Brotherhood of St Laurence
Working for an Australia free of poverty

Brotherhood of St Laurence response to the Aged Care Legislated Review

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Brotherhood of St Laurence response – Aged Care Legislated Review

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Brotherhood of St Laurence response – Aged Care Legislated Review

Introduction

The Brotherhood of St Laurence is an independent non-government organisation with strong community links that has been working to reduce poverty in Australia since the 1930s. Based in Melbourne, but with a national profile, the Brotherhood continues to fight for an Australia free of poverty. We undertake research, service development and delivery, and advocacy with the objective of addressing unmet needs and translating the understandings gained into new policies, new programs and practices for implementation by government and others.

Financially and socially disadvantaged older Australians are a core focus of our work. We have a long history of developing policies and practices to ensure that groups or individuals requiring special and/or additional support are provided with an optimum level of care, and that their specific needs are met. The Brotherhood has been actively monitoring the impact of Consumer Directed Care on vulnerable older people, together with other not-for-profit care providers.[1] We are concerned that vulnerable consumers risk being significantly disadvantaged by the shift to individualised funding and marketisation of services and are facing unequal access and outcomes right along the continuum of care. It is these concerns that primarily inform our response.

The Brotherhood welcomes the choice and control accorded to consumers under the principles guiding consumer directed care. We note, however, that the system works better for some consumers than others. It appears to work best for consumers who are in affordable, appropriate and secure housing; are socially connected and have family and other informal support; have good literacy, numeracy and digital competency; are proficient in English language; have access to appropriate transport; can access expert advice; and have income additional to the Age Pension.

While recognising that the current system includes some measures to remediate disadvantage, we do not believe these go far enough. Significant interventions are required to address the barriers faced by older adults experiencing disadvantage in their intersection with aged care services. For example:

- The current system relies on the capacity of consumers to make informed choices, without providing sufficient information or support to navigate the system
- There is little provision for buttressing the capabilities of those with limited literacy (digital, financial, health), poor family and informal supports, or cognitive impairments to make optimal choices
- People experiencing financial and social disadvantage are at greater risk of missing out on critical services because of their inability to pay for care or services above the value of package funds
- High transport costs, particularly for those living on the outskirts of our cities and in regional and remote areas where public transport is scarce, can compromise access to care
- Social isolation is increasing among home care consumers because the block funding that supported community engagement activities no longer exists and some consumers feel that they cannot afford the cost from their individual budgets

[1] The Consumer Directed Care Homelessness Working Group comprises staff from the Brotherhood of St Laurence, Sacred Heart Mission, the Salvation Army, Vincent Care Victoria and Wintringham.

- Consumers with limited English language proficiency without informal access to interpreters are not adequately supported
- Special needs populations have limited capacity to advocate on their own behalf for the services they need.
- The complex needs of some of the most vulnerable consumers – such as those experiencing homelessness – are not being addressed. The system is amplifying their disadvantage.

The Productivity Commission recently recognised that, with increased competition and user choice, government needs to invest in regulatory bodies and support services to assist users to navigate the system.[2] We call for the Australian Government to play a stronger role in driving the desired public policy outcomes by supporting older adults to navigate their choices, setting and robustly monitoring quality care standards and supporting the additional care requirements of special needs groups.

While mindful that aged care services are well down the path of consumer directed care, we are concerned that the shift to individualised funding has severely restricted the capacity of providers to support initiatives of broader public value. This will undermine efforts by local organisations to build inclusive, age-friendly communities that promote wellbeing and enjoyment of life.

As commercial providers become more prominent in the aged care market, the value-add of local not-for-profits and volunteers is at risk of disappearing. The diversity of providers and the mix of formal and informal care – which are recognised strengths of the Australian system – may be eroded. In the next wave of reforms, measures to avoid this need to be developed.

The introduction of consumer directed demand in the vocational education and training sector has vividly illustrated the risks of a marketised system where government/s fails to provide the stewardship and robust oversight necessary to deliver good system outcomes.

2. Response to Criteria in the Legislation

2.1. Whether unmet demand for residential and home care places has been reduced

In this context, unmet demand means:

- a person who needs aged care services is unable to access the service they are eligible for e.g. a person with an Aged Care Assessment Team / Service (ACAT or ACAS) approval for residential care is unable to find an available place; or
- a person who needs home care services is able to access care, but not the level of care they need e.g. the person is eligible for a level 4 package but can only access a level 2 package.

