Submission to the Royal Commission into Aged Care Quality and Safety

Aged Care Program redesign: services for the future

Prepared by

COTA Australia

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COTA Australia

COTA Australia is the national consumer peak body for older Australians. Its members include State and Territory COTAs (Councils on the Ageing) in each of the eight States and Territories of Australia. COTA Australia and the State and Territory COTAs have around 40,000 individual members and supporters and more than 1,000 seniors' organisation members, which jointly directly represent over 500,000 older Australians.

COTA Australia's focus is on national policy issues from the perspective of all older Australians as citizens and consumers and we seek to promote, improve and protect the circumstances and wellbeing of older people in Australia. Information about, and the views of, our constituents and members are gathered through a wide variety of consultative and engagement mechanisms and processes.

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Introduction

COTA Australia welcomes the opportunity to comment on the Royal Commission into Aged Care Quality and Safety's Consultation Paper 1 - "AGED CARE PROGRAM REDESIGN: SERVICES FOR THE FUTURE".

COTA maintains its support for the future of aged care as broadly envisaged by the Aged Care Roadmap's 'Destinations'. This includes it being a system rebuilt around genuine consumer choice and control and creating a continuum of care regardless of the location in which that care is delivered. Our vision for the aged care system is agnostic as to where and how care and services are delivered.

We are pleased to see the Government's commitment to part of this vision, in its response to the Royal Commission's Interim Report in which it reaffirmed the Government's policy that it will establish "a single unified system for care of our elderly in the home" and create "a single assessment workforce and network".

We also want to see a clear timeline to place funding in the hands of consumers in what is currently referred to as residential care, following the Government's in-principle commitment in the More Choices for a Longer Life package in 2018. An implementation strategy is now in the Government's hands (after much delay) and must be enacted forthwith.

We have also called for a clear and transparent plan to reduce the waiting times for Home Care Packages to no more than 60 days, involving both staged financial commitments and a workforce recruitment and development strategy, with the target to be achieved within two years.

COTA Australia has taken the challenge laid out by the Royal Commission's Interim Report and is developing a transformational aged care model for the future. In doing so we have consulted with a range of stakeholders to better inform our thinking as part of our ongoing response to the Royal Commission. We do not anticipate the final version of this model to be available until late February or early March 2020. Should the Royal Commission wish to be provided with an early draft of our model, we would be pleased to provide a confidential not-for-publication version upon request. We will of course provide a copy to the Commission once it has been finalised.

A discussion of the use of the term 'consumer'

COTA Australia notes criticism of the use of the term 'consumer' within the aged care sector. Criticism has included that referring to the older person at the centre of the care relationship as a 'consumer' promotes what the Royal Commission has identified as the transactional nature of the current aged care system. Further, we note that many consumers do not themselves self-identify with the word 'consumer' and some are concerned by the inclusion of consumer language within a human service context. We also note, however, that surveys have consistently shown that older people also do not self identify with terms such as 'seniors', 'aged', 'the elderly', or even 'elders', nor with 'clients', 'care recipients', etc. Nor do they like to be referred to by any of these terms.

As one of the leading 'consumer' organisations, we wish to provide context for the Royal Commission in its deliberations on this matter. The use of the word 'consumer' emanates from and is embedded in the "consumer movement" which emphasises the pivotal role of the consumer and respects the life experience and valuable input of the individual. The consumer movement seeks to increase consumer protections and reform the practices of corporations and government in favour of the interests of consumers. In the healthcare sector, people who accessed health services were traditionally referred to as a 'patient'. However, such language was associated with a person who receives care without necessarily taking part in decision making about their care - while a 'consumer' in healthcare signifies someone who is involved in decision making about their care[1]. In addition, through this lens of actively participating in decision making, the term 'consumer' may apply to the individual or their delegated decision maker such as a partner, family or friends, not exclusively the older person.

This use of consumer within aged care since 2012 has sought to cast aside previous language such as "care recipient" which historically implied passivity, having things done to the older person and being grateful and humble for that. The alternative term 'customer' is best defined as a person who receives goods or services from a business and hence is are more closely aligned with the transactional purchase arrangement sought to be avoided. The term 'client' is similar to customer where the person receives ongoing professional service.

While we recognise that some older people may not wish to be referred to as 'consumers', we staunchly oppose returning to language which implies older Australians (or their family/friends) are not active decision makers about their lives. We are concerned that generic language such as 'people' 'older Australians' 'seniors' and the like will not maintain a focus on increasing older people's participation in decision making about their care. Further, the tendency of medical professionals to infantilise older patients further runs the risk of older people being framed as frail and unable to make decisions for themselves.

Finally, we note terms such as 'carer' can often be confused between care workers / staff and informal carers / family and friends. While attempts to distinguish 'formal' and 'informal' carers have been made, it has had minimal success and has failed to include them within a decision-making frame. In all of COTA's work we take and mean the term 'consumer' to include family/friend/other designated carers, who are consumers in their own right.

While we appreciate that some have sought to associate 'consumer' with financial transactions, and that no one term will satisfy all individuals, we would urge the Royal Commission to place priority on the issue of decision making when determining the appropriateness of language and terminology.

For the purpose of this submission, we will continue to refer to 'consumers' as older people and their informal carers where substituted or supported decision making is required.

[1] Health Consumers NSW 'Who is a health consumer? and other definitions', Accessed 19 January 2019. Available from: https://www.hcnsw.org.au/consumers-toolkit/who-is-a-health-consumer-and-other-definitions/

Principles for a new system

1. What are your views on the principles for a new system, set out on page of this paper?

In general, the principles set out in the Royal Commission's consultation paper are sound. However we make the following comments:

Royal Commission Principles	**COTA Australia comments**
The aged care system should:	
• be underpinned by respect and support for the rights, choices and dignity of older people	Agree, however respect and support for the rights, choices and dignity of older people must occur well before older Australians access aged care. The reframing of attitudes towards older people is a societal issue and **this principle should transcend the aged care system**.
• ensure quality and safe care is fundamental to the operation, funding and regulation of the system	COTA suggests principles should be aspirational and therefore 'high quality' care should be our objective. Accordingly, this principle should read, "ensure **high** quality and safe care is fundamental to the operation, funding and regulation of the system".
• provide equity of access, regardless of location, means or background	Agree
• be transparent, easy to understand and navigate	This principle should include the concept of comparability so that older people and their families can compare the information provided. Accordingly, we suggest "be transparent, easy to understand and navigate, **and be comparable between service providers**"
• deliver care according to individual need	COTA is apprehensive about the word "need" as historically this has meant that the aged care professional tells an older Australian what they "need" and decides for them. We would suggest that to ensure consumer choice and control remains paramount any reference to need should be **accompanied by choice** and should be **located higher on this list** to emphasise the importance of consumer choice and control. Therefore, we suggest amending the principle to read "deliver care according to individual needs **and choices**", and making it **higher on this list**.

• maximise independence, functioning and quality of life for older people	Agree
• support older people to have a good death	COTA would be concerned if 'support' is taken to imply the Aged Care system is primarily responsible for a good death, whereas we understand this is primarily the role of the state health system and its palliative care services (particularly when considering in home care). If the Commission believes the future role of the aged care system should be to support a 'good death' then we would seek the Commission's view on the delineation between the aged care systems responsibility and the future role of the healthcare sector?
• support older peoples' informal care relationships and connections to community	Agree
• enable the recruitment and retention of a skilled, professional and caring workforce	A "caring" workforce is not enough. This principle should include "…caring workforce**, with the right attitudes towards older people.**"
• support effective interfaces with related systems, particularly health and disability	Agree
• be affordable and sustainable, both for individuals and the broader community	This principle should read, "be affordable and sustainable, both for individuals, the broader community **and government.**"
• be capable of being implemented, monitored and evaluated.	Agree

We suggest the following **additional principles** should be added to the above suite of principles for future of the Aged Care system. The aged care system should:

- **Provide care on a timely basis**.
- **Be free from abuse, neglect or exploitation**.
- **Ensure that older Australians are full collaborators in the co-design of the aged care system**.
- **Ensure that older Australians and their family/friends are at the centre of decision making about services available broadly and services specifically for them**.

Making the system simpler

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

In your response, you may wish to consider the following:

- In what ways could the aged care system be made easier to access and navigate?
- What information, services or structures are needed to support older people to make informed choices about aged care, and to have appropriate control over the services they receive?

Consumers and their families are key participants in design and promotion of a new system. It is critically important that at the heart of the redesign of the aged care system is the principle of choice and control for the consumer. The purpose of the system is to support and enable older people to maximise their quality of life and to make informed choices about their health and wellbeing. Information and engagement with the system should promote and reinforce this message. The perspective, understanding and experience of consumers in accessing and engaging with the current aged care system and how this might be improved is a key in designing and promoting the new system. Design concepts and information on the new system must be tested and informed by consumers with lived experience of the aged care system before implementation.

