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Dear Sir / Madam

MAV Submission to the Royal Commission on Aged Care, Quality and Safety

The Municipal Association of Victoria (MAV) welcomes the opportunity to present this submission to the Royal Commission on Aged Care, Quality and Safety regarding the Consultation Paper 1 Aged Care Program Redesign: Services for the Future.

The MAV is the legislated peak body representing Victoria's 79 councils and is a signatory to the Trilateral Statement of Intent on Community Care (February 2017) between the Commonwealth, State of Victoria and Victorian local government (represented by the MAV).

The MAV participated in a Roundtable discussion with Commissioners and key stakeholders regarding the aged care service system in Sydney in February 2019 and provided a detailed submission addressing service system issues which was presented at a hearing of the Royal Commission in Adelaide. Refer to the Statement of Clare Lynette Hargreaves, Manager Social Policy, Municipal Association of Victoria, 14 March 2019.

This submission is informed by consultation with and evidence provided by Victorian local government.

The MAV recommends that the Commonwealth:

1. Take heed of the findings of the 2019 Tune Review of the National Disability Insurance Scheme Act 2013 report to mitigate against any such problems impacting on those who engage with the aged care system.
2. Establish a formal National Partnership Agreement on community aged care supported by Bilateral Agreements to achieve continuity of care and access and equity for older people. (Bilateral Agreements have the capacity to recognise the different starting points of each jurisdiction and build on the strengths of the existing system). This would ensure the integrity and strengths of the Victorian service system, which was not in need of reformation, are maintained.
3. Embrace the subsidiarity principle – that a central authority (C/W) should have a subsidiary function and perform only those tasks which cannot be performed at the local level.

4. Ensure an evidence-based approach informs the funding for and supply of services and that these be place-based and responsible for meeting the diverse needs of all older people in a defined geographical area (to prevent cherry-picking of easy to service/inexpensive clients).
5. Retain block funding on a price/volume basis which ensures that differing and variable needs of clients are met within a funding envelope.
6. Reinstate annual growth funding for CHSP and discontinue Level 1 Home Care Packages and roll the funding allocation into CHSP
7. Continue Commonwealth and State/Territories investment in local government to support councils to act as effective public sector stewards at the local level.
8. Create a new funding stream for service navigation and coordination.
9. Strengthen wellness and reablement approaches in program guidelines.

The MAV strongly recommends building on the existing well-functioning Victorian approach to community care and I trust this submission informs the final recommendations of the Royal Commission.

Yours sincerely

KERRY THOMPSON
Chief Executive Officer

MUNICIPAL ASSOCIATION OF VICTORIA

Background

Nationally local government has a legislative commitment to promote the health and wellbeing of all its residents including older people (in Victoria through the Local Government Act 1989 and the Public Health and Wellbeing Act 2008).

Aged care services have historically been delivered through a successful trilateral partnership between the three spheres of government. Local government in Victoria has a 70-year history of planning for, funding and providing aged care programs, services and facilities in response to the specific needs of its ageing residents.
It has been committed to its ageing citizens and to this end has augmented Commonwealth funding of aged care services by an estimated $200M pa. This commitment is now being jeopardized in direct response to the aged care reforms and the marketisation of services.

Significant evidence before the Royal Commission has demonstrated the nature and extent of market failure, and consequently much needs to be done to ensure service quality and user safety as well as geographic coverage and access for all. Reform of the aged care sector ought to be underpinned by knowledge, transparency, clarity, certainty and collaboration.

Principles underpinning a new service system

Senior representatives from the Municipal Association of Victoria (MAV), local government, the Australian Services Union-Vic Branch (ANMF) and the Victorian Department of Health and Human Services workshopped principles to underpin the aged care service system in December 2019.

This group identified eight core principles for a future CHSP program that seek to ensure flexibility, local planning, equity and accountability. Some of the principles identified exist already in the CHSP and the group has recommended these be retained in any new model, however guidelines and intergovernmental oversight and accountability to operationalise these could be strengthened in a renewed program.

