

Aged Care Royal Commission

UnitingCare Australia summary submission, incorporating second response to investigation of the impacts of the COVID-19 pandemic on aged care services and response to Financing Aged Care (consultation paper 2)

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About UnitingCare Australia

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

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

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

We focus on articulating and meeting the needs of people at all stages of life and those that are most vulnerable.

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Executive summary

UnitingCare Australia believes that this is the time to lay the foundation for a more economically just and sustainable society that is better prepared for the future. We believe that reforms to the aged care sector have failed to deliver a system that meets community expectations because, in designing and implementing programs, governments have failed to take adequate consideration of the fact that the users of services exist in a broader social and economic context. This has enabled successive governments' failures to adequately fund critical services.

Modelling commissioned by UnitingCare Australia¹ demonstrates that:

- Australia has the highest institutionalisation rate of seniors at 6.4% of those aged 65 and over compared to other OECD countries, which average 3.6%;
- Australia has a relatively low expenditure per bed compared to other OECD countries, with an estimated spend of \$47,000 per bed compared to the average of \$62,000 per bed of the OECD countries analysed; and
- these factors are coupled with supply shortages of home care packages across Australia.

This apparent over institutionalisation of older Australians into permanent residential age care indicates that there is considerable capacity for further government investment into the aged care sector to reduce the high penetration rate of elders into permanent institutions and length of stay.

At the same time, Australia has the lowest spending as a proportion of GDP at 1.0 per cent amongst countries with similar funding models. UnitingCare Australia believes that Australia should maintain a funding model that makes services easily accessed by anyone, with the cost of adequate services borne by all taxpayers, not just service users. UnitingCare Australia supports consumer co-contributions to the cost of services in circumstances where a user pays approach increases equity and provided that it does not result in future disbenefit, for example where a co-contribution acts as a disincentive to use a service with long-term benefits.

This funding model exists in principle, however the public component cannot meet the goal of a single, universally accessible system, because it is underfunded. **UnitingCare Australia believes that the Australian Government must immediately commit to adequate investment to support current demand. This would require a restoration of the real value of expenditure on individual consumers, and proportionality between the size of the older population and expenditure.**

Given Australia currently has a higher proportion of older people living in residential aged care, we believe that the OECD average spend of 1.6 per cent of GDP should be considered a minimum spend that reflects systems with fewer individuals reliant on long term residential aged care. **We recommend raising the ongoing investment in residential aged care to the equivalent of 2 per cent of GDP in order that hours of care and allied health support in residential services**

¹ <https://unitingcare.org.au/wp-content/uploads/2020/02/190725-UnitingCare-Australia-INTERNATIONAL-RESEARCH-ALTERNATIVE-MODELS-OF-AGED-CARE.pdf>

meet community expectations, and immediately increase funding to home care services in order to improve access and reduce current unacceptable wait times. As the overreliance on residential care is reduced, we believe that the system can be more efficient and absorb growth in the population without requiring continuing increases relative to GDP i.e. can be maintained at 2 per cent of GDP.

This long-term vision for a sustainable system depends, however on:

- improved interface between, and equitable access to, disability, health and 'aged care' services to enable an efficient and effective system of services aligned to needs;
- government actions needed to improve security of income and housing, embed preventive health approaches, and achieve equity of contributions to services through an appropriate balance between taxation and means tested co-contributions.

Based on the community sentiment research published by the Royal Commission, we believe that elders in the community would welcome a model than enables them to access services as simply as they access Medicare—including the capacity to be 'bulk billed' but also with the understanding they may be charged above the rebate amount. Those with superannuation should be required to use it for living expenses, including the costs of ordinary health and domestic assistance services, potentially through imposition of the Medicare levy on superannuation incomes that are currently excluded from taxable income, or resource-contingent loans (similar to HECS, with costs repaid out of the individual's estate and therefore reflecting total wealth).

An equitable system is one that meets the needs of geographically and socially isolated communities and it is unlikely that this can be achieved by continuing to formulate public policy on the basis that services systems are independent of each other. The following figure represents the system we believe Australia needs, to be prepared for the future.

A platform for innovation and change: connect evidence and policy via the National Cabinet

Integrated services for older people

Align the health system to the needs of older people

Older adults get the health services they need - where and when they need it: they have access to clinical interventions that maintain their intrinsic capacity and enhance their experience of ageing

Build a sustainable long-term services system

Older people and care givers get the services and support they need to live with dignity and enjoy their basic human rights: sustainable and equitable systems and services improve services for older people with significant losses in intrinsic capacity and reduce the burden on caregivers

Research

Outcomes measurement and data collation

Ensuring the human resources necessary for integrated services

Community services

We believe that the experiences of many older people who are not connected to the aged care system—particularly those with weaker family or community connections—have not been well served throughout the pandemic. Seven areas that Ms Claerwen Little identified at the outset of the Royal Commission as being in urgent need of attention have been exacerbated by the pandemic. We therefore make the following recommendations for priority action in these areas.

Our recommendations

We recommend the following directions to the Royal Commission:

Recalling the ‘Ageing to our Full Potential’ work,

1. immediately, through adequate investment of government funding, lift funding to the sector to 2 per cent of GDP so that every older person has access to safe, reliable, and relational services when they need them to live their lives well;
2. begin the transition to the services system we need to live life to our full potential:
 - ‘second horizon’ (mid-term) reforms which see more effective investment, leading to an outcomes-based system that fosters innovation and investment in a wider range of options for consumers

- ‘third horizon’ (long term) reforms, through which we see genuine ‘consumer direction’ of services achieved by a seamless interface between the range of services individuals need, regardless of age;
- 3. remedy lack of security of income and housing, and equity of contributions to the cost of public services, through appropriate public policy that complements the framework of health and community services provision; and

To address the absence of leadership around a dialogue respecting rights and adjusting inequities:

- 4. support intergovernmental cooperation as a necessary foundation for adapting to demographic change;
- 5. articulate the role of local government in preparing for future population needs;
- 6. endorse the EveryAge Counts aim: whole-of-government action on ageing and ageism, and that governments maintain a ministerial position responsible for ageing and older Australians, which has cross-portfolio responsibility, to ensure that policies and programs take an integrated, life-course approach and aren’t relegated to siloed health and social welfare portfolios;
- 7. recommend a review of government policies and programs with the aim of removing ageist differences in access to public services and entitlements;
- 8. identify opportunities to build on the renewed sense of community that we are experiencing in the ‘COVID era’, for the benefit of older and younger people alike, and reflect the recommendations at Appendix 1 in recommendations on emergency preparedness and response;

To address the lack of government funding to provide care and unwillingness to discuss funding options involving greater consumer contribution:

- 9. recommend a mix of funding arrangements, rather than a ‘one size fits all’ approach, that meets the following aims:
 - to enable consumer choice, including a range of individual, community and large-scale service arrangements
 - to reflect measures of staffing adequacy (levels and mix) and other quality indicators and to ensure that funding is adequate to meet the actual cost of care
 - to provide incentives to expand the range of flexible accommodation and care options, including high-level care funding in a range of settings in the community
 - to optimise equity of private/public funding balance and align with retirement income policies
 - to simplify assessment processes to complement individual strength-based planning approaches and a navigation platform that permits consumers to access information and receive advice on the spectrum of services available to them;

10. specify expectations as to the nature of services that providers may be accredited to offer and an effective model to ensure that the range of services required by individuals is in fact provided, with reasonable accessibility;
11. specify the basis upon which governments should determine access to and levels of subsidies—that is, the circumstances in which subsidies are warranted, based on individual consumer need and public benefit principles;
12. recommend methods of delivering subsidies that remove constraints on the operating models open to providers and ensure equivalence of revenue from ‘like’ services, whether they are delivered in health, disability or community service contexts;
13. recommend Budget allocation options that overcome the problems of capped supply such as under-provision of community-based services and underfunding of residential care services, while enabling the community to establish the desirable balance between service types;

To address the lack of co-ordination between agencies and services:

14. recommend structural changes that enable individuals to access and navigate services via a single—preferably local—process;
15. recommend structural changes to remove barriers to choice, particularly those that result in inequitable access to health services or differential treatment based on age (for example the arbitrary cut-off of access to the NDIS);
16. recommend structural changes to reduce duplication and inconsistency of regulation across jurisdictions and between levels of government;

To address funding and regulatory regimes that maintain the status quo and discourage innovation:

17. recommend a real and transparent ‘needs-based’ approach to funding, that responds to the need to meet future community and individual expectations, not the cost of continuing to deliver the existing range of services and the current standard of care;
18. identify a pathway to transition to a system in which there is a range of services that can respond flexibly to individual need, without compromising continuity of care;
19. outline regulatory arrangements that protect the rights and interests of vulnerable individuals, whilst enabling service providers to implement best practice approaches to supporting the ageing process;
20. support research and development investment in transformative design, infrastructure and service models;
21. support investment in scaling up demonstrated, innovative programs;

To address absence of agreed outcomes and how they are measured:

22. address the need for development of measurable quality of life outcomes that can be contextualised within a continuous improvement framework;
23. support the accreditation system as the primary point at which service quality and safety should be assured;
24. articulate the principles that would underpin a compliance system where publicly available, informative and contextualised benchmarking enables comparison of quality of life outcomes, sector wide continuous improvement, risk-based enforcement of quality standards and provision for earned autonomy;

To address gaps at all levels of the aged care workforce:

25. support implementation of the Workforce Taskforce Strategy and adequate government investment in critical elements, prioritising:
 - modernising and realigning VET, and providing advanced training in more complex areas
 - building workforce capacity and recognised aged care specific skills e.g. dementia care, end of life care, mental health, culturally specific care, rural and remote specialisation
 - developing training programs for volunteers and family members to maximise the benefits to consumers and carers alike.

To address significant gaps in the interface between aged care and other health systems:

26. advance the vision that it is possible in the long term to create an overall high-quality system that makes health, disability and social support services (including housing) accessible for anyone in Australia by creating pathways to:
 - identify cost effective opportunities to increase elders' access to some types of clinical services that can reduce the need for hospital admissions (for example portable x-rays or dialysis in regional and remote areas);
 - maximise use of preventive and enabling approaches to enhance the wellbeing of individuals, as part of broader population health approaches;
 - reduce the rate and period of hospitalisations by increasing supply of services (at assessed level of need, including where this means additional funding for services to support individuals with behavioural and psychological symptoms of dementia);
 - create the protocols and financial arrangements between jurisdictions that are necessary to ensure that access to clinical services can occur within the context of compassion and with minimal disruption;
 - create more holistic services through cooperation, improved interface and outreach, particularly in regional and remote areas or to meet the needs of specific groups or communities.

Introduction

UnitingCare Australia's purpose in making this submission is to bring together in a 'closing statement' our thoughts at this point in the Royal Commission's investigation. The experience of the COVID-19 pandemic has sharpened our perspective on the place of older people in our community and reinforced our commitment to achieving a framework in which individuals have access to services based on need. In addition, recently released Royal Commission papers on community attitudes to ageing and aged care and on financing of services, have led us to take a 'step back' for a moment to consider the system in the bigger scheme of things.

The Royal Commission's research papers four, five and six reflect that a key public conversation has not occurred: who is responsible for ensuring older people are cared for? Many comments in the reports would suggest that aged care is seen as a 'public good', and that it is the responsibility of governments to ensure that services are available. It seems it is not helpful to consider services to older people from the perspective of intergenerational 'fairness' however the research did not ask questions about the fairness of the taxation and welfare systems more generally.

The Aged Care Sector Committee (ACSC) Roadmap was intended to be a considered reconciliation of the views of stakeholders—including service operators and consumers—on the policy objectives that should guide an 'aged care system', but it failed to gain traction with government. The ACSC did not believe that they had the authority to consider interdependencies that affect outcomes for older people including health, housing, superannuation, and retirement incomes. Taxation more generally was not even raised as an 'intersecting' issue. The complexity that these interdependencies generate potentially explain why the research projects reflect ambivalence in the community: the answer to the question 'who is responsible for ensuring older people are cared for?' is probably 'it depends'.

The Aged Care Royal Commission has the capacity to make broader recommendations that embed their conclusions in a systemic approach to lifelong equity. Such an approach would better reflect the way in which social determinants influence consumer behaviour and consumer needs from conception to old age. Equity and ownership by the community are essential characteristics that a system must address.

In terms of economic inequality and equity of access to social resources, Australia is at a critical juncture. As the COVID-19 pandemic continues to unfold and economic recession sets in, decisions are being made that will play a decisive role in shaping economic inequality now and into the future. Government policy responses risk compounding or creating new inequalities and exclusions, with far-reaching consequences for economic recovery, social cohesion, and the extent and distribution of hardship. At the same time, the current crisis has increased awareness of the need for robust social protection systems and public services. While there are many challenges and risks, the current moment presents opportunities to enact policies that build a fairer, more equitable and economically-just society.

Pre-existing inequalities will likely deepen as communities and governments grapple with the economic consequences of the pandemic. Australia is potentially heading towards the highest

rate of unemployment since the Great Depression. A long tail of high unemployment is expected to persist for some years. Individuals who are now approaching retirement will be one of the most affected cohorts. At the same time, there is the threat of austerity cuts to vital social supports and services as the Government seeks to recoup a substantial budget deficit. Community services play a crucial role in mitigating economic inequality, yet many were already facing funding pressures prior to the pandemic.

In this context, there is a pressing need for public policy that has the key goals of sharing the economic costs and preventing an increase in poverty and inequality. UnitingCare Australia believes that this is the time to lay the foundation for a more economically just and sustainable society that is better prepared for future shocks. This cannot, however, be a conversation that weaponises intergenerational differences. It must be a conversation about the common good.

