Submission to the Royal Commission into Aged Care Quality and Safety

Creating a fit-for-purpose aged care system that supports the most disadvantaged

Brotherhood of St Laurence

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Summary

This Royal Commission provides a timely opportunity to reform Australia's aged care system. In the view of the Brotherhood of St Laurence (BSL), reforms must include holistic policy, structural, practice and service changes to promote an inclusive, accessible aged care system in which all people, irrespective of background or means, receive high-quality care.

This Royal Commission is a unique opportunity for aged care reform

Aged care is in crisis. Many older people are completely unable to engage with the system, due to limited personal resources and/or the complexity of interfaces like My Aged Care. If people are deemed eligible, waiting periods for Home Care Packages range from months to years. There are few transitional supports for these older people. Residential aged care has become subject to a high degree of regulation. While some regulations play a valuable role, many more have detracted from good care or undermined the autonomy and dignity of older people and the workforce.

Given our service footprint, we have a strong focus on older people with past or present experience of disadvantage and/or service exclusion—those older people for whom the aged care system works least effectively. This growing group of diverse older people are most in need of reforms that will enable them to age with dignity, agency and respect. This group has also benefited least from previous regulatory and practice reforms. The ways to deliver solutions for those experiencing disadvantage are often quite different, as personal needs and circumstances can be diverse and challenging. Yet, for all older people the objective is the same: *substantive equality*—equitable outcomes and equal opportunities—must be achieved through a redesigned aged care system.

The aged care system requires urgent regulatory, service and practice reforms. However, it also requires systemic, long-term changes. Many immediate reforms have been well documented in research and government evaluations, as well as by providers, advocates, witnesses and the current Commission itself. The Interim Report reinforces the urgent need for reforms that view the aged care system as a *multilevel problem requiring multilevel solutions*. This submission focuses on longer-term changes to ensure sustainable, equitable aged care.

The aged care sector requires substantial redesign

Our recommendations consider how current arrangements could be reformed to improve outcomes for all older people, irrespective of their backgrounds, healthcare needs, capabilities, financial resources and capacity. Ensuring people access appropriate care when they need it will promote net beneficial outcomes for older people, their families, networks and communities. We also anticipate that improved access to high-quality aged care will increase overall financial viability by diverting people away from more expensive crisis responses and high-needs care, wherever safe and possible. The BSL recommends that the Commissioners consider the following three foundations for an effective aged care system:

- market stewardship and service navigation support
- quality aged care based on empowering all older people and the workforce
- secure, age-appropriate housing options to complement aged care

Market stewardship and service navigation support to ensure that all older people, irrespective of background, have access to quality care and support

Unfettered market principles have contributed to the fragmentation of mainstream service systems. Marketisation has had a negative impact on aged care, particularly for older people experiencing complex disadvantage. Reforms should prioritise those older Australians who cannot easily exercise choice and/or exit options in competitive markets. The system must also enable the viability of diverse providers—big and small, metropolitan and regional—that are able to cater for diverse needs. The BSL calls for policy- and systems-level reforms, including expanded roles for governments and providers, and a navigator function. We view navigators as essential, helping provide clear pathways and ensure that the benefits of market reforms are distributed equitably. While targeted at older people experiencing disadvantage, our model of system navigators, Community Aged Care Coordinators (CACCs), would improve outcomes for all older people, their families and/or networks by facilitating transitions into and between available services, including accessing and utilising personal funds.

Recommendation 1: Introduce a comprehensive market stewardship framework for aged care to ensure that the benefits of marketisation are shared equitably.

Recommendation 2: Introduce a block-funded Community Aged Care Coordinator (CACC) role for suitable geographic areas to identify at-risk older people in community and help them navigate systems so as to minimise crises and maintain their connections to place.

Quality in aged care, reconceived to empower all older people and the workforce

Older people, particularly those facing complex disadvantage, are increasingly excluded from high-quality aged care and defining what a good life looks like for them. Rather, reforms have commodified older people by defining their choice and control largely as consumer rights and protections. At the same time, aged care work has become more administratively burdensome, shifting the focus further away from frontline interactions. The BSL argues that this shift has compounded system failings. Mutually reinforcing and iterative relationships between aged care staff and participants, including devolving decision-making closer to the point of care, would vastly improve quality. These practice changes, with relevant training, would ensure that parties most critical to high-quality care—recipients and practitioners—are directly and actively involved.

Recommendation 3: Enable older people to be more involved in their care by embedding person-centred practice approaches and tailored interventions in quality standards.

Recommendation 4: Ensure that quality care is reinforced through workforce education, training and professionalisation.

Secure, age-appropriate housing options to complement aged care and support ageing in place

Disadvantaged older people remain excluded from many services, often entering aged care following a personal and/or healthcare crisis. The BSL recommends enabling ‘ageing in place’ through a greater emphasis on multilevel solutions, with housing at the centre of responses.

Ageing in place is a noted preference for many older people, who want to maintain connections with their friends, families and communities as they age. Reforms should ensure that aged care promotes social connections, complemented by policies that foster age-friendly communities to reduce service dependence. Specialist supports and services, such as supported accommodation, are also required to meet the needs of some older people experiencing disadvantage. Proactive policy, systems, and service reforms that place accommodation at the centre will support growing numbers of older people to age in place with a strong sense of community and ongoing access to services.

Recommendation 5: Prioritise strategies for ageing in place, including:

- targeted interventions for people experiencing disadvantage
- a holistic view of place that includes existing community resources and supports.

Recommendation 6: Develop housing alternatives for older people experiencing or at risk of disadvantage, to provide:

- alternative, age-appropriate accommodation that supports older people to age in place
- integration with wrap-around health and social support services to aid efficient and effective use of personal, CHSP and/or HCP funds
- links to other health and allied social services, including high-needs aged care, to smooth transitions across the service system.

Recommendation 7: Expand commitments under the National Housing and Homelessness Agreement to ensure that there is a targeted strategy for older people.

The Brotherhood of St Laurence and aged care

The BSL is an independent non-government organisation with strong Anglican and community links that has been working to reduce poverty in Australia since the 1930s. The BSL has a history of supporting people at greatest risk of social and financial disadvantage. Based in Melbourne, but with a national profile, the BSL continues to fight for an Australia free of poverty. We undertake research, advocacy, service development and delivery with the objective of addressing unmet needs and translating the understandings gained into new policies, programs and practices for implementation by government and other providers.

The BSL has long been involved in raising awareness about the circumstances and needs of older people. Through the Research and Policy Centre (RPC), the BSL promotes understanding of ageing issues. Research projects undertaken jointly by RPC and our Aged Care division have included: adapting to consumer directed care; understanding networks of care; improved care for those with dementia; mature-aged workers and carers; and the social inclusion of older people. Aged care remains integral to our ultimate vision to work with others to create:

- an inclusive society, where everyone is treated with dignity and respect
- a just society, which challenges inequity
- a compassionate society, where we demonstrate care for each other
- a sustainable society, for our generation and future generations.