The principles proposed by this group are:

1. Home care services are accessible, responsive and flexible to meet the needs of older people at the early intervention stage.
2. Funding for home care services uses population-based service planning and resource allocation methods to plan for local needs.
3. Home care services are transparent and accountable for the delivery of quality service.
4. Home care services support choice and enable personalised approaches.
5. Home care services are provided by a skilled and appropriately qualified workforce.
6. *Home care services are tailored to the unique circumstances and cultural preference of each client, their family and carers.
7. *Home care services are holistic and person-centred, promoting wellness and reablement approaches.
8. *Carers are recognised and supported to access services and supports to assist them in their caring role.

*denotes existing service delivery principle in the *'Commonwealth Home Support Programme – Program Manual 2018-2020'. Note some are not word for word replicated.*

Furthermore, whilst the Royal Commission Consultation Paper states that the concept of 'stewardship' and service system 'market development' are out of scope, the MAV is of the view that it is imperative to incorporate these as principles. The successful design and delivery of any system is dependent on the planning, resourcing and oversight of such, to ensure the design concepts can be implemented and that people do not fall through the gaps, including those who are vulnerable and disadvantaged. It also ensures that the current and future needs of the community are being considered in order to create a responsive, holistic and integrated system.

Another principle might include the concept of a 'feedback loop' to ensure difficulties or challenges with the system (or perhaps gaps in the system) are captured in a timely manner to create a more agile, flexible and responsive system.

The Consultation Paper raises some interesting concepts around wellness and reablement, the need to focus on future care planning and move away from transactional approaches to aged care, however these concepts do not appear to be reflected in the principles as they stand.

How could redesign of the aged care system make it simpler for older people to find and receive the care and supports that they need?

The model proposed on Page 7 of the Consultation Paper does not reflect how the current Victorian service system operates or how a proposed service system would operate from the perspective of the service user. Developing a model through the lens of a client and their journey would inform a more realistic, wholistic and responsive service system.

The Consultation Paper states on Page 5:

> *The aged care system should be changed to support older people and their families to understand the system and get the services and care they need, including by getting much better information and face-to-face support.*

The MAV would argue that this is not a new initiative, rather it has been a role embraced and funded by Victorian local government for the last 70 years and given councils' history and extensive experience, they are well placed to be funded to manage demand and deliver services for their communities in a planned, coordinated and integrated manner. In 2017-2018 the contribution to the CHSP by Victorian local government was estimated at $200M, thereby ensuring a complex and highly integrated service system which:

- Ensured residents of rural, regional and metropolitan municipalities had access to a place-based suite of home and community care services (CHSP) whether funded or not including system navigation.
- Undertook a holistic assessment of client needs via a strong and multi-tiered assessment framework.
- Planned, coordinated and delivered the full suite of quality and integrated services to diverse groups of people in conjunction with nursing and allied health.
- Provided continuity and certainty of service provision.
- Embedded wellness and reablement to maintain functional independence.
- Employed a large and highly skilled workforce – close to 7,000 people in 2017-2018.
- Collaborated and partnered with primary care and acute care providers.
- Advocated on behalf of vulnerable Victorians.

The Consultation Paper also states on Page 5:

> *The aged care system should be changed to move to individualised funding for care matched to need within the care stream, irrespective of setting*

The largest segment of the older population is being served by the CHSP. The transactional costs of moving to an individualised funding model would be prohibitive. Commonwealth funding for residential care totalled $12.2B for 181,000 clients nationally in 2017-2018 and Commonwealth funding for the Home Support Program totalled $2.8B for 780,000 clients nationally in 2017-2018.

Furthermore, access issues for older people can vary from person to person and region to region, so it is important to consider the wide ranging types of barriers that might exist, including considerations of vulnerability and disadvantage – particularly for those cohorts identified in the Aged Care Act 1997 (such as Aboriginal and Torres Strait Islanders, Culturally and Linguistically Diverse, Homeless, Financially Disadvantaged etc).

Drawing on conceptual frameworks of access used in the health sector, barriers (from a consumer's perspective) may include the following:

- Approachability - of the service provider as perceived by the elderly person (i.e. they can find information easily, compare service providers and their fees, literacy levels and languages are considered, format and medium of information is appropriate – i.e. considering use of radio/ GP clinics/ hard copy brochures or use of newspapers, face to face, telephone and web based options).
- Acceptability – of consumers (not having to jump through hoops, meet unreasonable criteria, feel accepted regardless of culture, values or gender).
- Availability – at the times and locations needed by the community and can be accessed independently (translators available, transport available, no waitlists).
- Affordability – of the service by the average pensioner, no hidden costs, transparent hardship policies.
- Appropriateness – of the service provider (staff suitably trained, provider has resources and can meet consumer's needs).
- How empowered and motivated consumers are to engage with, seek out and navigate the system (… is the system providing outreach/ in-reach for consumers totally disconnected from the system, case management/support, advocacy etc).