Principles of economic equity and implications for the aged care system

UnitingCare Australia has consistently advanced the position, in the context of reforms of financial aspects of the aged care systems, that the system must be considered in its totality. We also believe that there is a public role in funding essential health and disability services, on the basis of universal access.

The Uniting Church in Australia Assembly adopted, in 2009, the Statement 'An Economy of Life: Reimagining human progress for a flourishing world' and resolved (amongst other things)

To advocate social and economic policies which:

- *are based on relational rather than mechanistic models;*
- *support the growth of vibrant, safe and inclusive communities;*
- *overcome poverty and injustice, addressing, as first priority, the needs of people who are most vulnerable; ... and*

To call on Australian governments to develop economic systems and structures which recognise that human and ecological flourishing require much more than the creation of wealth by ensuring that public policy seeks to address first and foremost the wellbeing of all people, especially those most vulnerable... including:

- *regulatory reform of financial markets including systems of greater accountability;*
- *the reform of the Australian tax and transfer system to make it a progressive tool for the equitable distribution of wealth, including taxing the most wealthy at an appropriate level and providing adequate income support for those people who are most vulnerable and disadvantaged;*
- *the provision of universally accessible and affordable essential services such as water and electricity;*

- workplace relations policies which ensure just working conditions—fair and sustainable wages and conditions, with adequate protections especially for low-skilled low-paid workers, job security and predictability of hours;...²
-

These values are representative of the way in which the Church expresses its mission. It is an ‘outward looking’ mission that reflects the Christian tradition, but was born out of the Australian community, and values that the founding members considered universal. UnitingCare Australia and the services of the Church exist to pursue this mission, and these values constitute the prism through which UnitingCare Australia has considered all aspects of our contribution to the Royal Commission.

We believe that one of the key reasons that reforms to the aged care sector have failed is that in implementing programs governments have failed to take adequate consideration of the fact that the users of services exist in a broader social and economic context. General public ignorance of the existing system—including its reliance on public funding and relationship to the health system—has contributed to successive governments’ failures to prioritise the allocation of adequate funding to critical aged care services.

The Royal Commission’s research papers four, five and six bring to light issues that go beyond the remit of the Royal Commission, key amongst them the stress and anxiety many individuals experience when they contemplate their capacity to meet future needs, including needs for health services and the supports they will need to remain in the community. The Royal Commission paper on financing continues a conversation about a global approach to retirement incomes and financing aged care services that featured in both the Henry Tax Review and Productivity Commission review. We have not responded in detail to the Financing Aged Care paper in this submission, as we believe any response to the options considered would be contingent upon the services model ultimately adopted by government. This conversation should continue in parallel, once we understand the structural reforms that will transform services as the population ages. We have however suggested some further considerations in the context of the questions raised by the paper. **Annex 1** applies the principles of program design that UnitingCare Australia proposed in our January 2020 submission, and principles of funding design developed with other not for profit providers.

The impacts of the COVID-19 pandemic and implications for services for elders

We appreciate that the Royal Commission has initiated the process of learning from the pandemic immediately. As we now know, however, this will be a project well beyond the term of this Royal Commission. At this moment, responses to the situations thrown up by the ongoing pandemic

² *For a World Reconciled: Justice Statements from the Uniting Church in Australia 1977-2015*, Edited by Cynthia Coghill and Elenie Poulos, Uniting Church in Australia Assembly, 2016.

continue to challenge elders and service providers. We nevertheless hope that, out of the crisis, will come more opportunities to reflect on learning and accelerate change and innovation. There is the potential to take advantage of the disruption in ways that further our aspirations for the community, but also the risk that we will try to return to the status quo. UnitingCare Australia believes that in the final analysis we will be judged on how successfully we built on the opportunities presented, not by how quickly we 'returned to normal'.

The COVID-19 pandemic has impacted very significantly on older Australians. It has had specific impacts on users of aged care services, their families and circles of support and the related workforce. The vulnerability of older people to the novel coronavirus and the magnitude of the risks associated with the unpredictable and complex presentations of the virus itself have created a range of challenges that go well beyond those that are experienced when managing seasonal influenza or other infectious agents. For provider organisations the embeddedness in the service model of carers, family members, volunteers and members of the workforce who are not 'health workers' has created significant issues, as have the tensions of being considered a 'front line' service whilst working in environments not designed—or funded—to manage the health and social impacts of this virus.

An 'impact statement' highlighting the effects of the pandemic on various groups in the community is included at **Annex 2**.

As implied in our first submission to the Royal Commission regarding the impact of the pandemic,³ the situation has heightened and highlighted systemic issues including those relating to the fragmented approach to national and state/territory governments' responsibilities across the range of services needed by older people. It has also thrown into high relief the need for a community conversation about the services we expect to see provided in residential facilities, and how the government invests in those services.

The pandemic is ongoing and at this stage it is not possible for our network of providers to fully assess how the impacts on users (and potential users) of services, their families and our workforce will flow through to the sector. We also have limited capacity to assess the impacts of COVID on older people generally. We believe however that the experiences of many older people who are not connected to the aged care system—particularly those with weaker family or community connections—are likely to have been analogous to those of people with a disability, who have not been well served throughout the pandemic. This submission includes observations on what the experiences of individuals say to us about the need to 'mainstream' ageing as a constant in the life of the community.

³ Impacts of the COVID-19 pandemic on aged care services—June 2020. This and other submissions to the Royal Commission can be accessed at <https://unitingcare.org.au/royal-commissions/aged-care-royal-commission/>.

The transition that needs to start now

UnitingCare believes that we can achieve a system for future elders that places them at the centre, but this will take time and investment. Throughout this submission we will reiterate some of the key elements of our ‘vision’ that we consider must be implemented in the immediate future by relevant governments to begin a transition from the current public policy framework to one which is fitted to the Australia that will emerge over the next two decades.

Modelling commissioned by UnitingCare Australia⁴ demonstrates that:

- Australia has the highest institutionalisation rate of seniors at 6.4% of those aged 65 and over compared to other OECD countries, which average 3.6%;
- Australia has a relatively low expenditure per bed compared to other OECD countries, with an estimated spend of \$47,000 per bed compared to the average of \$62,000 per bed of the OECD countries analysed; and
- these factors are coupled with supply shortages of home care packages across Australia.

This apparent over institutionalisation of older Australians into permanent residential age care indicates that there is considerable capacity for further government investment into the aged care sector to reduce the high penetration rate of elders into permanent institutions and length of stay.

At the same time, Australia has the lowest spending as a proportion of GDP amongst countries with similar funding models, at 1.0 per cent. UnitingCare Australia believes that Australia should maintain a funding model that makes services easily accessed by anyone, with the cost of adequate services borne by all taxpayers, not just service users. UnitingCare Australia supports consumer co-contributions to the cost of services in circumstances where a user pays approach increases equity and provided that it does not result in future disbenefit, for example where a co-contribution acts as a disincentive to use a service with long-term benefits.

This funding model exists in principle, however the public component cannot meet the goal of a single, universally accessible system, because it is underfunded. UnitingCare Australia believes that Australian Government must immediately commit to adequate investment to support current demand. This would require a restoration of the real value of expenditure on individual consumers, and proportionality between the size of the older population and expenditure.

Given Australia currently has a higher proportion of older people living in residential aged care, we believe that the OECD average spend of 1.6 per cent of GDP should be considered a minimum spend that reflects systems with fewer individuals reliant on long term residential aged care. We recommend raising the investment to 2 per cent of GDP in order that hours of care and allied health support in residential services meet community expectations, and immediately increase funding to home care services in order to improve access and reduce current unacceptable wait times. As the overreliance on residential care is reduced, we believe that the system can be more

⁴ <https://unitingcare.org.au/wp-content/uploads/2020/02/190725-UnitingCare-Australia-INTERNATIONAL-RESEARCH-ALTERNATIVE-MODELS-OF-AGED-CARE.pdf>.

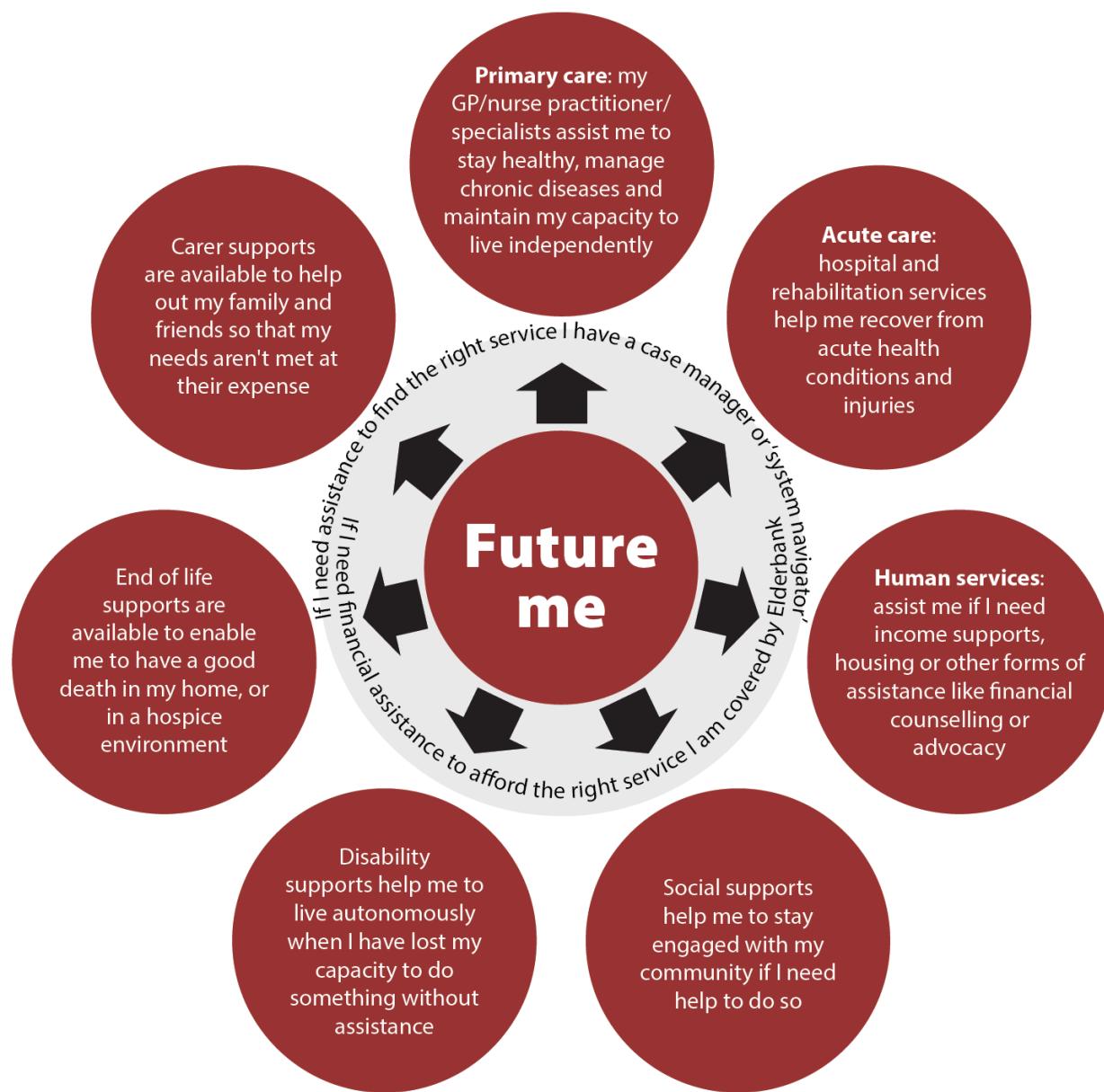
efficient and absorb growth in the population without requiring continuing increases significantly above 2 per cent of GDP.

This long-term vision for a sustainable system depends, however, on:

- improved interface between, and equitable access to, disability, health and ‘aged care’ services to enable an efficient and effective system of services aligned to needs; and
- the government actions needed to improve security of income and housing, embed preventive health approaches, and achieve equity of contributions to services through an appropriate balance between taxation and means tested co-contributions.

In short, we urge the Royal Commission to make recommendations for actions that:

1. **immediately, through adequate investment of government funding, lift funding to the sector to 2 per cent of GDP so that every older person has access to safe, reliable, and relational services when they need them to live their lives well;**
2. **begin the transition to the services system we need to live life to our full potential:**
 - ‘second horizon’ (mid term) reforms which see more effective investment, leading to an outcomes-based system that fosters innovation and investment in a wider range of options for consumers
 - ‘third horizon’ (long term) reforms, through which we see genuine ‘consumer direction’ of services achieved by a seamless interface between the range of services individuals need, regardless of age; and
3. **remedy lack of security of income and housing, and equity of contributions to public services, through appropriate public policy that complements the framework of health and community services provision.**



Elements of the aged care system in urgent need of attention

UnitingCare Australia believes that aged care providers and the workforce, on the whole, have demonstrated their expertise, compassion and accountability in the contribution they have made to care for Australia's ageing population as part of the nation's response to the COVID-19 pandemic. At the same time, it has been demonstrated that providers and the workforce operate in a system that can only be described as the 'poor relation' of the health system.

This system could have failed in the same way as aged care services have failed overseas if not for the commitment of providers to their communities. In her evidence in February 2019, UnitingCare Australia's National Director Ms Claerwen Little identified seven areas we believe account for the failure of the aged care system as a whole to meet expectations for the safe and high-quality services older people need. Without suggesting that the majority of providers are 'failing' or that the COVID-19 epidemic has resulted in a lesser quality of care or safety, UnitingCare Australia has framed this submission around these areas for improvement, as we believe that recent events have reinforced the urgency of action.