Our services attend to the needs of the most disadvantaged

At 30 June 2018, the BSL provided 773 Home Care Packages (HCPs) across metropolitan Melbourne; and 78 of the 86 beds in our two residential facilities, Sumner House and Sambell Lodge, were occupied (Sambell Lodge is under redevelopment and, when completed, will accommodate 114 residents).

The BSL runs several other services for older people. In Fitzroy, Sumner House is co-located with independent living units for inner-suburban pensioners with few assets and the Coolibah Centre. Coolibah provides meals, welfare support, social and leisure activities and a community for older people on low incomes, those living in insecure housing and those in BSL accommodation. In Frankston, Banksia Services work with older people with dementia and provide cottage respite care for people who are frail or living with disability. Banksia also supports its members to initiate, plan and engage in activities, maintain and build social connections, and raise awareness about disability and dementia.

Despite challenges, BSL aged care services emphasise social engagement, participation and case management. This emphasis is evident in staff recruitment and training. Our Home Care team is also based on high-quality case management to enable older people to live better lives in their communities. Case managers advocate for both clients and families, help people navigate complex systems and gain the most from their packages. In our residential facilities, the BSL supports clients through an inclusive culture and programs to accommodate complex needs. Support translates to a range of practices—from respecting diverse sexual identities to managing legal drug dependence without stigmatising residents. At monthly residents' meetings, clients can

provide feedback and hear about new developments. Services are enhanced by volunteers, chaplaincy, allied health professionals and a team of lifestyle enrichment coordinators.

People facing disadvantage require complex care and supports

The BSL is committed to providing the best quality care for older people. Many of our clients have complex needs that require intensive, tailored responses; without our services, most would struggle to find appropriate care and support. Coming into our services, clients can be socially isolated and have few friends or family to support them. Personal disadvantage can also increase risks of abuse and/or exploitation. Solutions for these older people require individualised, decisions that are developed closely with them.

Our residential facilities especially work with people with complex needs. More than 75% of our residents are supported, concessional or assisted, or low-means care recipients. Moreover, many have complex health, behavioural and social support needs, typically arising from long periods of poor health, institutionalisation, substance abuse, disability, homelessness, poverty and/or disadvantage. Due to their personal histories, residents can exhibit challenging behaviours, which may be related to intellectual disability, traumatic experiences or acquired brain injury. For those people in our care, 'mainstream services' often do not meet their needs, or present significant barriers to inclusion. We maintain a strong commitment to members of our community who have experienced or are experiencing homelessness, poverty, and/or social exclusion, and those with disability, chronic health conditions or complex behavioural, social and/or cultural needs.

Interim Report findings and BSL response

In its Interim Report, the Commission is direct and scathing in its assessment of aged care in Australia, noting that the system is considerably fragmented and underfunded. In extreme cases, treatment of older people in the system was noted to be cruel, uncaring and/or discriminatory (RCACQS 2019). The report clearly outlines the need for a fundamental transformation of the aged care system—including structures, regulations, systems, practice, objectives and funding. Similar observations have been made in reports by Carnell and Paterson (2017), Tune (2017), the Productivity Commission (2011, 2015), and submissions to the current Commission by the Australian Human Rights Commission, Australian Association of Gerontologists and COTA Australia.

The BSL is particularly interested in two of the Commission's observations of the current system: (1) that access to care depends directly on income and assets and (2) that inequitable outcomes are magnified for people experiencing disadvantage. In many instances, treating older people as informed consumers who can 'shop around' for the best service is a significant contributor to poor personal and healthcare outcomes. While they carry the responsibility, older people are often unable to find services, negotiate prices or assess the standard of their care. Accordingly:

> The notion that most care is 'consumer-directed' is just not true. Despite appearances, despite rhetoric, there is little choice with aged care. It is a myth that aged care is an effective consumer-driven market. (RCACQS 2019, pp. 9–10)

Yet, outside this admission, marketisation issues and their impacts on disadvantaged older people have not been fully explored. The BSL therefore takes this opportunity to expand on the identified issues and to outline multilevel solutions.

Identified challenges must be addressed through multilevel reforms

Effective aged care includes a broad range of supports and services that are supposed to cover all older people and escalate as their needs increase. While this submission focuses on the aged care system, several of our recommendations involve interrelated systems such as health or housing; this focus also speaks to our organisational aim to achieve lasting systemic change.

Multiple supports, systems and services are integral to the operation of aged care. From the perspective of participants, although these service systems are discrete, there is often a strong need for integrated solutions. Therefore, to achieve positive outcomes and a reform journey that can avert crises, embeds codetermination and builds the capabilities of those receiving care, we must create joined-up responses. In response to system fragmentation, we have taken a whole-of-system view that situates aged care in a complex services environment. Responsibility also falls across various levels of government. Our recommendations require integrated solutions, including cooperative partnerships between all levels of government, providers, communities, families and individuals. Many of these aims ostensibly extend beyond the Terms of Reference. Despite this, the challenges outlined in this submission require proactive, preventative and complex responses.

The most disadvantaged older people have distinct characteristics that often require tailored interventions, services, practice and supports

The BSL is especially concerned about the growing number of older Australians who are facing economic insecurity and social isolation, for whom the current system is not working. There are also considerable numbers of older people 'living on the margins'—not technically in poverty but living on low incomes. Many different indicators that can be used to assess disadvantage. The BSL takes a comprehensive approach, that looks at the intersection of disadvantage across personal and social dimensions (see Table 1.1).

Table 1.1 Dimensions and indicators of disadvantage

Dimensions	Indicators		
Employment	Participation & paid work	Unemployment & underemployment	Retirement
Education & training	Education outcomes	Retirement age	Lifelong learning
Economic resources	Income poverty	Asset poverty	Low-income & low-wealth households
Housing	Housing tenure	Housing stress	Homelessness
Mental health	Mental health outcomes	Cognitive impairment	Need for care & support
Physical health	Physical health outcomes	Disability	Need for care & support
Safety	Accommodation safety	Community safety	Other risks
Social participation	Social isolation	Access & mobility	Access to technology

Source: Kimberley, H & Simons, B 2009, The Brotherhood's social barometer: living the second fifty years, Brotherhood of St Laurence, Fitzroy, Vic., p. 4.