Refer to Section 4(2)(a) in the Act

[2] Productivity Commission 2016, *Introducing competition and informed user choice into human services: identifying sectors for reform*, study report, Canberra.

Significant data gaps mean unmet demand cannot be accurately quantified

Robust assessment of unmet demand in the aged care service system requires high quality macro and micro level data. At present this data is not available for analysis, making it impossible to accurately assess unmet demand. Despite this data gap, indicators that may reflect unmet demand, include:

- massive oversubscription for home care packages and residential care places in the 2015 Aged Care Approvals Round
- delay between approval for eligibility for care and entry into both the residential and home care system in some regions
- high number of hospital bed-days occupied by persons who could well be cared for in residential aged care facilities
- the reality that some consumers are unable to access the level of care they are assessed as requiring. In our experience the groups most affected at present include consumers on Commonwealth Home Care Support Packages or on Level 2 packages awaiting Level 3 or 4 care.

As the S2S Wait List is no longer the primary source of referral, providers have no accurate measure of how many eligible consumers are awaiting a home care package. They must instead rely on direct inquiries/referrals to estimate demand. They do not have the information needed to distinguish members of priority cohorts with special needs.

The National Queue may address this, as it will list consumers who have been approved for a home care package and have indicated they are actively seeking care after a comprehensive assessment by an Aged Care Assessment Team (ACAT). However, it is unclear whether providers will have access to (non-personal) information in the National Queue. Transparency about demand for packages would help providers understand and respond to the need in their area/s of operation.

Recommendations:

1. **Include in the National Queue transparent information about the numbers and characteristics of consumers eligible for a Home Care Package. This should include information pertinent to special needs and priority groups.**

2. **Require the Department of Health to report annually on the supply and demand for aged care services including:**
    - **the waiting time between approval and uptake of a Home Care Package**
    - **the number of eligible consumers on the Commonwealth Home Support Package awaiting a Home Care Package**
    - **the number of consumers on Level 2 awaiting Level 3 or 4 Home Care Packages**
    - **the number of referrals that are made by My Aged Care/ACAT**
    - **the impact on special needs populations**

Those who decline care because of out-of-pocket costs constitute a hidden pocket of unmet demand

In the past year, 19 people linked to the Brotherhood's aged care services have rejected or withdrawn from Home Care Packages for financial reasons. This issue is elaborated in the section on the effectiveness of means-testing below.

Non-uptake of packages due to the inability of an older adult to fund their required means-tested financial contribution and/or their daily fees may be wrongly interpreted as reduced demand for care, and so distort calculation of actual demand. It is important to understand why they have not proceeded and determine whether a policy response is needed.

Recommendation:

3. **Require the Department of Health to follow up people who do not take up care after being assessed as eligible to find out why. The future measure of unmet demand should count those people who have been assessed as needing care but have failed to take up a package on account of financial costs.**

2.3. Whether further steps could be taken to change key aged care services from a supply driven model to a consumer demand driven model

In this context:

- a supply driven model refers to the current system where the government controls the number, funding level and location of residential aged care places and the number and level of home care packages;
- a consumer demand driven model refers to a model where once a consumer is assessed as needing care, they will receive appropriate funding, and can choose services from a provider of their choice and also choose how, where and what services will be delivered.

Government has a responsibility to ensure that all Australians can access quality aged care

The Brotherhood supports the need to empower care consumers and provide them with greater opportunities for choice and control. However, we do not believe that the market-based reforms, as they stand, are sufficient to achieve this for many consumers, particularly those experiencing disadvantage or with extra vulnerabilities.

Accordingly, we urge that before any further steps are taken along the consumer demand driven path – such as individualised funding for Commonwealth Home Support Packages – appropriate remediation measures should be put in place to address unintended consequences flowing from the current reforms.

As market steward, government needs to take responsibility for ensuring that:

- older adults can navigate their choice of providers
- quality care standards are set and robustly monitored
- there is adequate supply of quality services, even in thin markets and for groups with low means
- the additional measures are provided for special needs groups to achieve equity of access and outcomes.

Marketisation of aged care services is fraught for vulnerable consumers

Choice in care is not straightforward. Consumer decisions hinge on a range of factors: the interplay of families and professionals; the availability of suitable care; and the economic, social and family resources individuals can draw on.