1. Absence of leadership around a dialogue respecting rights and adjusting inequities

Required response: 'Calling out' ageism and committing to actions to address unjustified manifestations of ageism in current policy and program settings

UnitingCare Australia's position as a provider does not give us the mandate to speak on behalf of older people generally. Through a range of other services, however, and through our connection to the Church's faith community, we have some insight into their experiences of the COVID-19 pandemic.

At any point in time, the majority of older people (around two thirds of those over 65) have limited or no interaction with the formal aged care system,⁵ either living independently or with the assistance of informal supports. Age in itself does not make a person 'vulnerable', however with age individuals can face an accumulation of chronic disease, disability, loss of family and connections, often coupled with factors such as financial disadvantage or insecure housing. This can result in vulnerabilities in situations such as we have seen during the COVID-19 pandemic.

The recommendations from Uniting Church in Australia's response to the Emergency planning and response issues paper of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability⁶ are included at Appendix 1 to this submission. The response highlights issues of the 'visibility' of the needs of disable people as a group in the community, many of which apply also to older people. In the following quote from that response [older people] has been substituted for 'people with disability':

...the needs of [older people] often seem to be forgotten or overlooked when emergency planning and responses are being prepared and implemented. The lack of inclusive emergency planning leads to the needs of [older people] being responded to on an ad hoc

⁵ In 2017, there were 3.8 million Australians aged 65 and over (<https://www.aihw.gov.au/reports/older-people/older-australia-at-a-glance/contents/demographics-of-older-australians/australias-changing-age-and-gender-profile>) whereas there are around 1.3 million individuals receiving an Australian Government funded aged care service.

⁶ The full submission is accessible at <https://unitingcare.org.au/publications/submissions/#>.

basis during the response to an emergency, after concerns have already arisen, rather than proactive, coordinated support being provided as the emergency unfolds.

The 2019–2020 bushfire season and the prolonged COVID-19 public health emergency have led to increased risk and incidence of abuse and domestic violence. They have also led to neglect, isolation and restrictive practices for [older people], and decreased access to essential supplies and support services. Enhanced safeguards are needed for [older people] during emergencies.

[Older people] are some of the most resourceful and resilient people in our communities, have a wealth of knowledge about matters that affect them and know the best ways to ensure that their needs are met...

This is an issue of ‘mainstreaming’: accepting and making visible the needs of a growing proportion of the population that must be taken into account when governments act. The World Health Organization (WHO) Global strategy and action plan on ageing and health⁷ reflects the fact that diversity and individuality grow with age: there is no ‘typical’ older person.

For some older people, there is systemic disadvantage in access to services due to remoteness, language, technology, literacy, culture, socio-economic status, cognitive impairment, sexual orientation and gender identity, disabilities, previous institutionalisation and other barriers. The WHO calls for public health policy to be ‘crafted to reduce, rather than reinforce, these inequities’.

As a generality, intersectionality of various ‘special needs’ can mean severely reduced access to services, or inability to identify an appropriate and/or safe service. In Australia, residing in a regional or remote locality makes it even more likely that services will be unavailable to safely meet the ‘special needs’ of an individual. Understanding and reversing this systemic disadvantage is at the core of UnitingCare Australia’s mission as it relates to aged care and other community services.

To ‘mainstream’ ageing, emphasis must be placed on ensuring that funding and approaches to care and support—both in an emergency and as a general rule—are tailored and targeted to need, as well as developed and implemented in partnership with communities. Services must have the capacity to ‘reach out’ to those in need. Structural changes must be made so that individuals can access services via a local point of contact that is attuned to the needs of diverse and vulnerable individuals in the community.

Equally important however is that the health and community services system mirrors population need, so that the services that promote healthy ageing are available to all. The pandemic has demonstrated very clearly the importance of community services to the integrity of our social infrastructure, alongside health and disability services. These services complement the formal and

⁷ <https://www.who.int/ageing/global-strategy/en/>.

informal arrangements that constitute the ‘long term’ services system, providing emergency or ad hoc supports that individuals can call upon when in need.

UnitingCare Australia supports the recent announcement that the National Cabinet will permanently replace COAG, as an acknowledgement of the need for a more cooperative approach to addressing national priorities. The demographic shift shorthanded as the ‘ageing’ of Australia’s population is a challenge we believe needs to be met as a national priority. We believe, **however, that local government also has a critical role** in addressing most, if not all, such priorities and support calls for local government to be represented in the National Cabinet process.

Systemic stereotyping of older people and characterisation of the process of ageing as negative are damaging both to individuals and to society as a whole. The experience of COVID-19 has demonstrated that the community deeply values older people in a way that we believe is not reflected in the current public policy dialogue or the decision making around investment in services for ageing Australians. Just as Australia is increasingly investing to meet the needs of people with a disability, we need investment to ensure that people’s needs are met throughout their life’s journey.

Policy settings that are based on age rather than need necessarily make generalisations, including assumptions about the value of individuals’ lives. The arbitrary way in which aged care residents were differentiated from the rest of the populace in documents such as the Communicable Diseases Network Australia guidelines⁸ is a case in point.

Assumptions around which ageist policies are built may also relate to the contribution that older individuals are believed to make to the economy or society. This is wrong, regardless of whether the ‘non-market’ contributions of individuals are factored in. Even if it were not true that older people contribute to, and are an intrinsic part of, a thriving community, in Australia we value each other as humans, not as economic participants.

The planning for the post-COVID ‘recovery’ phase has to date not included the opportunity for the community services sector to make the case for investment in built and social infrastructure to be included. This is despite the desperate need for investment in the health and disability workforce and the opportunity to create social and built infrastructure that meets the needs of the future population. A recent study highlighted the transformative benefits of home modifications for people living with a disability and their carers, including reduced dependency on both informal and formal supports and the associated wellbeing this brings.⁹ The continued failure to recognise the economic flowthrough of demographic change as anything other than a shortage of ‘working age’ people is incomprehensibly shortsighted. Our future is everyone.

⁸ see <https://unitingcare.org.au/wp-content/uploads/2020/06/UnitingCare-Australia-May-Submission-200602.pdf>

⁹ <https://theconversation.com/renovations-as-stimulus-home-modifications-can-do-so-much-more-to-transform-peoples-lives-140639>.

We urge the Royal Commission to:

4. support intergovernmental cooperation as a necessary foundation for adapting to demographic change;
5. articulate the role of local government in preparing for future population needs;
6. endorse the EveryAge Counts aim: whole-of-government action on ageing and ageism, and that governments maintain a ministerial position responsible for ageing and older Australians, which has cross-portfolio responsibility, to ensure that policies and programs take an integrated, life-course approach and aren't relegated to siloed health and social welfare portfolios;
7. recommend a review of government policies and programs with the aim of removing ageist differences in access to public services and entitlements; and
8. identify opportunities to build on the renewed sense of community that we are experiencing in the 'COVID era', for the benefit of older and younger people alike, and reflect the recommendations at Appendix 1 in recommendations on emergency preparedness and response.

2. Lack of government funding to provide care and unwillingness to discuss funding options involving greater consumer contribution

Required response: a mix of targeted and general investments in:

- *services to match demand for all types of aged care service, with priority to services that reduce or delay future service needs*
- *technology to improve access, safety and quality of care delivery*
- *innovative ideas and service models, particularly approaches that improve outcomes for those who are under-served and/or in hard to reach communities.*

Almost from the outset of the pandemic, the National Cabinet set high expectations for providers, particularly in terms of their management of access to residential care facilities.

Approximately \$850 million¹⁰ has been 'made available' to assist 'older consumers' during the pandemic. Despite numerous calls from the sector, however, there has been no systematic

¹⁰ This total appears in the Prime Minister's announcement of \$205 million in additional funding to the sector (1/5/20, accessed at <https://www.pm.gov.au/media/new-covid-19-payment-keep-senior-australians-residential-aged-care-safe>). The Prime Minister refers to '\$101 million to support providers directly impacted by an outbreak' that is apparently in addition to the funding measures announced elsewhere (\$101.2 million on 11/3/20 and \$444.6 on 20/3/20 - details of measures included in the whole of

process to allow providers to seek supplementary funding to cover the additional costs directly associated with managing the risks created by the pandemic.

Significant costs have been incurred to prevent outbreaks of COVID-19 in residential aged care facilities and to implement the protocols necessary to keep home care service users safe. Much of the funding provided by government has not, however, been able to be used by services to cover these costs.

Actual new expenditure to date remains unclear as several allocations were either:

- a. for supplementation of government agency activities—for example the Aged Care Quality and Safety Commission (ACQSC) received additional funding to create infection control education and training materials and \$12.3 million was allocated to support the My Aged Care service
- b. available only in the event of an outbreak—and surge workforce funding was and is only available where a service’s existing avenues have been exhausted and the alternatives provided by the Australian Government are used; or
- c. difficult to direct towards increased cost of existing services—for example, notwithstanding a 1.2 per cent supplementation of individual Home Care Packages, the additional funding was assigned to a consumer’s individualised budget, and legislation limits severely the ability of providers to raise charges to access these funds without consumer agreement.

Furthermore, the Aged Care Quality and Safety Commission directed some providers to deliver home care package services without raising charges to the individual home care budget on the basis of the User Rights Principles.

Perhaps most concerning, the \$234.9 million for a COVID-19 ‘retention bonus’ to ensure the continuity of the aged care workforce went from an (announced) after tax to a taxed payment, and was delivered in such a way that it had a divisive effect on the workforce. The lack of recognition of the full range of frontline workers in the sector led some providers to offer equivalent cash or in-kind bonuses to other workers, adding to the increased budgetary strain due to the virus. Bonuses were less for workers in home care, and workers in CHSP were not eligible at all. Perversely, the same worker could receive the bonus in respect of hours worked with a HCP recipient, but not a CHSP recipient.

The additional \$205 million in funding for residential aged care services announced on 1 May 2020 was hard won and only partially covered the costs incurred by aged care services to implement pandemic responses in residential facilities. The request for similar support for HCP service providers was rejected. This unwillingness to support the sector—and thereby consumers and workers in aged care—stands in contrast to the massive financial commitment to other parts of the health system, not to mention other parts of the economy such as the airline industry. At a

continued from above... government submission to the Senate Inquiry into the Government’s response to COVID-19 sum to approximately \$750 million [https://www.aph.gov.au/Parliamentary Business/Committees/Senate/COVID-19/COVID19/Submissions](https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/COVID-19/COVID19/Submissions).

'micro' level, the differential treatment is demonstrated by the issue of access to Personal Protective Equipment (PPE) for both aged care and disability services. While hospitals have had access to the National Stockpile for day to day operations, access by aged care providers is generally¹¹ restricted to situations in which an outbreak (of COVID or any other infectious disease) has occurred, rather than extending to preventive use. In the initial stages some residential care facilities experienced such a shortage of supplies as basic as hand sanitiser, that at times visitors could not be permitted at all as health directions could not be complied with.

Strategies to manage and minimise the potential exposure of older individuals to the virus included refresher training for staff in infection control protocols, replacement of group activities in the community and in residential facilities with one-to-one activities, restrictions on volunteer programs and visits in residential facilities and introduction of protocols around residents leaving and re-entering facilities. These preventive actions have driven a degree of innovation and adaptation in service delivery that will have continuing benefits. For example, remote delivery of a range of services (not just in aged care) has increased knowledge around the effectiveness of 'telehealth' solutions that will have broad application.

In human and financial terms, however, protecting consumers comes at a cost that is not factored into the delivery model. The additional infection control measures needed for every visit in the community add direct cost and take time to perform. Providers have borne the extraordinary costs of flu vaccinations for 100 per cent of home care staff; technology to support consumers; regular and costly communications with clients and additional nursing input for infection management is significant. Currently in Victoria, every staff entry to a consumer's home (including by care managers) requires full PPE and some services use disposable seat covers and other measures to ensure shared vehicles are safe. As the only state to experience significant community transfer to date, Victoria is only just coming to terms with the implications for elders in the community. Providers and staff were already under significant duress. Residential aged care and CHSP have been supported, but not the needs of the HCP program—notwithstanding that HCP consumers often have complex social and clinical needs, and staff work every day in challenging and diverse settings, with the increasing risk of exposure to COVID-19.

