



**Submission to the Productivity Commission
Inquiry into Aged Care**

Caring for Older Australians

COTA Australia

on behalf of all State & Territory COTAs

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EXECUTIVE SUMMARY

The need for substantive reform in support and care for older Australians has been well documented in the Productivity Commission's research report of 2008, the 2010 Intergenerational Report and elsewhere. In this submission we add to that case with a strong position on access to appropriate support and care as a basic right. Most of the submission then focuses on outlining what a new system would look like.

We are advocating a new aged care system based on the principles in the National Aged Care Alliance's *Leading the Way: A New Vision for the Support and Care of Older Australians*, in the development of which COTA played a key role, utilising feedback from older people.

In line with those principles we are proposing fundamental change that puts individual people at the centre of the system and attaches funding to them rather than to service providers. Individuals would have an entitlement to funding to meet their assessed needs and have more control over what type of services they use and who provides them. This in turn should lead to a more responsive system that meets older people's changing needs in a more flexible and timely way.

The first step in is to ensure that people's need are assessed appropriately and that people are aware of the support and care services that are available so they can exercise the right of choice. To do this we are proposing the establishment of a network of "Gateways" that provide information, initial assessment and approval, and direct referral to lower level support and care services. Gateways will have the capacity to ensure there are regular reappraisals of people's needs and to refer them for further assessment if required.

For people with higher and more complex needs comprehensive assessments would be undertaken by an independent assessment service (Care Assessment Service) building on the model of the current Aged Care Assessment Teams but moving them away from state health department control.

The Gateway will have explicit responsibility for assisting individuals to access appropriate care, either in the community or where necessary in a residential facility.

The assessment of needs will be translated into a level of funding to which people will have immediate entitlement. The submission identifies a number of ways this funding could be allocated such as vouchers; allocations with providers; with a third party budget holder; or some combination. All of these warrant more investigation. Individuals and carers must have the choice about how much control and responsibility they want and so there may need to be a range of options.

Older people consistently express their desire to remain living in their community for as long and with as much independence as possible. In order to achieve this funding for community support and care needs to be substantially increased. Many people go into residential care because the level of funding and number of community care packages available does not currently support enough care at home.

We advocate that funding for accommodation and support and care should be separated and that government subsidies for support and care be the same regardless of where the care is delivered.

We are also calling for the level of subsidy for all services to more accurately reflect the cost of providing them and that there should be an independent evidenced based process to determine those costs and subsidies and maintain their real value.

Individual people and their families would be responsible for their own accommodation costs, whether they are in their own home or in residential care - with a robust system of government assistance for people who are not able to do so. This should provide access to increased funding for accommodation and provide incentives for some more innovative approaches to older persons' housing.

We identify a number of special needs groups who currently have difficulty having their needs met. These include: people with dementia; people with lifelong physical or intellectual disabilities; people with mental health problems or psychiatric disabilities; lesbian, gay bisexual, transgender and inter sex people; people from culturally and linguistically diverse backgrounds and Indigenous people. These groups often need more specialised care which would require additional funding, provided either as a grant to service providers who specialise in meeting those needs or an additional individual allocation. In addition there needs to be more education and training for workers to enable them to meet the specialised needs of some of these groups.

Informal carers are a crucial part of the service system and they need to be better recognised as part of people's chosen care team. We are recommending the introduction of a separate carer assessment to identify their support needs and a separate allocation of funding for those needs to be met. Both carers and care recipients have identified the need for greater flexibility in both the type of respite and when it is delivered and we think this could best be delivered through a consumer directed care approach.

The funding of services is a critical issue and we have already mentioned the need to determine subsidy levels are based on real cost determinations. Part of the cost of those services would be met by the users with a national fees system which would be applied uniformly across all services as with the current resident charges for residential aged care.

We look at two possible ways the government component of the subsidy could be financed - the current approach through consolidated revenue and a social insurance scheme. The merits of each are discussed and we suggest that this needs more work.

The submission then briefly addresses two other issues; workforce and quality. The recruitment and retention of an appropriately skilled workforce is essential to ensuring there is a sustainable quality care system into the future. This workforce needs to be appropriately remunerated to make aged care an attractive option for all levels of staff. In addition there needs to be more specialist education and training to equip people to work in a person centred model so that they can meet individual's needs.

The movement to funding individuals and the separation of accommodation from support and care both raise a number of issues for maintaining quality and standards of aged care. There would need to be a new quality regime that works consistently across all settings.

In the penultimate section of the submission we discuss possible transitional arrangements. These centre on the need for an industry restructuring package as government investment moves from residential to community care and moves responsibility for accommodation back onto individuals.

1. COTA AUSTRALIA

COTA Australia is the national policy arm of the eight State and Territory Councils on the Ageing (COTA) in NSW, Queensland, Tasmania, South Australia, Victoria, Western Australia, ACT and the Northern Territory.

COTA Australia is the only national consumer peak body in the ageing sector, with over 1,000 COTA member organisations representing more than 500,000 older Australians. COTAs also have a direct membership of over 40,000 seniors.

COTA Australia has a focus on national policy issues from the perspective of older people as citizens and consumers and seeks to promote, improve and protect the circumstances and wellbeing of older people in Australia.

COTA policy is developed in accordance with five major policy principles

1. Maximise the economic, social and political participation of older Australians
2. Promote positive views of ageing, reject ageism and challenge negative stereotypes
3. Promote interdependence and consciousness across generations
4. Redress disadvantage and discrimination
5. Protect and extend services and programs that are used and valued by older people living in Australia

(see *Attachment 1*) and through consultation with older people through representative State and Territory Policy Councils all represented on the COTA Australia National Policy Council.

We welcome the opportunity for ongoing opportunities to engage with the Commission as it deliberates on the wide range of issues within this inquiry and begins to develop approaches to these. COTA looks forward to helping facilitate a strong consumer voice in the Commission's processes of investigation, discussion and debate, and formulation of recommendations

2. THE NEED FOR REFORM

There are several drivers of and imperatives for major and radical reform of aged care in Australia. The most commonly cited are the fiscal and financial pressures, which we discuss at 2.3. COTA prefers, however, to focus first on the drivers that arise from the conviction that policies, programs and services to support older Australians should be designed with their rights and needs as the paramount consideration.

2.1 HUMAN RIGHTS AND A NEW PARADIGM OF AGEING

There is considerable discussion about the projected “changing expectations” of future users of aged support services. We discuss this in more detail at 2.2. However COTA believes these are not only the expectations of future cohorts of older people; they are actually the real preferences of many or most of the people currently using or wishing to use such services. It is not so much that expectations are changing but that people’s needs and preferences are now being more often and more clearly articulated.

Underpinning this change is a more fundamental or foundational shift in how our society views, treats and values older people.

Our currently dominant social construct of ageing is that old age is a time of steadily diminishing capacity and value, a period of increasing dependency on others, a time of growing withdrawal and stasis.

Underpinning this construct is a paradigm of life having a ‘best by’ date. The often unstated assumption is that life has a point or period when it is at its best. After that we are “over the hill” or “on the downhill slope”, with the “best years behind us” or another of many more similarly negative colloquialisms.

Older people are increasingly laying claim to a different paradigm of ageing, which gives explicit recognition to the fact that even if experiencing physical and health challenges they continue to have roles that have value and meaning. Most older people still have goals to achieve, contributions to make, a life to live.

Rather than life having a ‘best by’ date the new paradigm sees life as a continuum of growth and development throughout the whole life course. This paradigm takes an optimising view of the possibilities of later life. It challenges the stereotype that older people have less to offer than others and are therefore to be “looked after” rather than supported and facilitated in their continuing, or indeed renewed or restored, engagement in fulfilling and productive life

The design of our current aged care system arises from the old paradigm. Its dominant mode of care and its major resources are organised around the assumption of dependency and tend to do things to or for people rather than providing support to encourage and enable people to do as much as possible for themselves.

The current system does not take a strengths based and restorative approach to support and care. It does not place its highest priority on the earliest possible and basic support being immediately available to maintain, strengthen and even develop capacity. It does not focus on prevention of frailty and dependency but tends to add to dependency and role depletion.

This paradigm shift is not simply a question of different attitudes. It is about the fundamental right to be treated as an equal and fully valued citizen and human being.

The changing paradigm of ageing is a human rights issue and a citizenship rights issue.

We do not underplay the severe personal, familial and societal impacts of major health challenges, including dementia and other neurodegenerative diseases, for individuals and society. These may be more associated with ageing but they do not and must not be used to define ageing any more than ill health defines or changes a person's rights at early ages.

One clear implication of a rights approach to aged support and care is that the provision of aged support and care services should be provided as an entitlement on an equitable basis for all people in need. This is on the same basis as pensions and public hospital care. Once need is through the approved assessment tool and process, people should be able to immediately access funds to obtain the support or care they need.

2.2 CHANGING CONSUMER AND COMMUNITY EXPECTATIONS

As noted earlier another driver for reform is changing community expectations about aged support and care, particularly around individuals' preference and increasing determination to stay living in the community for longer and to exercise more choice and control over the supports and services they receive. In surveys and consultations COTA has undertaken, people and their carers consistently identify the following desired outcomes:

- ability to access different forms of support and care immediately it is needed
- being able to access support with ease and confidence
- flexible services that meet people's interests and needs
- increased independence and control over their own lives
- support services complement not displace people's and their families capacities
- access to services in their local communities
- availability of culturally appropriate services
- improved quality of support and care when self chosen and managed

It is clear that many people do not think the current arrangements deliver those outcomes.

The Issues Paper asks whether the current system is adequate. Some might argue that the system is 'adequate' because most people do get some form of service even if it is not the type of service they really want, or not in their desired location, or not available in a reasonable timeframe.

COTA maintains that the proper and appropriate measure of adequacy is to assess whether people are having their needs optimally met – whether they have access to the service they want in the setting of their choice at the time it is needed. Indeed we should further assess adequacy by whether or not the system adds or detracts value to people's quality of life.

For example, for decades there has been a disproportionate investment in **residential** aged care. This has meant that many people have gone into residential care when they could have stayed in their home for much longer, in some cases for ever, if enough of the right level of community based support and care services had been available. In this we include appropriate and affordable housing, the lack of which is another cause of inappropriate assignment to residential care.

COTA's consultations with older people also provide many examples of where a preferred form of support or care is not available and the person is offered no alternative to the 'standard fare' or 'set menu' which the provider has decided is all that will be offered. The aged care industry acknowledges that many people are not assessed against their needs but against the services that are on offer.

These issues arise in both residential and community care settings and they are supported to some or even a significant degree by the funding system.

People tell us they would like to tailor the support and care they receive to their specific needs and capacities, partnered with that which chosen family, friends and neighbours can also provide. They tell us that when this does not happen their basic quality of life is undermined and compromised.

2.3 ECONOMIC PRESSURES

Economic pressures for reform come from both the macro and micro-economic perspectives. At the macro level there has been much discussion about the rapid ageing of the population over the next few decades and the impact this will have on the demand for health and aged care services. For example:

- The Productivity Commission's own 2008 research paper on Trends in Age Care described the pressures on the current arrangements and made a cogent argument for substantial reform.
- The 2010 Intergenerational Report made it clear that continuing with the same policy settings would present a serious fiscal challenge as it would mean a substantial increase in GDP being devoted to aged care services and place a heavy burden on future tax revenues at a time when the number of working age taxpayers was decreasing.

