

Community development – rather than community consultation – approaches have the potential to yield individualised solutions for smaller populations, which not only enable cultural and social safety for groups within the community, but which strengthen community infrastructure and the contribution that social services sectors make to local economies.

Additional questions

Financing aged care

What are the strengths and weaknesses of the current financing arrangements and any alternative options that exist to better prepare Australia and older Australians for the increasing cost of aged care?

UnitingCare Australia was involved in development of the Principles for Aged Care Services Funding, which were developed by ACSA and six of the major Not for profit (NFP) aged care organisations and published by ACSA in November 2016.¹¹ They continue to stand as a sound guide to UnitingCare Australia's positions on funding, notwithstanding the evolution in the sector since that time.

The principles urged that the funding model for services should be designed comprehensively, including all current supplements and consideration of arrangements for consumer financial contributions, and be able to be applied across home and residential care (in line with the recommendations in the Aged Care Sector Committee's Roadmap for Reform). We strongly support reforms of the Government's budgetary approach to ensure that funding is adequate to ensure every person eligible for services and supports can access those services in a timely way. This includes considering the lack of consistency between NDIS and Aged Care funding allocations per individual.

¹¹ <https://www.acsa.asn.au/getmedia/01066d0d-f54f-4ab1-86ea-a9fc6daac8/ACSA-Principles-for-Aged-Care-Services-Funding.aspx>

UnitingCare Australia's position is that the funding imbalance in the aged care system represents a structural deficit that must be addressed to ensure sustainability of the system, particularly for vulnerable consumers. We believe that, to restore sufficient confidence to invest in additional service capacity, governments must:

- work together to give an assurance that structural issues will be addressed (for example through a rigorous and fully transparent cost of care study and equitable measures to ensure full coverage of costs)
- outline a clear transition pathway that includes support for adequate training of both government and provider workforces to be ready for a new system and
- provide clear measures to ensure that stability in the sector is maintained and – whatever the funding model developed – continuous monitoring, adjustment and amendment are used to ensure that the funding model delivers equitable outcomes for all individuals as the population needs profile changes over time.

We note that a failure to address the structural deficit not only threatens the viability of some services, but will block the capital investment needed to upgrade and improve existing residential facilities as well as expand the number and development of additional age care places. It is also importance to learn from the sector's experiences with ACFI – the disruption to the sector caused by the manipulation of ACFI to address budgetary issues cannot be understated.

We believe that there is a public role in funding what are essentially health and disability services, on the basis of universal access (as per the Productivity Commission's recommendations that led to the Living Longer Living Better reforms). As noted previously,

In this context we also note that consumer choice and control are affected by many factors outside the current Commonwealth funded aged care system. Differential access to specialist and allied health services is just one factor that flows through to the cost of care in a given facility. This is not just an issue in regional and remote facilities and demands consideration as part of a broader perspective on how community access to services is optimised.

The current system is not needs based, it is based on a population methodology looking at the ageing population and the percentage of people who will most likely need care. The methodology does not effectively account for individual characteristics, disease trajectories and other factors impacting people's need for services. Without increased rigour in methodology, resource allocation in the system may not necessarily reflect the needs of the ageing community into the future. We are not able to identify any data or estimates of level of need, location of need, best practice in terms of meeting that need or active seeking of providers to meet a need where the market has failed. It is also concerning that there continues to be so little understanding of behavioural elements relevant to services for older people in general, including the elasticities of demand and supply of services.

We believe that basing the future system on assumptions based on the current funding arrangements and constrained consumer choices represents a serious methodological flaw.

Anecdotally, we know that differences in the level of co-contribution (either between programs, or levels of program) and therefore perceived value for money influence uptake of services. This

extends to underuse of services that would prevent or ameliorate chronic conditions associated with ageing.

There are various points of 'misallocation' of resources in the system including Australia's relatively high (internationally) rate of use of residential care, which arguably represents an underuse of more appropriate services in the community—whether these be services within the system (home care options) or outside, for example housing services; this form of misallocation can be due to lack of diversity in services offered by the sector (for example for higher levels of care in the home) or substitution due to inadequate funding of services such as palliative care or social housing.¹²

As noted above, the current structure of the aged care system – based on assessment at a point in time, which then gives rise to an 'entitlement' to care – potentially undermines the system objective to promote reablement and maximum independence of older people in the community. Thus we consider predictions of future demand based on current systems and use are flawed at best. They are based on suboptimal 'signals' and restrictions on access to many types of service (including at younger ages) that might defer or reduce the need for residential aged care at the individual and population level.