In the BSL's view, caring for older people experiencing these and other forms of complex isolation and exclusion is central to the effectiveness of the aged care sector. Groups that are likely to be at risk and should be attended to in reforms include:

- Low-income households and people living in poverty: Different methods of measuring poverty (especially before or after taking housing into account) make a big difference to estimates of how many older Australians (and how many age pensioners) are living in poverty. Even the more optimistic recent estimates of the Grattan Institute (Coates & Chen 2019), however, point to an 8% poverty rate (after housing) for Australians aged over 65 years, which equates to more than 300,000 people. While people over 65 who own their homes are generally at much lower risk than those who are renting, a considerable number of older Australians—especially women and those with insecure housing—face financial hardship as they consider aged care needs.
- Culturally and linguistically diverse (CALD) communities: Older people from CALD communities are a growing demographic. In 2018, approximately 30% of people using home and residential care were born overseas, a substantial increase on previous figures (GEN 2019b). Older people from CALD communities are more likely to come from lower socioeconomic backgrounds; face substantial language barriers; and have differing cultural practices, norms, and expectations for services (AIHW 2018). These issues often present barriers when accessing aged care.
- Aboriginal and Torres Strait Islander people: Indigenous Australians are another group facing multiple, systemic barriers to services and community inclusion. Indigenous Australians using aged care services are significantly younger on average than other service users and often report chronic illnesses or multiple morbidities that lead to premature care (GEN 2019b). Indigenous Australians may also experience racism and discriminatory treatment, poor cultural awareness and/or culturally inappropriate services, and language barriers.
- Those at risk of or experiencing homelessness: More and more older people are experiencing or at risk of homelessness, with this category intersecting other forms of socioeconomic disadvantage. As the AIHW (2018) notes, the problem of homelessness 'will likely continue to increase over time due to an ageing population and declining rates of home ownership among older people'. Indeed, between 2006 and 2016, the number of homeless people aged over 55 increased by 49%. In 2016, 18,600 people (16% of all those experiencing homelessness) were aged 55 or over; and older women are the most rapidly growing homeless group, increasing 31% between 2011 and 2016 (AIHW 2018).

In many instances, socioeconomic or cultural disadvantage is overlaid and exacerbated by complications arising from drug and alcohol dependency, physical or cognitive disability and/or multiple chronic health conditions. In our experience, too many of these older people remain completely excluded from the aged care system until their personal or health needs reach crisis levels. They are then 'bounced' into permanent care. Given the BSL's mission for an Australia free of poverty, much of the focus in this submission is on key reforms that can help prevent crises, empower older people and break the cycle of disadvantage.

1 Market stewardship and service navigation support are essential to ensure that all older people have access to quality care and supports

The BSL contends that redesigning Australia's aged care system should include structural, regulatory and service-level changes to ensure that the market functions efficiently and equitably for all participants. Two significant, but essential, changes are: explicitly addressing market failure through an expanded stewardship role; and greater integration across different service systems. Older people facing disadvantage, including financial hardship, social exclusion and/or chronic health conditions, typically require the most tailoring and supports. These changes each require stronger market stewardship, with an active role for government, to ensure a minimum standard of care and greater accessibility. We also argue for the introduction of a community-based navigator role.

Market stewardship is needed to promote efficiency and equity

From 1996, the Australian aged care sector has undergone comprehensive marketisation and a trend towards greater competition between providers (Davidson 2015, 2018; Simons, Kimberley & McColl Jones 2016). Markets are often seen to promote efficiency by increasing responsiveness to consumer decisions, broadening available offerings and maximising choice. These changes are, in turn, seen to deliver net positive outcomes for everyone. Overall, these aged care reforms have not been entirely negative. However, while there are numerous examples across the country of older Australians receiving quality home and residential care, there is also considerable evidence that marketisation coupled with system complexity has not delivered positive outcomes for all.

Benefits have often been limited to individuals with greater resources, capacity and/or more robust networks. Due to the focus on profitability, the diverse needs of older people often go underrepresented (Davidson 2018). Navigating available services and supports can also be confusing, challenging or even traumatic (Borgstrom & Walter 2015; Larkin & Mitchell 2016; Moran et al. 2012). Furthermore, in a market where exit is often the primary means for consumers to demonstrate their preferences, aged care service users are at a distinct disadvantage: the 'informed choices' available to an older person with deteriorating health, a person experiencing cognitive decline, a person receiving palliative care, or anyone experiencing discrimination or exclusion are extremely limited.

A stronger understanding of the barriers to service inclusion is crucial to ensuring that the benefits of markets are distributed equitably. For example, the shift to consumer directed care (CDC), while effective for older people with resources and strong personal networks, at its worst has exposed many people to predatory providers, exploitation and abuse. At its best, many older people have lost opportunities for social interaction. In our own experience, prior to the transition to CDC, the BSL was able to prioritise social inclusion and participation in our services through add on programs and dedicated activities. Following reforms, such activities have become increasingly difficult to resource, especially for small providers. Ultimately, social outcomes and activities have been eroded as block funding has largely disappeared. The BSL's own evaluation of the impact of the early stages of CDC showed that potential positive outcomes associated with greater choice and control could be diminished by factors such as limited personal capacity, poor health, and/or

absence of personal supports (Simons, Kimberley & McColl Jones 2016). Older people with cognitive impairment, chronic health conditions or multiple morbidities, poor digital literacy and/or other life skills, and with limited family or network supports were identified as most at risk. Other research also shows that markets are a poor mechanism for service distribution and delivery for people with complex needs (Carey et al. 2018; Considine et al. 2011; BSL 2016, 2019; Steel 2019; Fenna 2019). The solution to much of the imbalance in aged care rests with restructure and stewardship.

A stronger emphasis on market stewardship and greater government responsibility for promoting access to aged care would address many issues throughout the sector. As Carey et al. (2018) observe, regarding the disability sector, market stewardship involves more than simply funding individual budgets, including 'actively [monitoring] the market for inequities and not just [protecting] citizens from worst case scenarios (i.e. fraudulent providers) [also steering and managing] the market to ensure it is benefiting all citizens'. The BSL has done extensive work on market stewardship, including in our submission to Productivity Commission reviews on thin markets (BSL 2019) and human services (BSL 2016). In our view, the government must:

- provide clear, accessible and relevant information
- provide linkage and referral services to support individual choice and control
- actively regulate and monitor markets, to ensure quality, responsiveness, choice and value
- supplement 'thin markets' through commissioning specialist services to meet community needs (or offering funding to innovative new providers)
- promote service innovation and the dissemination of best practice.

These six elements remain crucial to effective, equitable and sustainable markets—including aged care. Additionally, we argue that the functions of navigation, information, advice, linkages and case management would be best achieved through a specific role, such as the model outlined below.

Commissioning of providers should be based on best practice, geography and intentional support for a range of providers working with a range of participants. A proactively stewarded market would also allow for specialist providers to enter the sector, develop and invest in their workforce and accommodate a wider variety of clients with different needs. As noted in the BSL's recent thin markets submission (2019, p. 5):

- effective facilitation of markets requires investment in infrastructure that supports all participants to navigate the market and access supports (as required)
- partnerships and collaborations must be incentivised if they are to survive and thrive
- information alone will not encourage new entrants or ensure quality, but must be accompanied by support for providers to develop effective models that deliver good services
- workforce issues require investment in the content, quality and accessibility of training to increase the supply of skilled workers, and also improvements to working conditions
- price limits, while often an important safeguard, cannot be a barrier to flexibility or quality
- market inequalities require systematic and nuanced responses, including stewardship.