These macro level budget pressures on aged care will develop alongside others, in particular the projected increases in the overall cost of the health system. That increase has been clearly shown to be only in minority part attributable to population ageing. Increased health costs will however add significantly to budgetary pressures in the decades when a much larger proportion of the population is likely to be in need of good health care and aged support services while at the same time the proportion of income taxpayers is substantially reduced.

At the micro-economic level it is also becoming increasingly clear that there will need to be a significant increase in the resourcing of both community and residential care if the industry is going to be sustainable and if Australia is to continue to have good quality support and care that everybody can access.

There are a number of pressures on the financial viability of the industry at the moment.

- The need to be able to pay competitive wages at a time of growing workforce shortages and increased competition for staff, not only from within the health and community services but from other industries.
- The cost of capital for residential care exceeding available sources of income for capital, especially given changing accommodation standards and preferences. This issue is becoming critical in some areas such as WA and Queensland.

- Indexation of government subsidies consistently below price inflators for both wages and goods and services, with almost no means for this to be compensated for by providers as user charges are tightly government regulated

The combination of these factors is leading a number of current and potential providers and investors in the industry to question whether it is viable to invest e.g. in Western Australia and Queensland there have been providers' strikes with residential care providers refusing to apply for new approvals for high care and returning approved high care bed licences.

The reputable Grant Thornton industry survey shows that financial returns do not justify commercial investment in the sector.

These financial pressures are in part created by the current regulatory and funding structure of the aged care system. Aged care is among the most regulated industries in Australia. There is an understandable service quality-control rationale for that but aged care finances are also almost totally government controlled with few market disciplines applying and little opportunity for value add.

Either government commits to a very substantial increase in the funding of the current aged care system and to maintaining the real value of that over coming decades, or we step back and look afresh at how we structure, manage and fund aged care so that it better meets the needs of older people and can be sustainably financed so that the real costs of support and care are fully met.

2.4 TIME FOR CHANGE

On an internationally comparative basis Australia's current aged care system has served many of its users and their families well over recent decades. It has gone through a number of major improvements since the 1980s. These have focused primarily on improving service quality and user rights within the current service paradigm. There are now marginal returns at best in further 'tweaking' the current system.

Over the last decade we have seen (and we have participated in) several attempts to deal with the long term challenge of financing an aged support and care system into the future, and redesigning the current system so that, for example, it is more community care focused and more consumer focused. None of these attempts have resulted in substantial change. They have all faltered because there has not been the will to make the move to a new system. It is now past time for such change.

In this submission we have not sought to provide a comprehensive critique of the current system. The Productivity Commission has done a good job of this itself in past reports as have COTA and other stakeholders. We are happy to enumerate these in the Inquiries debates if need be. However we have pointed in this section to the main drivers of reform and we now go on to outline the aged support and care system that older people tell us they would like to see.

3. THE NEW AGED SUPPORT AND CARE SYSTEM

COTA is advocating a new aged care system based on the principles espoused in *Leading the Way: A New Vision for the Support and Care of Older Australians* strongly advanced by us and endorsed by the National Aged Care Alliance (NACA). A copy of this statement is at *Attachment 2*.

In essence this is about moving to a system that has individual choice and control as its guiding principle. This requires significant re-engineering of the current system so that remaining in the community is the default position for older people and support, care and accommodation is designed to make that possible.

There are a number of different ways that people become users of the aged support and care system.

For many the process starts with a need for information and advice on options about how to respond and adapt to changing personal capacities. Over a period of time the older person may move from needing lower amounts of support to higher levels of support and care, both personal and clinical. The pace at which that happens varies greatly with research indicating that early support for one or two basic needs can often maintain people at that level for a long time. (Howe and Gray 1999)¹

For other people:

- the level of support increases over time as their capacity to meet their own needs decreases and they have time for adjustment and to rearrange their lives to fit in with their changing circumstances; or
- the change is more abrupt with the first contact with aged care services being as a result of a health crisis, often requiring an acute hospital stay and then a high level of care with no time for adjustment to personal and living arrangements; or
- there can be a more mixed set of circumstances, with levels of need increasing and then decreasing in response to health challenges and the level and nature of support and care provided by both the health services and aged care. The availability of services such as transition care, immediate rehabilitation, slow stream rehabilitation, accessible primary care, etc is critical to people being able to maximise restorative opportunities.

It is important to re-emphasise that for many people there is not a linear progression from low level support to high level care, and that with a different approach there would be less progression than there is now. We are not talking about a “continuum of care” but rather a set of interlocking pieces with processes in place to identify the right place for individuals with particular needs at any given point in time.

The proposed approach integrates all the support and care services into a system that allows for the multitude of needs outlined earlier. We need a clear map, with well defined entry points, a compass to help people navigate through the system and guides to help people to find their way

¹ Howe, A.L. and Gray, L. (1999) Targeting in the Home and Community Care Program, July 1999—No 3. Aged and community service development evaluation reports, No 37. Canberra, AGPS.

through the multiple options available at every point.

As argued in section 2.1 the new aged support and care system needs to be restoratively and preventatively focused. It needs to be rooted in what one leading innovative provider characterised as "COTA's aspirational perspective on the roles of older people". .

COTA also advocates an expansion of the range of health promotion strategies and programs that support active and inclusive ageing to delay the need for care and support through the removal of barriers to ongoing social, economic and cultural participation. We support the call in the recently released *Smart Technology for Healthy Longevity report* from the Australian Academy of Technological Science and Engineering (ATSE) which calls for a new national approach that shifts funding and policy models to prevention of illness and injury among older people rather than spending on hospital beds and aged-care facilities.²

Such strategies need to include the development of more age friendly built environments, accommodation based on universal housing design principles, and innovative and integrated local transport options as well as significantly increased investment in preventative health programs.

3.1 THE GATEWAY NETWORK³.

People find our current aged care system exceptionally difficult to inform themselves about, enter, and navigate. This includes people who are highly skilled in their profession and not unused to navigating government services, but aged care defeats them.

Older people (and their families) often express frustration at having to go to separate services for information, screening, assessment and access to services. They have to make separate trips, separate phone calls and have to give the same information many times over. The current system of information and referral is under-resourced and quite fragmented, often resulting in people accessing the wrong services for their needs, and/or experiencing long delays that can be extremely detrimental.

The first piece of a new aged support and care system is the development of a Gateway that will:

- undertake promotion of positive ageing and awareness of availability of support for older people;
- provide people with information on relevant support and care services;
- undertake basic screening and assessment to help direct people to the most appropriate services; and
- make direct referrals to basic support and care services.

The Gateways will be used by people accessing aged support and care from the community for the first time allowing them to access information and assess the options available to them.

They will also be the continuing referral point for aged care and support for people who enter

² Australian Academy of Technological Science and Engineering(ATSE) 2010; *Smart Technology for Healthy Longevity*

³ Gateway is a working title. Serious consideration needs to be given to finding a name for this mechanism that clearly identifies what it is delivering and encourages older people to use its services.

hospital and then need a change to current support or care, or to access it for the first time. For planned hospital admissions discharge planning should be done at admission and so the Gateway would have been involved in the planning for post-hospital support and care services.

For unplanned admissions the hospital based geriatric assessment service would make recommendations for support and care that could then be followed up with the Gateway, for more comprehensive assessment or direct referral to services(see 3.3 below). This could all occur whilst the person is still in hospital.

This will remove the need for hospitals to maintain referral-level knowledge of the aged care system and eliminate the unsatisfactory and conflicted process of people being assessed in hospital while in an acute care phase, with hospitals trying to clear beds by getting an older person into any aged care service regardless of suitability.

One of the key recommendations of Professor Ian Philp, National Director for Older People in the UK Department of Health from 2000 to 2008⁴, was that an older person's care journey should be managed outside the hospital and formal health system. The Gateway will make this possible.

It is important that there be a co-design process for these services, involving older people and their carers along with service providers and other key stakeholders.

The right decisions from both a consumer and a system perspective at this point will have substantial efficiency dividends and ensure resources are used in the most effective way.

3.1.1 Education / awareness raising

The Gateways will have a pro-active role working across the whole community to:

- Promote positive understanding, role models and images of ageing
- Raise awareness of services and when and how to access them
- Have a health promotion role in collaboration with other services

3.1.2 Information provision

The Gateways will provide information that older people need to help them to remain living independently including detailed information on support and care services in their area. They will give people the tools to navigate the system on their own and also assist with that navigation as required. Older people have consistently flagged the need to have access to the same person each time they ask for information or advice so that they do not have to start from scratch each time and that person acts as their navigator or concierge.

The information provided will have the following characteristics:

- Accurate and up to date and include both national and local service information.
- In plain English and in key community languages.
- Focus around response to needs and so have a menu with many options.

⁴ Keynote Address, Redesigning Healthcare for the Ageing Population, IQPC Conference Sydney March 2007

- Same information provided through a variety of channels.
- All gateways to have access to web-based information which is regularly updated.
- Individuals can access through visiting a shop front, phoning or using the internet.

3.1.3 Basic screening and assessment

The Gateways will screen people and where appropriate undertake an assessment for basic needs. To do that they would use:

- A national standard tool that puts an emphasis on:
 - Promoting independence and building on existing strengths
 - Identifying restorative options that accord with individuals own aspirations
 - Identifies the need for a more in depth assessment.
- A recall system that follows up at intervals determined by the outcomes of the screening and /or assessment.
- Initiate and use a consumer held -electronic care record linked to E-health records that are being implemented.
- Assistance in accessing services, sometimes referred to as a concierge, as it may involve appointments, booking etc. This is not a case management role but more one of facilitation.
- Undertake a carer's assessment and refer carers for training and support services including respite (see section 4 for details).

3.1.4 Referral / entry level approval

The Gateways provide:

- Direct referral to low level service(s) (part of current HACC) with an emphasis on those that are supportive of independence.
- Referral to more comprehensive assessments.

3.2 ENTRY LEVEL SUPPORT AND CARE SERVICES (HACC type services)

Evidence suggests that small quantities of low level support and care are very effective to maximising independence and keep people to stay living in their community longer (e.g. Howe and Gray 1999).⁵ This makes them cost effective and COTA believes there needs to be substantially more investment in them.

Key issues here are choice and the capacity of the consumer to determine what services they get, who delivers them and when they are used. Older people and their carers are best placed to know what will support them to remain independent and stay at home for longer.

⁵ Howe, A.L. and Gray, L. (1999) Targeting in the Home and Community Care Program, July 1999—No 3. Aged and community service development evaluation reports, No 37. Canberra, AGPS.

The key elements of an enhanced support and care system will be:

- Direct referral from the Gateway with entitlement for assessed quantity of services, set in dollar terms (possibly within a series of levels). This only covers individual services and would be designed to meet relatively low levels of need with more work needed on where this benchmark should be set.
- Support and care services would be defined by their ability to meet assessed needs taking an outcome focus and a wellness approach.
- Services provided need to promote independence and wherever possible have a restorative function as well.
- The entitlement could be made available in many ways with the individual given the choice so that they can decide how much control and responsibility they want to take for organising their services. We are suggesting three options (with people able to combine them):
 - i. Dollar value voucher to be used to purchase services from a list of approved providers
 - ii. A banked entitlement with a concierge or broker who then purchases services from approved providers with the individual determining which services they want.
 - iii. A banked entitlement with a service provider who can offer a wide suite of services. This would be transferable or convertible to (i) or (ii) but not to cash out.
- Initially we are not suggesting a cashing out option but as the industry restructuring proceeds (see 11.2) this would become an option. However the Commission needs to do more work around this taking into account international experience and the implications for individuals and their carers.
- The level of entitlement would be means tested with maximum dollars allocated to people on a full age pension and then a sliding scale of entitlement with an income and asset means test applied. This will allow for higher levels of funding to be offered to those who do not have the means to purchase it privately.
- Individuals would be able to purchase any level of service using a combination of entitlement and own/family resources, as is currently the case.
- Service providers from which publicly subsidised support and care services can be purchased will need to be quality accredited and approved.