Any system redesign should build on existing, trusted relationships that older people already access to support and inform themselves. For the purpose of this submission we'll refer to these as 'Local Contact Points'. Current local health and community services should act as key information points where older people can receive face to face information, check eligibility, register for the system (providing key contact details) and ask questions. Services including general practitioners, local government and other seniors-focused community groups should receive information and resources to enable consumers to register and engage with the system. The primary focus of such information points should be to promote how to access aged care services.

Once an individual has engaged with the aged care system (i.e. registered) a key stage of the redesign process should be the development of truly independent Assessment and Case Management services. Assessment and Case Managers can also act as system guides from the initial stages of registering with My Aged Care, all the way through to when their ongoing services commence. Assessment and Case Management services should be local and independent of care providers. Such services should provide a full wrap-around suite of services that ensures the consumer always has an independent person on their side, working in their best interest. These local assessment services would also be responsible for resourcing local contact points for older people, as it will be critical for such local contact points to connect with their local assessors in order to feed into the system.

After the assessment of needs step is completed, consumers should be able to have their assessors act as case managers to "walk alongside" them and assist them through the aged care process, provide advice and develop a care plan.

Tailored Information on general financial costs should be provided at the early engagement stages. Consumers should be able to make informed choices about any financial decisions or commitments and receive clear and concise information. Early contact, registration, assessment services to provide general financial calculator resources tailored to individual need to inform consumer decisions, are key to simplifying the system.

General promotion and awareness of a new system, emphasising the message of consumer choice and control and enhancement to quality of life is required at the outset. Older people (and many others in the community) have psychological barriers and negative perceptions about the aged care system, in particular the residential system, and therefore they may be reluctant or resistant to seek information about or engage with the service system. The development of a campaign which includes a suite of social marketing initiatives is needed to promote how the system can support the quality of life and ongoing contribution of older people as well as who to contact for information and support. This campaign must start from a foundation of valuing older Australians and their lifetime contribution to society.

There need to be specific mechanisms to support vulnerable populations. These should be developed to engage with and support vulnerable populations to be informed and make decisions about their care. This includes culturally appropriate information and service engagement for Aboriginal and Torres Strait Islander, Culturally and Linguistically Diverse (CALD) people, people experiencing homelessness and LGBTI people. Ensuring independent assessment and case management providers have full access to interpreter and language services and have staff trained in cultural awareness is vital. Developing tailored resources for current services working with vulnerable populations to support engagement with aged care system are also key initiatives.

Information Technology Capability (including My Aged Care) must be developed and improved. Access to the aged care system for consumers must continue to be enhanced by improvements in information technology to make it more user friendly, to provide accurate and timely information and to book face to face appointments. A “Trivago” type system (absent financial incentives) to book services for consumers in real time as part of the assessment and case management process would be an asset. In order for such measures to be effective, it is time for priority investment to be placed into ‘Business to Government’ data sharing and infrastructure.

Some eight years after reforms have been announced, it is disappointing that more work has not been done to build interfaces between the various IT staff scheduling and client record management systems used by providers within the sector, and the systems used by the Federal Government. This has meant that data complex solutions have not been explored, as in the current context they would make the system more complex for the consumer, if feasible at all.

One hypothetical example of what it would mean if this was fixed is if IT systems were to talk to one another the consumer could have their aged care package value presented to them via their My Aged Care client portal and be able to directly engage a range of service providers who specialise in the services they are seeking, while also being able to see the overall balance of their allotted services. The impact of business systems not talking to Government and the Government’s current IT systems having a limit on the number of transactions it can handle has severely limited policy in this area. This has resulted in only one provider being able to hold the overall package funds to simplify the transactional arrangement for Government IT systems to handle, which in many cases has enabled providers to substantially counteract the intention that consumers should have full choice and control.

Information, assessment and system navigation.

3. What is the best model for delivery of the services at the entry point to the aged care system—considering the importance of the first contact that older people have with the system? This includes looking at services provided by phone and website as well as face-to-face services.

In your response, you may wish to consider the following:

- How could face-to-face services most benefit those older people at the entry point to aged care (or when changing programs)? What should those services include? Who should they be directed to? Where should they be located and who should provide them?
- What model of system navigation is most appropriate for aged care? How would that model change as older people's care needs increase or if they move into permanent residential aged care?
- How could the role of a system navigator relate to that of a care coordinator or case manager? What are the benefits of these functions being performed by the same person independent of the service provider? Would there be any drawbacks to that model?

It must be recognised that older people (like all people) access information in a variety of ways. An older person's capability and confidence with different contact channels and media is variable. Older Australians have told us that they prefer more personal engagement either face-to-face or face-to-face followed up by telephone. Online solutions and written materials alone are not enough, are not sufficiently interactive, and reinforce the transactional nature of assessments as conducted today. COTA's original proposal for a Gateway to the aged care system, in our initial and follow-up submissions to the 2011 Productivity Commission Inquiry[2], proposed a face to face option for all consumers, through local "gateways" that would provide information, assessment and direct referrals, supported by website and call centre capacity. While nuanced variation and terminological differences are reflected in what we are saying today, we would be much closer to where the Royal Commission wants to go if our recommendations then had been adopted as part of Living Longer.Living Better.

Local solutions for information provision are essential. Older people are often active and engaged members of their local communities through membership of community groups, church activity, volunteering etc. They may also be engaged in activities targeted at older people such as U3A and seniors' groups. These connections are an important source of connection and trusted information. In addition, they may be socially isolated, leaving local primary health services as one of very few opportunities to interact with socially isolated older people. This includes General Practitioners, Pharmacists, community services and allied health services. Local Government will also play a part in some older person's networks.

Any design of the aged care system must leverage off and build on these existing, trusted relationships. Local Contact Points should act as key information points where older people can receive face to face information, check eligibility, register for the system (providing key contact details) and ask basic questions. These local contact points should receive information and

[2] See submissions at https://www.pc.gov.au/inquiries/completed/aged-care/submissions/sub337.pdf and https://www.pc.gov.au/inquiries/completed/aged-care/submissions/subdr565.pdf

resources to either enable consumers to register or facilitate registration and engagement with the system.

The best model of an Entry Point to aged care should:

- Support the consumer to make well informed choices and decisions about their health and wellbeing
- Encourage individual capacity-building by informing the consumer about universal services enhancing health and wellbeing (e.g. reablement or restoration services)
- Record basic contact information and needs, quickly and efficiently
- Have strong links with generic, broad community support services (e.g. social support, clubs, transport, food services)
- Determine eligibility and prioritise for assessment
- Deliver comprehensive, wrap around assessment and allocation, tailored to individual choices and decisions about needs
- Offer case management to support and guide consumers through from assessment and registration process to service delivery
- Provide real time booking of care services.

The essential functions of Entry Point services are:

1. Information: promoting information, including via local contact points, including specialist navigation services
2. Registration: administrative mechanism for initial contact information and consumer expressed service need
3. Screening: determining financial eligibility (where needed)
4. Wrap Around Assessment and Case Management

Information

As discussed in the earlier section on making the system simpler, existing, trusted relationships should be leveraged to ensure trusted information is disseminated through 'Local Contact Points'. The primary focus of such information points should be to promote how to access aged care services.

Examples of such local contact points include:

- Current local health and community services including general practitioners,
- Local Government
- Seniors-focused community groups (e.g. seniors clubs and similar, local church parishes, University of the Third Age (U3A) branches.)

While some of the navigation style services may be provided by the truly independent case manager/assessor, there will remain an ongoing need to ensure that vulnerable cohorts of the ageing population continue to be proactively brought into the aged care system. This may include

'diversity' system navigators, but also include 'mainstream' older Australians who are socially isolated and may not connect via one of the above mechanisms.

Registration

Registration provides a comprehensive, integrated administrative mechanism that records initial contact information and consumer expressed service need. It acts as the service touchpoint that enables the consumer to make decisions about accessing care services through screening and wrap around assessment.

COTA envisages a registration step as an end point for consumers who are accessing certain services for the first time in a time limited manner. This may include such things as social support or community transport, where the provider may be able to 'register' them into the system on the consumer's behalf.

Such a process would be greatly assisted if the consumer no longer had to repeat themselves to Department of Human Services / Services Australia when the Department may already have details of the consumer as part of Centrelink and/or Medicare databases.

Ideally, a future aged care system would align base level eligibility with Commonwealth Seniors Health Care Card and Pensioner Health Care Card eligibility, so that all holders of either of these cards, who were over a certain age, would be able to simply provide their Name, Date of Birth and Health Care Card number as sufficient information to register them with My Aged Care. Health Care Card holders would be quickly and efficiently registered, either directly themselves or by the provider of a handful of 'early access' service types.

(COTA supports such 'early access' services being those noted by the Royal Commission's Consultation Paper within its Community Engagement stream, but **not** those identified within the 'Help at Home' stream – as discussed below).

Regarding issues of privacy and consent around Centrelink data, COTA believes consent could be sought when the age pension is applied for and that legislative changes to enable an 'opt-out' approach as part of transition arrangements over the next decade could be put in place to enable the use of such data for this purpose.