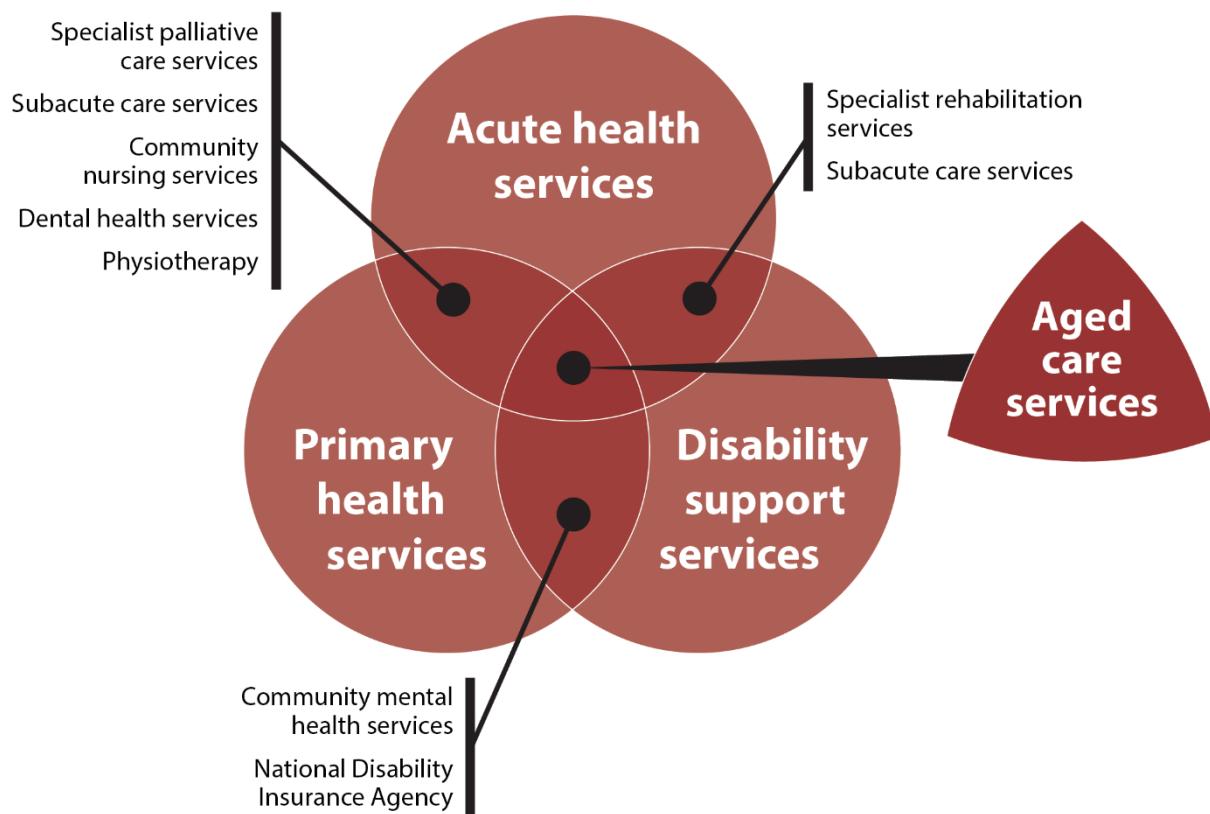
Our first submission to the Royal Commission's investigation of the pandemic detailed the issues around expectations that residential care facilities should be prepared to provide hospital-standard care in the event of an outbreak. The challenge that aged care providers have faced in mitigating the risks associated with the pandemic represent a very clear demonstration of the situation in which providers have found themselves over many years—expectations of the services entailed in providing 'high quality and safe' care grow and expand, while government contributions to revenue have declined in real terms. The messages and expectations about whether a residential aged care facility is a home or a hospital remain confused.¹² On the basis of

¹¹ Throughout July, Victorian providers' access to the national stockpile varied. Initial access for use in facilities in high risk areas was removed shortly later and there was a period in which home care services did not have access, notwithstanding confirmed cases in consumers and the workforce. This lack of consistency added to uncertainty and management workloads.

¹² See for example Joseph Ibrahim's editorial in the *Australian Journal of Advanced Nursing* 37(3), accessed at <https://www.ajan.com.au/index.php/AJAN/article/view/226/26> on 20/07/2020.

the level of funding for residential services, residential aged care facilities provide a home with some supportive care rather than an acute care facility.

Aged care services as they are currently envisaged sit at the intersection between acute health, primary health and disability support services.

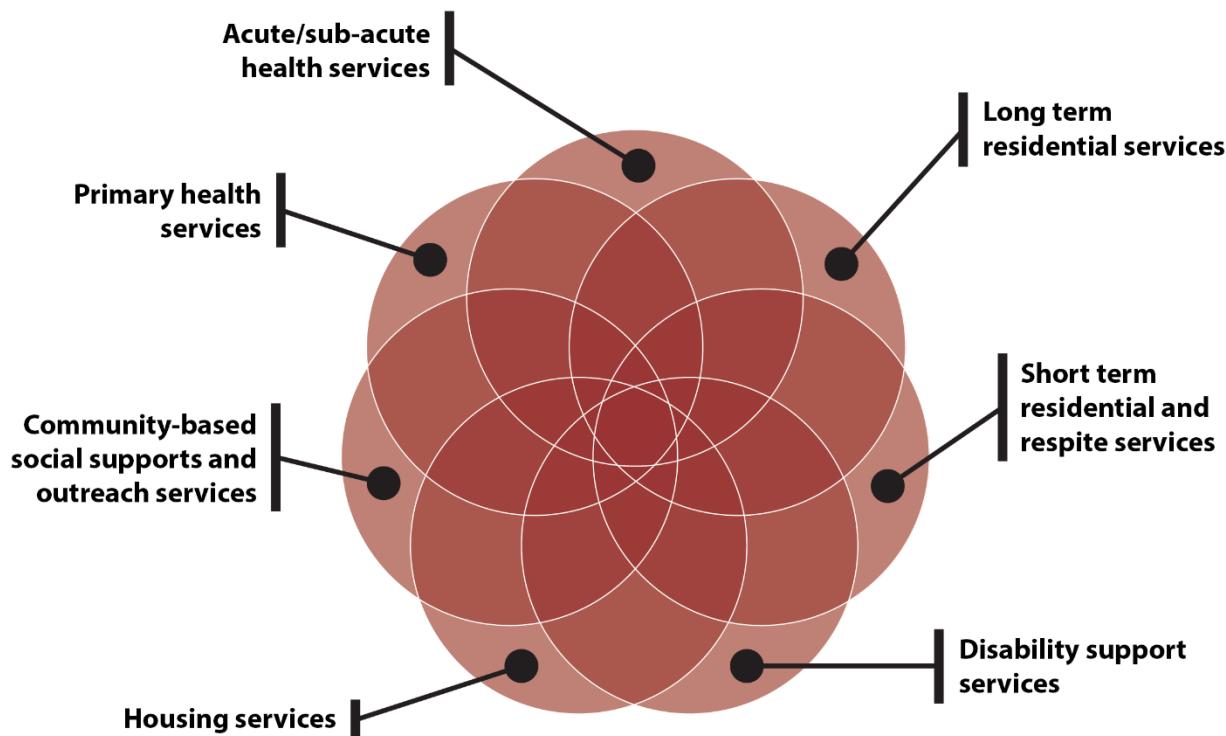


As the population grows and ages over the next decade and beyond, it will become increasingly less efficient to grow an ‘aged care services’ sector in isolation from other services that will increasingly duplicate each other. For example, as more individuals who have been able to access the NDIS reach and move beyond the age of 65 it will be increasingly inequitable to fund disability support services that specialise in meeting the needs of older clients differently depending on the age at which a disability was acquired.¹³ It is important to acknowledge also that the life expectancy of people living with disabilities increases alongside that of the population as a whole.¹⁴ The needs of individuals living with a disability change over time (for example as social

¹³ ACI funding for care related services and supports for elderly people with high and complex care needs is \$77,000 per annum. Younger adults (younger than 65 years) living with disabilities who have high and complex care needs are typically funded under the SIL funding stream (through NDIS) typically in excess of \$280,000 per annum for care related services and supports. If the Royal Commission would be assisted by some de-identified case studies comparing funding of NDIS recipients vs ACI recipients with similar care regimes one of our UnitingCare Australia service providers could provide examples to highlight the funding disparities.

¹⁴ The Australian Bureau of Statistics and Australian Institute of Health and Welfare have accessible data on life expectancy without a disability however it is difficult to discern the impact of disability on life expectancy. Increasing understanding of the health problems associated with common causes of disability such as Down’s Syndrome have led to significant increases in life expectancy over a period of decades, in

circumstances change, or cognitive decline interacts with a physical or intellectual disability) and there will be increasing demand for services that are attuned to these needs.



The potential for greater diversity includes the potential for creating highly specialised services that meet the end of life needs of older individuals with acute-level clinical needs, while maintaining the social aims of the residential system. This should be a deliberate action not a 'service creep'. Where there is a demand and capacity for this type of service, accreditation should enable services to enter this space and provide 'hospital standard' care, in the way that hospices currently do. Likewise, there is growth potential in specialist rehabilitation services, affordable appropriate housing, mental health and community-nursing services. These services must, however, be funded at a similar level to equivalent public health services.

We urge the Royal Commission to:

9. **recommend a mix of funding arrangements, rather than a 'one size fits all' approach, that meets the following aims:**
 - to enable consumer choice, including a range of individual, community and large-scale service arrangements
 - to reflect measures of staffing adequacy (levels and mix) and other quality indicators and to ensure that funding is adequate to meet the actual cost of care

continued from above... that case from around 10 years at birth to 50 to 60 years

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3010180/>.

- to provide incentives to expand the range of flexible accommodation and care options, including high-level care funding in a range of settings in the community
 - to optimise equity of private/public funding balance and align with retirement income policies
 - to simplify assessment processes to complement individual strength-based planning approaches and a navigation platform that permits consumers to access information and receive advice on the spectrum of services available to them;
10. **specify expectations as to the nature of services that providers may be accredited to offer and an effective model to ensure that the range of services required by individuals is in fact provided, with reasonable accessibility;**
 11. **specify the basis upon which governments should determine access to and levels of subsidies—that is, the circumstances in which subsidies are warranted, based on individual consumer need and public benefit principles;**
 12. **recommend methods of delivering subsidies that remove constraints on the operating models open to providers and ensure equivalence of revenue from ‘like’ services, whether they are delivered in health, disability or community service contexts; and**
 13. **recommend Budget allocation options that overcome the problems of capped supply such as under-provision of community-based services and underfunding of residential care services, while enabling the community to establish the desirable balance between service types.**

3. Lack of co-ordination between agencies and services

Required response: Fixing MyAgedCare and investing in case management or navigator services to ensure that anyone seeking to access services can do so without barriers

The Royal Commission has already identified the complexity that can be associated with the MyAgedCare gateway and UnitingCare Australia has expressed its support for simplification of the system. Improvements to accessibility would also be achieved by removing barriers created by a lack of continuity across services provided by different agencies and/or levels of government.

Since the beginning of the pandemic it has been clear how easily individuals can be deterred from seeking services, including essential health and home care services, and how quickly capacity and independence can decline. We are now starting to see, with confidence in safety restored, that services and supports in the home can maintain capacity and independence and delay entry to residential services. The experience has also reinforced the importance of social and spiritual supports for individuals, whether they live in the community or in residential care facilities. Many of these supports are under-recognised and/or unfunded, effectively relying on the good will of

providers to fund the time needed to incorporate ‘relational’ aspects of care into their models of delivery.

Services have seen a significant increase in uptake of home care packages in the last quarter, accompanied by a smaller but distinct drop in residential entries. It is not possible to say with certainty if this is part of a longer-term trend based on need and preference, how much community-based services are being temporarily supplemented by friends and families or the effect of changes to the process of accessing services through MyAgedCare. It does, however, highlight several elements that must inform service design:

- while there will continue to be a need for the specialised services provided through residential care, there is nothing ‘inevitable’ about entry into residential aged care or the point at which this might occur—the vast majority of older Australians live in the community and wish to continue to, for as long as they can;
- improved outreach to those in the community and incentives to maintain the level of community support for older individuals have the potential to be a highly effective and cost-efficient way of improving wellbeing for older people;
- we are not aware of any evidence that making it easier to access entry level services has led to any ‘inappropriate’ use or overuse of services;
- relaxation of rules around delivery of Commonwealth Home Support Program (CHSP) services has enabled providers to be more responsive to consumer need, however given the broad range of directives issued to aged care providers, general community directives and public, private and local government service provision the population became very confused as to what services were available and from which providers; and
- increased attention to each person’s unique needs has had positive aspects however group activities are a critical element of meeting social and spiritual needs.

There are two very clear examples of the perversity of artificial constraints in policy and program design and/or lack of coordination in response to the pandemic. First, the restriction of access to the enhanced Community Visitor Scheme (CVS) to ‘aged care recipients’. Universal access to CVS or similar schemes would be valuable not just for elders but for anyone vulnerable to loneliness and social isolation. The pre-existing constraint on access creates a discontinuity of service, even though it is precisely the type of service that could assist in maintaining the independence and autonomy of older individuals in the community, including for special needs groups.¹⁵

Second, the diversity of public health measures relating to visitor access to residential facilities (which affected not only family and friends’ access, but also allied health visits), and lack of clarity surrounding the circumstances in which residents would be accepted by acute health care services created considerable stress and uncertainty for everyone, most importantly, for residents and their families. Members of the UnitingCare network operating in jurisdictions where formal

¹⁵ The National LGBTI Health Alliance Silver Rainbow (LGBTI inclusive ageing and aged care) LGBTI Digital Community Visitors Scheme was a successful national project that provided LGBTI elders with a Virtual Community Visitor via Skype. Elders in the program received up to one hour per fortnight of calls with an LGBTI peer, and all technology and training was provided as part of the program. It ceased when funding was discontinued.

relationships between health and aged care services were established (for example South Australia) found this a valuable mechanism that improved coordination.

These examples reflect the challenges created by Commonwealth–state arrangements that place boundaries around services based on programmatic arrangements rather than need. The measures introduced to relax Commonwealth Home Support Program rules disrupted analogous ‘boundaries’ that usually exist between providers under that program. The capacity to use funding flexibly across their funded services types and Aged Care Planning Regions (ACPRs) in 2020–21 has been followed up with narrower flexibility provisions for 2021–22. The variation of the program and funding rules during the peak of the COVID-19 management allowed for some creative solutions to be developed and also allowed responses in areas of unmet demand that will now be lost to service users once elements of the usual program rules are reinstated.