3.3 ASSESSMENT FOR MOVING TO MORE COMPLEX LEVELS OF SUPPORT AND CARE

People's needs change. Chronic conditions can worsen despite good self and clinical management strategies; people can have an acute episode or trauma which affects their ability to continue to function as independently as they have been; or over time in very old age frailty can have a

cumulative effect on capacity for full independent living.

The system needs to be able to respond to changing needs, to increase people's entitlement and to ensure people have access to good information and advice about the options that are available to them to meet these higher needs. Individuals (and their carers) are in the best position to decide when this is the case and an effective gateway will provide them with the knowledge and information to lead them to elect for further assessment if they want it at this point.

The Gateways will only be able to self-refer to services up to a certain level, to be set either in dollar terms or a set of needs. Before people can receive support and care above this level they would need to have a comprehensive assessment which would be undertaken by a specialist Care Assessment Service (CAS), a function currently performed by the ACAT. The assessment would, as far as possible be undertaken in the person's normal living environment

There are many possible routes to such an assessment, including:

- Consumers can initiate a complex assessment and approval by going directly to the CAS
- A service provider, a GP or a carer can make a referral to the Gateway which refers on to CAS
- If the person is in hospital the hospital makes the referral to the Gateway which makes an appointment with the CAS. However such an assessment must not be undertaken in an acute hospital bed.

The assessment service should be established as an independent service that is separate both from the health system, at commonwealth and state levels, and from aged care service providers. It needs to be a national service that uses a standard set of assessment tools and processes. Assessment service users must have the right to appeal decisions made by the assessment authority.

3.3.1 In-hospital assessment

The following principles should be applied to assessment undertaken on people in hospital:

- No long term assessment solely in the acute phase. If the individual has previously been in the aged support and care system then their e-record would form an integral part of the assessment.
- The assessment should involve the hospital geriatric service providing information to CAS.
- Long term decisions should only be made after the individual has had some access to transition care which facilitates recuperation or short and long term rehabilitation.

Many older people in hospital have been accessing support and care services prior to their hospitalisation. Their support and care entitlement must continue during their hospital stay with the funds held and accessed after the acute stay when they return to the community.

3.3.2 In community / after hospital

The key features of the assessment process are outlined below:

- *Guaranteed minimum time to assessment*

Assessment needs to be timely so that people can access the support and care they need as soon as it is needed. There must be a performance guarantee and we are suggesting it be that a complex assessment must be undertaken within 10 working days of referral.

There are two systemic benefits of this. The first is that it should deter people from seeking an assessment 'just in case' they might need it, which has been an issue in some areas⁶. The second is that an assessment would be current and therefore service providers would be able to place more reliance on the information in it when looking at how they are going to meet people's needs.

- *Assessing for need*

It is at this stage that the entitlement to funding to meet needs is established. The assessment tool would look at the range of needs and then a dollar value would then be assigned to meeting those needs. This would then become an individual's entitlement to support and care.

Given that people at this level are likely to have more complex needs and need more than one type of service, the entitlement would also include funding for coordination of multiple services.

Assessment of needs will include factors such as language, cultural needs, support network, social needs and capacity to undertake activities of daily living and behavioural issues. There would also be a carer assessment (see the Carers section for more detail).

This assessment will also include looking at the potential for modifications to the living environment that might make it possible for somebody to remain living at home. There would be a separate funding source for assistance with such modifications. It is expected that the use of a range of assistive technologies to support older people remain in their own homes will be an increasing component of such modifications⁷.

- *Outcome of assessment*

The assessment results in a dollar value entitlement as with the basic assessment. There will be a maximum level of subsidy. It can be could be allocated in a combination of one of three ways as outline in 3.2 above.

There needs to be a benchmarking of support and care exercise to set the dollar values (see the funding section of this submission and the COTA submission to the ACFI review which has been provided separately).

⁶ see ACAP National MDS and reports for evidence of this.

⁷ The Queensland Smart Home Initiative is an example of assistive technologies used to support people to stay at home. For more information go to www.qshi.org.au

3.4 SUPPORT AND CARE SYSTEM

3.4.1 Separation of support and care from accommodation

One of the fundamental differences between what is being suggested here and the current system is that the entitlement is to support and care, with accommodation being treated separately (see section 7 for details on accommodation).

This separation assists with removing the distinction between community and residential support and care and would allow for a dollar value to be put on people's needs regardless of their setting of support or care. This in turn would give individuals more real choice on where they receive their support and care. However the maximum level of subsidy available may mean they are unable to get the support and care they need in the community if it would be significantly more expensive than in a residential setting. This requires a full and complete costing of the various options, including short and long term costs which would need to include the requirement for capital in the residential care setting.

Support and care may need to involve some basic "hotel" services such as laundry, cleaning and meal preparation where the individual requires assistance with these. It will be necessary to identify and cost the basic hotel services that could be included in the support and care component of this system.

The default position in this approach is that support and care will be provided in the community and services will be designed around that principle. Currently the investment is skewed heavily towards residential care and people almost have to make a case as to why they should remain in the community rather than going into residential care. This investment pattern will change as people exercise their right to choose when the funding is allocated to them rather than to the provider.

3.4.2 Individual Entitlement

The second major difference is that the entitlement to funding is attached to individuals rather than to providers and regions as at present.

The funding could be taken to a provider or a broker of the individual's choice to purchase a negotiated set of services. The consumer has consumer choice and flexibility as to what they get and who provides it.

3.4.3 Community Support and Care

Subsidised support and care will only be accessed from approved providers and must meet quality standards that are related to desired outcomes. Individuals may choose to purchase care services outside the subsidised care sector.

There will be a support and care plan developed in consultation with the client and his/her carer as a result of the assessment which will identify the needs that are to be met by the support and care services.

There will be the capacity for individuals to access residential-based care on a temporary basis and this could be either "casual" as part of an overall support and care plan, or an accepted part of any transition from community to residential care.

There will be a greater role for use of assistive technology to support in home support and care, and funding could be used for this purpose. We would support ATSE's first recommendation that "there is an urgent need for the Australian Government Departments of Health and Ageing (DoHA) and of Innovation, Science and Research (DISR) to develop a National Research and Development Agenda on 'Technology and Ageing' to ensure national coordination of existing programs relevant to gerontechnology, that is linking the medical aspects of ageing to advanced technologies. This approach would complement the National Strategy for an Ageing Australia and the National Enabling Technologies Strategy and would be in line with the Australian National research Priorities."⁸

3.4.4 Residential-based Care

There will still be a need for some forms of residential or congregate support and care for:

- People for whom support and care in the community is too expensive. What constitutes "too expensive" requires discussion. Is it when the same support and care can be provided for a cheaper price in a combined care and accommodation setting? Should it be the same dollar value as is used for disability programs?
- People whose complex behavioural needs require constant monitoring, supervision and support and therefore a secure environment
- The very frail and vulnerable (likely very old) who want constant and immediately available professional care and support
- Older people who have sub-acute care needs, requiring appropriate nursing and medical support. This group may be short term users of residential care.
- Significant palliative care needs.
- People using residential care for "recuperative" periods (in/out) then return to the community.

However, some of the above will be more possible than in the past in community housing / seniors living, with the use of assistive technology and more innovative housing design which clusters people together whilst still maintaining independent living as far as possible.

It is important that the regulation and funding of residential care promotes the capacity to have periods of combined or interwoven community /residential care.

⁸ ATSE 2010 Smart Technology for Longevity: Recommendation 1

4. SPECIAL NEEDS GROUPS

If the aged support and care system is redesigned to be person centred around the principles of consumer choice and control then the needs of special needs groups are more likely to be identified and met.

However to varying degrees between various population groups with particular needs, there may still be a need to encourage providers to tailor their services to meet particular sets of needs and to develop specific training packages to support this; and the funding models will need to take account of the extra cost of providing such support and care. The additional funding could be delivered either as grants to services that target special needs groups or as an additional allocation to individuals or probably a mixture of these as an additional individual entitlement is of no benefit if there are no services which offer the appropriate support.

It will also be necessary to ensure that quality standards across all care settings include explicit reference to the special needs groups and have performance indicators to measure how well the service is meeting the diverse needs of older people.

These points apply to all special needs groups. In this section we draw attention to the specific needs of each group within our constituency, acknowledging that in cases such as special training these are specific examples of the same principle. However in a transitional context it will be necessary to continue to pay attention to specific groups.

Across all special needs groups it is also important to point to the need and value of engagement in aged support and care of community organisations and other services in those special needs communities.

4.1 PEOPLE WITH DEMENTIA

As the population ages the number of older people with dementia is going to increase significantly, as Alzheimer's Australia has repeatedly demonstrated.⁹ This means an increasing number of people accessing aged support and care are going to have dementia and therefore providing for their needs becomes part of all aged support and care services' core business.

Other submissions especially from Alzheimer's Australia will deal with this issue in more detail and they will advocate for most of the strategies below. However COTA indicates its strong support for the following:

- Substantially increased funding for research into dementia and more emphasis on possible prevention measures including better information on possible risk factors. Dementia research may not seem to be 'in scope' for this inquiry, but we point out that significant progress to prevent, treat or delay dementia onset would have a more dramatically positive effect on aged care demand than any other preventive health measure.

⁹ Go to www.alzheimers.org.au and then to Publications and Resources to review numerous reports.

- Increased investment in dementia training and skills development within the workforce and increased recruitment and retention of clinicians and health professionals with those skills is essential.
- Specific training for workers supporting people from culturally and linguistically diverse backgrounds with dementia, particularly for language and dealing with trauma.
- Inclusion of an explicit standard for dementia care built into any quality regimes for both community and residential support and care. The revised residential aged care standards currently being developed include such a standard.
- Enhanced access to respite services for people demonstrating behavioural or psychological problems as a result of their dementia.
- Development of care protocols for people with dementia in acute wards and emergency departments.
- Improved coordination of dementia support and care at the interface of the acute and community sectors, which could be achieved by improved discharge planning and improved access to specialist dementia services.
- Improved early diagnosis and better access to information and early intervention programs building on existing initiatives such as the National Dementia Support Program.

4.2 OLDER PEOPLE WITH A LIFELONG PHYSICAL AND / OR INTELLECTUAL DISABILITY

The support and care needs of older people with a lifelong physical and intellectual disability require special attention. An increasing proportion of people with an intellectual and physical disability are living well beyond middle age and into their 60s and 70s, increasing the diversity of needs of older Australians and the workforce requirements and training to support these special needs groups.

In November 2009 the Inquiry into Planning for Options and Services for People Ageing with a Disability was referred to the Senate Community Affairs Committee which is due to report in September 2010. COTA has put a submission into that inquiry which is available on the Committee's website.

COTA is recommending that:

- Consistent with the NACA vision statement and COTA's principles against age discrimination, people in receipt of disability support services should not lose those services because they reach a particular age. Disability related needs do not stop when a person reaches 65 years. Aged support and care service entitlement should not become a substitute for continuing disability service entitlement.
- As the care needs of people with a disability increase due to the ageing process they should gain aged care and support entitlements in the same way as all other people. They must be able to use these entitlements in an integrated way with their disability support payments.