As in our first submission to the present Commission, we assert the importance of developing a comprehensive market stewardship strategy for the aged care sector. This strategy should incorporate the above frameworks and objectives.

Recommendation 1: Introduce a comprehensive market stewardship framework for aged care to ensure that the benefits of marketisation are shared equitably.

Community Aged Care Coordination is a first step towards greater equity within the aged care market

While a fully stewarded aged care market will involve considerable cultural and structural changes, the BSL strongly recommends that the government should begin with support for system navigation and linkages. Currently, older people and their families experience aged care in one or more disconnected stages. Rather than a smooth continuum, with needs determining care, each 'stage' of aged care (home support, home care and permanent residential care, not to mention health and social services) operates separately. Moreover, there is little integration with other age-specific or mainstream services. Individuals often must exit one service/system to enter another. When doing so, individuals are responsible for navigating the process—from information gathering to decision making and enacting the necessary steps to move to the next phase of care.

Transitions may not only worsen health outcomes but also put great strain on individuals and their families/personal networks. Time without supports and/or services can directly contribute to physical and mental health issues (Borgstrom & Walter 2015; Howden-Chapman et al. 2011; Larkin & Mitchell 2016; Moran et al. 2012; Manthorpe & Samsi 2013). In our services, many clients enter residential care early due to their histories of institutionalisation (either disability or the justice system), substance abuse disorders and/or homelessness. When crises affect these people, there are few care options; in many cases the only available option is permanent residential care, although this is often not the ideal. For example, one of our clients entered residential care requiring ongoing cancer treatment—his condition only determined after he was hospitalised. Another resident had lived in and out of temporary accommodation, like hostels or rooming houses, his entire life and was now in BSL care as there was nowhere else for him to go. His health needs were also extreme, becoming a major barrier to community-based care and leading to his entry into our services. Both these clients have ended up in the highest care either prematurely or unnecessarily as a result of the lack of appropriate interventions and services. These real examples show how gaps in available care have flow-on effects, in both increased demand for residential care and/or increased hospital admissions. Moreover, they demonstrate the difficulties in disengaging and reengaging in different service systems. Each transition represents a challenge for protecting individual rights, particularly when people are declining physically, cognitively or both.

Supports, services and systems must endeavour to break the cycle of crisis and response; the BSL would like to refocus the attention on preventing older people from experiencing crises, this also maximising their dignity and autonomy. In our experience, timely interventions, access to relevant information, help with system navigation, and other supports are far more appropriate for the changing aged care landscape than responses centred around crisis-points.

There are several ways to conceptualise such a navigator function. A comprehensive review of aged-specific navigator-style models has been undertaken by Australian Healthcare Associates for the federal Department of Health (2019). COTA is also undertaking navigator trials. Table 1.1 summarises the key features of four approaches, including village-like models such as Local Area Coordination (LAC)[1]. We note that internationally LAC programs have the strongest evidence base and offer strong social return on investment for both governments and communities. We also note a substantive difference between navigator roles and case management roles in guiding and managing the transition between stages and types of care.

[1] Local Area Coordination here refers to programs running in various locations, prior to its distinctive use under the NDIS.

Table 1.1 Different service navigator models and key features

Model type	Programs	Location	Key features
Village model	Local Area Coordination (LAC)	Australia, United Kingdom, New Zealand	LAC acts a facilitator to support individuals living in the community and develop the natural assets of that community, empowering individuals to find community-based solutions. Activities focus on timely and relevant information, building trusting relationships, planning for supports, links to (formal and informal) services, and other tasks that span traditionally separate roles. A social return on investment analysis conducted in Derby (UK) showed a 3:1 to 4:1 return on investment and significant economy of scale, with more LACs generating greater returns.
Health/ professional-led navigator model	Access & Support Program	Australia, Canada	Outreach linking services for those facing barriers to entry to aged care Victorian service supported by Commonwealth (for people aged 65+) and state funding (for Aboriginal and Torres Strait Islander people aged 50+) Initial evaluation work shows success in linking vulnerable people to aged care
Peer navigator model	Gatekeepers	Australia, United States	Community-based service providers who have contact with older people (such as postal workers, supermarket staff) and can initiate referrals to government agencies who then provide information, assessment and linkage with aged care services Little evidence available on effectiveness; requires ongoing training
Hub model	National Aged Care Advocacy Program (NACAP)	Australia, Canada, United States	Targeted information and transition support for people with defined needs to access government funded aged care services Available over the phone or internet portal. Variously inaccessible for those without telephone access, internet connection and/or literacy skills

Adapted from: Department of Health 2019; Marsh 2016; Broad 2015.

In our view, many issues in aged care could be addressed through the introduction of a new practice and service approach, Community Aged Care Coordination (CACC), to provide older people with greater support and more tailoring of services. This model incorporates elements of

case management, local area coordination, social work, navigation, care planning, community visitors and various other roles. Crucially, it brings these traditionally siloed functions into a single role. The proactive support provided by CACC would maximise the older people's dignity, safety and capacity. We argue the model would also create value for governments by diverting people from expensive crisis services and high-care alternatives (where possible).

CACC borrows directly from international experiences with LAC and disability services, in addition to other domestic and international community-led initiatives. LAC has a substantial literature, both within Australia and internationally, which give our proposed model substantial validity (Broad 2015; Broad et al. 2012; Marsh 2016). Although we conceive CACC as having universal eligibility and improving outcomes for all older people, interventions would have a particularly strong impact for older people at risk of disadvantage and/or service exclusion. This new approach would have four principal functions:

- **Avert crises:** As a single point of contact, placed in local community infrastructure—such as council facilities or primary health centres—CACCs would be ideally placed to identify older people in need of care and any changes in individual circumstances. The BSL sees CACC (like LAC in England, Scotland and New Zealand) as having a key role in engaging with 'hard to reach' groups, including people labelled as 'difficult' by formal, statutory services (Broad 2015; Marsh 2016; Roorda et al. 2014; Vincent 2010). Averting crises also involves navigating transitions across service systems, supporting family and/or carers to coordinate care, some assessment of need/s and capacity, and planning assistance. In this manner, by developing trusting relationships and ongoing links with services, CACC could de-escalate issues.
- **Navigate multiple systems:** In addition to several aged care stages, there are other service systems that older people must navigate (most notably health and social services). All these systems are complex; for older people experiencing disadvantage, navigating or accessing these services is virtually impossible. These challenges reinforce the importance of timely and relevant information, advice, advocacy and support between services as people move through different types of care. Currently, case management in hospital outpatient settings looks at factors like home, environment, individual capacity and available services/supports. CACCs would perform similar roles within the aged care system. The outcome of this preventative work would be smoother transitions across the continuum of care as people age, irrespective of backgrounds or personal resources.
- **Facilitate housing security:** Housing security for older renters can be extremely limited, while age-appropriate housing and supported or service-integrated accommodation is virtually non-existent (Anglicare 2019; Ong et al. 2019; Daley, Coates & Wiltshire 2018; Mission Australia 2017; Productivity Commission 2015). If an older person does not have a home, in-home support cannot be provided. This can lead to crises and/or presentation at homelessness services. CACCs could provide information and advocacy, which are fundamental to securing and maintaining stable housing. Links to appropriate services could also assist older people to avoid crisis and access supports. In the United Kingdom, LAC has improved housing security and promoted delivery of services into the home. Activities have also enhanced the capabilities of individuals to advocate and navigate the system (Marsh 2016; Kingfishers 2016). However, housing solutions will only be possible with changes at the state and territory

level to improve age-appropriate housing supply and other accommodation alternatives. We explore the role of housing and service-integrated accommodation below.