Market-based provision works best in circumstances where services are transactional, clearly defined, easily substituted and discretionary, and where the cost of changing providers is minimal. Market-based supply is suited to consumers of home care services:

- whose needs are not complex and can be met by regular, standard home supports
- who can complement formal care with informal carers and care networks
- with sufficient literacy skills, particularly financial and health literacy, and
- with sufficient financial resources and adequate housing.

For these consumers, the relationship with services and formal carers is closer to parity. If the consumer is unhappy with a provider or a service, they would have the capacity to seek alternative options in the market, and to use informal carers or networks to supplement formal care during the process. In such cases, the risks of market failure are not high.

However, market mechanisms struggle to deliver efficient, quality and responsive outcomes for consumers whose needs and life circumstances are more complex. The Productivity Commission (in its current inquiry into competition in human services) highlighted the difficulties of further applying user choice in areas of service provision targeted at the most vulnerable. [3]

People disempowered by a lifetime of disadvantage, or isolated in older age, or with reduced decision-making capabilities typically require considerable additional support to make informed choices about their care. The quality of the interpersonal relationship with care professionals will be pivotal for ongoing engagement and wellbeing. Power imbalances between care provider and care recipient are likely. The costs and risks of changing providers are high, particularly in residential care. The risk of provider or systematic market failure is also high.

Competition alone does not provide sufficient incentive for residential providers to deliver high-quality care or value for money.

Thin markets require intervention

For care consumers who live in rural and remote areas, or even on the outskirts of our major cities where markets are 'thin', a consumer-driven demand system is unlikely to deliver supply or value without government intervention.

[3] Productivity Commission 2016, *Introducing competition and informed user choice into human services: identifying sectors for reform*, preliminary findings report, Canberra.

We note that the National Disability Support Scheme (NDIS), which represents a radical shift towards consumer-driven provision, stipulates that the government will continue to block-fund specialist disability services and those in rural and remote areas where an open market cannot thrive.

Not-for-profit providers may be crowded out,

A key message from the recent Competition Policy Review (the Harper Review)[4] was that increased competition and market-based supply should not 'discourage or crowd out' not-for-profit service provision and voluntarism, both of which are integral to the current aged care system.

Australia's aged care industry is increasingly competitive. The most recent Aged Care Approvals Rounds saw demand for allocated packages exceed supply: there was almost a 20:1 ratio of packages sought to those allocated. With the effective uncapping of the number of registered providers, a significant increase in the numbers of for profit providers is anticipated. This is consistent with international trends. In the United Kingdom, for example, which is further along the path of individualised funding, percentage of not-for-profits and for-profits in aged care industries has shifted from 70% NFP and 30% FP to 30% NFP and 70% FP.

Operating in a competitive environment may affect the power relations between provider organisations: smaller, local not-for-profit organisations are likely to be at a disadvantage, with insufficient resources to compete efficiently with larger organisations and particularly with private providers.[5]

Already, Australia is seeing the concentration of aged care services among larger providers. The number of residential aged care providers dropped by 159 between 2010 and 2015, yet the number of residential care places increased by 9520.[6]

For consumers, this will mean reduced real choice and loss of the particular values and innovation that social purpose organisations bring to the aged care sector. There is a danger that commercial providers will focus primarily on segments of the market with the highest rate of return.

Volunteerism and efforts to support social inclusion are at risk

The capacity of organisations with a social purpose to harness local effort and resources is likely to be diminished by a wholly individualised funding model.

For example, through its aged care services, the Brotherhood seeded an innovative response to the transport challenges and social isolation facing older adults on Melbourne's Mornington Peninsula. Leveraging the previous block funding, the Brotherhood facilitated the establishment of Peninsula Transport Assist (PTA) which provides transport at little or no cost. PTA is a consortium of community-based organisations, residents and local councils and relies on voluntarism and resource sharing.

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[4] Harper, I, Anderson, P, McCluskey, S & O'Bryan, M 2015, *The Australian Government Competition Policy Review: final report*, Commonwealth of Australia

[5] S Wickramasinghe & H Kimberley 2016, *Networks of care: valuing social capital in community aged care services*, Brotherhood of St Laurence, Fitzroy, Vic., citing P O'Shea & M Darcy 2007, 'Does "competition" kill "social capital"?', *Third Sector Review*, vol. 13, no. 2, pp. 49–69.