For more information about the access framework refer to:
https://www.publish.csiro.au/py/pdf/PY16093.

Information, assessment and system navigation

The system needs a suite of options to meet different needs of a diverse and non-homogenous consumer of aged care services – and thus a range of options is required, including:

- Web based options
- Telephone based
- Face to Face
- Outreach, and
- Case management

Many older people receive information through their GP or health professional, and therefore focusing on interface points as a means of enhancing continuity of care would be beneficial – such as having trained workers co-located at GP clinics, who can respond to enquiries or issues, link people into the system and also provide a feedback loop back to the steward of the system in order to address systemic issues in a timely manner.

Ideally, workers would be clinically trained (such as social workers) in order to support individuals as well as screen for health and welfare concerns. Trained professionals also have a better understanding of systemic disadvantage and discrimination, and a broader and more holistic approach to addressing consumers' needs and concerns. They would also have more experience working with people with more complex and diverse needs and would be able to undertake a care planning function, as well as offer assistance with future planning (such as enduring powers of attorney and advanced care planning etc).

Entry-level support stream

A significant access issue for many consumers is 'availability', not simply 'affordability', therefore it is important that consideration is given to what supports and services are available to meet the needs of the consumer. If there is a 'thin market' where some services or supports are either non-existent or not enough to meet the needs of the community, elderly people are forced to either go without or to wait for unreasonable periods of time for support, which puts them at risk of entering residential care prematurely. As such, there needs to be a steward to oversee the market to ensure there are no gaps and/or people are not falling through the cracks.

The markets maturity and availability differ widely depending on the region and municipality, and therefore consideration of demand and demographics is imperative in distribution of funds and resources to municipalities. Thin markets may exist or emerge due to lack of funding associated with:

- Delivering an appropriate service for particular cohorts (for instance it may be more expensive to 'service' people from an Aboriginal and Torres Strait Islander background due to the need for specialized/trained workforce, or more expensive to deliver services to rural/remote parts of a municipality due to distance/transport costs).
- A particular service activity that is inherently expensive to deliver – such as community based social support (due to travel/transport expenses), delivered meals and/or home maintenance services.

These services require an increase in funding, with consideration of increasing the unit cost for services that target consumers with higher needs, and/or providing block funding with a focus on individual or community outcomes rather than focusing on service hours as an output or measure. In communities with high disadvantage where consumers cannot afford services, Consumer Directed Care is not appropriate – as the onus is on providers to collect fees to remain financially viable/sustainable, which can be either extremely difficult or impossible.

Investment stream

To reorient the system to be more proactive and preventative, it ought to:

- Foster closer ties with allied health practitioners to enhance restorative interventions, screening, awareness raising and measures into programming.
- Enhance relationships with training institutions and/or influence curriculum to enhance understanding of the needs of aged people, signs to look for (for early intervention), offer placements and work experience in aged services (particularly in-home maintenance/ building and trades).
- Strengthen community awareness of options available to keep people safe in their homes.
- Provide enhanced health screening for early intervention – using outreach and engaging community elders.
- Increase awareness of health issues – signs, symptoms, prevention, supports (i.e. for dementia and/or for safety concerns such as falls prevention).
- Fund care planners, case management, clinically trained workforce.

The most important interventions for people experiencing a crisis include:

- Better pre-planning of rights, options and pathways before a crisis happens.
- Flexibility of the system to adapt and respond in a timely and suitable manner (i.e. increase to 24/7 care within 24 hours for a short period of time whilst other (longer term) options can be explored)
- Availability of information on services and supports.

Care stream

Is the concept of 'reasonable and necessary' as used in the National Disability Insurance Scheme applicable to the level of support that could be funded under this stream?

The challenge with this concept is the objectivity of who is defining 'reasonable and necessary' and the inconsistency between people determining this. Clinically trained workers may reduce the need to be to prescriptive whilst upholding the consumer's needs and dignity.