Where a consumer does not have a health care card this would be a signal that financial eligibility assessments should be considered and that a financial screening process may need to occur. As most consumers without a health care card have not engaged with Centrelink, the only alternative database of existing information held by Services Australia would be the Medicare database, or via MyGov and the Australian Taxation Office, information held by the Tax Office. COTA recognises the sensitivities around using either of these databases for the purposes of establishing client information and that therefore a non-Health-Care Card holder may need to provide all their information again to confirm their eligibility and level of required financial contribution. Alternatively, consumers could have the option to consent to use of those existing data bases.

COTA supports registration being available online, through general practitioners, local government, navigation support services and some providers of select 'community engagement' services. Upon registering, all consumers should be allocated a case manager/assessor to be the single point of contact for that consumer as their needs progress through assessment, and to service commencement.

COTA does not support all providers being able to provide registration for consumers. COTA firmly regards the conflict of interest between registration/assessment/case management, and service

provision as being too systemic and substantial to permit service providers to undertake those functions, except in rare circumstances where there is no other practicable solution. Even in the current system we have deep concerns around client capture by providers who promote themselves as helping consumers 'register' with My Aged Care and then tell the consumer they must use that provider for their services.

Registration is part of an integrated ICT platform based within My Aged Care. The benefits of a comprehensive, integrated registration mechanism include:

- Effective, efficient and comprehensive data collection and extraction to support consumers and improve the system
- Responsiveness to consumers, through online availability or through localised service support
- Avoidance of duplication of information
- Leveraging off trusted relationships, partnerships and arrangements.

Financial Contribution Screening

Screening is a mechanism and process that determines financial eligibility for care services which is an essential and critical part of the screening process. It is particularly important when considering whether it is financially beneficial for more affluent consumers to purchase services via the Government-subsidised aged care system.

While pensioners and health care card recipients may need to contribute some funds towards their care costs, client contributions should not be a barrier to accessing the services. Therefore, once registered, noting that Centrelink already has their financial information, an automatic letter can be sent to the individual informing them of their financial contributions based on this existing financial information. Clients should be afforded the opportunity to submit updated data if their financial circumstances have changed, to facilitate a reassessment.

However, for non-pensioners or health care card recipients, Services Australia would not hold the necessary financial information to provide informed advice about their financial arrangements. While we recognise that formal assessment of financial arrangements is necessary, we also submit that an early 'indication' of financial commitment should be able to be calculated with five minutes over the phone based on a handful of questions. Accordingly, the registration and screening process for a non-pensioner or non-healthcare card recipient should involve an indication of financial contributions on the phone, followed by an automatic letter generated confirming financial contributions, including with an opt-in consent around checking information against ATO held data.

COTA believes that in any future system there should not be a distinction between 'My Aged Care' and 'Department of Human Services'. Consumers should give their information once to the Government, be it over the phone with My Aged Care, in person when speaking with their Assessor and Case Manager, or via post to whichever address is used. The Government may behind the scenes elect to use two different teams to process financial eligibility from other systems, but the general public should not see the distinction.

The benefits of the screening function are that it:

- Provides consumers with clear, broad information about service costs to inform decisions
- Addresses eligibility for people without a Health Care Card
- Enables a transparent and timely pathway to more comprehensive assessment

Assessment and Case Management – a combined wrap-around approach

One of the criticisms of the current assessment process is its transactional nature. The system is also rightly criticised for fragmentation and duplication – where an 'assessor' completes the care plan, only for it to be ignored/changed by a 'case manager', only for a new assessment to be completed by a 'service provider' in relation to the individual services. COTA proposes that Case Management services be combined with Assessment Services from the earliest point of intervention. We believe that such an approach would transform consumer experiences from a transactional commencement into a relational one from the very beginning.

Developing robust consistent care plans and OHS assessments, conducted by the case manager/ assessor and provided to all service providers, will negate the need for reassessments. Should the advice of providers be that OHS assessments must be conducted by each provider, such an approach should be of the physical environment and not of the consumer. That is to say the consumer should not experience the additional assessment happening to them. If legislative changes are required to legally enable a service provider to rely on the OHS assessment of the assessor, then such changes should occur to remove the repetitive assessment of individuals by the system.

COTA envisages a future where at the point of registration an individual is allocated a case manager. The role of the case manager is to "walk alongside" the individual through the aged care system - from the beginning of the process through to at least six months after ongoing services have commenced, and to potentially be available on as 'as needs' basis thereafter.

The 'assessment and case manager' works with the older person in a consumer directed approach to optimise the experience; to guide and support the consumer's decision-making about care options and choice of service provider; and to support the older person to gain maximum benefit from the aged care system, acting as an advisor, coach and system navigator. Case managers also have a critical role in connecting older people with supports outside the aged care system that support their broader health, well-being and social needs. While some well informed and confident older people may only require short term case management (or hardly any at all – very rare), we recognise that some may require this level of support for longer periods of time. Case management should be available as the need arises or on an ongoing basis and the quantum of case management should be available based on assessed need, not based on a trade-off by consumers between services and case management.

Assessment provides a comprehensive, individualised assessment process based on consumer input and engagement to determine clinical need and other personal and social support. The aim of assessment is to support consumers to establish their current and ongoing needs, develop one care plan with agreed appropriate and preferred services, and to allocate appropriate resources. COTA notes concerns raised by some consumers who have been part of the 'active assessment' trial areas. COTA believes many of these concerns are linked to the transactional nature of an assessor only seeing you once. Asking an older person to show you how they get on/off the toilet, and in/out of bed can be humiliating when you've only met someone once. COTA envisages that by combining case management and assessment into one team, a deeper relationship between the older person and their case trained and empathetic manager/assessor is more likely to occur.

Similarly, an assessor/case manager will need to have a deep understanding of the geographical area in which they are working. Local knowledge about which organisations provide which services and how is essential and means such assessment services must be local if they are to remain effective.

COTA therefore advocates a combine wrap-around assessment and case management model that includes the following elements:

1. **'Reablement first' approach:** before assessment, reablement is strongly encouraged (unless there are clear medical reasons why it should not occur) enabling full assessment to be undertaken when the older person is most confident and to provide the most accurate picture of need, informed and directed by the consumer.

2. **Assessment and budget allocation:** single, individualised assessment and budget allocation with a range of mechanisms for consumers including:

    a. Vouchers

    b. Card

    c. Funding package with set price list

3. **Initial case management services:** (of no less than 6 months) to provide consumers with a consistent person to walk alongside them while they commence ongoing services.

The benefits of wrap-around assessment include:

- Changes to the assessment process shifts from a transactional approach to a relational approach by offering a case manager from day one for service navigation and assessment (provided at registration stage)
- Focused on consumer wellbeing and readiness for care services
- Separates case management from service delivery, particularly at the early stage, ensures that care and services are in line with consumer need and choice rather than provider capacity. It also ensures that vulnerable clients receive appropriate support
- Provides consumers with more effective choice and control over budget allocations for care and support
- Establishes a comprehensive single care plan based on a true reflection of consumer choices and ongoing need

An assessment organisation would also need to conduct some level of prioritisation of all new clients coming through to determine their acuity and need with clear timeframes of when any assessment must be completed. COTA would strongly urge such benchmarks are published for each region.

A note on the need for Assessors / Case Managers to be independent of service providers

COTA is of the very firm view that assessment services and case management services must be independent from service providers. Too often we hear of aged care provider linked case managers promoting their own organisation's services and/or interests over the needs or expressed preferences of the consumer, often at considerable difference in cost to the consumer's preference. This may include ACATs recommending residential care, seemingly to get consumers out of hospital beds and against their express wishes. Or it may be service providers strongly promoting their own organisation's services over another provider, to the point the consumer tells COTA they believed based on the conversation with the assessor they HAD to use that aged care organisation, or insisting that services be provided by their organisation rather than using a commercially equivalent service (e.g. a meal, transport) that is as good or better and costs less.

A redesigned aged care system must provide structural separations between case managers working exclusively for the benefit of aged care consumers, and any person employed by an aged care provider, or their parent and/or associated companies.

We note that the NDIS has taken a similar approach with all 'Local Area Coordination' (LAC) charged with supporting NDIS participants in developing their plan, finding and receiving services and reviewing the plan annually. COTA Australia understands that an organisation is ineligible to be a LAC provider if they or any of their related body corporates (i.e. subsidiary, or parent company's subsidiary) is also an NDIS Registered Provider of Supports in that area. This does not negate the suggestion that service providers should continue to provide *care coordination* services and be responsible for the holistic delivery of services which they have been assigned. Given that the individual person who performs 'case management' functions within an organisation is rarely the person who provides day-to-day services to the client, it is possible that with stronger Business to Government IT systems communication from a front line worker employed by a service provider can be seamlessly relayed to a case manager employed by the assessment and case management provider.

The delivery of a truly independent case manager/assessor may change the type of cases that present through the National Aged Care Advocacy Program (NACAP) and may require legislative changes to enable a case manager to make a complaint to the Aged Care Quality and Safety Commission (ACQSC) about a service provider, distinct from the consumer themselves. Similarly, as COTA has argued for some time, the role of NACAP providers and the ACQSC must be expanded to include these pre-service delivery stages of aged care, so that consumers may complain about their assessor and case manager to the ACQSC and seek support from their local NACAP provider.