The reigning-in of flexibility, without review of the costs and benefits of the approach taken in 2020–21, may prove to reinforce one of the known drawbacks of fixed funding with strict reliance on inflexible program funding conditions. The flexibility permitted because of the COVID-19 pandemic allowed a new level of local responsiveness and cooperation with the local community and individuals within that community. If the number of providers in ACPRs is reduced, with no incentives for cooperation between providers, the risk of under-provision of services and reduced choice is increased. If any equity in access to services is to be achieved in regional and remote and ‘special needs’ areas, there must be incentives and opportunities for cooperation and communication across services, ‘systems’, agencies and jurisdictions.

We therefore urge the Royal Commission to:

- 14. recommend structural changes that enable individuals to access and navigate services via a single—preferably local—process;**
- 15. recommend structural changes to remove barriers to choice, particularly those that result in inequitable access to health services or differential treatment based on age (for example the arbitrary cut-off of access to the NDIS); and**
- 16. recommend structural changes to reduce duplication and inconsistency of regulation across jurisdictions and between levels of government.**

4. Funding and regulatory regimes that maintain the status quo and discourage innovation

Required response: regulatory change and needs-based funding to enable:

- ***direct incentive funding to programs and providers which increase consumers' wellbeing and capability***
- ***innovative ideas and service models, particularly approaches that improve outcomes for those who are under-served and/or in hard to reach communities.***

UnitingCare Australia does not deny that a factor that will inhibit transition to a new model of service relates to existing aged care providers' commitment to the current system, particularly to the way in which they deliver residential care services. This is a system in which the physical as well as intellectual and social capital investments have been enormous, over many years. There is a very fine line in some instances between maintaining supply and resisting change, hence the importance of more information about supply and demand as the basis for planning, and structural adjustment for providers as the basis for transition.

UnitingCare Australia supports the community in calling for a different kind of service.¹⁶ The shift to enable better access to services in the community must occur, in a planned and systematic manner, to ensure continuity of services to those who need them. The balance between community services and residential services must reflect demand based on preference, noting that undersupply of community services tends to impact most on low income households.¹⁷ Based on community sentiment, and the fact that Australia appears to 'over use' residential services, we propose that radical steps need to be taken to enable innovative service models, including funding options that reward outcomes, not outputs. We believe that variations on the National Aboriginal and Torres Strait Islander Flexible Aged Care program could be equally successful in enabling place- and community-based services if extended into smaller, underserviced communities.

Underfunding must be addressed as it directly inhibits change and innovation: many projects that would see construction of new facilities and upgrades are on-hold as there is no confidence in the capacity for these projects to generate returns on investment under current funding arrangements. As noted above, a degree of increased flexibility around CHSP funding enabled services to be more responsive to individuals. This is a small demonstration of how the current

¹⁶ The Royal Commission's recently published research papers reinforce the direction of community attitudes found in research commissioned by UnitingCare Australia <https://unitingcare.org.au/wp-content/uploads/2020/02/Newgate-UnitingCare-Aged-Care-Research-Summary-report-Jan19.pdf>.

¹⁷ see <https://unitingcare.org.au/wp-content/uploads/2020/02/190725-UnitingCare-Australia-INTERNATIONAL-RESEARCH-ALTERNATIVE-MODELS-OF-AGED-CARE.pdf> and <https://www.oecd.org/social/C-MIN-2017-6-EN.pdf>.

system constrains the way in which funding is used or is so inadequate that it discourages innovation in new service offerings that respond to individual needs.

The response to the pandemic situation that CHSP providers have demonstrated also illustrates the importance of maintaining funding alternatives that enable delivery of individualised services in situations where a fully individualised funding model would fail. Applying approaches that embrace flexibility and responsiveness is the obvious way to encourage diversity and specialisation of in home and residential services. It is an alternative way of conceptualising the framework through which we achieve ‘increased choice’.

The pandemic has highlighted the financial vulnerability of the aged care sector. Large not for profit organisations, including many of UnitingCare Australia’s network members, can and do rely on their own resources to manage one-off/localised incidents such as a cyclone or bushfires or to support services to communities that are financially unviable under current arrangements. What is evident from the pandemic is that when there is a sustained challenge that affects every aspect of a business, the response an organisation must mount to manage the impacts is costly, the cash reserves necessary to implement a fully effective outbreak response strategy are tightly constrained, and there is very limited recourse for organisations to recoup the costs.

Sustained underfunding was already limiting the system-wide capacity to provide services and to expand as the population ages. The cost of responding to the pandemic has created a situation in which, without change, there will be assets that cannot be refurbished or replaced when they are due to be ‘retired’. In other words, there may in fact be a contraction of supply in the sector. At the same time, there is increasing emphasis on ‘additional services’ as a way of generating surpluses. It is deeply concerning that an industry media service can report that ‘[a]n Australian study has shown a continuing tailored exercise rehabilitation program can help aged care residents maintain physical function despite an expected decline in this group’ and not question the fact that access to such a program is funded through payments for ‘additional services’.¹⁸

The lack of any spare capacity in the system translates to a lack of diversity in options and a scarcity of the resources in a system that would enable experimentation and development of new approaches. In this context spare capacity is not inefficiency—it refers to the capacity to ensure that there is a richness of staff who can perform essential roles, that organisations have resources to support continuous improvement—including training and research and development roles—in their workforce. Borrowing the language of ecology, the current system has nowhere near the level of integrity that would permit adaptation and long-term resilience; funding barely provides for performance of essential functions in the absence of a challenge such as the current pandemic.

The COVID-19 pandemic has shown that there are persuasive arguments for accelerating a shift away from models of care that create large cohorts of potentially vulnerable individuals in residential facilities. It has highlighted the conundrum around the physical challenges of ensuring that older people have equitable access to health services. The ‘hospital in the home’ (HIH) model of care, for example, has great potential as a way of increasing older people’s access to specialist

¹⁸ ‘Residents benefit from ongoing exercise: research’ by Natasha Egan, Australian Ageing Agenda 8/7/20, accessed at <https://www.australianageingagenda.com.au/clinical/residents-benefit-from-ongoing-exercise-research/> on 9/7/2020.

clinical services, particularly where the disruption caused by hospital transfer is a risk for the individual. When applied to the situation of a COVID-19 outbreak, however, HIH must be complemented by safe isolation and 'cohorting' in a facility. Physical, staffing and other constraints (for example, regulatory rules around resident tenure) vary and in some situations there are insurmountable obstacles to providing the full range of services that an individual might need, *in situ*. The lack of generosity in the funding system amounts to a demonstration of satisfaction with the conditions that those in residential care experience, and of complacency about the lack of support that individuals experience in the community.

A platform for innovation and change: connect evidence and policy via the National Cabinet

Integrated services for older people

Align the health system to the needs of older people

Older adults get the health services they need - where and when they need it: they have access to clinical interventions that maintain their intrinsic capacity and enhance their experience of ageing

Build a sustainable long-term services system

Older people and caregivers get the services and support they need to live with dignity and enjoy their basic human rights: sustainable and equitable systems and services improve services for older people with significant losses in intrinsic capacity and reduce the burden on caregivers

Research

Outcomes measurement and data collation

Ensuring the human resources necessary for integrated services

Community services

The diagram aligns with the WHO's '10 priorities: Towards a decade of healthy ageing' www.who.int/ageing.

We believe that the most powerful things that the Royal Commission can make recommendations on will be:

17. a real and transparent 'needs-based' approach to funding, that responds to the need to meet future community and individual expectations, not the cost of continuing to deliver the existing range of services and current standard of care;
18. a pathway to transition to a system in which there is a range of services that can respond flexibly to individual need, without compromising continuity of care; and
19. regulatory arrangements that protect the rights and interests of vulnerable individuals, whilst enabling service providers to implement best practice approaches to supporting the ageing process.

We also urge the Royal Commission to support:

- 20. research and development investment in transformative design, infrastructure and service models; and**
- 21. investment in scaling up demonstrated, innovative programs.**

5. Absence of agreed outcomes and how they are measured

Required response: developing an outcomes-based framework that includes benchmarks for measurable quality of life indicators

UnitingCare Australia considers that one of the most challenging aspects of the pandemic to date has related to the management of visitors to residential facilities. Our network members have a range of legal and ethical responsibilities towards service users, their carers and supporters and members of the volunteer and paid workforces. This issue has highlighted that the current regulatory approach has not achieved the purpose of underpinning public confidence in the safety and quality of services provided by accredited organisations. We believe that the lack of agreed measures of performance make it virtually impossible for an organisation to demonstrate safety, quality and continuous improvement in a way that is meaningful for the community, either as service users or tax payers.

In a situation of great uncertainty at all levels about the potential scenarios that might play out—uncertainty that will continue for some time—providers have had considerable challenges around the legal and financial risks associated with their responses to the pandemic and their capacity to maintain services.

UnitingCare Australia supports the basic approach reflected in the Aged Care Quality Standards framework. The way in which it has been implemented to date by the Aged Care Quality and Safety Commission makes it very difficult, however, for providers to have confidence that they can make professional judgments in good faith and taking into account the information that is available in the moment, without being at risk of non-compliance.

Areas of uncertainty have included the risks related to:

- limiting residents' movement in a facility if quarantine were necessary;
- requiring movement of residents to create 'isolation' areas; and
- consistency in delivery if staff needed to be re-deployed to maintain staffing levels in residential services, or conversely, meet the needs of individuals refusing care in their home due to concerns about infection.

In previous submissions we have suggested that a key issue with the current system is the lack of capacity to objectively evaluate whether a given action, process or outcome is consistent with aged care regulations. This issue was heightened in the context of extraordinary measures to

protect residential care communities, which in this instance included requirements to comply with state and territory health directions that at times were not fully consistent with guidance provided by the Australian Government.

UnitingCare Australia believes that the public backlash against visitor access restrictions and the Australian Government's response that suggested any measure beyond the Australian Government's guidelines were unnecessary and harmful to residents was:

- a. undermining of managers;
- b. failed to support aged care workers; and
- c. ignored the wishes of those residents who supported visitor restrictions.

Given the pervasive mistrust of 'the aged care system', there is a tendency for situations which may or may not represent failures of care to be treated as systemic failures. This in turn can result in anxiety or loss of confidence for users of services in which there has been no failure.

Within the UnitingCare Australia network, the first stage visitor restrictions ranged from 'concierge' systems (visitors met on arrival, screened, advised on infection control etc.) to effective bans on visitors, other than in circumstances warranting exceptional treatment, such as end of life situations. These measures were coupled with strategies to maintain 'virtual' contact with families and provide alternatives to group activities, with a very high awareness of the potential for isolation of older people in their homes, and associated poor mental and physical health outcomes.

Individual organisations responded within the context of their governance arrangements including risk management and outbreak preparedness plans, developed to suit their specific situations. Organisations ensured that restrictions on visitor access were reviewed and relaxed as appropriate to local conditions (and in the case of Victoria, re-introduced). The systems coming into play in this situation are scrutinised as part of the ongoing regulatory process, however there continues to be a sense of distrust in managers and their capacity to deliver safe and appropriate services.

In making its recommendations, we believe it is essential for the Royal Commission to:

- 22. address the need for development of measurable quality of life outcomes that can be contextualised within a continuous improvement framework;**
- 23. support the accreditation system as the primary point at which service quality and safety should be assured; and**
- 24. articulate the principles that would underpin a compliance system where publicly available, informative and contextualised benchmarking enables comparison of quality of life outcomes, sector wide continuous improvement, risk-based enforcement of quality standards and provision for earned autonomy.**

6. Gaps at all levels of the aged care workforce, exacerbated by limited funding, difficult working conditions and inequitable pay

Required response: targeted investments in workforce development and restructuring, general investment to increase staffing levels, and increased support to informal carers

UnitingCare Australia supports the work of the Aged Care Industry Workforce Council and the Remote Accord as key 'champions' for implementation of the workforce strategy set out in A matter of Care: Australia's Aged Care Workforce Strategy (known as the Pollaers Report¹⁹).

The Pollaers Report should have made governments aware of the importance of promoting aged care as a career option, and of addressing the difficulty that the industry has in attracting workers, in large part because of negative public perception and rhetoric around ageing, the elderly, death and dying and the aged care industry more broadly. This awareness is not reflected in the manner that governments speak about aged care. For example, health staff and essential service staff have had significant acknowledgement and support throughout the COVID-19 pandemic, yet before the recent upsurge of cases in Victoria, aged care workers were seldom if ever mentioned in terms of the importance that such work with older individuals represents for the community. While the importance of these other health-services related roles is undeniable, this is most disappointing for aged care workers.

The common response, that aged care workers are included when talking about 'front line' health workers, is no comfort and verging on disingenuous when the 'retention bonus' for aged care workers is considered. The explicit exclusion from this scheme of any workers other than nursing or direct care staff reflects a lack of insight into the complexity of aged care services and the range of 'hands on' roles that are critical to quality care. A key concern with the strategies put in place to meet surge staffing needs is the way in which it is assumed that additional staff can immediately step in to care roles, or that community and residential-based staff are interchangeable. As noted in our June submission and as members of our network have advocated, it is our view that improved exchange between health and aged care workers, for example through medical outreach models, requires suitable cooperation and preparatory work between the relevant facilities and recognises the specific skill sets involved in caring for elders.

Below is a case study of the workforce assessment and planning one organisation undertook in the first weeks of the pandemic. This process was implemented in the context of existing workforce pressures in aged care (i.e. challenges in recruiting and retaining staff) and the unique issues that exist in rural and regional areas.

