1.What are your views on the principles for a new system, set out on page 4 of this paper?

I believe that the principles outlined for the new aged care system are central tenants to promoting a positive approach to ageing. At present the system of care for older people is unwieldly and based not on humane principles, but upon a procedural and a production style approach, to care. Such an approach diminishes the value of older people in our society which subsequently diminishes us all.

As a society we need to be demonstrating more positive images of ageing across our society. An expectation has developed that older people will need care, have an entitlement to that care, and that care will be provided with a hands-off approach from families and communities. A whole of society approach needs to be embraced to enable opportunities for older people to prolong their ability to be actively engaged in life and not spend extensive time receiving care that they may able to do without with enabling and timely interventions.

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

Firstly, the Aged Care system could be made easier to access, by the realisation that for the current older generation, there is an uneven access to on-line computer systems. More face to face support by independent practitioners to advise and guide older people and their significant others would alleviate significant stress.

Secondly, the inclusion of ongoing face to face care coordination with older people by enhanced Aged Care Assessment Teams (ACAT) would greatly improve outcomes for the older person. ACATs consist of highly skilled independent clinicians who in the current system focus on the assessment phase of the older person and service linkage with no opportunities for ongoing face to face care coordination. This has a negative outcome for consumers who then must endure repeated assessments by service providers and delays in services being initiated.

ACAT is currently made up of highly skilled clinicians who are well versed in providing holistic care. Revising the focus of ACATs and integrating the care coordination role would promote much improved flow of information and enable greater individual and personalised care whilst reducing the stress of older people and their families trying to navigate "the system".

Thirdly, the ACAT model must maintain a publicly governed *independent* multidisciplinary team approach that has no linkage to care providers to ensure that quality is preserved. An additional threat of not maintaining the current independent model is that intelligence from the My Aged Care system could be used to generate "referred business". Impartiality, as provided by current ACATs, ensures older people and their families are assisted to make independent and informed choices about aged care and are provided with information to assist them in having appropriate control over the services they receive.

Fourthly, the implementation of a standardised approach to fees for Home Care packages (HCP). Currently there are organisations advertising that they will waiver the basic fee for a HCP. This means that the funds available for the individual are eroded much more quickly than for HCP recipients who pay the daily basic fee contribution. The consequence of this is that those that are paying a contribution fee can access more service at their existing HCP level whereas those not contributing are prompted, *often by the same basic fee waiving*

providers, to request a higher-level HCP. Thus, inequity against those that are made to contribute compared, to those non-contributing HCP recipients.

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

Entry level services were historically provided by block funding models to service providers. At a minimal cost entry level services can support many older people to maintain their independence. *It is worth noting that some of these services need not necessarily be the responsibility of the public purse – for instance domestic assistance and garden maintenance as is the case in New Zealand.* The My Aged Care Contact Centre should be able to make these entry level referrals directly without a RAS assessment which would put more money back into service provision.

The block funded service providers developed networks of care through location-based forums and were able to refer individuals to other services and then onto higher level services via ACAT as a need was identified. Essentially, they did what the RAS now do and although the expectation was that RAS would reduce the number of "assessments" for the older persons this is not the reality. After RAS makes referrals to providers, the providers then embark on their own systems of "onboarding" individuals which inevitably results in another assessment or care planning meeting and further delays in accessing services – routinely up to two weeks. Additionally, not uncommonly a RAS assessment leads to a referral to ACAT.

Funding to Community Health Nursing and Community Allied Health should also be increased to ensure wellness and reablement goals can be attained. In tandem with an additional supply of Short-Term Restorative Care (STRC) packages this would ultimately reduce the number of older people who require long term services. Current Transitional Aged Care Program (TACP) providers are well placed to manage these packages.

Greater provision of permanently funded RACF Respite beds would also reduce the need for longer term care arrangements. If a carer could be assured of being able to readily access up to 12 weeks of respite per year this would provide the support required to elongate their caring roles. A current lack and immediacy of access results in poor outcomes for our older people and premature entry into permanent RACF care.

As outlined previously ACATs are well versed to assist with care coordination and navigation. Embedding staff within ACATs who could assist with the care coordination and navigation would streamline access for older people *in the context that services or care arrangements are in adequate supply*. A model like the RACF Placement Officer Role could replicate the necessary support for older people and their families across community care levels. This role exists within some Local Health Districts, and if following an inpatient ACAT assessment the older person is requiring RACF, they are then referred to the RACF Placement Officer who works with the family to find a suitable RACF.