- In order to be able to respond to the complexity of support and care needs of people with an intellectual/physical disability, workers (nurses and personal care workers) in residential and community support and care settings need to be provided with appropriate training to maximise the individual's independence, social inclusion and functional abilities. Such training also needs to include training to identify and treat depression; and how to manage challenging behaviours.

4.3 OLDER PEOPLE WITH A PSYCHIATRIC DISABILITY

The needs of people with a lifelong psychiatric disability require particular attention. Many people with a lifelong psychiatric disability are living longer although people with schizophrenia, bi-polar disorder, and chronic alcohol related mental health problems and personality disorders have a significantly reduced life expectancy. Suicide only partially explains this shorter life expectancy with delays in diagnosis of chronic heart disease and cancer being major factors.¹⁰

In addition to the needs of people with lifelong mental illness are the increasing mental health needs of specific older population groups including older CALD people with post traumatic stress disorders, an increasing proportion of older people with a range of affective disorders, the need for culturally appropriate mental health services for older Indigenous people and the need for more services in rural and remote locations.¹¹

Mental illness is also a major health issue for older people who are homeless and these people are subject to stigma by society on two fronts, homelessness and mental illness.

COTA is advocating for:

- models of support and care that ensure that the needs of people who are both homeless and mentally ill are not further marginalised by frameworks, criteria and quotas informed by notions of stable accommodation and growing older gracefully.
- training of the aged support and care workforce to include components on the support and care of older people with a mental illness, intellectual or physical disability, with innovative strategies developed to provide support and care for older homeless people.
- strategies that build on people's strengths and work to maximise their functional abilities and social inclusion.

4.4 GAY, LESBIAN, BISEXUAL, TRANSGENDER AND INTERSEX (GLBTI) PEOPLE

Approximately 8% of the population identify as gay, lesbian, bisexual, trans and intersex (GLBTI). By 2051 it is estimated that there will be over 500,000 million GLBTI people aged 65 years and in Australia. Despite the size of this minority group, older GLBTI people have been almost invisible within ageing policy.¹²

¹⁰ (www.abc.net.au/rn/talks/8.30/helthrpt/stories/s409295.htm)

¹¹ (www.mja.com.au/public/mentalhealth/articles/hall/hall.html).

¹² GRAI 2010: We don't have any of those people here: retirement accommodation and aged care issues for non-heterosexual populations.

Many older GLBTI people not only lack family support networks in their older age but also continue to be stigmatised and discriminated against both from residents and clients of older people's services and by service providers. Because of this it is clear that many of them experience unmet needs.

They also have concerns around social isolation and their same-sex partner not being included in decision making, support and care planning and being their 'families of choice' from their service providers. For more detail on these issues go to Catherine Barrett's My People report¹³ and the GRAI report of 2010. It is clear from these two reports and other work that this group has very particular needs that are not being met currently.

COTA is recommending that:

- GLBTI people are identified as having special needs which need to be met with additional support and improved access to services.
- Development of specific services and projects for older GLBTI people, including best practice guidelines for services.
- Staff training to ensure people are treated with dignity and have access to the same quality of support and care as other groups.

4.5 OLDER PEOPLE IN RURAL AND REMOTE LOCATIONS

Australia has an ageing population, with the ageing more marked in rural areas. Thirty-five per cent of Australians aged over 65 years live outside the major cities. People over 65 account for 12% of people in the major cities, 14% in regional areas and 7% in remote locations. In the 2009 HACC community consultations in Queensland a number of problems were identified for people living in rural areas. They include:

- limited access and choice in respite services
- long waits for ACAT assessments and home modification services;
- fragmented information about services that are available

The access and range of services available to older people in rural areas is limited with difficulties experienced in terms of workforce recruitment, retention and training, distance to services [complicated by lack of transport options] and economies of scale in terms of providing residential aged care services.

COTA is suggesting the following measures:

- The integration of assistive and communication technologies into community support and care options could address some of the lost support resulting from fewer carers. This has particular relevance in rural and regional areas.
- Specific measures need to be put in place to ensure comparability of service access and

¹³ Catherine Barrett, 2008: My people; a project exploring the experiences of Gay, Lesbian, Bisexual, Transgender and Intersex seniors in Aged Care Services

choice for older people in rural and remote areas who need support and care to either remain in their own home or seek residential support and care in their local community.

- Role of and/or extension of the Multi-Purpose Service program that provides a range of residential, acute, community and primary care services for older people.

There will need to be a different cost structure for rural and remote areas. There are two key issues that need to be addressed when looking to make such services viable.

- Costs of some inputs are higher, i.e. some wages, freight costs, travel costs, lower scale effects, etc. This can be dealt with by having a rural and remote loading added to the value of the entitlement.
- Distances between clients and between clients and home base often means the number of services able to be provided in a day is significantly decreased and the time to deliver to an individual is significantly more than in more populated areas. This means the entitlement to services needs to be increased to take account of travel time otherwise people in rural and remote areas simply do not get services.

4.6 CULTURALLY AND LINGUISTICALLY DIVERSE (CALD) OLDER PEOPLE

By 2011, nearly 23 percent or more than 1 million Australians aged 65 years and over will have come from a culturally and linguistically-diverse background; by 2021, this figure will reach 30%. The post war migrant cohorts from source countries such as Italy, Greece, Germany, Netherlands and Poland are ageing more rapidly than the rest of the Australian population. It is vitally important that any discussion on the needs of older people reflect the cultural and linguistic diversity and needs of older migrants and refugees. Access to culturally and linguistically appropriate information and services are paramount in a multicultural society.

The promotion of ethnic specific residential aged support and care services is essential to the social inclusion and cultural participation of CaLD residents. In a perfect system all residential aged support and care facilities would be inclusive and actively support all forms of diversity. However while all services must be accepting of diversity, it is impossible under current funding models to provide the necessary depth of support for everybody.

Language is one of the key issues. In a residential facility proper funding for language support would mean rather than using a picture board to communicate residents would have adequate numbers of bi-lingual staff and other residents to chat with who speak the same language. In community support and care there is some evidence from CACP providers that assist clients from CaLD backgrounds that the use of interpreter services is paid out of the client's funding for their package. This means that clients from CaLD backgrounds are in fact provided with a "lesser" package of support and care than those clients for whom English is their first language.

Once a person enters residential aged support and care, they seem to 'disappear' from the local community. It is important for the resident to still be part of their cultural and religious community. Once they enter residential aged support and care they are not eligible for the funding they previously had when living at home and allowed them to take part in cultural and religious activities with their community. The move to a funding entitlement and separation of accommodation and support and care should allow people to use some of their entitlement to meet these social needs.

The Federation of Ethnic Communities Councils of Australia will provide a comprehensive submission around the specific needs of older people from CALD backgrounds. COTA is suggesting the following:

- Flexibility in service agreements to facilitate collaboration between services and improve responsiveness to CALD aged support and care needs,
- Greater funds are required to educate and inform CALD communities on aged support and care options.
- Funding for interpreters and other language specific services should be additional to the support and care entitlement.
- Targeted recruitment and specialist training of bilingual carers in the main CaLD language groups with cultural competencies embedded into all aged support and care training.
- A commitment to research in best practice in the provision of CALD aged support and care services and initiatives.

4.7 ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

COTA does not believe that it should speak for Aboriginal and Torres Strait Islander people and does not seek to do so in this submission. We anticipate that Aboriginal and Torres Strait Islander organisations with which we regularly consult are themselves making submissions. Our comment is therefore a statement of the general principle that there should be culturally appropriate and secure support and care services available to all Indigenous people regardless of where they live.

The proposed move to individual entitlement and more individual choice and control should benefit Aboriginal and Torres Strait Islander people as it will everyone else in the community. They would be eligible for additional funding to ensure their specific needs are met and it may be necessary to provide incentives to services to encourage them to meet these needs.

In addition we are suggesting that:

- There be an increase in the number of identified services, both residential and community, in urban, rural and remote areas.
- Requirements be placed on all support and care services to ensure that their services meet Aboriginal and Torres Strait Islander people's needs. Currently mainstream services are not good at doing this and the lack of an Indigenous specific standard in the accreditation standards needs to be addressed.¹⁴
- All services, from information provision through assessment and support and care service provision should be culturally appropriate.
- All tools and processes used should be culturally appropriate. COAG initiated some work around ACAT assessments for Indigenous people and this needs to be used to inform the design of appropriate assessment tools and processes for both the Gateway and CAS assessments.

¹⁴ Office of evaluation and Audit ,2009: Performance Audit of residential Aged Care for Indigenous Australians

- All staff in support and care services should be required to undertake some cultural awareness training with cultural competencies imbedded into all aged support and care training.

4.8 VETERANS

Veterans are an accepted special needs group in the current aged care planning process and COTA recognises the specific reasons for this and for veteran aged support and care to recognise, for example, unique mental health requirements for veterans.

COTA is not speaking specifically for the veteran community but liaises closely with the Returned and Services League in this regard. However COTA again believes the proposed move to individual entitlement and more individual choice and control should benefit veterans as it will everyone else in the community. They would be eligible for targeted funding to ensure their specific needs are met and it may be necessary to provide incentives to services to encourage them to meet these needs

5. CARERS

The role of informal carers particularly in the provision of community support and care needs to be more widely and comprehensively recognised and measures put in place to support them and better enable them to keep caring as long as they wish to do so.

The projected decrease in family support and care networks into the future needs to be considered in the construction of any new service delivery model, as the same level of support and care from family members as now cannot be relied upon. Smaller families, women's career trajectories and more dispersed family arrangements will necessitate greater reliance on community support and care. In addition when older people relocate in their retirement, the loss of a partner or a change in their health status can precipitate entry to residential support and care because of the lack of family care and support networks to enable them to remain at home.

5.1 CARER ASSESSMENT

There should be separate carer assessments undertaken at both the basic and complex stages of a person's support and care assessment. This carer assessment needs to occur as soon as possible after the person they support and care for is assessed. If the person is in hospital the carer must not be assessed until the person returns home.

The carer assessment is the basis for a support and care plan for carer/s needs. The assessment identifies the carer's needs for training, support and respite.

Carer entitlements can apply whether or not the person they support and care for is actually receiving services but would need services if the carer was not there. This is important as a carer may need support when the person they are caring for has refused services.

5.2 RESPITE SERVICES

Respite services need to meet the needs of both the carer and the support and care recipient if they are to provide effective support and be well utilised. Many carers have expressed reluctance to use respite because they know the older person they are caring for does not enjoy the activities on offer. It is important that respite offers activities that are suitable and stimulating for the older person.

To do this respite services should treat the older person as an individual with interests and community connections that should be catered for. If respite is given as a dollar value entitlement then there would be more scope for building services around the individual older person and their carer. This would also assist with provision of more appropriate respite for people in the special needs groups identified in section 3 above.

One of the major criticisms of respite support and care is that it is simply not geared towards the carer's needs. Many community based respite services are only available during business hours on weekdays and so do not allow carers to use respite to access things like church services and other weekend activities.

Carers are best placed to know what services would provide them with the respite from caring that will enable them to keep caring. For this reason all respite needs to be available as consumer directed care with a dollar entitlement that can be used to purchase services as required. As with

the low level services discussed in 2.2 above there would be three possible ways to put this into operation, a voucher, an entitlement held by a broker or an entitlement held by a service provider.

There needs to be further consideration of the financial costs incurred by carers. The current carers allowance grossly undervalues the real costs and loss of income associated with being a carer. The income threshold is too low for prospective full-time carers. This needs to be reviewed along with making costs (such as mileage and hours away from work) legitimate tax deductions for carers.