UA believes that alternative system designs that promote consumer behaviours such as maintaining financial self-reliance for longer, whilst providing effective 'safety nets' for individuals with limited resources, may effectively address patterns of behaviour that lead to substitution of government subsidised services for commercial services that an individual would normally engage e.g. domestic cleaning and home maintenance.

We believe that it is critical that the approach to allocating funds is designed with the benefits of early and adequate use of services such as physiotherapy, occupational therapy, hearing and sight services and appropriate support for home modifications and equipment, balanced against the potential to 'ration' subsidised services through use of greater consumer contributions or 'stricter' prioritisation of consumer need.

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?

UnitingCare Australia believes that the discussion of safety and quality of services in Australia must start from first principles and progress in parallel with development of the service model. The regulatory model must support the model through which consumers are able to direct their own services, underpinning the complementary service system.

We anticipate having the opportunity to comment in detail at a later date, as the Royal Commission considers how to achieve rigour at all levels in a future, user-directed system. We would urge the Royal Commission to consider issues including

¹² see for example the Ansell Strategic study commissioned by UnitingCare Australia that was tabled to the Royal Commission by Ms Claerwen Little on 20 February 2019:

<https://agedcare.royalcommission.gov.au/hearings/Documents/exhibits-2019/20-february/UCH.500.001.0201.pdf>

- ensuring that any regulatory system embeds measurable outcomes that can be benchmarked, and are informative for consumers and their supporters
- how to balance safeguards against poor performance against allowing for provider expertise and judgment when working with service users
- how best to incorporate adaptability, so that evidence from research and best practice is consistently applied
- how best to nurture good governance, continuous improvement, self evaluation and risk management as well as 'learning' based responses to adverse outcomes/instances.

It is important to understand how and why the services system is not working for some individuals, but it is equally important to understand success in the system, and the ways in which regulation promotes or impedes success. It is also important that not everyone who ages uses care. There is considerable evidence around the factors that contribute to thriving in later life. Whether it is starting from a better socioeconomic base, educational attainment, lifetime access to health services as needed, strength of connection to family and community, or having good genes, this knowledge must be translated to services and interventions across an individual's life.

Regulation will not drive innovation. As noted in the body of our submission, there is a genuine need for elements of competition based on responsiveness to individuals' needs. There must be consistency within the system – accreditation of governance models must result in devolution of responsibility for risk management and service design, rather than a duplicative process whereby inspectors substitute their own judgment for that of the practitioner.

We also believe that, whilst the Royal Commission is charged with grappling with the negatives of the system, it is impossible to measure how much scarcity – previously of residential places, now of funding for residential services and home care places – has been a factor in negative outcomes for individuals rather than a failure of regulation.

UnitingCare Australia believes that regulation must be broad and flexible enough that it can adapt to every situation. Currently, due to scarcity, individuals are limited in how they can meet needs as it is not possible for every option to be available in every community: the system is not working as intended as it is predicated on a sufficiency of services, uniformly distributed. If urgency and immediacy of need were addressed, especially for restorative/reablement services, the outcomes from the system would be vastly improved. Currently the elements of the system designed to meet low level needs are blocked up with higher needs individuals in the community, who in fact need rapid access to services to prevent irreversible declines in capacity.

Quality and safety are nebulous concepts: in particular, the outcomes that a remote community is looking for will be very different from in an urbanised environment. At the risk of stereotyping, self-reliance is often paramount, and involves solving problems based on local resources. The regulatory system must be cognisant and accommodating of differences in context and cohort, to enable culturally specific and culturally safe services to evolve to meet the diverse needs of older people.

There is an additional aspect of balance, where regulation impacts on the lifestyle components chosen by an individual. UnitingCare Australia is concerned that the pressure on the regulatory system – particularly in relation to residential care services – has reached a point where risk

aversion has started to contradict the principles of consumer choice and control, removing the capacity of providers to adapt their services to the preferences and needs of individuals using their services. The intense scrutiny that has been applied to the sector is resulting in proportionally more of each organisation's resources going into compliance rather than service delivery. This is an unsustainable system.

Large not for profit organisations like UnitingCare Australia's individual network members are well represented amongst services that are operating at a loss. Our mission means that we continue to provide services to a standard we believe is safe and meets community expectations, however the drawdown in reserves of organisations demonstrates that the growth in acuity when entering the current aged care system has not been matched with funding increases. Where the lack of resources leads to individuals missing out – for example due to a protracted wait for home care or because customised equipment is excluded from public funding for residential care, no amount of provider regulation will lead to safety and quality of care for that person.

'Quality and safety' are moveable targets, subjective concepts which for each individual are based on personal histories and expectations. The need is to respond with innovation – to move beyond the confines of a 'system' to address social isolation, connect communities, networks and volunteers. The full suite of needs of the individual will only be met when these connections are made.