[6] *Aged Care Funding Authority annual report*, July 2016 and *Residential aged care In Australia*, AIHW, July 2010

The Brotherhood has also developed community social and learning activities to combat isolation and maintain consumers' knowledge and skills. For example, we link clients with dementia or disability to volunteering opportunities in the general community, such as gardening and wood work, or to volunteer in other Brotherhood programs because they want to give back to the organisation. We have also developed peer support groups (such as dementia support groups and support networks for carers) and connections with the wider community (such as awareness raising on dementia by engaging with local schools, libraries). These activities create social value that extends beyond the service. However, they are proving unsustainable under new funding arrangements.

We urge the government to develop measures to ensure that the mixed economy of care is retained, and to support the capacity of the aged care sector to draw on the skills and resources of the surrounding community. We note that as part of the roll-out of the NDIS, Local Area Coordinators have been funded to undertake community capacity building, including opening up mainstream activities, services and clubs for people with disability. A similar approach could be explored in aged care.

Recommendation:

4. **Provide strong stewardship to ensure that aged care market services meet policy objectives. As a minimum, the Australian Government has an overarching responsibility to:**

    - **Provide citizens with clear, accessible and up-to-date information about the quality and performance of providers to enable them to navigate the system and exercise informed choice**
    - **Establish, robustly monitor compliance with and enforce quality standards**
    - **Provide special needs groups with the additional support to achieve equality of access and outcomes in the aged care system**
    - **Actively monitor home care markets to ensure that there is a sufficient mix of providers (including not-for-profit providers) in each market to deliver the benefits of increased choice for consumers, and drive improvements in quality and responsiveness**
    - **Act to supplement 'thin' markets by commissioning services**
    - **Support initiatives to build the social inclusion and participation of aged care consumers in their local communities**

2.4. The effectiveness of means testing arrangements for aged care services, including an assessment of the alignment of charges across residential care and home care services

In this context:

- means testing arrangements means the assessment process where:
  - the capacity of a person to contribute to their care or accommodation is assessed (their assessable income and assets are determined); and
  - the contribution that they should make to their care or accommodation is decided (their means or income tested care fee, and any accommodation payment or contribution is determined).

Refer to Section 4(2)(d) in the Act

Out-of-pocket expenses can discourage people taking up the care they need

Earlier in this submission, we highlighted the issue of hidden unmet demand resulting from failure to take up home care packages because of financial constraints.

We have observed instances where out-of-pocket care costs have dissuaded people from taking up the care they require. This undermines preventative care, contributes to adverse health and wellbeing outcomes, and increases the risk of requiring more costly intensive care or hospitalisation. It also places significant stress on family members and other informal carers.

We are particularly concerned about the impact of the income-tested fee on those whose incomes are marginally above the threshold of $25,792. For example, a person with an income of $28,000 (and assets of $30,000) would face a fee of $52.50 per fortnight.

On top of this, consumers may be charged a daily fee of up to $9.58, which equates to $139.58 per fortnight. For our hypothetical consumer with an income of $28,000, the two fees would add to $192.08 per fortnight. In our experience, this is too high for households with finely balanced budgets – particularly private renters who typically have lower disposable incomes on account of their higher housing costs.[7]

Recommendation:

5. **Rescale the income-tested fee contribution rates for those with incomes marginally above the income free threshold of $25,792 to reduce the amount of the contribution they are required to make to their care costs**

Disjointed government assessment processes are problematic

The time-lag, often up to three months, between seeking a means assessment from Centrelink and receiving the required response places both service users and providers in a tenuous position:

[7] Per Capita, the Benevolent Society and The Longevity Innovation Hub 2016, *The adequacy of the age pension in Australia, an assessment of pensioner living standards*, Per Capita.

- Consumers are in the dark about whether – or how much – they will need to contribute to the income-tested fee. This leaves them in a vulnerable position as they ponder whether to wait for the determination or to accept the package immediately and risk having to pay accumulated contributions/fees
- On receipt of advice from Centrelink, some consumers decide the cost is too high and that they no longer wish to proceed
- Applications to waive fees on the basis of hardship are complex and time-consuming. The forms do not allow for identification of those with no income.
- Home care providers face the dilemma of whether to commence care before knowing whether a consumer can or will pay their co-contribution or if they will reject a package following their Centrelink assessment. Providers do not receive compensation for associated costs.