¹⁹ A matter of Care: Australia's Aged Care Workforce Strategy <https://www.health.gov.au/sites/default/files/a-matter-of-care-australia-s-aged-care-workforce-strategy.pdf>

Workforce assessment and planning steps

Identifying staff with booked leave and how these plans could be changed/modified in agreement with staff

Identifying at risk/vulnerable staff (e.g. immune compromised, older workers) and developed specific strategies to mitigate risk of exposure—alternative duties, working from home.

Conducted some preparation for surge workforce (with variables; unwell/isolating staff, or staff unable to come to work due to home schooling).

Risk assessment for working at home (instructions/permissions/safety of work stations) and had to develop increased ITC capacity for an increased number of home-based workers. ZOOM (licenced) determined as remote meeting software: Zoom accounts/training/work instructions established.

Survey was sent to 350 Home Support Workers who hold a combination of Certificate III and current flu vaccination. Over 100 responded to indicate they would be prepared and available to undertake additional work in Residential services if needed.

Contractors (e.g. allied health services: process to maintain consistent contractor at site (so only one person per profession at specific site—maintained allied health Podiatry, Physiotherapy, Speech, Dietitian as needed. No issues).

Outcomes:

In residential services a decrease in agency usage (down 1.2% in April as compared to prior month) due to potential workforce not having second jobs to attend as well as deferral of annual leave.

In community services: with clients initially opting to decrease services, and nil cases of COVID 19 in clients or staff (and therefore minimal impact of quarantine/isolation), we had surplus staff for hours available.

Immediate reduction in volunteer numbers given the direction around risk for vulnerable people and the age of most part of the volunteer cohort. In some cases volunteers able to be reassigned to other tasks.

Weekly staff newsletter was implemented so consistent messaging went out. Regular updating of information on website and regular letters to residents/families as situation changed.

Staff repeatedly encouraged to rely on state Health and organisational information due to the amount of information available to general public on social media (especially about such issues as visitor restrictions, availability and use of PPE).

Important elements to note are the female-domination of the industry, and that the workforce itself is ageing. Thus, in planning for adequate staffing levels during the pandemic, it was necessary to accommodate both a high number of individuals with caring responsibilities, and the potentially higher level of susceptibility of members of the formal workforce.

Carers, family, friends and volunteers are also deeply embedded in services, providing assistance that complements the role of the formal workforce. Many of these individuals are older and had to ‘stay home’ or were affected by the steps that had to be taken to protect the health of service users. UnitingCare Australia acknowledges that the personal impacts on the broader contributors to aged care are different but as important as the impacts on the ‘formal’ workforce. The range of impacts on families and carers who have for periods been unable to make care visits to residential facilities is well known, and led to the creation of the visitor access code.²⁰ It is less visible, however reduced access to and uptake of home services and respite services points to stress and pressure on carers in the community. While not a financial blow, having to be ‘stood down’ from volunteering has for some been as impactful as losing paid employment. Staff too lose the benefits of the assistance and support they gain through relationships with carers and volunteers.

We know that the loss of visits and support from carers and volunteers impacted to differing extents on residents of aged care facilities. As the Royal Commission has already acknowledged, providing care and support services is relational work—it requires time and skilled staff to ensure good outcomes for care users. The pandemic has, however, re-made the point in our January 2020 submission, that there are some aspects of community life that cannot be replicated by an aged care service.²¹ Maintaining an individual’s ties to their community must be a priority for service providers and governments.

We urge the Royal Commission to:

- 25. support implementation of the Workforce Taskforce Strategy and adequate government investment in critical elements, prioritising:**
 - **modernising and realigning VET, and providing advanced training in more complex areas**
 - **building workforce capacity and recognised aged care specific skills e.g. dementia care, end of life care, mental health, culturally specific care, rural and remote specialisation**
 - **developing training programs for volunteers and family members to maximise the benefits to consumers and carers alike.**

²⁰ The Industry Code for Visiting Residential Aged Care Homes during COVID-19 <https://www.cota.org.au/policy/aged-care-reform/agedcarevisitors/>

²¹ At page 8, <https://unitingcare.org.au/wp-content/uploads/2020/02/UnitingCare-Aust-submission-to-ACRC-Aged-Care-Program-Redesign-January-2020.pdf>

7. Significant gaps in the interface between aged care and other health systems

Required response: provide incentives for individuals—regardless of life stage—to participate in activities that promote long-term health improvement, reablement, quality of life and wellbeing improvements, or community-led initiatives and promote a model of community services that meets these needs

The clearest example of the issues with aged care and health during the COVID-19 pandemic—the uncertainty relating to hospital transfers in case of outbreaks in residential care facilities—was addressed in our June Submission to the Royal Commission.

Concerns over treatment of older people in the acute care system—including the ongoing issue of hospital access for those in residential care—have been the subject of public discourse for some time. As we have noted in previous submissions, UnitingCare Australia strongly supports the right of every individual to live as and where they choose, and to access health services from their home, including end of life services. Current arrangements do not—and in our view should not—enable aged care services that are ‘hospitals for the aged’.

Maintaining—and improving—the character of residential care facilities as homes is important. It is not an impediment to improving safe access to acute care services. At the same time there are other imperatives: aged care must be delivered by a skilled and adequate workforce (judged according to the acuity profile of users), paid at levels comparable with similar positions in other human services sectors; and visits to hospital should be made only when necessary and not compromise a person's health.

Residential aged care facilities are not hospitals and do not provide the same service as hospitals, just as hospitals are not a substitute for residential aged care facilities. Each has its own system of accreditation and quality frameworks suitable for the differences in capability necessary to fulfil differences in scope and purview. There is unexplored potential for services that bridge the gap between the two, however we do not believe that creating a system of aged care that equals the clinical capability of the health system is likely to be the best investment.

There is considerable potential to avoid escalation of health issues, including in the areas of mental health and cognitive decline, and to reduce the number of ‘avoidable’ hospitalisations, by investing more in hours of care, targeted early intervention and preventive services for older people. Early planning around an individual’s advance care directives is also critical, and as with other aspects of care planning, the time to engage must be funded.

When we speak of ‘mainstreaming’ ageing, it is critical to ask whether the National Long-term Health Plan²² adequately address the health profile of an ageing Australia. In that document,

²² https://www.health.gov.au/sites/default/files/australia-s-long-term-national-health-plan_0.pdf

which presents the current system of aged care as the strategy for older people, there is minimal ‘interface’ between health care and the aged care system. Strategies such as the National Preventive Health Strategy, National Injury Prevention Strategy and National Strategic Action Plan on Pain Management must consider the perspectives of older people in the community—not just those ‘in the system’—and prioritisation of investment must be equitable. These strategies *should* provide incentives for individuals—regardless of life stage —to participate in activities that promote long-term health improvement, reablement, quality of life and wellbeing improvements, or community-led initiatives and promote a model of community services that meets these needs. They must also ensure that programs of targeted and tailored outreach, support and access, support people who are vulnerable to missing out on services.

Supporting actions needed to ensure cultural safety and to meet the needs of diverse and vulnerable groups for lifelong health

Within services, delivery models should ensure that there is no loss of individual identity. Many changes can be made immediately as they are cultural in nature. Resources such as ‘Real Care the Second Time Around’ are essential for building understanding of the range of experiences that impact on the capacity of individuals to access and participate in services.

Cultural safety and respect for cultural traditions are central concepts in consumer direction of services for First Nations’ people. The draft National Closing the Gap Agreement states that:

[a]ll Australian governments recognise the need to address intergenerational change, racism, discrimination and social inclusion (including in relation to disability, gender and LGBTIQ+), healing and trauma, and the promotion of culture and language for Aboriginal and Torres Strait Islander peoples.

Meeting these needs goes well beyond what is delivered by ‘mainstream’ services. Services that recognise the role of healing and accommodate culture and first language have the potential to shift the system from one which can be a site for perpetuation of trauma, to one in which ‘two way learning’ enriches communities.

ARRCS Reconciliation statement

Reconciliation is the coming together of Aboriginal and Torres Strait Islander people and non-Indigenous people to build a healthier society. We do this through acknowledging the disparity that exists between Aboriginal and Torres Strait Islander people and non-Indigenous people and then by working together to end that disparity. In doing so we build stronger communities and healthier relationships, and improve opportunities, for the benefit of all Australians.

Our vision for Reconciliation is to advocate for Aboriginal and Torres Strait Islander people through our services in a way that empowers self-determination for economic, social and cultural development. We will be unified in creating a place of belonging

and respecting the connections Aboriginal and Torres Strait Islander peoples have to communities, lands and cultures in the Northern Territory and beyond.

At ARRCS, we seek to work in ways that reflect our commitment to recognise Aboriginal and Torres Strait Islander people as the First People and to treat their cultures and beliefs with respect. We believe in coming together as one to ensure Aboriginal and Torres Strait Islander communities from Darwin to Kaltukatjara (Docker River) receive the quality services, comfort and care to which all Australians are entitled.

Innovate RAP (2020–2022)

Our Reconciliation Action Plans (RAPs) are built on the Australian Framework of Reflect, Innovate, Stretch and Elevate. Our new Innovate RAP focuses on four key areas:

Relationships—Governance and partnerships: To continue to foster meaningful relationships between ARRCS and Aboriginal and Torres Strait Islander communities in order to provide the best possible service and care.

Respect—Cultural appreciation and traditional languages: To strengthen and celebrate the shared history between Aboriginal and Torres Strait Islander people and non-indigenous Australia in the aged care and disability support sector, valuing differences and striving towards culturally appropriate care.

Opportunities—Employment and capability building: To create opportunities and explore supplier diversity with Aboriginal and Torres Strait Islander people and business, building the capacity of the organisation while forming a dynamic workforce.

Governance and tracking: To understand and respect Aboriginal and Torres Strait Islander cultural perspectives, history, beliefs and their preferred way of being cared for.

The relationships between areas of responsibility, particularly between aged care providers/regulators and health departments, are not transparent to the public. For example, in relation to visitor access, the announcements of the Prime Minister, televised live, had immediate cut through, were easy to find on the internet and were backed up by published media statements. What was unclear to the general public, however, was that each state and territory translated the National Cabinet position into Emergency Directions, which were not necessarily identical to the Prime Ministers announcements. This became more apparent over time. Directions were quite different in each jurisdiction, leading to some confusion. Aged care services were also perceived—by members of the public who do not see similar requirements imposed in any other context—as having unfairly imposed influenza vaccination requirements on visitors.

There is also a sense that if COVID-19 spreads in an aged care service it is because of failure on the part of the provider, notwithstanding the influence of government health agencies on decisions

made in the context of managing the outbreaks to date. This is not dissimilar to the way in which influenza outbreaks are perceived.

While many aspects of the aged care–health interface are bureaucratic, there are elements of ageism embedded in the way in which the rights of older people are considered in health contexts. A de-institutionalised aged care model would support older people to realise their desire to age in place within their communities, to acknowledge the limitations of services and the choices they have available to them, without compromising their access to services that should be available as of right. In times such as the present, there needs to be shared accountability for the outcomes according to roles and responsibilities. This is currently not the case, as there is insufficient acknowledgment that health and aged care are inseparable.

One of the key lessons from this experience must be that public health planning should incorporate system-wide strategies to better protect older individuals and communities taking into account the greater vulnerability of older people to many infectious agents.

As noted above, in South Australia a model of public health cooperation was created during the pandemic. There have been weekly meetings between the Office for Ageing Well, SA Health, aged care peaks/provider representatives and a consumer advocate advisory group. This has been very effective as a way to contextualise the needs of older people within the broader public health response and may be a model for the future. Providers in SA believe this was an effective way of enabling aged care providers to contribute their perspective and expertise in relation to public health directions that were implemented and then continually reviewed, resulting in good (workable) outcomes in managing issues such as visitor access and their protocol for provider–health service preparedness in the event of a COVID-19 outbreak in a facility.

We hope that in making its recommendations the Royal Commission will:

- 26. advance the vision that it is possible in the long term to create an overall high quality system that makes health, disability and social support services (including housing) accessible for anyone in Australia by creating pathways to:**
 - identify cost effective opportunities to increase elders' access to some types of clinical services that can reduce the need for hospital admissions (for example portable x-rays or dialysis in regional and remote areas);**
 - maximise use of preventive and enabling approaches to enhance the wellbeing of individuals, as part of broader population health approaches;**
 - reduce the rate and period of hospitalisations by increasing supply of services (at assessed level of need, including where this means additional funding for services to support individuals with behavioural and psychological symptoms of dementia);**

- **create the protocols and financial arrangements between jurisdictions that are necessary to ensure that access to clinical services can occur within the context of compassion and with minimal disruption; and**
- **create more holistic services through cooperation, integration and outreach, particularly in regional and remote areas or to meet the needs of specific groups or communities.**

Annex 1: Design and funding principles and their implications for financing the aged care system

UnitingCare Australia believes that one of the key reasons that reforms to the aged care sector have failed is the unwillingness of governments to invest adequately in services for older people.

The global approach to financing that is being considered by the Royal Commission must take into account the way in which individual services are financed. The aged care system as it currently operates has many inefficiencies that reduce the funds available for hours of service. This includes the cost of managing ACFI and home care payments, and the (increasing) cost of meeting compliance requirements. It is also inefficient that the system relies on cross subsidies between services—this includes transfers within organisations, from services operating with a surplus to those with an operating deficit—and must deal with multiple compliance and funding arrangements when delivering similar services under community health, disability and aged care programs. The role of service providers should be to identify the best ways of meeting an individual's needs safely, while maintaining their rights and dignity. The outcome should not be determined by the source of funding.