6. FUNDING OF SUPPORT AND CARE

6.1 GOVERNMENT AND INDIVIDUAL FUNDING

The first part of the funding question is about how much individuals pay and how much is subsidised by government and in accordance with what criteria.

Currently there is a mixed system with government providing subsidies and users making a contribution. This is unlikely to change so the question becomes how much is by subsidy and how much by personal contribution, on what criteria and how those personal contributions can be made.

There needs to be a national fees policy for all government subsidised services that is mandatory for all service providers and provides consistency across support and care settings.

These national fees would be built into the costing structure with user contributions related to capacity to pay - with both an individual service cap and an overall cap regardless of number of services. User contributions would go into a pool and then be distributed to service providers, with the Government paying into the pool the user contributions that would have been made if there was not an overall cap.

There would be no restriction on purchase of additional services above entitlement and user contribution, as is the case now.

It is worth noting that there are a small but growing number of people who purchase support and care without any government contribution. There are a small number of providers who work exclusively in this sector. This is mainly in the HACC type services especially domestic assistance and some social support. Any system of regulation needs to ensure it does not inhibit the growth in such providers as they offer choice and to some extent take the pressure off the service providers providing the government subsidised services. In the proposed system individuals are assessed as having an entitlement for support and care which can then be spent via approved providers. The funding would relate to meeting needs (outcomes) not service type and the subsidy would not cover accommodation costs.

One of the issues which needs further work is the capacity to pay family and friends to provide support / care if chosen by individual. There is a precedent in the child care arena where family members can be the registered care-giver and the parent can then receive the Child Care rebate. It would be instructive to look at how this has operated. There has also been a strong push from the disability sector for family support and care givers to be able to be paid through consumer directed support and care models.

6.2 SYSTEM FUNDING

The other part of the funding question is around how government will fund the system. It is obvious that there will need to be a significant increase in the funding of aged support and care over the next 20-30 years. The challenge is to work out from where to source the increased funding given that a fully user pays system is not a realistic or desirable possibility in Australia.

There are many possibilities here and we are looking at two broad areas; using tax revenues through the consolidated revenue process; having a specific funding source through a social insurance scheme, or a blend of these two options. There are a number of other options including hypothecated taxes and levies which could be used.

6.2.1 Consolidated revenue

The current system funds aged support and care services predominantly from consolidated revenue which comes from all tax payers. This means that current taxpayers fund aged support and care services for the people who need them with most of this responsibility falling on working age people paying income tax, as income tax makes up some 64 per cent of tax revenues in Australia¹⁵. Currently direct user contributions for aged support and care services differ significantly across the different programs, accounting for about 5% for HACC services; 16% for CACPs; 5% for EACH and EACH-D; and 30% for residential support and care. Accommodation charges and bonds account for the majority of this 30%.

The main advantage of the current system is that it can be funded from a large taxation pool and so the risk is spread across the whole tax base, with Government being able to move funds around to meet changes in funding requirements. This allows Government to be responsive to changing economic circumstances.

It is also seen as universal and is consistent with how all other government services are funded. And has elements of progressivity (income tax), although GST is regressive and flattens this effect.

However at present there is no entitlement to aged support and care services and funding for these services is doubly rationed and capped, so government controls the level of expenditure with an iron fiscal fist. There are no guarantees for future provision and in part it is this funding model which is to blame for lower than desirable levels of investment in community support and care and lower than sustainable funding for the industry as a whole.

One of the main disadvantages of this approach is that it is funded by the current generation of taxpayers to provide services which they are not using. One of the consequences of the ageing of the population is that the number of income tax payers as a proportion of the population is declining and so they will have to meet increasing funding levels for aged care services which will probably mean that income tax rates will have to rise.

This may not be critical in isolation. However there are many other predicted pressures on the public purse – such as escalating health care costs. When self interest conflicts with aged support and care interests who will prevail?

6.2.2 Social insurance

COTA joined with Aged and Community Services Australia (ACSA) to look at possible funding models and produced a brief discussion paper on a possible social insurance approach (see *Attachment 3*).

¹⁵ Australia's future tax system at www.taxreview.treasury.gov.au

A social insurance or social savings approach would require all tax payers to pay into an aged care fund all the time they pay income tax. This fund is quarantined and can only be used to provide aged support and care services. The fund is used to provide aged support and care services for those who need them as they need them. This spreads the burden of funding across a number of generations, and across the whole population (like the Medicare levy). There could also be user contributions.

One of the benefits of a contributory social insurance scheme is that it would give a greater sense of entitlement to service based on assessed need and Government would have to ensure they are provided. For Government this poses the risk that the cost of such provision would be greater than the fund and so it would be required to provide potentially unrestricted additional funding. However if the scheme is properly actuarially based this risk is relatively low

There are a number of key questions that would need to be clarified and decided if a social insurance scheme was implemented. These include:

- Which services would be included in the scheme and would this change over time?
- The level of the premium or levy. Ideally it would need to be sufficient to meet the needs of the scheme in the long run although it is accepted that in the medium term there will continue to be a need for additional funding from Government through consolidated revenue.
- Who pays? It is important to capture as large a proportion of the population as possible and so it important to capture not just working age people but all other people who have the means across the population.
- What about people who can't pay? There would need to be provision for Government making payments into the scheme on behalf of people who are unable to make a contribution.

6.2.3 Price

One of the real concerns at the moment is that the current funding model does not ensure viability of service providers. The current subsidy level and allowable user charges do not reflect the costs of the inputs required to meet people's needs.

There need to be independently set prices for support and care services (as is now to be done for hospital episodes and is already done for the MBS). These prices must be related to efficient best practice (incorporating proper workforce costs) which is thereafter indexed to actual price rises.

To achieve this there needs to be agreement on what support and care is being provided and what the desired outcomes from that actually are. This becomes more difficult when there is consumer choice over service types but it is essential.

7. ACCOMMODATION / HOUSING

A major issue at the moment is the cost of capital for residential aged care. In low care and extra service providers are able to charge entry contributions which they can use, subject to regulations, to fund capital expenditure. In high care they do not have that option. Although there are periodic accommodation charges they are not sufficient to meet the cost of capital funding.

One of the guiding principles here is that most people pay their own accommodation costs throughout their lives and can continue to be responsible for this even when they have support and care needs.

In the reformed system most support and care will be provided in the community at home. However as outlined in 3.4.4 there are some groups of people who will continue to need a combined care and accommodation (residential care) setting.

If individuals choose or need to have their needs provided for in a congregated residential setting of accommodation integrated with care then the system needs to ensure that it is available and they can access it. The support and care would continue to attract the same level of government subsidy as if they were still in the community and they would be expected to meet, subject to their capacity to do so, the cost of their accommodation.

Providers who want to offer residential care would be approved as combined care and accommodation providers. They would be required to offer a variety of payment methods (themselves or via financial institutions) for people to pay their accommodation costs e.g. by rent, loan, purchase, deferred fees etc. Government regulation would ensure the financial security of people's investment.

If one member of a couple requires this form of support and care and both want to continue to live together, then the provider must have a facility for couple accommodation as is the law in Denmark. This would need to be subject to a means test that would ensure people with insufficient means do not end up liable for onerous double accommodation costs.

Government will need to regulate to ensure prices are transparent, comparable and fair in addition to the normal provisions of consumer protection and unfair contracts law which should apply to aged care contracts. There would also need to be guaranteed security of people's capital through the recently announced enhanced set of prudential arrangements.

7.1 PEOPLE WITHOUT MEANS

There will need to be specific and special provisions for people without sufficient housing means, for example in insecure or rental housing inappropriate for support and care, or who are homeless. They would qualify for government accommodation assistance through an income and assets test. This subsidy would be with an approved combined provider or to access appropriate seniors housing in which support and care can be provided.

There may also need to be some incentives for providers to keep a certain number of places for people who only have the government subsidy to pay for their accommodation.

7.1.1 Homeless Older People

The separation of accommodation costs from those for support and care and increased levels of investment in community support and care should make it easier to fund services for people who are homeless. However there need to be more flexible models of support and care for older homeless people particularly those with chronic health conditions including mental illness.

7.2 HOUSING PROVIDED SPECIFICALLY FOR OLDER PEOPLE.

COTA and ACSA, working as the Older People's Affordable Housing Alliance, in its Discussion Paper "A Fair Share for Older People" (see *Attachment 4*) called for the creation of a National Older Person's Housing Strategy. As well as addressing affordability issues it also looked at the need to ensure housing design facilitated the provision of support and care.

The separation of accommodation from care and support and the increasing number of older people should lead to more innovation and increased private sector investment in seniors-specific housing types.

The delivery of community support and care into congregated or clustered seniors living can provide similar efficiencies to residential care. There are a number of models in Europe and in Sydney the Benevolent Society is just about to develop its Apartments for Life project, which is based on the Habitas model in the Netherlands.

Appropriate neighbourhood design, including pedestrian friendly environments, and the provision of local community transport options will be required to support people to continue living in their communities.

While the Issues Paper takes a broad view of 'retirement villages' there are other forms of accommodation such as private rentals, rooming houses and community and public housing where a number of issues are not being addressed.

As the National Housing Supply Council notes in its 2010 State of Supply Report¹⁶ at Chapter 8 'Housing demand in an ageing population':

"As the population ages and longevity increases, there will be a considerable increase in the number and proportion of older people seeking housing assistance, support to remain in their home, and transition to other housing options better suited to their emerging circumstances.

"Maintaining independent living for as long as possible is an important priority for most older people. Meeting the housing needs of older Australians is as much about health, mobility and maintaining connections with friends, family and support as it is about housing, income and housing costs.

"The solutions, therefore, need to be found in a 'joined up' approach that views older households' housing needs as one element in a more holistic view of maximising their independence as and when their circumstances change and their need for support increases. This extends the challenge to society as a whole, including funders and providers of support

¹⁶ www.nhsc.org.au/state_of_supply/2009_ssr_rpt/default.htm

services, health care agencies and families, to work in partnership with providers of housing and housing assistance to deliver high-quality and affordable outcomes.”

Universal housing design or at least the setting of minimum design standards for all ‘senior specific housing’ is essential if there is to be real capacity for ageing in place¹⁷. This would give older people increased choice to remain in their homes in the community as they would be either already equipped or easily adaptable for higher support needs.

Universal housing design standards would also address some of the issues around developments such as residential parks, which target older people as a lower cost retirement village option, utilising demountable units, but which provide accommodation that is often found to be totally unsuitable for people with care and support needs. Privately provided rental accommodation [both for profit and not-for-profit] can likewise be unsuited to the provision of care and support.

There must be adequate consumer protection for people moving into all types of retirement housing options but not through the Aged Care regulatory framework. Retirement Villages are covered by specific legislation in most jurisdictions but it would be helpful if there was a harmonisation process across all the jurisdictions to ensure all Australians have the same protections and that the level of protection reflects fair trading.

Such protections should extend to other forms of housing provided specifically for older people such as residential parks and age specific clustered private rental units.

The introduction of seniors housing information services where they do not yet exist would assist seniors to make good housing choices at all stages of life.