Similar concerns apply to assessments for people requiring residential care.

- Residential care providers are required to reach agreement on the costs to the resident within 28 days of admission. This is challenging while still awaiting the outcome of an income assessment.
- Another problem encountered in residential aged care is delayed advice to the provider when a guardian (such as State Trustees) completes the means test application. The guardian receives the assessment and it can take months for the provider to receive the information.

Moreover, assessment notices are sometimes inconsistent, with advice to consumers differing from that sent to providers.

Recommendations:

6. **Integrate the care assessment and means assessment process**
7. **Provide a copy of the mean-test assessment to the service provider as well as to the consumer and any guardian.**

2.5. The effectiveness of arrangements for regulating prices for aged care accommodation

Refer to Section 4(2)(e) in the Act

In this context:

- regulating prices for aged care accommodation means the legislation that controls how a residential aged care provider advertises their accommodation prices.

Regional and concessional ratios are essential for people of low means needing residential care

The Brotherhood believes that further relaxing pricing controls could encourage providers to focus on consumers able to pay higher accommodation costs. Strong and clear measures are essential to ensure access for lower income people needing care.

Accordingly, we endorse retention of the current 40% concession ratios in residential care, which provide a powerful incentive for providers to accommodate 'supported residents' of low financial means. We also endorse retention of the regional supported resident ratios, which provide a minimum number of places in each region.

Recommendation:

8. **Retain the regional and 40% concession ratios for residential care to ensure equity of access for people with limited financial means.**

2.6. The effectiveness of arrangements for protecting equity of access to aged care services for different population groups

Refer to Section 4(2)(f) in the Act

In this context equity of access means that regardless of cultural or linguistic background, sexuality, life circumstance or location, consumers can access the care and support they need.

In this context different population groups could include:

- people from Aboriginal and/or Torres Strait Islander communities;
- people from culturally and linguistically diverse (CALD) backgrounds;
- people who live in rural or remote areas;
- people who are financially or socially disadvantaged;
- people who are veterans of the Australian Defence Force or an allied defence force including the spouse, widow or widower of a veteran;
- people who are homeless, or at risk of becoming homeless;
- people who are care leavers (which includes Forgotten Australians, Former Child Migrants and Stolen Generations);
- parents separated from their children by forced adoption or removal; and / or people from lesbian, gay, bisexual, trans/transgender and intersex (LGBTI) communities.

Transparency is needed to ensure vulnerable older adults retain priority access to aged care services

The current system provides priority access to aged care services for certain population groups. The Wait List is to be replaced by the National Queue. While consumers are being assured by the Department of Health that their place in the National Queue will take account of their needs and circumstances as determined by the ACAT[4], there is a lack of information about the criteria or weighting to be used.

We believe there are some additional circumstances (not identified in the current legislation) which ought to be explicitly factored into the assessment of relative needs; these include cognitive impairment and dementia; disability; and mental ill-health.

Recommendation:

9. **Establish transparent criteria and weighting of the needs and circumstances that are to be taken into account in determining a person's place in the National Queue. Consider extending the definition of special needs populations to people with disability, cognitive impairment, and those experiencing mental ill-health.**

Case management support is critical to equity of access for consumers of home care services experiencing disadvantage

The Brotherhood's experience is that poor financial and health literacy, poor informal supports, poor digital literacy/access and additional complexities such as poverty, insecure housing, cognitive impairment and mental ill-health make navigating the complex care services system nearly impossible. A small research study concluded that without significant case management support these consumers did not have the ability to engage actively with the choices and controls available through the CDC system. [8]

Evaluations of the early CDC pilots conducted by KMPG produced similar findings.[9,10] These reported concerns that consumers from socially and financially disadvantaged backgrounds face greater challenges in moving to the CDC model. In particular, the level of case management was likely to be inadequate to meet their needs and experiences of these groups.

Many vulnerable consumers are isolated from family and social contact; have low literacy, numeracy and digital literacy; and do not have internet connections. Buttressing such consumers with the knowledge of a case manager is critical for effective choices. Intensive case management support, rather than lighter touch case management, is fundamental to their engagement and capacity to access the service and supports they need. A systematic review of different home and community care service models found that case management (compared with the consumer-directed care and integrated care models) has the strongest evidence base for improving health and clinical outcomes, such as improved function, appropriate medication use, increased use of community services and reduced nursing home admissions.[11]

Yet, alarmingly, many consumers who would benefit from higher level case management are missing out. They simply cannot afford the cost, given that it means a reduced budget for other services and supports. With individualised budgets ruling out cross-subsidisation, the most vulnerable consumers have experienced a reduction in case management support and/or a reduction in services since individualised budgets have come in.