In the context of discussion of alternatives to the Aged Care Financing Instrument, we worked with ACSA and other church providers to develop Principles for Aged Care Services Funding, which were published in 2016.²³ In the following section, we consider these principles alongside the system design principles spelled out in our January submission, and articulate how these provide a prism through which to consider financing aspects of system design.

UnitingCare Australia strongly supports the same depth of examination being given to the funding model for community-based services and supports as has been focused on residential care (through the RUCS), as this is where we see the greatest potential for dramatic improvements in wellness through re-ablement and preventive actions as well as the opportunity to ensure more effective allocation of resources to meet consumer preference and optimise care in the community. There are lessons from the private health insurance sector about the value of investing in preventive therapies. **UnitingCare Australia believes that a key principle must be that financing arrangements enhance the incentives to take positive steps to improve health for the future.**

²³ <https://www.acsa.asn.au/getmedia/01066d0d-f54f-4ab1-86ea-a9fcfa6daac8/ACSA-Principles-for-Aged-Care-Services-Funding.aspx>

System design principle/s articulated in UnitingCare Australia's January 2020 submission	Funding principle/s	Implications for system funding
<ul style="list-style-type: none"> Government must ensure that the point of entry to services is accessible to individuals regardless of social or cultural background, means or locality, and services must be sufficiently flexible and inclusive to cater for the range of individual identities, cultural and social safety needs, and clinical needs that present in older individuals. Government must ensure that the interface between the system and individuals/their support people is sufficiently simple and intuitive that they do not need to 'learn' a new system to be able to benefit from services to which they are entitled, and the system should not result in different standards of outcome for people based on literacy, expertise or resources. 	<p>1. Outcome Focused</p> <p>The model should be aimed at maximising health and wellbeing, and support reablement, prevention and restorative approaches to aged care services. Performance should be measured through the achievement of outcomes (not merely inputs or outputs) while funding recognises the cost drivers, such as workforce demands and required skill levels, in achieving the desired outcomes.</p> <p>2. Transparent and Simplified</p> <p>The model should be simple and completely transparent to support trust and engagement between funders, providers and consumers, and to make it easier for consumers to understand and providers to administer.</p>	<ul style="list-style-type: none"> UnitingCare Australia has proposed a 'demand' driven system of services, accessible via referral not 'eligibility'. We believe that there should be a single, universally accessible system, with no stigma attached to use of publicly funded services. 'Public good' services should be easily accessed by anyone, with the cost of adequate services borne by all taxpayers, not just service users. It is difficult to plan for disability and to a degree counterproductive: we need a model that encourages use of preventive approaches (including safe and appropriate housing) with a view to maximising individual self-reliance and minimising the need for long term, high dependency residential care. <p>Taking into account these factors, we believe that governments need to improve security of income and housing, and equity of contributions to health and disability elements of ageing services should be achieved through the taxation system.</p> <p>From a consumer perspective, having to contribute to a separate savings pool to provide for services needed in older age—on top of compulsory superannuation, the Medicare levy and general taxation—will add to the burden of those who already experience insecurity.</p> <p>The government must address the inequities in the systems that enable high wealth individuals to avoid tax, and ensure that policy settings around co-contributions to services are consistent with the basis of taxation concessions for superannuation. That is, those with superannuation should be required to use it for living expenses, including the costs of ordinary health and domestic assistance services.</p> <p>Consumers accessing services in the community should experience a model that is as simple as Medicare—including the capacity to be 'bulk billed' but also with the understanding they may be charged above the rebate amount. Most transactions should be managed through a streamlined payment system at the point of service use.</p>

System design principle/s articulated in UnitingCare Australia's January 2020 submission	Funding principle/s	Implications for system funding
<ul style="list-style-type: none"> • Human rights do not diminish with age, therefore all those with a role in supporting our elders (governments at all levels, family, communities and service providers) must practice respect and support for the rights, choices and dignity of older people. • The system must act as a social safety net, where additional resources or pathways to services are needed, and should incorporate encouragement to plan for the future and potentially the need for early intervention in age-related issues, regardless of age. • In considering the needs that the system is designed to meet, governments and service providers must recognise both basic needs—physical and security needs—and higher order needs that enable the individual to thrive—love 	<p>3. Equity</p> <p>Funding should support all consumers based on their assessed needs, including those with special needs. This requires flexible funding allocations, weighted on individual needs to ensure diverse consumers are able to be appropriately supported. The approach should also ensure that specific consumer groups (e.g. rural and remote, LGBTI, CALD, Indigenous, older people living with disability, those with mental health needs or people who are socially isolated) have access to quality support and care. It should further take account of the particular complexities encountered in appropriately supporting consumers with multiple chronic diseases and problematic behavioural patterns.</p>	<ul style="list-style-type: none"> • Access to affordable and appropriate housing and universal health care (including allied health services) should be given in Australia, including in regional and remote areas. • The end point for which we should be aiming is full equity of access to services and supports across our society. • Those who have experienced economic and/or social exclusion in their lives will most likely need complex supports to continue to live in the community, and will be least well equipped to access services. • The range of services for which subsidies are available should take into account the full range of needs of individuals and parallel the types of services available to younger people with disability. • Equitable financial contributions to provision of public services should be achieved through the taxation system. <p>Financing arrangements should promote approaches similar to successful chronic disease and disability management approaches i.e. they should reward coordination of services and demonstrated outcomes. Uptake of best practice and evidence-based services should also be promoted.</p> <p>UnitingCare Australia supports consumer co-contributions to the cost of services in circumstances where a user pays approach increases equity and provided that it does not result in future disbenefit, for example where a co-contribution acts as a disincentive to use a service with long-term benefits.</p> <p>The approach to financing services should be based on equity of lifetime contributions. Options such as imposition of the Medicare levy on superannuation incomes that are currently excluded from taxable income, or resource-contingent loans (similar to HECS, with costs repaid out of the individual's estate and therefore reflecting total wealth) should be considered on this basis.</p>

System design principle/s articulated in UnitingCare Australia's January 2020 submission	Funding principle/s	Implications for system funding
and belonging, independence and self-actualisation—and how they can best be met, potentially from outside the system.		The benefit of 'insurance' in the form of a scheme in parallel to superannuation may be outweighed by reduced lifetime and retirement incomes for individuals with limited savings capacity.

System design principle/s articulated in UnitingCare Australia's January 2020 submission	Funding principle/s	Implications for system funding
<ul style="list-style-type: none"> • The system must balance the individual's right to autonomy and to continue to make life choices; regulation must limit choice only where this is the most effective response to risk; the sector must work with regulators to develop consistent, objective measures of individual outcomes as the basis for continuous improvement and best practice identification and management of poor outcomes. • Governments have a responsibility to fully meet the cost of providing services and supports necessary for individuals to thrive, however individuals and the broader community have a responsibility to work with health and social systems to minimise, throughout their lives and to their best capability, reliance on formal services. 	<p>4. Consumer Choice and Control</p> <p>The model should support consumer choice and control across the continuum, recognising different cost structures in the delivery of aged care services. The model should also recognise that consumer choice, control and flexibility can be achieved in aged care services through models including, but not limited to, the funding following the consumer model that will be implemented for home care packages.</p>	<ul style="list-style-type: none"> • There are many interpretations of 'consumer choice and control' that exist, with various ways to support consumer direction. • In some situations this does not equate to an individualised funding model. The example of Homeshare has been raised by us and Homeshare Australia in a number of contexts, as an example of an approach to individual support that cannot be funded (efficiently) through individualised payment structures such as the NDIS. • Alternative options including block funding or pooled funding across services must be available where this is a cost-effective way to provide affordable services to meet a known demand. • Evidence, including that commissioned by the Royal Commission, is that individuals do invest in their future wellbeing. Those who are well resourced and 'health-literate' do so at their own cost as they understand it is the best way to ensure autonomy and self-determination as they age. <p>This suggests that the community more broadly would benefit from a financing model that</p> <ul style="list-style-type: none"> • rewards individuals who adopt healthier lifestyles and • enables public health initiatives, including outreach services, to raise everyone to this level and to overcome barriers to participation.

System design principle/s articulated in UnitingCare Australia's January 2020 submission	Funding principle/s	Implications for system funding
<ul style="list-style-type: none"> • Support individuals to live well, including where necessary and possible taking best practice clinical services and delivery into the community context—at the end of life health care should intrude or disrupt life as little as possible. • The system must include services that meet support needs of informal carers—beyond the need for respite—service providers and families must recognise the importance of maintaining relationships and connections to community. 	<p>5. Flexible and Scalable</p> <p>The model should ensure that it can be adapted, where the funding follows the consumer across the continuum of care (home-based, residential and respite etc.), to support longer term planning and goal setting for individuals and to support an integrated aged care system. Regulation and application of funding should enable supplementary resource allocation for episodic, short or medium time periods to provide for very specific needs associated with acute episodes of illness, post-acute periods or for palliative care.</p>	<ul style="list-style-type: none"> • The current system is inflexible and promotes an institutional approach to residential care. It is ungenerous. • The lack of resources is coupled with a lack of understanding of the system, which together can make accessing services difficult, stressful and at times traumatic. • An individual who lives alone should not have to enter residential care following an acute health event because they cannot access support to recover at home. • A person who requires palliative care should not have to access a home care package in order to get nursing care at home. • Aids, assistive technology and home modifications should be universally accessible (on similar terms to the NDIS), however this is an area where government support can be exploited <p>The financing model must allow for the flexibility to respond to situations of need. It must recognise that 'economies of scale' can come at the expense of enabling individuals to live well. It must not signal to consumers that residential services have no purpose beyond 'waiting for the end'.</p> <p>In a society in which ageing is 'mainstreamed'</p> <ul style="list-style-type: none"> • services enabling households, informal carers and family supports are as embedded as services for the individual; • the types of scheme that can be used to leverage increased supply of affordable housing can be adapted to provide options that are appropriate to people with disabilities or adaptable housing that enables people to age in place • financing is sufficiently flexible to follow the services model as it evolves over the coming decades, and is not based on the options that are available now.

System design principle/s articulated in UnitingCare Australia's January 2020 submission	Funding principle/s	Implications for system funding
<ul style="list-style-type: none"> • Governments must work with providers, professionals and researchers to ensure that individuals receive services and supports based on best available evidence and that the outcomes of interventions are being measured and meaningfully benchmarked as part of services' continuous improvement and risk management strategies. 	<p>6. Efficient</p> <p>Minimising red tape should be a key feature of any future funding model. All possible resources should be allocated to direct service delivery. The funding model should support evidence-based practice and discourage practices that do not deliver tangible benefits to the consumer.</p>	<ul style="list-style-type: none"> • The 'failure' of the residential aged care funding instrument has been characterised as its openness to 'manipulation' by providers to maximise claims. • An alternative interpretation is that it created the opportunity to underinvest in the system. System funding that is well constructed, with objective external assessment models and objective cost of care studies will reduce the need/opportunity for providers to manipulate a service funding model, but—particularly if linked to private insurance—there may be built in incentives to minimise payments to providers or exclude claims if costs are capped. <p>The financing model should incorporate signals about performance and it should be simple to administer.</p> <p>System wide 'efficiencies' should be gained by identifying better practice or more cost-effective modes of delivery (for example, in some instances 'tele' health services may reduce costs without compromising outcomes).</p> <p>Consideration of the merits of financing models should include consideration of the transaction costs incurred when</p> <ul style="list-style-type: none"> • providers must interact with multiple funding points • there is any capacity for uncertainty over fee-for-service • there are perverse incentives that result in regulation that does not have direct and measurable benefits.

System design principle/s articulated in UnitingCare Australia's January 2020 submission	Funding principle/s	Implications for system funding
<ul style="list-style-type: none"> The system will only work effectively if there is sufficient funding—subsidies and/or co-contributions—and access to services at the point of assessed need, recognising that the system must cater to approximately a 40-year ‘bandwidth’ over which individuals will have multiple trajectories depending on genetics, life experiences and underlying health conditions; the system must have the flexibility to respond at a point in time when the individual needs help, in a way that enables them and their carer/s to live their best life. Governments at all levels, communities and service providers must work together to ensure that outcomes for individuals and their supporters are not compromised by a lack of funding or sufficiency of skilled, caring professionals 	<p>7. Certainty and Sustainability</p> <p>The model should ensure the aged care system is financially sustainable and not prone to financial volatility. Investment in service expansion and innovation to achieve positive outcomes for older people and their families will follow stable and predictable baseline funding, which anticipates projected areas of growth in the number and changing profiles of care needs of residents. The model should recognise a commitment to quality, safety and continuous improvement as standard prerequisites for service providers.</p> <p>8. Value for Money and Affordability</p> <p>The funding model should represent value for money and affordability for consumers and for government. Those consumers who can afford to pay should contribute to the</p>	<ul style="list-style-type: none"> The most critical aspect of financing is ensuring that the system enables investments in the services that will meet future demand. Current funding levels are such that previously scheduled capital investments are difficult, if not impossible, to justify on the basis of economic returns. Certainty and sustainability start from the ‘fee for service’ model, which then sits within a budgetary model. The model that determines fee for service should be equally efficient in identifying needs and the cost of services in residential care and home care, as well as ‘hybrids’ and respite. Accurate calculation of the ‘unit price’ of a service is essential to provide certainty to providers as to the relationship between projected revenue and costs. There is considerable uncertainty regarding the resources available to the future cohort of formal service users; options that involve high user contributions and rely on private insurance to mitigate the risk of catastrophic costs to individuals must be considered on the basis of our limited understanding of the ‘private’ aged care market and how it may evolve. <p>Maintaining the sustainability of the health care system is consistently challenging, with lower income individuals happy to rely on the public system. If this were replicated in a parallel system, and high wealth individuals were willing to self-insure as they already pay considerable amounts for services, it may be difficult to achieve stability in the sector based on consumer contributions.</p> <p>UnitingCare Australia noted in our January 2020 submission that affordability is a difficult concept to articulate. How does a community compare the ‘affordability’ of \$8 billion dollars in childcare subsidies with \$8 billion dollars-worth of home care packages to eliminate wait times? The funding principles speak of value for money: the community will contribute where they see a return on their investment. This is the future system in which they may find themselves, as well as the system which their parents or grandparents will experience.</p>

System design principle/s articulated in UnitingCare Australia's January 2020 submission	Funding principle/s	Implications for system funding
with time to meet those people's needs.	<p>costs of their care, but Government should provide a safety net for consumers who are unable to make a financial contribution.</p> <p>The funding model should recognise that providers need to generate market-based returns, at an appropriate level to support delivery of effective services and to continue to invest in the sector. The model should also recognise the need to support those providers who deliver aged care for communities where a local market may not otherwise sustain them.</p>	'Value for money' is a consideration that is not transparent in the private health system. The financing system for services to older people must be transparent in terms of the value people see in services delivered. There is no transparency in the cross subsidies embedded in the current system, which are necessary due to underfunding of low means residents. Likewise, there is no transparency around the cost of underservicing at earlier points in the system, or the genuine cost-benefit of residential care to the community. The community therefore relies excessively on residential aged care, whilst not having the information available to support a public conversation about willingness to fund home care at a higher level.