7.3 HOUSING DEMAND IN AN AGEING POULATION

Our call for a National Older person’s Housing Strategy also seeks to throw the spotlight on the major demand pressures for private and public rental housing and appropriate forms of owner-occupier housing as the population ages. Since that call the National Housing Supply Council’s 2010 State of Supply Report previously cited has supported our concerns. Its key points are:

- *“Ageing of the population will have significant impacts on the housing sector as the proportion of older households (households in which the reference person is aged 65 or over) is projected to grow from 1.6 to 3.2 million households from 2008 to 2028.*
- *This represents an increase from 19 per cent of all households in 2008 to 28 per cent in 2028.*
- *The projections of underlying demand indicate that there will be pressure on both private and public rental markets to meet the needs of older renter households. Underlying demand for private rental from older households is projected to rise from 146,200 in 2008 to 321,400 by 2028, and public rental demand is projected to rise from 86,500 in 2008 to 189,800 in 2028.*

¹⁷ The National Universal Design roundtable (of which COTA is a member) recently launched its guidelines for liveable housing incorporating universal design principles – see the Roundtable’s design standards and Strategic Plan at www.fahcsia.gov.au/sa/housing/pubs/housing/Pages/livable_design.aspx

- *Underlying demand in the dominant owner-occupier sector is projected to grow from 1.3 to 2.6 million older households over the projection period.*
- *In 2008, there were 184,400 households with the reference person over 85 years. By 2028, this number is projected to rise to 351,200, an increase of 166,700 households.*
- *Lone-person households are projected to increase from 47.6 per cent of all older households in 2008 to 51.7 per cent in 2028. As lone-person older households grow in numbers, they may increasingly seek smaller dwellings.*
- *Challenges remain to ensure that there are sufficient options for older households to age in their own home or alternative appropriate accommodation close to family, health services and other forms of support.*

These figures dramatically highlight the need for a more concerted, well-resourced and specific focus on housing supply for older Australians than has been the case for many years. COTA believes the Productivity Commission must draw this to the attention of governments as part of the report of this inquiry.

Without sufficient stock of appropriate and affordable housing there will be a crisis in aged support and care, as such housing is critical to both older people's welfare and quality of life has a major impact on the capacity of other support and care services to deliver effective outcomes.

8. WORKFORCE

A national aged support and care workforce strategy needs to be developed as a matter of urgency. However this needs to be not only a macro or global over view, but a workforce planning exercise that builds from individual service or facility up, by region, to jurisdiction, to national addressing key strategic questions (see *Attachment 5* from Workforce Planning Australia).

Such a strategy cannot occur in isolation. It must take account of the workforce strategies of both related industries (e.g. the various parts of the health system) and other industries that will compete for the same labour. In WA for example this will include the resources sector, and we understand that the finance and banking sector has been specifically targeting nurses.

The most critical immediate issue is the need for aged support and care services to be able to offer competitive remuneration. Aged care and support services are in competition with the other parts of the health system and other industries for staff and so it is imperative that their funding is sufficient to allow them to provide competitive remuneration for all staff. This is particularly true at present for registered nurses. The Government has put in place a new set of initiatives to train, retain and recruit nurses into aged support and care but without comparable pay scales this is always going to be a difficult and uphill task.

Another key reform is changing the culture of aged care and support services to person centred support and care that has the focus of maintaining independence and enabling individual choice. An important part of this shift is the recognition of the role of informal carers as part of the support and care team. They have a complementary role and increase the total support available for an older person and make an important contribution to their quality of life. This culture shift requires resourcing as it means putting in place a system-wide change management process so that all existing and new staff are working within the new paradigm.

There need to be accompanying changes around occupational health and safety management, particularly when working in people's homes. Standards that are set for an institutional setting where there are other support staff to do specific tasks often do not translate well when the support and care is being provided in somebody's home. This is particularly true for domestic assistance support where the restrictions at the moment on moving furniture, using stepladders, reaching above the head, etc, significantly reduce the value of the service to a number of clients. There needs to be some research into the context of the work, appropriate training for workers and employers, use of appropriate safety equipment, etc.

There needs to be a greater adoption of assistive technology with all staff trained to use it and to see it as an essential complementary part of their practice. Again this requires training in its use and acknowledgement in awards and scope of practice guidelines of its place in the care system.

As the system moves to providing higher and more complex care at home the vexed question of medication management and administration will need to be dealt with. Currently drugs and poisons legislation and regulation is a State and Territory issue but there needs to be some process of harmonisation or at least agreement on a minimum set of provisions. The role, keeping in mind safety concerns, of informal carers and staff other than registered or medication endorsed enrolled nurses' needs to be looked at with a view to increasing the scope for them to administer medications.

8.1 VOLUNTEERS

It is imperative that any workforce strategy recognises the place of volunteers in the current aged care workforce, particularly for community-based support and care, but also residential care.

Many community aged care services are delivered entirely by volunteers or rely heavily on the support of volunteers for their service delivery. There are important questions to be asked and answered in relation to the sustainability of this model and the support requirements for ensuring that these services continue to be delivered.

The management of volunteer staff is unique and distinct from that of paid staff. Done well, which is not always the case, it requires appropriate funding, resources, professional development and recognition. This needs to be taken into account both in maintaining current volunteer effort and in any exploration of new opportunities to effectively engage volunteers in the delivery of aged care services in Australia.

There should be a separate specific review of the sustainability and appropriateness of continuing to deliver through volunteers those services which are currently highly reliant on volunteer staff, such as Meals on Wheels in some states. While the contributions of volunteers are properly valued and respected, services that substantially rely on them face challenges of longer term sustainability and in some cases capacity to respond to people's needs in the way we have advocated in this submission.

Such a review will need to take into account changed and changing trends and standards in volunteering, against which the future sustainability of a volunteer workforce in aged support and care services may well be called into question.

We think it is very likely that if there is to be a continuation of significant use of volunteers in this sector effort such a review would need to recommend a range of measures that will require financial and other government support to place volunteer based services on a more sustainable basis.

9. QUALITY

The relationships and divisions of responsibility between the Department of Health & Ageing on the one hand and the Aged Care Standards and Accreditation Agency, the Aged Care Complaints Investigation Scheme and the National Aged Care Advocacy Program on the other, need to be redesigned to clarify boundaries, strengthen roles and ensure greater independence of quality agencies from the funder and regulator. COTA believes that all compliance, complaints and advocacy programs should be and be seen to be independent of the funder, i.e. the federal department.

9.1 ADVOCACY

In a more consumer driven system there is a greater need for individuals to be supported to help make choices and to have those choices respected. An important part of any quality aged care and support system is to have a robust advocacy system to help address the power imbalance which exists between individual people and families who need support and care and the people in organisations who provide support and care.

We need to expand and further develop the National Aged Care Advocacy Program (NACAP first usage) to ensure it provides good coverage to people receiving community support and care. This requires additional investment and probably some legislative change to give advocates and those for whom they work certainty of independence, autonomy and authority.

There may be value in exploring whether a formal linkage between the NACAP and consumer advocacy organisations like the COTA network would add value and capacity to the advocacy process at a system level. The South Australian experience over twenty years would suggest this may be the case.

We believe it is also worth discussing whether the Community Visitors Scheme (CVS) could be reformed to give it a “front line” education, awareness and advocacy role, as we understand to be the case with some CVS schemes in the disability sector. This could provide invaluable support to and supplementation of the NACAP services.

There needs to be a review of related schemes run by States and Territories to review overlap or gaps and ensure there is sharing of information and there should be strong linkages with state initiatives particularly in the areas of elder abuse and guardianship.

9.2 COMPLIANCE SYSTEMS

Support and care accreditation and compliance need to be completely separate from accommodation standards which should be covered by existing building regulations under the Building Code of Australia and possibly legislation for particular accommodation types like the retirement village legislation.

There needs to be an integrated approach across current HACCC, community package and residential care systems so that providers only have to comply with one quality regime. The system needs to have a modular approach so that providers need only comply with the elements of the system that apply to the type/level of service they are providing.

One of the most important reforms is that there needs to be greater user involvement in accreditation and compliance processes. COTA's submission to the Accreditation Process Review dealt with this and is at *Attachment 6* for information.

The quality systems need to be designed around a constant feedback loop and continuous improvement rather than periodic snapshots of documentation. This is particularly true for user views where the traditional method of periodic resident (and carer) satisfaction surveys lose immediacy of reaction to particular events.

9.3 COMPLAINTS

COTA is advocating for action on the key issues identified in the Review of Aged Care Complaints Investigation Scheme (CIS), in particular the separation of the CIS from the funding Department. The key issues were:

- the need for the CIS to improve its communication processes with both consumers and providers;
- the importance of encouraging a range of options for managing complaints – from resolution at the local provider level, to mediation and investigation by the CIS;
- the perception that as the funder and regulator of aged care services, the Department is not the appropriate body to manage the complaints investigation process;
- the need to revise the complex management and accountability structure within the CIS and the Office of Aged Care Quality and Compliance to ensure more effective complaints management;
- the impact of the workload and competing priorities of CIS staff on the ability to achieve quality outcomes;
- the need for more specific and ongoing training for CIS staff; and
- the necessity to amend current CIS processes and practices to achieve a more efficient and effective system which achieves satisfactory outcomes for all parties.¹⁸

¹⁸ Merrilyn Walton, 2009: Review of the Aged Care Complaints Scheme.

10. INTERFACE WITH THE HEALTH SYSTEM

The aged support and care system is not part of the health care system and needs to continue to be separate from it.

Some aspects of aged support and care are similar to aspects of primary health care and they need to be closely interconnected. As we have indicated earlier in the submission, sub-acute care may be provided within a community or residential setting in which aged support and care services are being provided. However as operational systems health and aged support and care need to be separate just as disability services and health are separate systems.

We do know that the interfaces between aged support and care and the health system often work poorly and sometimes to the severe detriment of older people. This is not a surprise since interfaces are a major problem across the health system itself and harmful events frequently occur as a result of this breakdown. We need new or improved processes and arrangements to manage the interfaces and interconnections much better than happens at present

The acute health system in particular is not an aged-friendly environment and re-engineering the health system for an ageing population is a current focus of concern in health reform¹⁹. COTA is concerned that in many ways the health system demonstrates ageist attitudes and practices that are often deeply embedded.²⁰

It should not need to be said but we feel the need to emphasise that older people have full rights as citizens to use the health system regardless of where they are living and the state of their health and their point in the life cycle. As we argued in 2.1 they do not have a 'use by' date and the approach to their health challenges should be a restorative and rehabilitative as it would be to a person of a younger age.

In that context our position is that health services should be provided and funded through the health system regardless of where they are actually delivered, including if delivered in a residential aged care facility or to a person in community in receipt of packaged support or care. The same services cannot be a "health service" if delivered in a hospital or sub-acute facility but then become "aged care" if delivered in a residential care setting!

Therefore, for example, in section 3.4 we identified two groups of people who may need to use residential aged care:

- (i) those needing sub-acute care, and
- (ii) those in need of palliative care.

This care may be provided in the aged care facility, either by its staff or by in-reach services from the local hospital/health care network. However such care should not be funded out of a person's aged support and care entitlement but should be funded by the health system at the same level as

¹⁹ See various publications on the National Service Framework for Older People, Department of Health, UK. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003066; and DH_4133990 and DH_4092957

²⁰ Di Gibson, COTA National Policy Forum on Ageism and Age Discrimination, Canberra June 2010.

if it were being provided in a hospital, a sub-acute facility, or at home to a person not a recipient of aged support and care services.

We offer below some other brief points about several key interfaces between aged support and care and health.

10.1 TRANSITION CARE

To ensure that no one moves to residential care inappropriately and that assessments for long term support and care needs are only undertaken when the person has been given the opportunity to recover, there needs to be a significant increase in the provision of transition, recuperative and rehabilitative care.