- **Promote and maintain connection to place/community:** Being based in community is a natural advantage for CACCs. For many older people, the choice to age in place reflects priorities including familiarity and available supports (Ong et al. 2019; James et al. 2019). While secure housing is one key need, CACC also aims to bring in other community assets. For instance, CACC could support an isolated older person to engage in social activities or introduce them to local volunteer/activity groups. Where groups do not exist, CACCs could help establish informal networks. For older people experiencing disadvantage, a sense of community can be even more important; our residents maintain strong links with people and places in Melbourne's inner-north. Enabling older people to maintain such connections to their communities is an important aspect of supporting people to age with dignity and agency.

Importantly, elements of these roles already exist. Indeed, the BSL provides comprehensive case management as part of our home care offer. In our view, case management has been effective and is essential to supporting older people experiencing or at risk of disadvantage. However, across the sector, charges for this vary considerably and high charges can seriously reduce the resources available for care or make this essential support unaffordable to those who most need it. As a result, many older people 'fall through the gaps'. The BSL argues that CACC, however structured, must be funded separately from individual packages, to provide a robust, person-centred service without diminishing the resources for each person's aged care needs.

By supporting older people to navigate system intersections, assess market offerings and access services, CACC would support healthy ageing in community and delay the need for permanent residential care for as long as possible. Finally, as well as supporting each person to access services, CACC provides opportunities for capacity building within a community. We recommend that this role be embedded across Australia as part of a collective impact strategy. Coordinators would have a secondary responsibility to work with service providers to create responsive and accessible pathways into care. This, we argue, would also improve connections with mainstream services and help prevent avoidable crises. The success of CACC, however, would be contingent on several structural reforms indicated above, including social housing and other cooperative policymaking between Commonwealth, state and territory governments.

Recommendation 2: Introduce a block-funded Community Aged Care Coordinator (CACC) role for suitable geographic areas to identify at-risk older people in community and help them navigate systems so as to minimise crises and maintain their connections to place.

2 Quality in aged care needs to be reconceived to empower all older people and the workforce

Medical discourse remains dominant throughout aged care, often to the detriment of other dimensions of quality care. Good aged care is more than just caring for the body: it requires a mix of health care, to address complex comorbidities as people age, and supportive/social care, to address loss of independence, social connection, mental health and other issues.

Currently, this combination of health and social care is overseen by a purely clinical and overly systematised framework. In turn, this environment affects policies, structures, practice and services. While clinical standards ensure that many aspects of care are consistent and of high quality, personal and social care has often been an indirect casualty. As Ibrahim (2019, p. 1: *added emphasis*) notes, 'there are situations in which *clinical care* is beyond reproach, and yet [care is] judged as being poor because of the occurrence of an undesirable outcome'. For example, a residential facility might have an extremely low rate of falls and associated injuries because they totally restrict their residents' movement and autonomy. In this imagined scenario, while clinical outcomes are (arguably) positive, other measures of good care have suffered, including the dignity of the residents.

Good care is about relationships, not greater regulation

Good care should be understood as a process, negotiated between practitioners and older people, where everyone involved has active but different roles. Most aged care policies, systems, practice approaches and services currently operate with 'experts' providing solutions to older people. Yet, framing care as a product or commodity ignores the role that those receiving care have in shaping systems and practice (Mol, Moser & Pols 2010).

Efforts to create better care outcomes include substantive practice and service changes to better reflect person-centred care and enable older people have a real say in their care. These are positive steps forward as, rather than a fixed set of conditions, good care is relational and iterative. Mol (2008) argues that care is an adaptive process that emerges from interaction between professionals or practitioners, and recipients or service users (and/or their families). Good care is thereby closely tailored to individual circumstances and aspirations; our staff also identified person-centred approaches as essential to good care and best practice. Accordingly, a theory of good care needs to address the key aspects of decision making, relationships and practice development. This means adhering to the following principles:

- relationships are mutually reinforcing and iterative, not transactional
- decision making is devolved close to the 'point of care'
- practice development seeks out, adapts and applies innovations in good care.

If these three foundational principles are adhered to, the diverse elements of good care can be maintained. In our view, good care involves prioritising approaches that place relationships between workers and older people at the centre of a reimagined aged care system. In practice, this focus necessitates professional development, trust building, strengthening personal capacity

of staff and codetermining solutions with older people to ensure the measured outcomes are of value to them.

For some people, good care may be harm mitigation. Others may have a specific goal or goals they want to achieve—being able to walk without assistance or engaging with community. Good care outcomes can therefore be extremely diverse. For example, some BSL residential clients stated they were happy to be safe and cared for; others expressed a strong desire for greater inclusion, independence and agency. Good care involves meeting these different needs. With new standard in aged care focusing on choice and control, it is important that barriers (especially structural ones) to achieving this are well understood and factored into responses. As explored in the previous section on marketisation, choice is not simply about making decisions; it is about having real opportunities to pursue a life of value.

Governments must rethink how care is provided

The current aged care system often deliberately shifts authority away from the point of care to upper management. Here, decisions are often influenced by centralised processes, rules and assumptions, with limited reference to individual circumstances and other 'intangible' factors. The logic and needs of systems and providers, rather than people and good care, determine how and what choices are made. In practice, this means a proactive shift in how aged care is delivered, refocusing on quality and person-centred approaches.

In many facilities daily life can become regimented, and managing risks often influences what decisions made about care—sometimes to the point where older people are robbed of voice and decision-making capacity. The BSL maintains that people function best when they are active agents in their own lives and can make meaningful, independent decisions (Alkire & Deneulin 2009; Sen 2000). We would therefore like to see a stronger focus on dignity, autonomy and quality of life, beyond foundational standards and clinical practices. Promoting residents' independence ensures an improved quality of life through increased agency and engagement in activities outside the facility.

