australian nursing federation

Review of Subsidies and Services in Australian Government Funded Community Aged Care Programs Submission

Department of Health and Aged Care

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The Australian Nursing Federation (ANF) was established in 1924. The ANF is the national union for nurses, with branches in each State and Territory of Australia. The ANF is also the largest professional organisation in Australia, with a membership of over 150,000 nurses, employed in a wide range of enterprises in urban, rural and remote locations in both the public and private sectors. The ANF's core business is the industrial and professional representation of nurses and nursing.

The ANF participates in the development of policy in nursing, nursing regulation, health, community services, veteran's affairs, education, training, occupational health and safety, industrial relations, immigration and law reform.

Introduction

The ANF welcomes the opportunity to provide a submission to the Department of Health and Ageing *Review of Subsidies and Services in Australian Government Funded Community Aged Care Programs*. We note that the Review will focus on identifying areas where current structure and funding arrangements could be refined and service delivery improved, with the view to identifying opportunities for a more integrated set of aged care programs that support frail older Australians as their needs change.

It is reassuring that the Review will specifically look at identifying the service needs of frail older Australians, particularly those with complex care needs, as well as the needs of carers; identify gaps and overlaps in services; examine the structure of subsidy and fee arrangements with particular regard to equity and choice; examine quality and accountability requirements; and assess the requirement for services into the future, taking account of changes in consumer preferences, demographic changes and the capacity for private provision.

It is also imperative that the Review examine the relationship between community care and residential care, and between federally-funded programs and those run by other jurisdictions, such as the Home and Community Care (HACC) Program as it is in this cross-over between programs where the ANF has identified there is a high risk of people 'slipping through the gaps'.

The ANF considers that the critical catalyst for ensuring each of these goals can be met; and maximising the benefits to those who need the services, is careful coordination of the care to minimise fragmentation of services and/or the need for migration from one service to another.

Issues

1. Service Mix – the range and diversity of community care services required for frail older Australians with complex care needs and their carers.

☐ **Factors that contribute to entry to residential care:**

There are a number of factors that dictate the time point at which a person moves from their own home to residential care. These include (the list is not exhaustive):

Personal election

- Diminishing confidence and fear eg.of falling and not being able to get up or alert anyone; security issues; a sense of loss of control of own environment.
- The requirement for a higher level of assistance with basic living and personal care needs which family, friends or community and home care services cease to be able to adequately meet (such as continence, mobility, hygiene, communication, nutrition etc).
- A sense of being a burden on family and friends because of increasing care and assistance needs.
- Home management and maintenance becoming too burdensome because of increasing frailty, diminishing mobility and the impact of multiple health problems.
- The loss of a partner, carer or other significant person who has been a critical support in enabling the person to remain in their own home.
- Loneliness and isolation from family, friends and what were normal daily activities and excursions.

External influences

- Pressure from family and friends that the person is no longer capable of living in their own home with current arrangements.
- Medical diagnosis of dementia or other neurological or mental health disorder that indicates a person is no longer capable of making safe judgments and is placing themselves and/or others in jeopardy.
- Medical diagnosis of multiple physical and/or neurological illnesses that mean that the person requires a level of care that the current community and home care services are unable to provide and the person is unable to afford to fund without subsidy.
- Previous carer dies or is no longer available to provide care, due to their own age and frailty.
- Physical environment has become so unsafe that a local council or public health unit recommends that it is uninhabitable.