System Navigation

COTA Australia notes the Department of Health will provide the interim report of the External Evaluators for the Aged Care System Navigators pilots to the Royal Commission. As lead contractor on behalf of a consortium of 30 partners delivering the pilots it is appropriate that COTA does not comment at this stage on the effectiveness of any model delivered by our partners in the trial over another.

However, COTA does make a systemic observation that if the wrap-around Assessment and Case Management model proposed above were to be adopted, the more intensive one-on-one navigation services may be more appropriately delivered by the Case Manager/Assessor, while the more educative/information type services could continue to be delivered by a network of navigators and local connectors.

Entry-level support stream.

4. *People maintain their homes and gardens, do laundry, cook meals, get themselves to appointments and attend social engagements across their whole adult lives—some people may choose to pay others to do these things—but mostly they handle them with little assistance.*
   As people age and need support with everyday living activities, how should Government support people to meet these domestic and social needs?

In your response, you may wish to consider the following:

- Should these supports be made available to everyone (or just those that cannot purchase assistance)?
- What are the most important early supports for people in their homes and communities? What evidence is available on how these supports prevent or delay a move to permanent residential aged care (or support older people's wellbeing, health and functioning)?
- Are there some supports that need increased funding? Are there new or innovative approaches that should be recommended for inclusion in this stream?
- What are the advantages and disadvantages of block funding, providing cash or a 'debit' card with a fixed annual budget to eligible people or a mixed funding model (combining block funding with other approaches) for this stream?

The provision of social connection and social supports for older people has clear benefit for older people and the broader community. Maintaining social connections and being part of a community are essential for health and well-being. Government has a role to play in supporting and promoting broader community engagement, particularly at the local level.

We note the Royal Commission has identified entry level support across two broad group of services (community engagement and help at home) reminiscent of the former HACC and current CHSP programs. While these programs have historically supported large numbers of people, they are largely not consumer directed and provide limited choice and control for consumers.

Community Engagement

This stream of activity is designed to support older people's health and wellbeing and connection to community allowing them to continue to participate in community life. These social support activities, transport and centre-based respite should be subsidised and available widely. Access to these supports should not require any assessment beyond basic financial screening and as discussed above with some alignment to pensioner health care card entitlements. Simply put, those older people with a pensioner card / health care card would receive automatic access to community engagement services, while those without either card would merely need to complete their financial screening process in a streamlined manner.

There is evidence to suggest[3] that older people identify that problems and risks related to wellbeing, living circumstances and social participation are particularly important to them. Older people surveyed have said that professional help focusses too much on physical health, indicating that they

[3] Lette, M., Baan, C.A., van den Berg, M. *et al. Initiatives on early detection and intervention to proactively identify health and social problems in older people: experiences from the Netherlands*. *BMC Geriatr* **15,** 143 (2015) doi:10.1186/s12877-015-0131-z

prefer to get more practical support that would enhance their self-reliance, like advice and help with administrative tasks, finances or completing forms for services[4]. This suggests that supports available outside the formal aged care system need to be promoted and encouraged. The importance of social connection is further reinforced with older people saying they would like support in preventing or decreasing loneliness, for example by getting information about opportunities for social interaction with other older people.[5 6 7 8]

Help at Home

Once an older person requires individual supports such as domestic assistance, laundry or meal preparation requests for these services should be considered more than entry level supports. The majority of older people choose to remain in their own homes for as long as possible, however this is often contingent on access to suitable support that is responsive to their changing needs[9 10 11]

COTA Australia would suggest that the services identified by the Royal Commission under help at home are better treated in the same manner as other 'care' services as outlined by the Royal Commission. The one variation to this COTA would suggest that all levels of home modifications and assistive technology should be included within the same funding allocation within this investment stream (i.e. minor and major).

COTA notes the suggestion by some evidence to the Royal Commission that it is preferable to return to the old HACC approach for all entry-level services. In the old system, service providers were responsible for assessing needs and eligibility. COTA is unconvinced by such claims as too often under the old system consumers ended up with services they did not want or need, because they were the only services available to them. The introduction of assessments for CHSP services has exposed the inconsistency between 'need' based on the assessment and the availability of services. COTA would note that while there may not have been a national system of demand identifying issues, there was nevertheless a lack of transparency about how the system operated.

COTA notes that the issue of unmet demand in CHSP has not attained the same national attention caused by the home care package queue. Nevertheless, COTA urges the Royal Commission to investigate further and seek out evidence from the Department of Health in relation to the number of services approved via the Regional Assessment Service, compared to the number of services actually commenced in those regions. COTA remains dismayed that only basic client statistics have been published[12] in regard to CHSP, with no demand insights or comparisons between number of funded services in a region, compared with the number of 'approved' services not yet 'commenced' via My Aged Care.

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[4] ibid.

[5] Hoogendijk EO, Muntinga ME, van Leeuwen KM, van der Horst HE, Deeg DJ, Frijters DH, et al. *Self-perceived met and unmet care needs of frail older adults in primary care.* Arch Gerontol Geriatr. 2014;58(1):37–42.

[6] van Kempen JA, Robben SH, Zuidema SU, Olde Rikkert MG, Melis RJ, Schers HJ. Home visits for frail older people: a qualitative study on the needs and preferences of frail older people and their informal caregivers. Br J Gen Pract. 2012;62(601):e554–60.

[7] Ibid.

[8] Bindels J, Cox K, De La Haye J, Mevissen G, Heijing S, van Schayck OC, et al. *Losing connections and receiving support to reconnect: experiences of frail older people within care programmes implemented in primary care settings*. Int J Older People Nurs. 2014;10(3):179–89.

[9] Productivity Commission. *Housing decisions of older Australians*. Canberra: Productivity Commission; 2015.

[10] Cutchin MP, Coppola S, Talley V, Svihula J, Catelier D, Shank KH. Feasibility and effects of preventative home visits for at-risk older people: design of a randomized controlled trial. BMC Geriatr. 2009; https://doi.org/10.1186/1471-2318-9-54.

[11] Wiles JL, Leibing A, Guberman N, Reeve J, Allen RES. The meaning of "ageing in place" to older adults. Gerontologist. 2012;52:357–66.

[12] See https://www.gen-agedcaredata.gov.au/Resources/Dashboards/Commonwealth-Home-Support-Programme-aged-care-serv

We remain deeply concerned that transferring domestic assistance, laundry, meal preparation and minor home modifications/assistive technologies to the pre-assessment stage of service delivery will not provide consumers with the necessary support within the system.

Funding mechanisms

Consumers of taxpayer subsidised aged care services should contribute to the cost of the services they use according to their capacity to pay. Services should be available to all on the basis of their eligibility. Safety nets for vulnerable consumers are essential and those who cannot afford to pay a fee should not be denied service.

COTA Australia is supportive of an aged care 'debit card' for consumers, where they elect to self-manage some or all of their aged care services. A debit card has the advantage that it promotes and facilitates choice and gives more control to the consumer providing greater flexibility of access to supports. If their use was widened to include commercial providers of some service types, such as commercial cleaning services or handyman services, this would increase the pool of available providers of these services.

The research undertaken by RMIT University on COTA Australia's "Increasing Self-management in Home Care Project"[13] demonstrated that consumers were able to undertake and manage a variety of activities to manage their own home care packages. More than 60% of consumers were using debit cards to pay for products and services relating to their care. More importantly, the research also found that no matter the level of self-management – one activity or many – consumers reported higher levels of satisfaction and wellbeing. It is not surprising that people reported feeling better because they had some control over their care. In the case of a debit card, if each occasion of services was identified by its type and quantity, as a Medicare record does, it would provide government with a record, or part of the total record, of what service types were used, in what quantity and in what geographic locations. This could be achieved without requiring any additional reporting from service providers.

[13] https://www.cota.org.au/information/self-management-in-home-care/self-management-resources-and-tools/

Investment stream

5. *The benefits from regular and planned respite, reablement and restorative care are well documented, but the services are in short supply.*
   What incentives, including additional funding, could be introduced to encourage providers to offer greater and more flexible options, including major home modifications and assistive technologies, which meet the needs of the older person, carer and caring relationship?

In your response, you may wish to consider the following:

- How could existing restorative and respite care, as well as home modifications and assistive technologies, be reoriented so that they are proactive and preventative?
- What are the most important aged care interventions for people experiencing a crisis or sudden change in their circumstances? What evidence is available on how these interventions prevent or delay a move to higher level packaged care or permanent residential aged care (or support older peoples' wellbeing, health and functioning)?
- Are there specific interventions that need increased funding? Are there new or innovative approaches that should be recommended for inclusion in this stream?

COTA Australia supports the Royal Commission's Investment Stream service types as enablers for optimising an individual's capacity to live independently - they are important contributors to facilitating older Australians to stay safely within their own homes and connected to their communities. However, for these services to have a solid preventative impact they must be well knitted into individual care plans, be responsive to individual needs and preferences, delivered by a skilled, experienced and empathetic workforce, with the right attitudes, and available when required and accessible locally.