Yet, these practices are often discouraged by accreditation requirements and the weighting of different standards in formal assessments. Overall, our clients are highly engaged; this includes maintaining ties to community, volunteering, activity groups, friends, family and various other outlets. For example, when one client had difficulty finding her way back to the facility, our staff provided a tracker so she could be located if necessary; as the tracker was also a pawnable item, the device even had to be attached to her walker. This supported her freedom and independence, while fulfilling the requirements to ensure her safety. However, making these decisions carries real regulatory and reputational risk, in addition to personal risk. Regulators at the Department of Health and Human Services especially did not understand why so many unexpected departures had been reported for this one client. Unfortunately, in this instance, the BSL had to make the decision to keep our client within the facility. As one staff member phrased it, acting on person-centred decisions requires both support and infrastructure.

To promote good care, aged care systems must facilitate and reward diverse practices. In understanding how frontline practice affects outcomes in aged care, Benjamin and Campbell's discussion (2014) of community work is useful. They discuss varieties of frontline work that are

crucial to 'community work', but are rarely captured by evaluation tools (Benjamin & Campbell 2014, pp.44–45). This work includes:

- **relationship building**, independent of programmatic activity, evaluation or outcomes, that 'meets a real need and matches [people's] existing capacities or goals'
- **adjustment work**, or responding to people's 'goals, needs and immediate circumstances'
- **codetermination work**, which recognises that people 'have the right to claim ownership over their path towards transformation' and seeks to reinforce that agency
- **linking work** that connects people with external and internal resources/supports.

Models of care should honour relationships, allow for varied practices, respect agency (including the judgements of frontline staff), and support collaborative environments. Yet, in the scenarios raised by Benjamin and Campbell (2014), such activities happen *despite* evaluation, regulation and assessment, rather than *because of* these same mechanisms.

Good care practice balances the aspirations, circumstances and physical needs of older people. Promoting the independence of BSL aged care residents ensures a higher quality of life. Being younger on average than other residential service users, our clients can and want to leave the facility during the day. Some with lived experiences of homelessness or social marginalisation also maintain strong ties to people and places. Accordingly, risk management at Sumner House and Sambell Lodge is different to a 'standard facility'. BSL staff work creatively to mitigate the risks of increased choice; residents who are 'high-risk' are provided with emergency buttons, to access immediate help and alert facility staff when needed. These sorts of decisions are crucial to good care, but require decision-making to be devolved as close the point of care as possible in order to take account of personal circumstances.

Unsurprisingly, placing people at the centre of their care improves both personal and clinical outcomes. Previous studies demonstrate that (when fully implemented) person-centredness can minimise functional decline, reduce mortality and hospital readmission rates, lower healthcare-acquired infections, and improve service quality and patient-carer satisfaction (ACSQHC 2012; Conway et al. 2011; Luxford et al. 2010). Placing people at the centre of care means more than meeting basic clinical standards or offering consumer choice. Rather, this approach reflects a holistic view of care for all older people, with interactions based on building meaningful relationships and valuing contributions, agency and autonomy.

Older people should have opportunities to shape and engage with their care

Codetermination—working *with* older people—can allow those in care to have a voice in the decisions that affect their lives. As Carr and Biggs (2018, p. 29) argue in a study of dementia care: 'Choice should be recognised as extending beyond the point of taking up a service to include interpretation within caring environments themselves'. Interpersonal connections and communication, situational awareness, decision-making abilities, and various other non-technical skills have also been linked to safer and more efficient clinical care (Flin, O'Connor & Crichton 2013). Giving older people voice is therefore central to ensuring that they live a life they value and to creating more responsive, tailored and effective services.

A key aspect of aged care quality is the processes by which services are regulated and accredited. Monitoring and compliance remain the main approaches to improving quality. Yet, as the OECD (2013, p. 12) observes:

> regulation, compliance and enforcement may not be strong enough. There are still questions regarding the effectiveness of fines, warnings and threat of closure. Too much of it can stifle innovation or discourage providers from going beyond minimum requirements.

Complex systems can increase the risk of poorer health and wellbeing outcomes, particularly when the intentions of policies are not well understood by providers or the workforce. As noted by Carr and Biggs (2018, p. 28): 'Mapping existing [aged care] regulation reveals considerable duplication, which can both be costly to providers and present hurdles to innovative practice.' Indeed, outlining rights in the *Aged Care Act 1997* and national standards has frequently failed to produce improved outcomes. Little or no progress has been made in achieving certain rights related to choice and control, dignity and free movement.

BSL staff spoke about overregulation and the need for 'common sense' frameworks. For example, in residential care food regulations can be so restrictive that older people cannot enjoy certain foods, participate in cooking as they would at home, or have food brought in because of alleged health risks. Beyond basic safety and hygiene, it is difficult to see how such restrictions benefit people in care. A focus on standards does not necessarily produce quality, particularly as application of principles like person-centred care can be highly situational and complex.

While the BSL believes that many aspects of accreditation are helpful for improving services, there have been multiple criticisms of how effective accreditation is in shaping high-quality services (Groves et al. 2017; Carnell & Paterson 2017; Productivity Commission 2011). Our staff echoed these criticisms. One staff member highlighted that the weighting of accreditation items often does not align with good care, particularly for our more complex clients who require additional or atypical supports. A senior manager described how the burden of compliance took time and money away from care, leaving little room for forward planning or innovative practice. They also described how accreditation is an amalgam of different assessments—without differentiation of the relative importance of outcomes. For example, clinical care outcomes and record keeping are given an equal weighting, which often leads to worse outcomes for both service providers and older people. It is evident that accreditation has some way to go to be responsive to the needs of people requiring care, their families or carers and the workforce itself.

Involving older people (and/or their carers) in service planning, delivery and evaluation is integral to respecting and promoting their rights and needs. It is also essential to providing good care because these people have distinctive insights. Beresford and Croft (2001, p. 302) argue that:

> The unique body of [service] users' knowledges [sic], based on first-hand experience … offers a crucial new perspective for public policy and social care and makes possible better-informed provision and discussion.'

Learning from and with service users is therefore important to service integrity and responsiveness.

While some older people may not be able to exercise agency, due to chronic health conditions or disability, providers should work to engage older people wherever possible. While this is already happening, and is affirmed in the new aged care standards, there is little structural support for providers to make this transition. There are also few platforms for older people to engage. People's ability to engage can also be 'limited by a lack of information about options and preparatory information for meetings, along with a lack of support or creative communication in decision making' (Carr 2004, p. 11). In the words of one of our residential clients, better engagement is about being 'flexible with the goalposts' to enable choice and participation.

Voice is a principle the BSL views as fundamental to the development of aged care, providing continual opportunities for feedback and communication between government, providers and service users. As highlighted by the Productivity Commission (2017, p. 3): 'People who use human services can lose their autonomy, and with it their dignity, if they have too little control over decisions that affect them.' Embedding participation and voice within aged care systems is an effective means of addressing these issues.

Recommendation 3: Enable older people to be more involved in their care by embedding person-centred practice approaches and tailored interventions in quality standards.