COTA strongly supports continuing increases in transition care beds. Properly managed Transition Care will frequently facilitate a person's return to home with appropriate supports when in the past they would have been assigned to residential care.

10.2 DISCHARGE PLANNING

The evidence is clear that while hospitals deal effectively with acute health conditions they often at the same time have a deleterious effect on the general health of older patients. This includes loss of muscle tone, medication issues, falls, disorientation, and malnutrition and dehydration.

Discharge planning used to be conceived as making sure that an older patient was removed from hospital at the earliest opportunity and hopefully provided with post-acute support at home, or located a bed in a nursing home.

Proactive discharge planning needs to commence (in the case of the majority of admissions that are planned events) before admission and set up a maintenance, restorative and rehabilitative program throughout a patient's acute care journey and beyond. In the case of emergent admissions it should start on admission.

In the case of people using aged support and care services discharge planning needs to be a partnership between the Gateway and the hospital, with the Gateway having primary responsibility for pre admission and post admission arrangements and ensuring that the hospital provides, or allows the Gateway to provide via in-reach, appropriate in-hospital support services.

10.3 PALLIATIVE CARE

The current system is poorly designed to meet the end of life needs of older people and their families. There is a need to deliver more seamless and coordinated care that is both person and carer focussed, across care settings and regardless of prognosis. Workforce training needs to ensure the values of dignity, compassion, respect, and empowerment are embedded in the end of life care provided. Palliative care in aged care will undoubtedly be better delivered if, as we observed earlier it is funded from the health system on the same level as formal palliative care services.

11. TRANSITION MEASURES AND ARRANGEMENTS

The reforms described above will require significant restructuring of the current arrangements and the key steps in moving to this new system are outlined below. From COTA's perspective the key criteria for transition arrangements are that consumers are fully protected, informed and involved, and have direct influence and choice over their care and support needs throughout transition. The transitions required include:

11.1 INFORMATION AND ASSESSMENT

The first transition task is to establish the Gateway network which is fundamental to the new system. Its development will require all current programs and resources to be consolidated within the organisational framework of the Gateway. This will include:

- Commonwealth Carelink,
- the seniors.gov.au website,
- the pilot Access Points program,
- HACC funded information services,
- Veterans Home Care and
- information provided by ACATs.

Work has already started on this with the allocation of \$32 million in new investment for the 'one-stop shops' but there needs to be a greater sense of urgency around ensuring the information elements of the Gateway are pulled together in a way that facilitates individuals accessing the services they need.

11.2 HACC TRANSITION

In order to move to an entitlement based HACC or Basic Services system the following steps are proposed in addition to those already identified in the COAG agreement on HACC.

- All growth funds from 1 July 2012 to be allocated to an "entitlement pool" for allocation to individuals as care and support entitlements, but current funds stay with providers for the moment.
- Undertake a study to identify the funding that can be made available for entitlement funds. This would include all funding that provides services to individuals.
- Continue to provide grant funding for HACC services that are not provided on a one- to-one basis e.g. group activities/classes; support programs to local seniors' organisations; peak body funding, etc.
- To move the individual service funds from grant funding to the "entitlement pool" there are two possible approaches that occur to us:
 - (i) Establish an average or median price per consumer and as consumers move out of HACC their notional funds revert to the pool to be available as entitlements for new clients; or
 - (ii) Transfer funds from providers to the entitlement pool in X % tranches over "Y" years (e.g. 10% per annum over 10 years).

11.3 COMMUNITY CARE PACKAGES TRANSITION ARRANGEMENTS

We will be moving to a system in which the number of community support and care packages is no longer rationed but are available in the form of a care and support entitlement with a specific value as soon as a person is assessed and approved as eligible. This will mean there will over time be many more community support and care packages.

In addition the value of these packages will increase so that they are a genuine alternative to residential care. This value will be determined by the independent pricing study referred to in 6.2.3.

While this is happening the first step is to substantially increase the supply of community support and care and at the same time fund it to a level that ensures it is an adequate and meaningful substitute for residential care. This could be done by the following package of interim measures:

- Increasing the price of the current CACPs, EACH and EACH D (while they continue pre major legislative change) to restore their purchasing power.
- Introducing new levels of packages between CACP and EACH at regular intervals while the longer term pricing study is undertaken and new legislation prepared. This would require additional packages to be made available at the new levels.
- Making all additional packages available from a central pool direct to consumers as they are approved, i.e. do not allocate them through ACAR to providers and regions
- A campaign of active promotion of community support and care as the centrepiece of the aged care and support system, both across the community and through all information, assessment and approval process points.

11.4 RESIDENTIAL CARE TRANSITION ARRANGEMENTS

As community support and care is properly funded and provided as an entitlement it will become a much higher proportion of total aged support and care. That will have a dampening effect on demand for residential care. However we note that total demand will be growing significantly and it is therefore unclear what the net effect will be on current providers.

Others with more resources than COTA need to do some modelling on potential effects. However it does seem likely there will be at least a short term negative effect on occupancy rates of residential care that is of a lesser standard or in areas that are not preferred.

There needs to be an industry adjustment plan that provides assistance to certain residential care providers to move out of the sector. There have been a number of such schemes covering a wide range of industries including dairy farming, car manufacturing and, possibly of most relevant here, community pharmacy. The key components of such a scheme are outlined below.

- The distinction between high and low care residential care (i.e. change the Aged Care Act) should be removed as soon as possible.
- The Government should introduce a financial compensation package for residential care providers leaving the industry which would include the return to government of bed licences. Government would have discretion as to whether or not to accept compensation applications and to specify the timing of and arrangements for withdrawal. This would

enable Government to manage the pace and distribution of the restructure, ensure resident placement, conversion, etc.

- These residential care places would then be progressively converted into community support and care funds (or in limited circumstances reallocated to areas of residential care need) and made available to eligible individuals.
- The conversion of unwanted residential care bed approvals into community support and care by the existing provider should be made easier and more attractive. There are a growing number of vacancies at the low care end of residential care and these would become eligible for conversion.
- Residential care would now be called combined care and accommodation. There probably still needs to be some form of approval process for agreement to new facilities being brought on-line, even people will now choose whether and when they go to a residential setting.
- The pricing model needs to have a reasonable vacancy rate incorporated if “choice” is to have meaning.
- We should also extend and promote the use of the Multipurpose Service model in rural and remote areas in line with the provisions of the recent COAG package.
- There is also the issue of WA and Queensland providers' failure to take up current allocations and the shortage of residential care places that will result from this in the short to medium term (some estimates predict a shortage of 5,000 places in WA within 5 years) and the need for transitional arrangements to cater for people who have a specific need for residential high care which may not be available. Some may be able to use enhanced community support and care services, and indeed some people currently in residential care may be able to move out to their preferred situation of community support and care (although this will not always be possible due to sale of home, etc) . However we will need to be alert to the higher level of risk that some people will be in inappropriate support and care arrangements.

12. CONCLUSION

In this submission we outline our vision for the future provision of support and care for Older Australians. We do not dwell on current problems but have chosen to propose solutions that, if adopted, will ensure older people will be able to live where they want to with greater assurance that their needs for support and care will be met.

Our focus is on putting the person first, identifying their needs and then building supports around them to promote independence and maintenance of a good quality of life. By moving funding from the service providers to the individual we aim to give people back the power to make decisions about what kind of support they need and the capacity to purchase it from a wider range of sources.

We also put an emphasis on acknowledging diversity of life experience and need. Our system would ensure adequate funding to meet the more complex needs some people have put and that there are services operating who can meet those needs.

There is obviously a lot more work needed to put more flesh on the bones of our proposal. We look forward to working with the Commission and other stakeholders to create this new and exciting system of aged support and care.

ATTACHMENTS

- 1. COTA Australia Policy Principles**
- 2. Leading The Way – Our Vision for Support and Care of Older Australians**
- 3. ACSA-COTA Roundtable On The Future Provision & Financing Of Aged Care**
- 4. Older Persons Affordable Housing Alliance: A Fair Share for Older People – The Need for a National Older Persons Housing Strategy**
- 5. Workforce Planning Australia – Questions for Aged Care Planning**
- 6. Submission to the Department of Health and Ageing on the Review of the Accreditation Process for Residential Aged Care Homes**

COTA POLICY PRINCIPLES

Members of COTA Australia adhere to five main policy principles:

- 1. Maximise the economic, social and political participation of older Australians and challenge ageism**
COTA Australia supports policies and programs that encourage and facilitate the inclusion of seniors in all aspects of Australian life.
- 2. Promote positive views of ageing, reject ageism and challenge negative stereotypes**
COTA Australia supports initiatives that recognise the capacities and contributions of seniors and actively combat ageism. COTA Australia believes that the impact of ageism, based on negative age stereotypes, restricts the participation of older people in all aspects of Australian life. This has adverse effects on the community and on older people.
- 3. Promote interdependence and consciousness across generations**
COTA Australia promotes policies that meet the specific requirements of seniors whilst taking account of the needs of the entire community for sound economic and social development. Senior Australians share an interest in long-term policies that serve the welfare of all Australians.
- 4. Redress disadvantage and discrimination**
COTA Australia believes that all people have the right to dignity, to security, to access high quality services, and to equality in participation in the community regardless of their income, status, background, location or any other social or economic factor. COTA Australia recognises that seniors are a diverse group with differing backgrounds and social, economic and health status and advocates strongly for those who are most vulnerable and disadvantaged.
- 5. Protect and extend services and programs that are used and valued by older people living in Australia**
COTA Australia develops policies and provides advice on maintaining and improving services and programs that seniors use and value. These include primary health care, hospitals, pharmaceuticals, employment services, utilities, public transport, residential care, housing and community care. It will seek to ensure that there is an adequate 'safety net' of services and income support, which all seniors can access according to fair and equitable criteria in order to maintain a reasonable quality of life.

National Aged Care Alliance

Leading the Way

Our Vision for Support and Care of Older Australians

September 2009

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Preamble

The purpose of this document is to present a shared vision for the future support and care of all older Australians so that they can live with dignity and independence.

It has been developed by the National Aged Care Alliance, a coalition of the leading consumer, provider and professional associations and unions involved in the provision of care and support for older people.

The challenges and changes needed in aged care have been well documented. Reforms over the last decade have increased the range of services and improved access and quality. However, it is now time for action to substantially change the system and take these reforms to the next level.

The reform agenda presented here transforms aged care in Australia by placing older people at its centre with a choice of timely, accessible and affordable services. In short our vision is built around putting the older person first.

The following organisations are members of the Alliance:

Aged and Community Services Australia, Aged Care Association Australia, Alzheimer's Australia, Anglicare Australia, Australian Association of Gerontology, Australian General Practice Network, Australian Healthcare and Hospitals Association, Australian Nursing Federation, Australian Pensioners' and Superannuants' Federation, Australian Physiotherapy Association, Australian and New Zealand Society for Geriatric Medicine, Baptist Care Australia, Carers' Australia, Catholic Health Australia, COTA Over 50's (Councils on the Ageing), Diversional Therapy Association of Australia, Geriaction, Health Services Union, Legacy Co-ordinating Council Incorporated, LHMU, Lutheran Aged Care Australia, OT Australia, Palliative Care Australia, Pharmacy Guild of Australia, Returned & Services League of Australia, Royal Australian College of General Practitioners, Royal College of Nursing *Australia* and UnitingCare Australia.

More information about the Alliance is available at www.naca.asn.au.

1

The Vision

Every older Australian is able to live with dignity and independence in a place of their choosing with a choice of appropriate and affordable support and care services as and when they need them.