For this to become the norm older Australians need to be aware of the potential benefits of these services, confident in their right to expect them to be delivered as part of aged care service system's offering and, depending on personal circumstances, be confident that sufficient financial assistance to purchase the services will be provided when required. Building the confidence, knowledge and assured financial capability of the consumer population will incentivise providers to provide older Australians, and their informal carer network, with more flexible, individually tailored Investment Stream options.

Older Australians would clearly benefit from increased funding, as part of a suite of individually tailored care and services, for the provision of:

- **Individual capacity building (restorative and reablement)** – these are services focused on restoration and reablement. Individual capacity building also focusses beyond the physical function of the individual to support building the individual's knowledge and confidence, which is supported by a case management approach. This will necessitate a significant expansion of the availability and accessibility of allied health interventions — provided by best practice multidisciplinary teams readily available within the community and residential settings to help build and maintain individual independence and maximise functioning. For outer regional and remote areas investment will need to be directed to the development and maintenance of in-reach multidisciplinary allied health teams who can regularly respond to the needs of older Australians living in geographically isolated communities.

- **Assistive technology (AT)** — both major and minor; and inclusive of equipment and home modifications. As asserted in the referenced National Aged Care Alliance paper, there needs to be a more consistent application of AT resources and eligibility criteria. At present schemes across the states and territories have different budgets, scope, eligibility requirements and levels of subsidy. Plus, home care packages are not designed to be used as an AT program where larger AT items are being sought. In addition, state and territory aids and equipment and AT schemes having traditionally ruled older Australians ineligible for support if they are receiving home care packages levels 3 and 4 or residential care

Restorative and respite care

COTA would propose that 'restorative' care be relabelled as 'Individual Capacity Building' investment, given the strong negative feedback provided to COTA by consumers to the terms 'reablement' and 'restorative care'. We would suggest such a stream of funding within the investment stream should be separate from 'respite' and the investment made in informal carers. These may be better described as a suite of services under 'Support for Informal Carers' but would need to be clearly distinguished from the new Integrated Carers Support Services commencing in April 2020[14].

At present, the potential for older Australians and their informal carer network to maintain or enhance their health and wellbeing is too frequently lost due to the challenges associated with accessing restorative and respite care in a timely manner. The demand for these types of service is widely known and obvious, but the supply is far from adequate to meet demand and facilitate timely and meaningful access. Investment in increasing the supply of these services across Australia is an imperative for the aged care system.

Older people need to need to be conversant with the potential benefits of the range of services on offer and have full confidence that the service they choose will be available when and where required for the service to be cost effective and sustainable. Proactively promoting and encouraging older Australians and their informal carer network to consider positively the possible impacts that restorative and respite care could have on maintaining and/or improving their quality of life is essential but will only be successful if the services actually deliver.

In addition to a significant increase in the supply and availability of restorative and respite care:

- Assessment of the need and preference for these services should occur as part of the aged care wrap-around assessment process and be included in the development of all care plans
- Carers and their personal needs and support preferences must be identified at the beginning of aged care service provision for an older Australian and reviewed on a regular basis or when there is a marked change in family/carer circumstances and/or arrangements
- Services need to be readily and locally accessible when needed or, where/when this is not possible, appropriate and meaningful alternatives put in place until the required services can be accessed
- Greater investment must be made in augmenting the current allied health workforce and ensuring that is it has the skills and aptitude to work with and support older people within a rights-based, person centred practice approach

[14] See https://www.dss.gov.au/disability-and-carers-carers/integrated-carer-support-service-implementation-updates-and-information

Services offered must be designed to reflect older Australians' and family/informal carers' preferences. In relation to respite, a recent Australian study[15] focused on understanding carers' (of people with dementia) respite preferences found marked support for cottage respite over traditional respite in residential aged care homes. Cottage respite, albeit severely limited in supply, was evidenced in the study as not only effective in supporting carers to maintain their health and wellbeing but also in delaying the older person's placement in residential aged care.

Assistive Technology (including Home Modifications)

The Assistive Technology funding steam provides resources that enable consumers to more effectively self-manage their care needs. This includes the provision of minor and major technological devices as well as home. The availability of new and effective assistance technology is increasing rapidly and should be invested in to improve quality of life and reduce costs on both the universal and aged care service system.

One form of Assistive Technology is Home Modifications. Sometimes the best solution will be a piece of moveable equipment, other times the solution will be to modify the house permanently. The assessment for such a decision is often the same. We therefore submit that all assistive technology, including home modifications, whether minor or major, should be funded as part of a single stream of AT services based on assessed need.

National Aged Care Alliance commissioned research[16] demonstrated that small investments in assistive technologies, in addition to promoting more positive health and wellbeing outcomes for older people, can also lead to considerable economic benefits in reducing care cost over time. COTA Australia understands that home modifications is just one form of Assistive Technologies. Nevertheless, some home modifications can have a significant and enduring impact on an older person's independence, autonomy, safety and participation, and on assisting them to stay well and safe within their home. The provision of home modifications and assistive technologies need to be part of a suite of care services as an outcome of an individual assessment and should not require consumers to trade off other services in order to access Assistive Technology.

Home modifications and many assistive technologies - for example, aids and equipment and digital monitoring devices, are readily available to anyone who is willing and able to pay for these. However, for an individual to optimise the benefits and for taxpayers to be confident of subsidy wisely spent, consumers need to be supported to exercise choice and control. In terms of home modifications and some assistive technologies, occupational therapists (OTs) have a critical role to play in facilitating the environment that supports an older person to remain safe and well. In relation to older persons living in their own home, it is vital that an OT undertakes a home environment scan prior to service delivery to identify risks in the home. For example: addressing trip hazards — loose rugs, dangling cords, poorly placed small items such as coffee tables, chairs and beds needing a raiser to be at safe height — increasing useability — installing handrails, grabrails, ramps or door widening. Plus available evidence indicates small layout changes can make a kitchen safer for older people, including those living with dementia, and enable/re-enable them to undertake activities such as making a cup of tea, toast, some meal preparation.

Response after a crisis

A range of supports, depending on the particular type of crisis/ change in circumstances may be appropriate. These supports should be part of a suite of services designed to meet the needs of the

[15] J. Harkin et al., 'Perspectives of Australian family carers of people with dementia on the 'cottage' model of respite: Compared to traditional models of residential respite provided in aged care facilities.' *Health and Social Care.* 2019. 1-12
[16] NACA Position Paper: 'Assistive Technology for Older Australians'. June 2018.

individual following an assessment. The assessment recognises that at crisis point the interventions and supports may be intensive and may then reduce or no longer be needed once the crisis is resolved. It should be recognised that an older person may take longer physically to recover from a physical injury or incident and that mental health and social issues must be addressed as a response to crisis. Immediate access to a range of services should include:

- respite care, particularly cottage respite
- allied health care — for example, dietetics, physiotherapy, speech pathology and/or psychology — focused on working with the individual to increase their independent functioning
- assistive technology, properly prescribed and implemented in a timely manner

Being able to scale service levels up and down is essential, and a review of an individual's assessed home care assistance type/level may be needed – to enable the purchase of the additional services/assistive technology. This reaffirms COTA's proposition that a combined 'assessment' and 'case management' model is preferable to enable the relationship approach to such reablement and restoration approaches.

The evidence on the effectiveness of the respite, reablement and restorative care interventions is varied and generally specific to particular population cohorts in specific care settings. In relation to assistive technology, the National Aged Care Alliance commissioned research and produced a substantial paper[17] investigating issues relating to the effective use of assistive technology (AT). This paper, the product of an extensive review of existing evidence and stakeholder engagement, has made a significant contribution to understanding the benefits of assistive technology (inclusive of home modifications). An upfront investment in obtaining the benefits — increasing and maintaining functional independence, slowing decline, decreasing falls — are identified as being cost-effective by offsetting health-related expenditure. For example, by minimising hazards that could lead to falls and secondary complications there is a resultant decreased need for health interventions such as GP visits, emergency presentations, or hospital admissions.[18] The paper stresses the importance of making AT options being available particularly in early intervention stages of disability/disease.

Investing in the provision of these services makes solid financial sense and acknowledges and protects older Australians' right to live well and die with dignity. Clearly, if the community/government is genuine in wanting older Australians to live in their own homes for as long as is possible, there needs to be the appropriate range of person-centred health and support services readily available within the community. Failure to deliver on this imperative will ensure more rapid demand for higher level packaged care or permanent residential aged care.

In relation to primary care, acute care and dental care, medical specialist care — cardiologist, gastroenterologist —the aged care service is not primarily responsible for the delivery of these services, but can and should facilitate timely and appropriate access. This needs to be acknowledged in aged care service funding.

[17] ibid
[18] Ibid. p.6.

Care stream

6. As people's needs increase and go beyond what can be managed with entry-level support or with their carer, they may need care services—personal care, as well as nursing and allied health.
What are the advantages and disadvantages of developing a care stream, independent of setting?