There are also sustainability and resource management issues that may need to be considered to ensure that the system is fair and equitable for all, rather than delivering a 'first in best dressed' approach.

What are the advantages and disadvantages of block funding, providing cash or a 'debit' card with a fixed annual budget to older people or a mixed model (combining block funding with other approaches) for this stream?

Block funding on a geographic basis requires the service provider to undertake whole of population planning and triaging of client needs. This has been a central feature of Victorian local government's approach to community care.

Some of the challenges that exist when funding follows the consumer include:

- Service providers rely on recouping fees for the service they deliver – which is a challenge for providers and risks providers unable to operate in this environment.
- Service providers reorienting service provision to meet targets, and not the needs of the consumer, which may require non-direct service delivery time such as capacity building, community development, enhancing system pathways, and address barriers and disadvantages.

- Service providers operating in isolation which can create a fragmented system with poor planning to meet the current and future needs of the consumer.

Specialist and in reach services

How could the aged care and health systems work together to deliver care which better meets the complex health needs of older people, including dementia care as well as palliative and end of life care?

Some options to enhance continuity of care/integration of the aged and health systems include:

- Co-location of services (for example ACAS, PAC and TCP being located in the hospital settings, or health professionals with aged experience located in medical centres).
- Clinically trained aged care workers to work in certain roles (intake, triage, outreach, navigation, case management) to enhance understanding of health conditions/systems, screening, early intervention/prevention and care planning.
- Increased access (available and affordable) of geriatricians, neuropsychologists and aged care mental health clinicians.

Designing for diversity

How should the design of the future aged care system take into account the needs of diverse groups and in regional and remote locations?

Some options to enhance the design of the system to include diverse groups and the needs of those living in rural locations include:

- Using a lens of vulnerability/disadvantage of cohorts identified in the Aged Care Act against the different types of access issues/barriers that might exist for them (as identified in question that outlines the different types of access – as taken from a conceptual framework of access used in health).
- Provision of a suite of options to recognize diverse needs.
- Funding that recognizes higher costs to deliver to certain cohorts or locations - Incentivizing providers with additional funds (or increased unit price) to cover additional costs/expenses to target diverse cohorts.
- Block funding with an outcome focus, rather than a transaction with measures against service hours.
- In addition to rural municipalities, recognise that there are areas within metropolitan municipalities that may be deemed rural/remote.

Financing aged care

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

Local government in Victoria has a 70-year history of planning for, funding of and providing aged care programs, services and facilities in response to identified needs of ageing residents. To this end local government has augmented Commonwealth funding of aged care services by an estimated $200M pa. In the event that councils decide to relinquish service delivery for CHSP, so will they discontinue subsidising the service system, which will greatly impact the quality and breadth of care currently provided. The Commonwealth is advised to note this critical issue.

The Commonwealth Government does not seek localised intelligence about demand for aged care services when planning funding allocations. CHSP funding is no longer based on demographics, need or demand, which creates inequality. Despite the 2019-20 CHSP growth funding round providing an additional $150M, there has been minimal growth funding allocated to Victorian local government – the main provider of CHSP. The MAV has ascertained that only one rural council was successful with an allocation of ~ $30K, despite numerous requests for millions of dollars from Victorian councils. The Commonwealth ought to utilise the State and local government to better understand the nature and extent of underlying demand.

The strengths of the long-standing cooperative model between the Commonwealth, the State and local government could be retained in a bilateral relationship with the Victorian State government.

Quality regulation

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

Clear regulation and oversight of an authority that has the power to influence outcomes – including ensuring risks associated with the service, can be adequately managed. In addition, there needs to be transparency of data and funding allocations b the Commonwealth to inform place based, responsive and culturally appropriate service planning and development.

Recommendations

In light of the above, the MAV recommends that the Commonwealth:

1. Take heed of the findings of the 2019 Tune Review of the National Disability Insurance Scheme Act 2013 report to mitigate against any such problems impacting on those who engage with the aged care system.
2. Establish a formal National Partnership Agreement on community aged care supported by Bilateral Agreements to achieve continuity of care and access and equity for older people. (Bilateral Agreements have the capacity to recognise the different starting points of each jurisdiction and build on the strengths of the existing system). This would ensure the integrity and strengths of the Victorian service system, which was not in need of reformation, are maintained.
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