We are also aware that case management can perform a vital advocacy role, and reducing it may increase the potential for elder abuse. The Consumer Directed Care model often relies on some family support to inform choices. CDC consumers may have less contact with case managers and hence less

[8] Simons, B, Kimberley, H, McColl Jones, N 2016 *Adjusting to Consumer Directed Care: the experience of Brotherhood of St Laurence community aged care service users*, Brotherhood of St Laurence, Fitzroy, Vic.
[9] KPMG 2012, *Evaluation of the consumer directed care initiative,* Department of Health and Ageing, Canberra.
[10] KPMG 2015, *Formative evaluation of the Home Care Packages Programme: detailed findings report,* Department of Social Services, Canberra.
[11] Low, LF, Yap, M & Brodaty, H 2011, 'A systematic review of different model of home and community care services for older people', *BMC Health Services Research,* vol. 11, no.93.

ability to report / identify possible abuse. Individuals with complex care needs (e.g. mental health or psycho-social issues) may be particularly at risk.

Recommendation:

10. **Provide supplementary funding for high level case management services for consumers that face significant barriers in navigating their care choices.**

Social isolation is likely to increase without specific measures to tackle it

A significant adverse impact we have observed since the introduction of CDC is reduced participation of Home Care Package clients in the Brotherhood's Social Inclusion Program, designed for socially isolated service users. Under earlier funding models the Brotherhood had been able to subsidise participation. With the full cost – including attendant care and transport –now having to be met from individual packages, many consumers have decided they cannot afford to participate.

The consequences may be serious, especially for consumers with mobility limitations and those who live far from family and friends. Social isolation has been shown to be a major risk factor for health, rivalling well-established risk factors such as cigarette smoking, blood pressure, blood lipids, obesity and physical inactivity.[12] Conversely, social networks of discretionary relationships contribute to longer life expectancy among older Australians.[13]

Recommendations:

11. **Require the Aged Care Assessment Team to explicitly consider social isolation when determining the level of support needed by a consumer. Where relevant, ACAT should identify social isolation as a specific area of need in the consumer's Support Plan**

Location and high transport costs contribute to inequities in access to care

Equity among consumers can be undermined by their residential location. In Melbourne's outer suburbs and semi-rural areas of the Southern Region (where public transport and taxi services are sparse), Brotherhood consumers spend a significant proportion of their packages on getting to and from services and other vital appointments and contributing to the essential travel costs of care and support workers:

- Over 30% of clients on Level 2 and Level 4 packages, and about 20% of Level 3 clients, use funds to purchase transport.
- Around 40% of clients on Level 2 packages, 50% of those on Level 3 and 58% of those on Level 4 contribute to their workers' travel expenses.

Brotherhood clients in the region rate transport as one of the most important elements affecting the quality of their care and overall wellbeing. Those without other means to pay high transport costs may have to reduce the services they can purchase – social engagement activities are often the first to go – and face significant barriers to accessing appropriate care services.

[12] House, J, Landis, K & Umberson, D 1988, 'Social relationships and health', *Science*, vol. 241, pp. 540–45.
[13] Andrews, G, Giles, L, Glonek, G & Luszcz, M 2005, 'Effects of social networks on 10 year survival in very old Australians: the Australian longitudinal study of ageing', *Journal of Epidemiology and Community Health*, vol. 59, pp. 574–9.

Recommendation:

12. **Provide a supplement to clients facing excessive transport costs to access care and support services. We suggest this be applied where a client reasonably needs to spend more than 25% of their package on transport.**

People with low English language proficiency may need additional support to engage interpreters

While providers ought to be encouraged to employ staff from cultural and linguistic backgrounds reflecting the communities they serve, it is not possible to cover all the cultural backgrounds and community languages in any region. Although this gap is often filled by family members or informal carers, it is sometimes necessary to pay for professional translators/interpreters from the home care budget, for example to translate a care plan. This reduces the funds available for other services, disadvantaging consumers from CALD backgrounds compared with their English-speaking counterparts. We know of older adults who have had to forgo translation services due to a lack of funds, which has compromised their interactions with health professionals and carers.