In your response, you may wish to consider the following:

- How could existing provision of personal care, as well as nursing and allied health, be reoriented so that they are focused on individual needs, and not on whether the older person is at home or in a residential facility?
- Is the concept of 'reasonable and necessary' as used in the National Disability Insurance Scheme applicable to the level of support that could be funded under this stream?
- What should be the eligibility or threshold for accessing this stream?
- What are the advantages and disadvantages of block funding, providing cash or a 'debit' card with a fixed annual budget to older people or a mixed model (combining block funding with other approaches) for this stream?

Care should encompass all individual care that is required by and delivered to the individual. As previously stated, dividing care into entry level and more comprehensive would be confusing for consumers and does not assist the simplification of the aged care system. Levels of care and support needed are not static. The needs of older people change over time, for example with periods of intense support following a crisis or life change. It is envisaged that care planning and supports provided are dynamic and responsive to individual need.

The new aged care service system should have a dedicated funding stream for care supported by other funding streams that support consumer access and engagement with the system and enhance the quality of life of older people. Care services are supported by case management, assistive technologies and home modifications; and are provided regardless of accommodation setting.

New approaches to accommodation and new models of accommodation are already part of the aged care system and with the removal of system constraints even more will emerge as central to rather than marginal to the system. However, the provision of care should not be fundamentally altered by the accommodation setting and funding for care should be agnostic of care setting. COTA supports the Royal Commission's recognition that there are three type of care and services provided under the care stream of funding (noting that community engagement should be available before assessment and continue to be available regardless of assessment outcomes):

1. **Help-at-Home / Basic Care** (e.g. domestic assistance, meals, laundry, shopping)
2. **Personal Care** (e.g. showering, toileting, dressing and eating)
3. **Nursing and Allied Health** (e.g. wound management, medication management, podiatry, physiotherapy)

In addition, separate funding should be available for Case Management (including supporting consumers to build confidence in managing and navigating their own care needs): specific focus on supporting vulnerable populations to access care and those requiring intermittent intensive support i.e. following a crisis.

Case Management

Case management supports consumers to engage with, access and navigate the aged care service system at the local level, to inform and advise on care decisions related to care plans and provide ongoing assistance to people who may move in and out of the aged care system. Case managers support consumers to make decisions and take actions regarding their assessed care needs and goals as defined in the care plan. It is critically important that case management which includes system navigation, provide support to older people to make decisions about care. This is particularly important to support vulnerable populations. Case management must be funded separately to care.

When older people reach the care delivery stage, they may choose to retain the case manager who supported them through the assessment phase or choose a new case manager. Case management supports consumers to access aged care services more effectively to address their care needs. Additionally, it also can connect consumers to services that are available outside of the aged care system that improve their health and wellbeing and may fully or partially divert the consumer from needing aged care system services.

Regardless of whether they continue to use the case manager who was their assessor, or they elect to choose a new case manager, COTA firmly believes that all case managers should be structurally separate from service delivery partners.

Specialist and in-reach services

7. How could the aged care and health systems work together to deliver care which better meets the complex health needs of older people, including dementia care as well as palliative and end of life care? What are the best models for these forms of care?

In your response, you may wish to consider the following:

- What would be required to support in reach of multidisciplinary health teams from the health system in the care of older people with high needs? What other services could be used (24/7 on-call services, embedded escalation to specialists, access to relevant ageing specialists, telehealth or other technological advances)?
- What is needed to ensure greater uptake of in reach health services (such as specialist palliative care) and aged care specific services (such as Severe Behaviour Response Teams and Dementia Behaviour Management Advisory Services)?

Residential aged care residents, despite having highly complex and multiple health care needs, frequently receive poor and inequitable access to publicly funded health and specialist medical services. This experience is common across all tiers of health care, including primary health care, care delivered by medical specialists and acute care provided in hospital settings, and is more pronounced in outer regional and remote areas. In addition to denying older Australians their human right to access high quality health care on the same basis as other Australians, this *patchwork quilt* approach to health care severely impacts their health and wellbeing including their capacity to die well and with dignity.

Attempts to fund and deliver stand-alone Australian residential aged care health services are unlikely to achieve the desired outcome and could result in the increased marginalisation of older Australians, and further entrench their experience of community isolation. A more workable and possibly cost-effective alternative is the development of multidisciplinary health in-reach models. Rather than placing the onus on the older person to travel to access health care, in-reach care models aim to surround older people with the suite of health and specialist medical services and skills that best complement their needs and preferences. In-reach health models open the aged care sector to participating reciprocally with health service providers in an effectively structured arrangements that deliver consistent care pathways across the continuum of care. They have the potential to provide older Australian living in the community or residential aged care homes with the health service capacity commensurate with the complex multidisciplinary, interventional and palliative management needs of current aged care consumers. Such models also enhance the aged care sector's capacity to coordinate high quality programs for the prevention and early treatment of acute medical problems and are more in keeping with community expectations.

The optimum success of health in-reach models would be contingent on the development of comprehensive multilevel collaboration and coordination protocols across the aged care and the health systems, operationalised at the local community level, and the capability and support structures to bring together at short notice the appropriate medical knowledge and clinical skill mix required to respond.

While open to the exploration of new approaches such as the multi-disciplinary team being proposed, COTA strongly believes that older Australians have the human right to access healthcare services like any other member of the Australian public, and our concern is that this does not now happen. Past examples of creating a separate system for older Australians has often resulted in substandard levels and quantum of healthcare services for older Australians. COTA would urge the

Royal Commission to adopt strong protection mechanisms to monitor and protect against substandard levels of health care provision being developed inadvertently as part of any recommendation's implementation.

Building on current system infrastructure, primary health networks (PHN) could be held accountable for facilitating a more open and collaborative interface between aged care providers and health services. PHNs, working in partnership with local constituencies including older Australians, could be invested with systemic responsibility for enabling inter sectoral coordination to ensure older Australians requiring access to health care receive the right care, at the right time in the place of their choice.

The efficient operation of in-reach health models would be dependent on locally based 24/7 service access platforms – telephone and electronic – staffed by clinically qualified professionals. These would triage and prioritise calls and depending on the outcome either activate or escalate pathways to coordinating the appropriate skill mix required to respond. At times other than crisis, the access platforms would also facilitate the ongoing provision of required care inclusive of regular reviews of individuals' care needs.

The development of finely tuned service access and/or escalation pathways is critical for the success of the in-reach model. Given the diversity that exists within and across communities, while adhering with best practice approaches, service access pathways would need to complement local circumstances. A possible way forward would be for PHNs at the LGA or the SLA level, to collaborate with local aged care and health care services on developing consistent and effective lines of communication that will support and enable the timely availability of multidisciplinary in-reach health teams that have the potential to comprise the continuum of publicly funded care services for older people. Particularly in outer regional and remote areas this will require the use of innovative communication and risk mitigation pathways to ensure the timely alignment of the right skill mix and expertise to appropriately meet the immediate and then follow-up health care needs of individuals requiring care.

Limiting some services

Older people should be able to access the services they require when they need them regardless of where they live. Ideally, services should be provided locally to meet the needs of older Australians - the complexity of an individual's needs should not exclude them from accessing the full suite of local services that meet their assessed needs and enhance their health and quality of life. However, realistically, even with the aid of technologically, this is may be unachievable.

Greater investment needs to be made in providing a more equitable spread of services and capacity across the country. In outer regional and remote areas there needs to be a greater emphasis on building local inclusive service hubs/centres that work either directly or with the support of technology to keep within the community connected to quality health and social support services. In relation to supporting older people, in addition to having aged care workers these hubs would need to have access to an experienced and skilled health team, including a general practitioner and allied and nursing practitioners, and strengthened by regular input from specialist medical teams. The hubs would also need to be integrated into local public hospital networks. The coordination between aged care and health care could be managed by the Primary Health Networks.

In situations where the best efforts to complement community expectations do not result in the older person gaining access, either directly or through the use of telemedicine, to an appropriate standard of quality and safe care, it is appropriate the person and, if appropriate, their informal carer network, have access to consultations with aged care clinical specialists to determine the best way forward.

Designing for diversity

8. Caring for people with diverse needs and in all parts of Australia has to be core business—not an afterthought. How should the design of the future aged care system take into account the needs of diverse groups and in regional and remote locations?

In your response, you may wish to consider the following:

- What role can the following interventions play: appropriate pricing to meet the differential costs of service provision where they exist; removing communication and other barriers; enhancing the understanding of the role of intersectionality, culturally safe care and of trauma informed care; flexible service models; and increasing accountability of the system?
- What interventions are required to meet the challenges of ensuring access to aged care in regional and remote areas? Are different funding models required? What role is there for technology in improving access? What other supports or interventions would be useful?

Older people are not a homogenous group. They have been shaped by diverse backgrounds and lifetimes of widely varied experience. Diversity is reflected in religion, spirituality, sexuality, culture, socio-economic background, geographic spread and family and personal experiences. An approach that individualises assessment and supports an older person to navigate the aged care system through case management will improve the experience for more vulnerable older people. An individual approach supports greater choice and control and leads to enhanced health and wellbeing outcomes.