☐ **Services that matter most in keeping people in the community**

- Service coordination to ensure efficient recognition of changing needs, ongoing assessment, rapid allocation of new services and seamless coordination of services.
- Services that enable ongoing social connection with family, friends and others providing companionship both in a person's own home and participating in events outside their home.
- Services that provide nutritional support.
- Care and support in personal hygiene and continence management (including constipation).
- Nursing assistance with managing medications and other health issues such as wounds, venous ulcers, monitoring of diabetes and ongoing clinical assessment of other health conditions.
- Household tidying, cleaning, laundry and other domestic services.
- Household repairs and maintenance, including gardening.
- Services undertaking advice for and providing modifications and safety accessories to improve the safety of the home environment as a person's sight, mobility and other faculties diminish.
- Assistance in maintaining safe mobility eg. regular and gentle exercise programs.
- Transport to enable a person to go shopping, participate in social events, attend appointments and not be isolated in their home.
- Telephone monitoring - and home visits to check on the person's safety.
- Pet support and care.
- Independent services enabling feedback to service providers, advocacy and support for a client group that may be very vulnerable to exploitation.
- The availability of affordable respite care in the home.
- Better integration of services for care recipients and carers ie. the provision of services for nursing care and respite services available from a single provider.
- Culturally appropriate services provided by Indigenous people for Indigenous communities.
- Funding to provide services for carers and care recipients in rural and remote communities.

☐ **Relative importance of service types currently under the programs covered by Review**

- The ANF regards it as unwise to rank the importance of the services as it is very often the combination of services or the particular circumstances of the client that create the imperative for a particular service.
- The focus of the care should be the client and the services should be seen as a product list that can be selected from as a need arises or level of need changes. For some clients, their pet may be the most important thing in their life and they would regard support and care for the pet as important as any support and care they may need.

☐ **Whether services not currently funded in community care should be considered for inclusion in the future**

- There should be a flexible and tolerant attitude to considering other services for funding. If the philosophy and focus of the program is the client's need, then there should be a system to assess and consider the appropriateness of any new services that a client may require. The product list should not drive the service – it should be driven by client need.
- Services such as exercise and mobility programs, massage and pet care are all examples of services that may contribute greatly to a person remaining in the community in their own home, for which consideration may be given to funding in the future.

☐ **The most appropriate balance between long term direct support and short term direct care or restorative/therapeutic services**

- With the integration of a broader range of services in a coordinated and continuous model of service delivery that is flexible enough to meet a variety of clients' needs, this question becomes superfluous. Services that are selected on the basis of competently and regularly assessed needs of clients do not require a 'balancing' at a bureaucratic level.

☐ **The role of case management and care coordination services**

- The ANF is of the view that the primary issue as far as the CACP, EACH and EACH Dementia and other community services is that there are too many uncoordinated funded services. The outcomes for clients are compromised because there is ineffective continuity of care. It is in this area of case management, and providing assistance to navigate a complex system, that the ANF considers significant investment is required. It is here that the knowledge, skills and experience of nurses can make a major contribution.
- Nurses have proven themselves in a number of care sectors as competent and effective care coordinators with the necessary knowledge, skills and experience to assess and make clinical and other care judgments for people needing a complex and long term array of services and care.
- Nurse practitioners working in aged care are already doing this within current funding constraints with some difficulty, and are achieving extraordinary results. With more flexible funding arrangements and the capacity for a single provider to deliver a broad array of services this would be made significantly easier.
- While nurses are not the only health and community professionals that are capable of fulfilling this role, they do have a unique perspective on the 24 hour nature of the potential needs a client may have or develop, especially when their health challenges increase.

☐ **Services for care recipients and carers are often separately sourced - the need for better integration of care recipient and carer services through program arrangements**

- The major complaint from clients and/or relatives is that when they require more hours, complex care or a service not specified under a CACP is that they have to go through a complex, upsetting and often expensive process to find what they require, often finding that services come from a multitude of suppliers.

Examples:

- Currently if a client with a CACP (funded for a maximum of 5 to 6 hours care per week) is in the situation where their care needs become more complex (for example requires an EACH or EACH Dementia package), the CACP provider is unable to provide the extra services under current arrangements and funding. Thus begins a convoluted process in trying to arrange for the extra care from another provider. The client loses the person or persons he or she knows and trusts and has to start all over again.
- Another example arises when a person requires Meals on Wheels. The CACP provider is not funded to provide this service and again there is a need to organise this service for the client by another agency.
- A third example arises when a person with a CACP requires respite care. The CACP provider is not funded to provide this service and must organise an alternative funded provider.

- Each of these very real scenarios is particularly distressing for the increasingly dependent, frail and often confused older person; as well as being very frustrating to a CACP provider who wishes to provide comprehensive care that enables a person to maintain their diminishing independence and their dignity.