System design principle/s articulated in UnitingCare Australia's January 2020 submission	Funding principle/s	Implications for system funding
<ul style="list-style-type: none"> Government services at all levels, individuals and communities, family and service providers all have roles in improving the interfaces between parts of the health and disability systems and for creating effective pathways to achieve individual goals. 	<p>9. Integrated</p> <p>The model should support seamless interactions between the sectors that care for older people, including aged care, primary and allied health, and acute care.</p>	<ul style="list-style-type: none"> Any funding system will have a social effect: NDIS arrangements privilege some younger people with a disability over older people. The lifetime cap on contributions to the costs of aged care arguably places an unfair burden on the younger generation. Means testing systems do not reflect elements such as the capacity of families to assist in meeting needs, or differential costs of care for those living in regional and remote localities. <p>UnitingCare Australia considers the long-term public policy outcome should be an integrated system in which there is equity of funding and service outcomes across disability, health and 'aged care' services and supports.</p> <p>The needs of older people need to be considered as part of a continuum of needs in the context of the impact of lifetime 'health disadvantage'; likewise, sustainability of aged care services must be considered as an aspect of sustainability of other parts of the health and community services systems.</p> <p>An equitable system is one that meets the needs of geographically and socially isolated communities and it is unlikely that this can be achieved by continuing to formulate public policy on the basis that systems are independent of each other.</p>

Annex 2: COVID-19 impact statement

Impacts of COVID-19 on residential care users and their communities

The most significant impact of the pandemic on residential care users has arisen from the precautions taken to prevent exposure to COVID-19.

Under normal circumstances residential care facilities are fairly exposed to the community via individuals coming and going, including staff and volunteers as well as family and healthcare visitors. The risk of infectious agents entering via visitors is well known, as it is more challenging to address ‘risky behaviours’ (such as non-compliance with hand hygiene, visiting when symptomatic) than is the case with residents and staff/volunteers.

In the first weeks following identification of COVID-19, the sector was faced with evidence from overseas that outbreaks in residential care facilities could be catastrophic. By the time directions were given to the general public to ‘stay at home’, there were already reports from the UK for example, of significant numbers of deaths in residential facilities. Guidance for residential facilities, when it came, reflected the worst potential scenario—a health system unable to manage the number of admissions due to the virus and significant numbers of aged care workers either unable to work due to infection or choosing to self-isolate to protect their own or their families’ health.

This was the context in which our organisations put in place strategies to manage and minimise the potential exposure of individuals to the virus, the keystone of their responses being restrictions on visits in residential facilities. Visitor restrictions were put in place with the awareness that there was the potential for impacts on care users, specifically reduced wellbeing due to lack of contact with family members and other supports. The balance between this risk, and the risk associated with the distress that many residents felt as a result of the known susceptibility of older people to the virus, has shifted over time. Group activities also had to stop, as well as the dining experience with a number of residents present. These limitations meant individuals had less social contact within the facility.

Within the constraints of public health orders, facilities have adapted arrangements according to their judgment regarding the magnitude of these risks. This has resulted in an extensive need to communicate more, from the residents’ point of view, through the use of technology, phone support, and initiatives such as ‘face to face through the window’ support. This also required an extensive amount of communication between families, staff and facility managers in order to give updated information and reassurance.

To counteract the risk of social isolation of residents in its facilities, Wesley Mission Queensland employed customer support staff (at carer wage level) who have been professional entertainers, and technology support people who have made it possible to participate in virtual activities within the facility or in virtual groups, and have assisted residents with dementia in using dementia-appropriate applications.

As restrictions for the general population in Queensland started to ease, state health orders continued to prevent residents of aged care facilities from leaving their home to visit families, go shopping and have their normal community contacts.

Initially the residents were very understanding of the need for restrictions but many have struggled as the rest of the community had restrictions lifted. This situation was replicated to various degrees across the states and territories and continues to be a challenge.

Impacts of COVID-19 on home care and support recipients

In a separate submission, Resthaven has identified the lack of home care packages and the resultant delays for people waiting for a home care package at their assessed level of need as 'a serious issue of sub-standard care by Government [that] reflects a level of ageism that is hidden in government policy and funding. Clearly one of the greatest areas of risk for older people are those assessed for care with high level needs and not receiving such care. This a systemic issue across all of Australia.'

The risk addressed via home services is not trivial when it is considered that, in order to be eligible for a level 3-4 home care package, it has to be established that an individual has need for an 'intermediate' or greater level care—usually support in personal care, meal preparation and medication support—to remain safely at home.

Government information for consumers in the form of a Fact Sheet 'It's OK to have care at home' was released quite late in the process of responding to the pandemic. This made it difficult for providers to maintain services to consumers as they were receiving advice from other sources such as the media (including social media) on things such as use of PPE, social distancing, and what constituted 'essential' services for the purposes of leaving home.

As a result, network members saw:

- cancellation of services, often by family members who were either concerned that receiving services increased the risk of contracting COVID for older, vulnerable relatives or who were more readily available to provide services themselves;

- a decrease in service provision: at the peak of the first phase of the virus in April 2020, use of HCP hours reduced by 30%, only returning to normal in June;
- there were government directives to place social group activities on hold (including CHSP-funded activities) making it necessary to take up flexibility provisions to meet client needs via individual supports.

Services introduced increased telephone calls, video calls and one-to-one visits to meet social and exercise needs and to check on welfare, and high risk registers were checked to ensure they included people at risk of social isolation/people with dementia and increased welfare checks were made for these individuals.

Some continued centre-based one-to-one allied health services as an essential service, meaning that the only change in therapy services was suspension of group programs.

Impacts of COVID-19 on members of the aged care workforce

Addressing the potential mental health impacts on staff has been a high priority since the emergence of COVID-19. As 'front line' workers, additional stressors for staff have included

- fear of contracting COVID-19 and giving it to their family
- fear for the residents themselves that they are going to get COVID-19 and die
- the pace in which change has had to happen in their work practices, e.g. closing of the dining rooms, changing social activities, increased workload
- loss of social connection with their work colleagues, e.g. fewer staff in staff room, implementation of social distancing, fewer opportunities to connect with their teams face-to-face than they are used to
- increased demand for customer support (some facilities have created new customer support capacity at an additional cost however this has helped to give the staff extra support in order to be able to manage the changes).

For community-based workers, one concern of staff was shared use of vehicles (staff/staff, staff/clients) until a protocol could be developed (cleaning instructions, disposable chair covers).

For facility managers there has been an incredible amount of stress. Employees in these roles are responsible for keeping up with and implementing legislation changes, changing processes within their facilities, dealing with a small number of aggressive families who are not happy with either the visitor/movement restrictions or influenza vaccination requirements with the constant concern that should they have an

outbreak, there will be negative media that will reflect upon them. At the same time they are required to maintain ‘business as usual’ service to residents and the regulatory requirements that this entails. Only a facility manager can action and carry out many of the changes required and this resulted in many of them working excessive hours to get through their workload.

Case study: actions put in place to keep residents and staff safe

In the first six weeks numerous actions were put in place in order to keep residents and staff safe to avoid a COVID-19 outbreak.

1. Extensive training in infection control and the application of using PPE.
2. Increased hours for cleaning.
3. A person at the front door of the facility for 8 hours screening visitors and contractors, taking temperatures and recording results (7 days a week).
4. Screening all staff at the beginning of every shift which includes temperature checking as well as screening questions.
5. Increased contact and communication required with families and residents to ensure that they understand infection control strategies put in place.
6. Twice weekly meetings with RAC Managers (Zoom) to ensure that infection control processes are in place and each facility is up to date with the latest infection control advice from Government.
7. Increased contact with staff to offer reassurance around how the facility is always working to be COVID-19 free.

Health directives requiring all staff and visitors (with the exception of those with medical exemptions) to be immunised against seasonal influenza were put in place to reduce the risk of influenza during the pandemic. Meeting this requirement took an exceptional effort on the part of providers, who in the past have relied on voluntary compliance with seasonal flu vaccinations. Given the short term of effectiveness of seasonal vaccinations, this may become an ongoing demand on providers.

Impacts on COVID-19 on UnitingCare Australia member organisations

A significant amount of time has been taken at an organisational/corporate level to ensure that there are strategies and steps in place to prevent and respond to a COVID 19 situation.

1. The formulation of a COVID-19 emergency response plan for residential aged care.
2. Executive COVID-19 meetings twice weekly.
3. COVID-19 Operation meeting weekly.
4. Extensive media and comms preparation out to staff, families, residents weekly.
5. Extensive purchase of PPE from the procurement department in preparation for COVID-19 within the organisations.
6. Extensive organisational audits to ensure WPHS and Infection Control practices are being adhered and responded to.
7. Increase of staff pool with extra training as a back-up team should there be a need in any of the facilities.
8. Policies and procedures have had to be changed weekly on an ongoing basis due to legislation.
9. Significant support needed for the Managers in regard to the visiting restrictions around process, timeliness and concerns being raised by visitors.
10. Extra staff needed to be seconded to assist with the flu vaccination requirements: for example one provider of around 1000 beds in residential aged care required 1000 staff members to be vaccinated in a 3-4 week period, which was achieved but incredible challenging.

Although there have been several 'one off' payments from government, there has been no assurance or a commitment to ongoing funding either for COVID-19, which is a long-term issue, or for general sustainability for the industry. There have been numerous papers presented to government about the need for reform and that it is almost impossible to provide a level of service that residents and families want and deserve, based on our present funding model.

There is a feeling on the part of organisations that the National Cabinet and AHPPC have failed to recognise and understand the aged care environment and risk. As a result, there have been difficulties in terms of information from various sources: many variations (state to state) as the Commonwealth Government would release information, then each State would legislate directions according to their legislative framework and interpretation of guidance. There was information supplied by the AHPPC (Australian Health Protection Principal Committee); The Voluntary Code; the

Department of Health, the Aged Care Quality and Safety Commission and use of language differently on the same topic, adding to ambiguity.

EXAMPLE: Complexity of legislation and how it translates to reality: Family from interstate came to SA to visit resident in end of life stage (allowable under SA Directive/legislation). Family wanted to see another “well” resident and found it difficult to understand that this was illegal (given they were from interstate, not quarantined/isolated, and resident was not in end of life stage) as clearly this other person did not fit the requirement of the exemption offered in the Direction.

Long term strength of balance sheets is being challenged, though the financial implications will largely be felt in 2020-21. Many of our organisations have seen residential occupancy decline as fewer individuals wished to enter care or could not compare facilities (although many UnitingCare organisations made ‘virtual tours’ available), and expect this to continue if/when community outbreaks occur. The recent experience in Victoria confirms that the direct costs of responding to the pandemic, for example by ‘upskilling’ community workforce to provide backup in residential facilities, will continue to rise if the pandemic continues, at the same time as revenue profiles are lower.

Appendix 1: Excerpt from Uniting Church in Australia Submission to Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability

Response to the Emergency Planning and Response Issues Paper July 2020

Recommendations

The Uniting Church makes the following recommendations to improve emergency planning and responses for people with disability and increase their safety and wellbeing during emergencies:

1. embed co-design by people with disability in emergency planning, response, and recovery across all levels of government;
2. representation of people with disability, including first nations and culturally and linguistically diverse people with disability, on government advisory and community committees for emergency planning and response;
3. emergency communication strategies that embed provision of up-to-date accessible information, including information tailored to specific circumstances;
4. accessible and inclusive emergency evacuation arrangements that are well communicated to people in the community;
5. a clearer definition of 'essential services' for people with disability and the continuation of these services during emergencies;
6. additional funding and resources for disability representative and advocacy organisations;
7. priority access to food and essential supplies for people with disability;
8. people with disability must have equitable and equal access to health care;
9. increased availability of personal protective equipment during emergencies and include priority access for people with disability and their support workers providing personal care supports;
10. ongoing availability of expanded telehealth;
11. access to supplementary income support for people with disability during emergencies so they are not financially worse off;
12. remove barriers to participation and build inclusion for people with disability within communities to safeguard against violence, abuse, neglect and exploitation.