COTA Australia previously called for a system of "Integrated Consumer Supports" that would assist consumers in feeling and being empowered to navigate and improve the aged care system[19]. As previously noted COTA's original submissions to the Productivity Commission 'Caring for Older Australians' Inquiry called for an aged care Gateway that included a substantial localised face to face component, but this did not happen in Living Longer.Living Better. Older Australians have always told us that they want more than online and telephone information, especially in the first instance, and experience with My Aged Care has reinforced this. Face-to-face contact is highly valued. Using existing infrastructure and local points of contact are highly favoured. We support FECCA's promotion of existing networks of ethnic community groups and ethnic seniors' groups as trusted points of contact for information and guidance. These points of contact are often conduits to accessing services for older people from CALD backgrounds.

The Aged Care Sector Committee's Diversity sub-group has driven the development of the "Aged Care Diversity Framework"[20] and subsequent actions plans[21] for older people with diverse characteristics and life experience. The Framework and the action plans are a valuable resource and guide in supporting consumer centred practice in service delivery as are other resources such as the "Inclusive Service Standards"[22]. Systemic approaches that transform services to be more welcoming, accessible and safe are vital.

[19] See https://naca.asn.au/wp-content/uploads/2018/11/NACA-Integrated-Consumer-Supports-Discussion-Paper-1.pdf
[20] https://agedcare.health.gov.au/support-services/people-from-diverse-backgrounds/aged-care-diversity-framework
[21] https://agedcare.health.gov.au/support-services/people-from-diverse-backgrounds/aged-care-diversity-framework-action-plans
[22] Centre for Cultural Diversity in Ageing, http://www.culturaldiversity.com.au/service-providers/inclusive-services-standard

The nature of services in rural and remote areas requires alternative approaches and funding. The issue of funding is explored in response to question 9 on financing approaches for 'thin markets'. A model that has currency and seems to be effective in remote areas is Multi Purpose Services (MPS). While we understand that there are still challenges in rural and remote areas, and with some MPSs being in the wrong places, the mix of services delivered through the MPS approach appears to better support care outcomes for older people in these areas. The MPS program has just recently been reviewed and the outcome of the review should be closely examined to assess the longer-term viability and suitability of this model for rural and remote aged care services. COTA notes that currently MPS consumers are asked to provide a different financial contribution than rural aged care service consumers. We would suggest that any future use of MPS should have equal treatment of financial contributions.

More broadly, COTA believes in the principle of equity, whereby if additional costs are incurred to deliver the same outcome this should not be borne by the consumer. For example, costs of travel in rural areas, cost of interpretation and translation (including translation of printed materials into appropriate mediums for people with vision impairment) should not be at the expense of individual consumers.

Financing aged care

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

Consumer Contributions

A foundation principle of funding should be that consumers of taxpayer subsidised aged care services should contribute to the cost of the services they use according to their capacity to pay. This recognises that:

- contributions should be equitable and proportional to services received, and
- current levels of taxpayer support are likely to be unsustainable into the future.

More broadly, an equitable assessment of capacity to pay should have regard to total wealth regardless of the form in which it is held (real property, cash, equities, superannuation, etc). There should also be consideration of existing financial assessments such as those conducted by Centrelink at the three points of full age pensioner, part age pensioner, no pension but Commonwealth Seniors Health Care Card recipient. Such an approach may consider alignment of these financial points with any tapered amount of client contributions towards care.

The levels of user contributions and the public/private share is a political decision. Such decisions are informed by sophisticated modelling by experts in means testing policy, including the use of appropriate tapers related to levels of wealth. Appropriate levels of consumer contribution based on wealth rather than income only also depend on appropriate and efficient financial products being available to consumers to allow utilisation of asset value.

Reforming the way client contribution amounts are presented

An option for consumer contribution could see the taxpayer subsidy and the consumer contribution set by Government. The way client contributions are set today is confusing for consumers and the 'basic fee' and 'income tested care fee' appear to many consumers to be a dual charge. On top of this consumers who contribute additional services and/or incoming refundable accommodation deposit feel like all the system does it take funds from them. Furthermore, some means testing arrangements (e.g. the part inclusion of home value in residential care) are severely regressive and unfair.

COTA suggests that there are a range of ways this could be improved. This includes:

- Assigning a self-funded retiree amount (i.e. full contribution amount) and a 'concession' amount (i.e. amount paid by full pensioners, part pensioners and health care card recipients). This would leverage existing and widely understood distinctions.

Combining all calculations behind the scenes and presenting each consumer with the cents in the dollar amount they will pay, compared to the contribution Government will pay for all amounts or individual service types. This could be presented as either c/$ or as a percentage rate. In this option the Government defines the subsidy that it pays for a certain individual with the subsidy reducing depending on the means testing component for the consumer. The fee is set and expressed as a value of cents in a dollar. As the value of the service rises, the cents in the dollar ratio remains and the consumer will contribute more for higher levels of service. So, consumers contribute based on

their capacity to pay and a consistent methodology is used to calculate fees. Expressing the contribution as cents in the dollar is easy to understand and provides more clarity than a contribution expressed as a percentage.

In developing a more robust, equitable, fair and sustainable user contributions system for aged care government will have to ensure that there are very strong consumer protections, and a genuinely competitive market in place to prevent price fixing, price gouging, over pricing, charging for services not used by the consumer, and removal of choice. Consideration will need to be given to ensuring no consumer experiences catastrophic risk. COTA will discuss this further, along with the conditions on which provider pricing could become more flexible, in a later paper on the funding and financing of aged care.

Considering alternative funding methods

Changes to retirement income policy and more comprehensive planning for retirement could see increases in the superannuation guarantee being linked to provisioning for the funding of potential aged care. This is a question COTA understands will be explored by the current Retirement Income Review and then by government as it considers the implications of the Review's report in mid-2020.

In this option when the compulsory superannuation guarantee scheme is fully mature government would mandate that a portion of the individual fund would be quarantined for use by the superannuant in retirement to help meet their future aged care costs. The structure of retirement products could allow for self-funding of aged care reducing the need to access taxpayer subsidised services or higher contributions to taxpayer subsidised aged care services.

This may simply be a hypothecated fund within a person's overall superannuation or may be a requirement that older Australians at the point of retirement purchase a 'longevity health and aged care insurance' product. Utilising an insurance approach would enable a community pooling approach to aged care funding in order to smooth out the individual's contributions between high needs and low needs in aged care, or no needs. Overall this approach would be more efficient, cheaper and less complex. The options of including health care costs, or limiting this to just aged care, should be considered as part of any future modelling.

Government Contribution

As the Royal Commission articulates a new standard for care in aged care it will necessarily mean that the overall cost of aged care services will increase. COTA supports those with means providing an increased contribution towards their care, provided the necessary safety nets are included in any such approach.

However, COTA also believes that the probable amounts that can be raised from higher user contributions are most unlikely to ever cover the increased funding required for a highest quality aged care system (even if there is a more robust and equitable means testing regime, and when the compulsory superannuation is fully mature, and if policy settings were changed to ensure preservation of some funds for aged care).This means that Government's annual contributions towards aged care will also need to increase - and increase substantially. Our views are subject to the outcome of detailed economic modelling for which we do not have capacity, but we hope that the Royal Commission will commission and share.

Currently aged care funds are contributed from general revenue, allocated on an annual basis and in the Forward Estimates. COTA is concerned that continuing to fund aged care on this basis runs the risk of any future Government seeking to reduce Government contributions, if not nominally then in failing to fully provide for increased numbers of consumers. Accordingly, we support exploring

whether there is merit in an 'insurance' style scheme similar to the NDIS whereby funds are taken from consolidated revenue into a dedicated fund able to be used exclusively for that purpose.

Associated with such an approach may be an increase in the Medicare levy for a limited time, to provide extra funds above current allocations. We understand estimates for a 0.5% increase to the levy are only around $2 billion per year, which is unlikely to be enough to fund increased ongoing aged care costs and higher standards, even with stronger user contributions. However, it would ensure that the broader community was seen to invest in the value of aged care in a contributory way beyond simply paying their taxes. This could be an important step towards increased respect for older people.

Funding Service Providers

COTA Australia does not support the continuation of block funding of services as it currently occurs. Firstly, this funding approach is inflexible, and encourages behaviour that is not consumer-centric. It is a system in which the funder and /or provider dictates, rather than the consumer driving the choice of services to be provided and the way in which these will be delivered. Secondly, older Australians have repeatedly told us that it is a model that discourages innovation in quality of services and/or service design. Grant funding is guaranteed with a regular income, regardless of the quality, or lack of it, of their service delivery. There is no impetus for quality improvement, originality or responsiveness in relation to consumer issues. Consumers are not able to exercise choice and control over their care and service options.