Education and training are fundamental to empowering the workforce and ensuring good practice

Workforce training and development have been strong themes throughout the Commission's investigations. However, the current discourse focuses on lifting qualifications and stronger guidelines/regulation of workforce practices, creating challenges for a sector that is already unable to meet demand. Major issues in the workforce include:

- The Aged Care Award, while recently increased, remains an insufficient living wage. For the workforce to increase to over 900,000 full-time equivalent staff by 2050 (PC 2011), in line with projected demand, aged care will need to become more attractive to prospective employees through improved working conditions and appropriate remuneration.
- There is insufficient funding for providers to adequately train workers on the job. Although qualifications across the sector are improving, almost 75% of care is provided by relatively unskilled workers (ACFA 2017). Unfortunately, work-related training and continuing professional development have been in decline since 2012 (Mavromaras et al. 2017). In our experience, the quality of training offered by vocational institutions can also very greatly: BSL management noted that workers presenting with the same qualifications could have very different skills. In these scenarios, although there is no specific funding available, organisations become responsible for upskilling workers.
- Providers rely heavily on agency and/or casual staff to maintain service levels. Some 78% of residential care workers are employed part-time and 10% on a casual or contract arrangement. Data from a 2017 workforce review indicates that the historical gap between home and residential care is narrowing, with 14% of home care and support workers on casual contracts and only 11% employed full-time (Mavromaras et al. 2017, p. 84). Reliance

on external staff is a significant barrier to developing a skilled workforce able to build relationships and trust with older people.

- Outsourced staff are also associated with increased risks to clients. Additionally, outsourcing is an example of allocative inefficiency: by relying on agency staff, providers and the government are effectively paying for two management structures and overheads.

Recent BSL research has argued for greater recognition of the skills and talents of the aged care workforce (Hart, Bowman & Mallett 2019). While critical, a focus on these issues alone will not have the systemic impact that is needed to reshape practice and improve care outcomes for older people. Ultimately, the quality of the workforce and opportunities for ongoing professional development will be crucial to the viability of the sector and the provision of good care.

Recommendation 4: Ensure that quality care is reinforced through workforce education, training and professionalisation.

3 Secure housing underpins quality aged care and ensures that people most at risk of disadvantage can access services and avoid crises

This section focuses on specific reforms to support diverse groups and proactively address their health, housing and personal needs. While the aged care system works reasonably well for many older people, secure housing for older renters can be extremely limited, and age-appropriate housing and supported or service-integrated accommodation is virtually non-existent (Anglicare 2019; Ong et al. 2019; Daley, Coates & Wiltshire 2018; Mission Australia 2017; Productivity Commission 2015). Unless strategies are in place to address both housing and access to care, more older people will experience avoidable crises. In the long term, these crises are also more expensive and may increase budgetary pressures as demand for high-care services grows.

Disadvantaged older people are especially at risk (Ong et al. 2019; James et al. 2019; Beer et al. 2019; AIHW 2018). Our experience also suggests that a growing number of people are prematurely entering residential aged care due to inadequate or inappropriate services in the community. We argue that aged care, health care, housing and community services should be better integrated to help arrest premature ageing; maintain people's dignity, agency and autonomy; and ensure older people can live independently for as long as possible. Since some of our recommendations involve systems that fall outside the *Aged Care Act 1997*, we call on Commonwealth, state and territory governments to work collaboratively on common goals for older people engaging with health care and housing. While we draw on our experience of working with older people with histories of homelessness, mental health issues and disability, our recommendations have broad applicability for all older people experiencing disadvantage.

Ageing in place requires policies that place housing at the centre

Place is important for older people. Research demonstrates that older people's preference to age in place (that is, in their own homes or neighbourhoods) reflect many different priorities, including their independence and social connectedness, availability of informal supports, familiar surroundings, and maintaining decision-making capacity (Boldy et al. 2011; Olsberg & Winters 2005; Pynoos 2018). Dementia practice and research also endorses a place-based approach (McGovern 2017).

While the term 'ageing in place' is applied widely, the broad policy implications of keeping people engaged and cared for have not been fully explored. Much of government policy over the last two decades has been designed to help older people remain or return to independent living in their homes (Davidson 2015). However, ageing in place is more than just remaining in the same home and describes 'keeping older people connected to their neighbourhood and community as part of a broader framework […] with the aim of improving their quality of life and giving them more control over their circumstances' (Brodsky, Grey & Sinclair 2018). As Benefield and Holtzclaw note (2014, p. 13), this wider framework 'involves addressing health- and age-related changes within a coordinated plan of healthcare, social, financial, housing, technology, and resource use'. To postpone the need for high care requires multilevel strategies to address the social, housing, and financial determinants and impacts of poor physical and psychological health among older people living in the community.

In addition, there are specific challenges to delivery of home care services for people who do not have stable accommodation. For those who live in the community, the stress of having to self-manage has also been shown to negatively impact the mental health and personal wellbeing of individuals and carers (Borgstrom & Walter 2015; Larkin & Mitchell 2016; Moran et al. 2012). Financial autonomy associated with home care can also increase the risk of elder abuse or financial exploitation (Manthorpe & Samsi 2013).

Despite these challenges, the opportunities afforded by a robust ageing in place framework cannot be overstated. Consultations with BSL clients confirm that community and social networks are fundamental to quality of life. Many of them have worked and/or lived in the area for most of their lives and continue to benefit from community connections, activities and social events as they move through our aged care services. The BSL maintains that in an ideal aged care system, all older people are supported in a similar fashion to remain in their communities for as long as possible. Yet this strategy requires more than just a framework; it requires suitable housing solutions, as the following section explains.

Recommendation 5: Prioritise strategies for ageing in place, including:

- targeted interventions for older people experiencing disadvantage
- a holistic view of place that includes existing community resources and supports.

Housing solutions are an essential support for the most disadvantaged

There is a significant and growing need for more age-appropriate housing as part of a comprehensive policy for service-level reform of the aged care sector. With more older people living in private rental accommodation governments need to consider how tenancy impacts upon people's ability to receive care and choose to stay in their home (Choice, National Shelter & the National Association of Tenant Organisations 2018). Older people renting have less income for everyday living needs (Anglicare Australia 2018a). Private rental laws in many states also allow for eviction without cause, and restrict renters' ability to modify their home to improve their quality of life, meet their care needs and ensure their residence is safe for visiting care workers.

Affordable, age-appropriate accommodation is extremely scarce. A recent study from AHURI (James et al. 2019) points to the shortage of appropriate housing for people aged over 65. Analysis by Anglicare (2019, p. 7) revealed that less than 1% of available properties were affordable and 'appropriate' for a single person on the Age Pension. There is also a growing number of older people experiencing homelessness and significant isolation and/or service exclusion. Insecure housing has a disproportionally strong impact on older people at risk of disadvantage, increasing exposure to financial stress, social isolation or exclusion, and (most notably) the growing homelessness rates in those aged 55 and over (Anglicare Australia 2018). Social housing has also not kept pace with demand and changing demographics. Rental stock will have to grow as the rate of home ownership declines and housing stress grows (Ong et al. 2019; Daley, Coates & Wiltshire 2018).