Recommendation:

13. **Make provision for consumers with low English language proficiency to engage professional translators/interpreters where critical to their care (e.g. translation of their care plan)**

Temporary reductions in Home Care Package funding during periods of hospitalisation hurt vulnerable consumers

The reduction to 25% of HCP funds following 28 days of hospital, respite etc. causes hardship to some consumers, especially those who do not have informal or family supports. During hospital and respite stays, these consumers continue to require support such as laundry, bill payments, social support, case management, escort, pet care, garden maintenance and transport to medical and other appointments. Without these supports, consumers may jeopardise their tenancy, their utilities connections or their insurance; and regular maintenance may also be missed. This can also undermine a person's confidence to return to their home or community.

Recommendation:

14. **Exempt consumers with poor informal/family supports from the 75% reduction in the Home Care Package funds during periods of hospitalisation or respite.**

2.7. The effectiveness of workforce strategies in aged care services, including strategies for the education, recruitment, retention and funding of aged care workers

Refer to Section 4(2)(g) in the Act

In this context, aged care workers could include:

- paid direct-care workers including: nurses personal care or community care workers; and allied health professionals such as physiotherapists and occupational therapists; and
- paid non-direct care workers including: managers who work in administration or ancillary workers who provide catering, cleaning, laundry maintenance and gardening.

A capabilities approach ought to be a core skill of aged care services staff

The aged care industry is undergoing a dramatic transformation in its approach to residents, clients, families and carers. The introduction of Consumer Directed Care, changing community expectations and the focus on person-centred care have directed attention to the quality of life of the service user.

The Brotherhood views care as a tool to assist each individual's quality of life, rather than as an end in itself. Our approach is predicated on Amartya Sen's capabilities approach. We work to enable choice, wellbeing and the opportunities for our service users to live a life of value that reflects their aspirations. Accordingly, we train our aged care staff in the capabilities approach.

To skill Australia's aged care workforce to deliver the choice and empowerment that underpins Consumer Directed Care, there needs to be a shift away from transactional tasks to forming relationships with service users. Research conducted by RMIT recently found that this requires staff who possess a range of capabilities pertaining to head, hands and heart. [14]

However, much training for the aged care workforce tends to be task-driven, focusing on standards, compliance and risk avoidance. Consequently, staff often lack the skills and agency to build relationships with and engage service users in order to understand and help realise their goals and aspirations.

Recommendation:

15. **Introduce workforce training approaches that strengthen staff capacity to engage with their clients' needs, goals and aspirations.**

A closer nexus is needed between aged care related training and employment

The disconnection between the quality of training and subsequent employability in the Aged Care sector has attracted media and public policy interest. In response, the Brotherhood has developed an Aged Care Skills Gap training program in partnership with the (Melbourne) Inner Eastern Health Group (Sir Eric Pearce House), Mercy Hospital, Australian Unity and Benetas. The Skills Gap program supports participants who have been churned through training with other providers to build the skills and

[14] Ramcharan, P, David, C, Jones, M and Moors, R 2015 *'I'm a person not a job!' Establishing core competencies for change in Brotherhood of St Laurence Residential Aged Care.* Centre for Applied Social Research, RMIT University, Melbourne.

experience they need to secure employment. The program has recently secured Victorian Government support.

While we acknowledge ongoing reforms to the training system, including mandated hours for practical placements, a much closer connection between classroom and on-the-job training is needed. The Brotherhood's Individual Support (Cert III) training includes a minimum of 200 hours of practical placement. This ought to become the industry standard.

We have found that workplace learning is most effective when undertaken in sessions throughout the course, rather than as a block at the end of the classroom based training. This allows learnings to be shared in the classroom and, helps trainers to focus on topics to get their students ready for employment.

We also have a partnership with RMIT whereby its Individual Support (Cert III) students are taught, together with students from the Brotherhood's RTO, at a Brotherhood aged care facility and spend time with staff and residents. In this way, students are imbued with the culture of the facility and the capabilities approach we use to promote quality of life.