☐ **Services for populations with special needs, eg Cultural and Linguistic Diversity, Aboriginal and Torres Strait Islander people, people with dementia, people in rural/remote areas**

- The needs of clients with special needs in a client focussed community aged care program would be easily met because the emphasis is upon the client needs. The services should be assessed and matched to needs by a sensitive and competent care coordinator, be they: a person who may be primarily Polish speaking; a person living 100 kilometres north of Hawker in South Australia; an Aboriginal elder with many health problems; or a school teacher with an Anglo-Celtic background.

2. Improvements to funding arrangements

☐ **How the current mix of grant and subsidy based programs respond to the ranges of individual need and any areas of potential gaps or overlaps in program arrangements**

- The ANF is of the view that the funding must be rationalised to enable better integration of a broader range of services in a coordinated and continuous model of service delivery that is flexible enough to meet a variety of clients' needs.
- For example, CACP providers could be funded to provide a broader range of services to a client group eg. Meals on Wheels and respite care.
- If a CACP client requires more complex care and the provider has the infrastructure to deliver this, as is often the case; a process needs to be developed for a provider to be able to apply through the funding body for additional funding to enable the provision of a seamless service.
- The key issue is that there is currently poor integration of services, with multiple funding sources creating a barrier to those seeking assistance and inefficiencies when the same services are funded under different programs. Improving integration and minimising duplication of services is the essential component in improving funding arrangements.

☐ **How the set of programs under review work as an integrated set of arrangements and linkages with other programs, such as residential care and the Home and Community Care (HACC) program**

- The ANF is of the view that this is sourced from a genuine philosophy of continuity of client centred care and coordinated, ongoing case management as discussed above.

☐ **The scope for integration where the same services are funded under different programs**

- The 'doctrine of good sense' should prevail and the client and the care coordinator and should be able to select those that will enable maximum symbiosis with other services the client may require – this is discussed briefly above.

3. Appropriate user contributions

☐ **The need to have a balance between Australian Government and client contributions to ensure programs are equitable and sustainable**

- There is no doubt that there are members of the Australian community who are more able to contribute to the cost of the community aged care services they may require than others, either because they have adequate equity or fluid assets themselves, or their families will wish to contribute if the person in need of the services is unable.

- The issue of fairness and equity is an important one here – the level of co-payment or client contribution should be structured to enable all Australian's entitled to community aged care services to be able to access them. There is economic and social modelling data that can support a case for enabling people to remain safely and comfortably in their own homes for as long as possible as opposed to funding them in a residential aged care facility which is seen by many in the community as 'the end of the road'. The alacrity with which the HACC funding and CACP funding has been taken up by the community, even with its gaps and flaws, is testament to the popularity of the scheme.
- A strictly commercial 'user pays' system that is beyond the reach of the standard Australian pension for this population will mean that there will be a significant proportion of the population that will not be able to pay and therefore will not have access to the same level of important services to those who can afford to pay. There is no doubt that there will remain a market for unfunded deluxe services for those who can and wish to pay for them.
- An asset testing process often is founded on creating arrangements to access non-fluid assets such as the residential property of the person requiring care in a variety of financial arrangements. These are much misunderstood and are often the source of great distress and anxiety for the person concerned who may have little capacity to understand or access what independent advice is available.

4. Operating Issues - improving the effectiveness and sustainability of its community aged care programs

☐ **The factors which affect the effectiveness and viability of community care services, quality and accountability mechanisms**

- Sensitive, effective and ongoing coordination and case management where a case coordinator has access to a broad range of 'product services' and funding that can be selected and matched to a client's developing needs.
- A broad range of 'product services' that meet appropriate quality and safety standards.
- Flexibility to negotiate across services for a package of services that is as seamless as possible.
- Flexibility in the funding models to enable seamless (or with invisible seams) service provision that meets client needs.
- Strong accountability mechanisms that ensure safe high quality services, for example:
    - ❖ a strong governance framework with emphasis upon appropriate stewardship of funds and transparent and powerful accountability mechanisms for any provider of community aged care services;
    - ❖ robust standards for the delivery of all types of services, as well as audit and oversight responsibility by an independent agency;

- ❖ the capacity for free and frank feedback from consumers and their 'significant others' regarding their satisfaction with the service;
- ❖ robust report and complaint mechanisms where there is an independent agency if local resolution initiatives are inappropriate or ineffective; and
- ❖ sound occupational health and safety policy and procedures to protect clients and workers.