Issues such as the lack of intermediate housing supports (which sit between home-based and residential models of care) severely undermine the capacity for older people to age in community (Productivity Commission 2015). Rota-Bartelink and Lipman (2007, p. 257) observe:

> There is a distinct lack of statutory provision for the older homeless population as well as a chronic shortage of higher-level supportive accommodation options [such as] 24-hour staffed hostel or self-contained flat/independent living units with appropriate support.

They also note the general lack of appropriate services to address gambling, substance abuse and mental health issues among older people. The BSL draws on the skills of social workers, lifestyle coordinators, a psychogeriatric specialist and other supports to address the complexities some of our clients present with. In contrast, a lack of such appropriate supports can result into early entry into residential care.

Targeted measures should include local housing solutions to ensure that people do not enter residential care until absolutely necessary. In their evaluation of older people at risk of homelessness in New South Wales, Fiedler and Faulkner (2017) recommend greater integration between different service systems (to help identify people at risk), promoting security of tenure through legislative change, and more housing options available to older people. Our strategy of supported accommodation speaks to all three of these recommendations, as well as adopting a holistic approach prioritises access to interdisciplinary services and supports.

There are various models for supported accommodation with features including integration with mainstream health and social services, capacity building and personal support/advocacy, secure housing and careful targeting. Table 1.2 is not an exhaustive list but represents prominent

models. Across Australia, different models are operated by providers such as Kalyra, Housing First, BlueCHP, Sacred Heart Mission, Villa Maria Catholic Homes and Wintringham. Accommodation for older people must not only provide stability but aaccommodate, or even facilitate, care delivery. Such 'supported accommodation' models would be a step before residential aged care. In effect, these intermediate solutions would perform a similar role to retirement living, but for people with limited financial means. Since many of these solutions must involve the state and territory governments, we call for greater cooperation in meeting the health and housing needs of older people. In the BSL's view, intermediate supported models should enable independent living in small, community-based accommodation, where home care can be delivered.

Table 3.1 Key features of evaluated Australian accommodation models

Model	Features	Author, date
Michael's Intensive Supported Housing Accord (MISHA)	'Housing first' model, providing holistic care to older men experiencing chronic homelessness. Aimed to provide support to enter and sustain permanent housing, ensure access to physical and psychological support, reduce social isolation and build the capacity of clients to live in the community. Following MISHA, 98% of clients maintained their tenancy over a 12-month period.	Mission Australia, 2017
Common Ground	Supported housing model, providing long-term accommodation for a combination of social housing tenants and people with experiences of long-term homelessness.	Mission Australia, 2017, p. 40
Assistance with Care and Housing for the Aged (ACHA)	Alternative model of support for older people with varying backgrounds, including institutionalisation; homelessness or insecure housing; gambling and substance abuse; and chronic mental and/or physical health issues. Addresses housing and support needs through: advocacy and assistance; help with removal and/or resettlement; housing support to act early and prevent recurrent cycles of homelessness; temporary assistance with essential living tasks and health needs (between referrals); capacity building; ongoing packaged care; temporary accommodation; consideration of physical, social and emotional needs and client care and housing goals; liaison with welfare and social support programs to enhance service use and efficiency; linkages to relevant community supports and aged care services; and follow-up and monitoring after re-housing. Referrals through Supported Accommodation Assistance Programs (SAAP), emergency shelters, hospitals, public and private housing organisations, and word of mouth. Operates Australia-wide, but is poorly funded and not well integrated with other homelessness/aged care programs.	Melville, 2008 Atkins, Williams & King, 2011 Fiedler, 2011

Housing for aged care could utilise several different strategies

The BSL has had considerable success as an organisation with another supported accommodation model working with homeless youth. Education First Youth Foyers (EFYF) represent a different approach that prioritises reengagement in education and inclusive social activities over crisis responses and behavioural targeting. EFYFs provide high-quality hostel-type accommodation to support service-connected young people to:

- engage with education and employment opportunities
- promote health and wellbeing
- encourage social connections and civil participation
- build housing and living skills (BSL 2017; Coddou, Borlagdan & Mallett 2019; Levin et al. 2015).

While the needs of disadvantaged young people differ significantly from those of older people, the foyer model demonstrates the benefits and viability of supported accommodation with tangible links to other services. More than alternative accommodation, what EFYFs also do is provide a comprehensive service that advances capabilities. An adapted foyer-like model for older people, strongly connected to with allied health, social supports and community activities, could have extremely positive impacts on the lives of older people. Older people would be likely to stay for longer periods as the service supports their changing/escalating health and personal needs. With some additional support and coordination, HCP funding could be used to directly support people in this model and ensure they gain the most from their packages.

Any strategy to provide housing for older people must build on the National Housing and Homelessness Agreement (NHHA)[2]. The NHHA, a series of eight bilateral agreements between the Commonwealth, states and territories, commenced on 1 July 2018 with the aim of improving housing and homelessness outcomes across Australia (CFFR 2019). The NHHA identifies several 'policy priority areas', including:

- affordable housing
- social housing
- growing the community housing sector
- homelessness services
- tenancy reform
- home ownership
- planning and zoning reform initiatives.

In 2017–18, total expenditure for social housing and specialist services across all levels of government was around $6 billion (AIHW 2019). In 2019–20, much of this investment is support delivered through Commonwealth Rent Assistance, around $4.6 billion, with only $1.5 billion

[2] The NHHA replaced the National Affordable Housing Agreement (NAHA) and the National Partnership Agreement on Homelessness (NPAH). The new agreement combines funding for these previously separate schemes, with dedicated homelessness funding to be matched by the States and Territories (AIHW 2019; CFFR 2019).

provided to the states and territories each year under the NHHA. However, housing issues are more than just growing stock and crisis support.

The BSL argues that the NHHA must but go beyond simply boosting supply, zoning reforms and a bare minimum of financial support for homelessness services. Mission Australia (2017, p. 8) has called for a greater diversity of housing options for older people, including an additional 60,000 social housing places, 75,000 affordable homes and 4,200 Aboriginal owned and controlled homes.

The BSL recommends significantly increasing support for new social housing solutions. We argue that housing alternatives must also be tailored to the needs of older people experiencing or at risk of disadvantage, to support their ageing in place.

Recommendation 6: Develop housing alternatives for older people experiencing or at risk of disadvantage, to provide:

- alternative, age-appropriate accommodation that supports older people to age in place
- integration with wrap-around health and social support services to aid efficient and effective use of personal, CHSP and/or HCP funds
- links to other health and allied social services, including high-needs aged care, to smooth transitions across the service system.

Recommendation 7: Expand commitments under the National Housing and Homelessness Agreement to ensure that there is a targeted strategy for older people.

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