Recommendation:

16. **Include a minimum workplace learning component of 200 hours in aged care workforce training, such as the Cert III in Personal Care. This workplace learning should be undertaken concurrently during the training program, rather than in a single block at the end.**

An aged care workforce strategy is long overdue

To support change, and to achieve the workforce size to support our ageing population, Australia needs a comprehensive aged care workforce strategy. This should address systemic issues including workforce attraction, capability building, supporting best practice and fostering innovation. There is capacity to build on the work commenced by the previous Australian Government.

Recommendation:

17. **Develop and fund a comprehensive workforce strategy for the aged care system in partnership with industry and consumer representatives**

2.9. The effectiveness of arrangements for facilitating access to aged care services

Refer to Section 4(2)(i) in the Act

In this context access to aged care services means:

- how aged care information is accessed; and
- how consumers access aged care services through the aged care assessment process.

Consumers need information and support to make an informed choice between providers

In a marketised system, it is critical that consumers are equipped to make informed decisions based on quality and performance of different providers, as well as their approach and their range of services and supports. In principle, we welcome the upcoming introduction of Quality Indicators.

Currently, there is limited information on the My Aged Care (MAC) website (which is backed by a phone service) to help consumers navigate the available providers. However, providers must disclose all relevant charges up front and make these charges publicly available on the website.

The system relies heavily on digital competency and access. This is particularly challenging for those older people with limited digital literacy or limited access to the internet. For example, ACAS tells people eligible for residential aged care that they should look up facilities on MAC. However, people from disadvantaged groups rarely have access to a computer, and often lack the skills to operate one. The Adult Language and Literacy Survey data shows older Australians are concentrated in the lowest levels of language and literacy skills, with many lacking skills at levels required for competent participation in today's society. Consumers experiencing social or financial disadvantage are less likely to be digitally literate and lack other skills such as health literacy, reading, numeracy or problem solving.

The recent review of competition policy (the Harper Review) noted that access to high quality, independent information is essential for the effective operation of a marketised system. The elements necessary to underpin consumer choice that the Harper Review enumerated are detailed in the following recommendation.

Recommendation:

18. **Empower consumers to exercise choice in aged care services by:**

- **Ensuring all users have access to relevant information including feedback (where appropriate) from previous users of the service.**
- **Providing disadvantaged groups greater assistance in navigating the choices they face by using accessible communications channels that suit their needs (online is not sufficient).**
- **Making intermediaries or purchase advisors available to help users whose issues or circumstances are complex. Policies need to be designed to align the incentives of purchase advisors with the best interests of users.**

Consumers experiencing disadvantage can have poor outcomes through the MAC system

Consumers from special needs populations are at higher risk of a poor outcome through the MAC system – such as a rejection, or an inaccurate assessment or referral. Some practical examples of challenges we have come across, together with recommendations to address these are set out below.

The MAC system has no capacity to identify those most at risk of falling out of the referral process.

People with vulnerabilities are being inadvertently dropped out of the process for reasons such as having no fixed address, failing to activate a package within 28 days of its allocation (or 56 days if an extension is requested), or declining a phone call.

Recommendation

19. **Enable MAC to flag where urgent support is required for the assessment process and referral to home care package**

Some consumers have been inappropriately identified as ineligible for services through the MAC system.

For example, those aged under 65 experiencing homelessness are not being referred to the support they are eligible for. In some instances, the system is deeming them ineligible, without referral for review or advocacy support. Consumers in this group can be challenging to engage and easily discouraged from further participation.

Recommendation:

20. **Ensure the MAC operator checklist for identification of Home Care Package eligibility includes consumers under 65 years who are Indigenous or at risk of homelessness.**

There is no funding support for a provider or ACAS to engage with and support consumers throughout the application and assessment process

This applies even if the consumer is at high risk of not following through on the process.

We understand that ACAS will soon be equipped to provide continued support (post referral to MAC) to advocate for the consumer to the home care package provider. We welcome this.

Recommendation:

21. **Notify the referrer and those advocating on the client's behalf, as well as the client, when a package becomes available.**

Providers may avoid vulnerable consumers.

In an open market, HCP providers can accept or reject any referrals on MAC for a variety of reasons. There is a real danger that vulnerable consumers who are costlier and challenging to engage will be avoided by some providers.

Recommendation:

22. **Examine the possibility of discrimination within MAC processes in the face of rejection of a referral by a provider for reasons that currently include: conflict of interest, further information to be added, insufficient capacity, no-one accredited, referral made in error, service no longer required, unable to process referral.**