☐ **Workforce requirements and development**

- A commitment to ensuring the availability of appropriately skilled, knowledgeable and experienced staff with a strong commitment to ethical, high quality and safe service.
- A commitment to respecting and supporting community aged care workers with appropriate financial remuneration and conditions commensurate with those of workers in equivalent industries.
- Standards for the educational preparation and ongoing educational development of all service providers, appropriate to the services that they provide.
- A licensing system for currently unregulated community aged care workers that will enable some: personal accountability; workplace tracking; and workforce data to be collected.
- Robust performance management programs for all workers to ensure high quality and safe services.

5. Future requirements

☐ **The factors that impact on service requirement, such as changing demographics, changing health status (including prevalence of dementia), increased availability of assistive technology, consumer preferences, carer numbers and circumstances**

Challenges

- The ageing of the community and the health and aged care workforce creating workforce shortages to meet the needs of the ageing baby boomers.
- People living longer and developing the more debilitating illnesses and the frailty of age that require significant investment in health, support and residential care services.
- Carers and family who would have provided care in the past are also ageing and unable to carry the burdens that they have traditionally carried.
- A more assertive generation of the community with higher expectations of Government and private services designed to meet their needs, who will be even more insistent on services that enable them to remain as independent as possible.
- Increasing stretching of superannuation investments as people live longer and draw on these funds for actuarially longer periods which will require careful policy and stewardship to sustain these funds so that they continue to provide an alternative to Government pension schemes.

- Environmental factors and climate change and the as yet unknown consequences of the extremes associated with global warming (eg. the large number of older Europeans who died in the hot summer of 2003).

Benefits

- A focus on healthy ageing which is and should continue to keep many people fitter and less likely to suffer the disabling illnesses and injuries that come from the lack of exercise, poor nutrition and social isolation.
- The development of design and technology to assist in all aspects of ageing and providing care and services to older people eg:
  - mobility aids,
  - sensory assistance aides,
  - continence aides,
  - architectural innovation in building, landscaping and internal design,
  - furniture design and fabrication,
  - alarms and call systems,
  - environmental controls, and
  - the automation of many household tasks eg. washing, dishwashing, clothes drying, gardening and mowing etc.
- The traditional milestones such as formal and complete retirement from the workforce are changing. People are more likely to transition into other roles and to lesser work hours in the future.
- The employer sponsored superannuation schemes results in the Government welfare system being supported to meet the living costs of older people who are no longer earning income from paid work.

☐ **Availability of alternative sources of care, including residential care and community care services that people might purchase privately.**

- The scope of this is only limited by a person’s imagination and income. Already we are seeing some remarkable entrepreneurial care and services coming on line. The marketplace and the breadth and flexibility of Government subsidy arrangements will tend to dictate the scope of these. However Government should be flexible enough to recognise where subsidy in some of these areas may avert a transition to total dependence on Government funded services.

- ☐ **Other areas that the Government should explore to ensure that the service system is well placed to meet the future needs of consumer and carers in an equitable and sustainable way**

- Innovation in risk management, quality and safety accreditation and accountability schemes that maximise the flexibility of service and care arrangements while ensuring that people's needs are met, that they are satisfied and are able to transition to the next level with minimal disruption.
- Ensuring the existence of a skilled and sustainable workforce to meet service demand.

- ☐ **The options in respect of promoting choice within community service programs and between community and residential programs**

- As indicated above, if the philosophy is founded on consumer need and choice, with excellent coordination and case management, this should not be difficult.

CONCLUSION

The ANF welcomes the opportunity to provide input to the Review and would be pleased to assist with any further contributions. The ANF is of the view that significant investment in ensuring competent and coordinated, ongoing case management for every client of the community aged care program is essential. It is in this area of case management, and providing assistance to navigate a complex system, that the services of nurses are vital and can make a significant improvement.