That said, COTA also recognises that certainty of some funding encourages providers to invest in program development, while purely competitive marketplaces may cause providers to focus solely on client acquisition. One way of promoting greater consumer centricity and innovation is to use an **enrolment** approach to service funding. Government may stimulate interest and competition amongst providers by calling for tenders for a range of services needed in a region or across regions and then appointing a number of service providers eligible to receive taxpayer subsidies for aged care services. Consumers choose provider/s and 'enrol' in the service. Providers only receive a subsidy for the amount of enrolments they receive at the rate per enrolment they provided in their competitive tender process. Tenders would be repeated on a three-yearly basis in order to ensure value for money is maintained. Service providers who are innovative and provide a consumer centric service are rewarded with enrolments.

Thin markets

Funding approaches may need to vary to address thin or niche markets. In existing 'thin' markets in rural and remote areas, individuals already geographically disadvantaged in their access to services are less likely to be able to exercise true choice and control.[23] Similar approaches may be considered in thin markets for diverse populations where limited competition may occur of an appropriate culturally competent nature. However, COTA notes examples of consumers in rural and regional areas having access to a choice of service providers for the first time, after the February 2017 changes, and other examples of Aboriginal communities pooling Home Care Packages to create adequate service provision in the area for the first time. Whether a market is genuinely "thin" needs to an evidence based decision, not a theoretically based assumption, and even then measures must be in place to maximise consumer choice and control.

[23] Carey G, Malbon E, Reeders D, Kavanagh A, Llewellyn G. Redressing or entrenching social and health inequities through policy implementation? Examining personalised budgets through the Australian National Disability Insurance Scheme. International Journal for Equity in Health 2017; 16(1): 192. https://doi.org/10.1186/s12939-017-0682-z PMid:29110663

The design of the aged care system needs to ensure that it delivers services to all people assessed as in need of support and care. This may mean:

- Government guaranteed levels of funding, which could include increased prices on a competitively tested basis, in areas where services might not have otherwise been provided.
- Dedicated funding for services targeted to special needs groups, where competitive approaches do not achieve quality service delivery consistent with consumer preferences.
- Ensuring that prices and supplements are adequate to meet the increased cost of specialist service delivery for consumers with special needs.
- Addressing historic funding anomalies that have created inequitable service distribution patterns across the country.

NOT COTA's FULLY DEVELOPED POSITION ON FUNDING AND FINANCING AGED CARE

This section is not a full explication of COTA's position on the funding and financing of aged care. We understand that the Royal Commission is developing another consultation paper on that subject for release in the reasonably near future. We will reserve aspects of our position on funding and financing until we respond to that paper. We are still consulting on some aspects of our position, although many of the fundamental principles are incorporated in this section and have been publicly articulated by COTA Australia for many years.

Quality regulation

10. How would the community be assured that the services provided under this model are delivered to a high standard of quality and safety?

In your response, you may wish to consider the following:

- Is there a case for different regulatory approaches based on the nature of the service provided rather than the location in which the service is delivered?
- Should some services only be provided in particular locations with appropriate support? Do some people have a complexity of need that would influence the location in which care is delivered to ensure quality and safety?
- How could a regulator assess the quality and safety of personal and nursing care and allied health services provided in people's own homes?
- Would the allocation of funds to older people rather than providers change the need for regulation? What kinds of consumer protection would be required, and would this apply to all services, or just some?

A regulatory approach must reflect that consumers want to exercise more choice and control with some safeguards. Service providers often cite the cost of regulation as one of the drivers of these cost differences. While regulation must ensure that services are safe COTA recognises that regulation should not be so onerous that it unreasonably increases the cost of services.

COTA recognises that there is a range of regulations sitting across different regulatory settings including:

- The Aged Care Act (and associated subordinate legislation)
- The Aged Care Quality and Safety Commission Act (and associated subordinate legislation)
- The Aged Care Standards
- Aged Care Charter of Rights
- Commonwealth Home Support Program Manual
- Federal non-discrimination legislation
- State building regulations
- Local council food regulations
- Industry workforce registration schemes (e.g. nursing board, allied health registration and proposed personal care worker registration).

COTA recognises the patchwork nature of regulation across different parts of the system and suggests the development of an aged care regulatory framework would help explain how quality systems may apply in aged care, but not be directly regulated by aged care. This framework, the product of a codesigned process, would advise all stakeholders of their rights and responsibilities in relation to the provision of quality, person centred and safe aged care service and be accompanied by a mandatory code of practice. The proposed aged care framework would need to be reinforced and supported by a range of assessment instruments that provide stakeholders, including in particular older Australians, with a multi-perspective critical analysis of the quality and the safety of care provided and experienced.

COTA believes the Aged Care Act must be rewritten from scratch, recognising that some consumer protections may be derived from places other than the Aged Care Act, utilising existing regulation. Government regulation of some form would continue to be needed to:

1. Ensure the provision of high quality and safe services
2. Facilitate sector wide uptake of continuous improvement based on best practice approaches
3. Maintain safeguards for all older Australians receiving services, with particular attention to the vulnerabilities of those who are financially or socially disadvantaged.
4. Guard against financial exploitation of consumers. (e.g. this could include setting maximum administrative costs)
5. Facilitate provision in areas where there is an insufficient supply, or the mix of services falls short of meeting local demand
6. Protecting consumers from exploitation when changes to personal circumstances require amendments to existing service provision

Different regulatory approaches for different services

COTA does not support a different regulatory framework for different services, however it does support variation in how the regulatory framework applies to different services.

Clearly a company providing lawnmowing services as a subcontractor should not be required to demonstrate its financial viability, HR practices and other more onerous regulatory requirements compared with a company whose sole purpose is to provide personal aged care services. The lawnmowing company services can be easily replaced if it fails commercially and the services are not day to day critical, whereas the personal care service may be day to day critical and not easily substituted in many circumstances.

Perhaps more importantly though is what extra-organisational governance structures does that professional have in place governing their work. Most allied health and both levels of nurses have a registration scheme recognised by the Australian Health Practitioner Regulation Agency (AHPRA). However personal care workers do not. COTA strongly supports the development of an industry registration scheme for all workers in aged care. Such a mechanism would enable quality measures to be considered at the individual worker level, rather than the organisation wide level where appropriate.

Personal and nursing care

In relation to assessing the quality and the safety of personal and nursing care and allied health services provided in people's own homes, there are several ways that could be successfully undertaken. Learning from other sectors, and to a lesser extent, residential aged care, the two familiar ways are via consumer experience and satisfaction surveys and an external assessment of suite of performance indicators.

The Department of Health is already progressing a consumer experience and satisfaction survey gaining feedback on the quality and safety of aged care services provided in people's own homes. The survey needs to inclusive of all aspects of care and support. In terms of implementation, it would make sense that the survey be distributed, collated and analysed by the Aged Care Quality and Safety Commission (ACQSC). The survey results could be made publicly on the ACQSC's website or

inform the performance differentiation data that will allow consumers to compare services from July 2020.

The Department of Health is also consulting with stakeholders to supplement the current residential quality/clinical indicator set. The suite of quality performance indicators needs, as far as is possible, to be the same across all aged care services. Further development of the residential aged care indicators needs to consider applicability of the indicators across the aged care sector.

Service assessment against the performance indicators would need to be built into a service's accreditation process. Additionally, an evaluation could be triggered by the number of complaints being raised with the ACQSC regarding the quality and safety of care provided by a service. As with the consumer experience and satisfaction survey results, it is critical that be publicly available through the same channels and over time benchmarked against similar type service outcomes.

In addition to the above, community-based services could be invited to publicly showcase their service provision on the Commission's website. This would serve a range of benefits such as sharing of good practice and building service confidence in taking lead action in promoting service innovation.

In a similar vein, professional bodies could work with the regulator and consumer groups to develop quality and safety manuals to inform and guide practice. These would also assist in building consistent intra disciplinary knowledge and practice approaches, as well as enable older Australians and their informal carer networks to have clear expectations of how each professional group contributes to and collaborates on the provision of quality and safe health care.

Funding in the hands of consumers and regulation

The allocation of aged care funding to older people rather than to a particular provider can open the door to an appropriate balance between consumer choice and regulation. Where domestic assistance (cleaning) is engaged through the traditional model, it is appropriate that traditional quality assurance processes are complied with. However, where the consumer openly purchases a non-aged care provider in the open market (e.g. using an aged care debit card) it may be appropriate that lesser compliance is placed on that provider.

In the NDIS we see some variability in regulation to reflect that consumers wish to choose mainstream services for particular supports. Regulation should not unnecessarily inflate the cost of services for consumers. For example, we have heard from older Australians that in comparing services such as domestic assistance, a specialist aged care service provider may charge more than double a mainstream cleaning service, and often for a less satisfactory service. The same experience is reported by consumers in relation to services such as gardening and gutter cleaning.

COTA Australia's "Increasing Self-management in Home Care Project" demonstrated the important role of case management. The consumers participating in the project wanted support on their own terms and the role of the case manager was to coach, build capacity, advocate, navigate the system, advise and connect. When funding is in the hands of the consumer, the independence of case management from providers becomes more important in supporting consumer self-direction, choice and control.