2

The Underpinning Principles

2.1 Older Australians are entitled to:

- live active, contributory and fulfilling lives
- have their individual and collective needs fully and equitably considered when governments are making decisions about health, housing, transport and other community services
- make decisions for themselves, in conjunction with chosen family and friends where appropriate
- be treated with equity and fairness regardless of cultural background, geographic location, health, gender, sexuality and capacity, including their capacity to communicate needs
- the removal of barriers and systemic limitations affecting the realisation of any of these principles

2.2 Where older Australians require support or care, they will:

- have access to services in their own communities and homes that:
 - are readily available, affordable and client-directed
 - promote wellness and wellbeing, and assist them in realising their aspirations
 - provide genuine choice to meet the aspirations, needs and preferences of a diverse older population
 - are underpinned by a commitment to quality improvement, evaluation and ongoing research
- be the principal decision makers about when they may need assistance and the nature of that assistance
- have access to affordable, effective and safe health and medical care
- have easy access to reliable and relevant information about the availability, quality and cost of aged care services.

3 What a reformed care and support system would mean for older people

A support and care system that meets this vision and principles will ensure firstly that when something, whether small or large, goes wrong in an older person's life and becomes an impediment to their full participation in family and community, supportive arrangements are promptly accessible, and fully responsive to the person's need, situation and preferences.

The goal of these arrangements is to assist in every possible restoration of function or situation, or to facilitate and enable people to maintain or restore their participation in community despite any frailty or disability.

As other physical, neurodegenerative (especially dementia) and/or other mental health challenges emerge, people will be able to promptly access care assessment that will result in an entitlement to a level of funding determined by the assessment. They or their chosen representatives can use this entitlement to obtain support and care either through approved providers or through their own networks and arrangements.

There will be a wide variety of choices and options available rather than predetermined menus. The mix of supports will vary from person to person according to their own support networks; personal aptitudes, preferences and aspirations; varying impact of disabilities; and other personal circumstances. Support and care services will be designed around these personal variables.

There will be a range of readily available support and care services linked seamlessly into the broader health system. These include easily accessible primary health care services; transition care after any acute health episode so no-one has a long term aged care assessment while acutely unwell; restorative and rehabilitative services to provide the greatest opportunity of getting back to full function after acute care; support and care services for people living with dementia; and palliative and end of life care.

Most people will receive care and support in their own homes, whether that is a 'family home' of long standing, or a retirement village, community or publicly owned housing, or a private dwelling chosen by people as their own later life housing option.

Some people's needs or circumstances will require them to access residential care and other supportive accommodation options. They may require constant care at a cost that can only be met in a supportive accommodation setting; or they may prefer the security of constantly available support staff due to their advanced frailty and/or cognitive impairment.

People will contribute to the costs of care according to their capacity to pay, and no-one fails to access care because they cannot afford it. The costs of accommodation are separate to care costs and people either purchase or rent, or enter loan/ licence arrangements for accommodation as they choose.

4

Fundamental reform is necessary to achieve this vision. The elements of reform needed for better care and support of older people are:

4.1 Promoting a society for all ages:

- high priority, well resourced and comprehensive initiatives to:
 - promote new and inspiring paradigms of the roles of ageing in our society, consistent with our Underpinning Principles
 - stimulate positive and inspirational representations of ageing
 - combat all forms of ageism
- a commitment to raising the profile of aged care and support by presenting positive images to demonstrate its significant contribution to enhancing the well being of older people
- acknowledgement that optimum care and support can only be achieved with significant improvements to other key public infrastructure, including government commitment to achieving crucial elements, including:
 - adequate public housing and support services;
 - mandatory adaptable, accessible and sustainable design standards for all housing;
 - an integrated public and community transport system, designed to comprehensively support and accommodate the needs and aspirations of the entire community, including older people;
 - urban design that ensures integrated public and living environments that are safe and accessible for all ages and promote active involvement in community life

4.2 Consumer focused, user friendly and equitable:

- funding for care and support services linked to each recipient so that the recipient and their family can determine how and where they receive their care and support, including the option to control how their funding entitlement is used
- removal of the current regulatory restrictions on the quantity and type of services providers can offer so that they can be more responsive to older people's preferences
- accessible and reliable information on the availability, quality and cost of care and support services provided through a range of portals linked to comprehensive, integrated, consistent and current data on a user-designed data platform that supports informed consumer decision-making

- a well-resourced national aged care assessment system which achieves consistent and equitable outcomes and provides high quality, rapid, seamless and appropriate assessments based on multi-disciplinary skills, taking into account each person's history and circumstances
- robust community-based support networks and arrangements designed to work with and strengthen individuals' capabilities and build on community and family networks and other social ties
- flexible care and support services designed around and responsive to the varied situations, lifestyles, needs, preferences and aspirations of older people
- readily accessible participatory processes and structures that enable consumer involvement in aged care and support decision-making at all levels, supported by well resourced consumer advocacy services

4.3 Entitlement to robust community care is front and centre - within a seamless continuum of care and support services:

- the separation of funding for support and care services and for accommodation, so that choices about each are as far as possible independent of each other, enabling greater options and choices in both services and housing
- the same care fees and subsidies across residential and community care for people with similar care needs to help with the exercise of equitable and free choice over where care and support is received, including the option of continuing to receive care in the community as needs change
- responsive and adaptable respite and temporary care and support options available as needed and sufficient transition, convalescent and rehabilitation services and facilities to meet need
- all levels and forms of services allow and enable older people to enter, leave and, most importantly, re-enter as needed
- a variety of housing and residential care and other supportive accommodation options that meet adaptability, accessibility and sustainability standards sanctioned by government, supplied by a variety of government, charitable and private providers in a range of types and standards which include sufficient accommodation for those who do not have the means to self-provide
- genuine integration of all aged care and support services within a more seamless continuum of health services from primary, to planned and emergency acute, to restorative; all equitably accessible by older people without discrimination
- access to appropriate and high quality palliative and end-of-life support and care from the earliest appropriate opportunity

4.4 Properly funded and flexibly and equitably financed:

- funding provided to individuals as an entitlement based on assessed needs, rather than being subject to quotas
- funding for care and support based on regularly updated independent benchmarking of the cost of providing care and support in an environment where recipients have full choice of such services
- user contributions to the costs of support and care services to be nationally consistent, transparent, equitable and affordable - with a variety of payment methods available
- no-one should be denied access to support and care due to financial incapacity
- flexible payment options for the cost of supportive accommodation options, including residential care, which provide genuine choice in how user contributions are made (e.g. loans, periodic payment, deferred contributions, rent), using a statutory framework to ensure transparency, security and like for like comparability in an environment where care recipients have full choice of services
- a dynamic and resourced workforce planning regime with adequate funding to ensure sufficient skilled, appropriately qualified and competitively remunerated staff are attracted to and retained in aged care and respected for their work

4.5 A framework of support for informal carers and families:

- formal acknowledgement and improved support for families, friends and community carers, including the development of long-term strategies to address their diminishing numbers in light of Australia's changing demographics
- acknowledgement that family and informal carers have the right to cease carer roles for short periods or permanently

4.6 Continuous improvement and quality control:

- optimum services continuously improved through shared learning founded on evidence-based practice and well-supported research programs which investigate all facets of ageing and of caring for older people
- funding for services to include provision for optimal levels of continuing and recognised qualifications, training and development for all staff and volunteers in aged care
- a robust and dynamic accreditation system for approved ethical age care providers across the full range of aged care and support services including community, residential, respite, and short and long term living options

- an independent national complaints service that meets the Australian Standard and is based on fostering feedback and complaints mechanisms from the service level up, focused on prompt complaints resolution, enhanced learning and service and system improvement
- accreditation and complaints systems that proactively foster consumer involvement in identifying service quality issues, fully protect all genuine informants, act with fairness and respect and promptly and appropriately correct malpractice, abuse and poor quality service

5 Reform Implementation

Implementation of these reforms will require broad support and the involvement of all stakeholders including most importantly representatives of and advocates for older people, aged care providers, industry and finance experts, and the Federal Government.

The complexity of aged care will necessitate transitional regulatory arrangements and funding to move from where we are now to the vision of care and support outlined in this paper.

Older Australians deserve and are entitled to a care and support system that ensures them the same freedoms and choices as all other Australians.



THE FUTURE PROVISION & FINANCING OF AGED CARE

March 2010



INTRODUCTION

In October 2009 ACSA and COTA hosted a roundtable bringing together aged care, financing and public policy expertise to consider options and models for the future provision and financing of aged care.

These are important issues to consider as Australia has an increasing aged population at the same time as the number of tax payers are decreasing. Spending on aged care is projected to grow from 0.8% of GDP in 2009-10 to 1.8% of GDP in 2049-50.

While the current aged care system does a good job for many people it can be inflexible to meet people's real needs. Aged care providers are struggling financially impacting on the level and type of care that can be provided. The need for reform of aged care and health services has been recognised by the Rudd Government and also by independent bodies such as the Productivity Commission.

Against this backdrop COTA and ACSA felt it important that the two parties who best understand the issues from the perspective of older people and those who provide the services – come together to propose solutions.

To develop solutions the Roundtable looked at overseas experience and translated that to the Australian context. Background papers were prepared to support this discussion and they can be viewed at www.agedcare.org.au or at www.cotanational.org.au

While a range of options were identified and discussed, the roundtable focussed on the development of a social insurance model. This paper is designed for discussion within ACSA and COTA membership to explore and build support for the concept and identify areas for further consideration and development. It is not a definitive statement as there are a number of questions, some on issues of a major economic nature and others on policy, which need to be discussed and researched before the model can be finalised.

FUTURE PROVISION OF AGED CARE

Before determining the best way to finance aged care services it is important to define what aged care services are required and what the system needs to be capable of providing.

It must first be recognised that access to aged care services is a fundamental right for all older people. Service provision will be driven by the consumer and what they want and need.

There will be a broad spectrum of support and care services (Assistance with daily living, Respite Care, Transition Care, Nursing Care) that people can move easily between.

Consumers will have real choice about the venue of provision, the type of services including advocacy, they receive and who provides the service, within the funding available to deliver services.

A service system built around the consumer will be flexible and adaptable to meet the varied needs of older people. The majority of services will be provided to support people to live in their own residence. Incentives, such as reduced transaction costs will support people to remain in the community in more suitable accommodation. Lower stamp duty on moving to more appropriate housing is just one example of what such an incentive could be.

The system will be affordable for the individual who requires services and the community. Individual older people will pay for their accommodation and living expenses where they can, just as they have throughout their lives.

The system will be simple to understand and communicate to individuals and the community more broadly.

The overall result will be services that consumers control and a sustainable aged care industry able to provide quality care and fund its capital requirements.

The most equitable way for such a system to be financed is through a social insurance scheme.

AUSTRALIAS AGED CARE SOCIAL INSURANCE MODEL

An aged care social insurance scheme would replace the current funding arrangements which provide predominantly Government funded services with older people making a (variable) co-payment and a system of financing based on general tax revenue.

The aged care social insurance scheme would be the responsibility of the Commonwealth Government. Government would set the levy, as they currently do for Medicare, and this levy would deliver an individual “standard” package of services and support. People may also pay a fee for the services received and/or be able to purchase additional services if they want or require more than the package delivers. It should be noted that Medicare does not cover the entire cost of services provided for all people using the service. Exactly what the aged care levy would provide and the need for additional service payments is a key consideration in finalising an aged care social insurance model.

Every person with a taxable income would be required to pay the levy recognising that we are all equally likely to require services and support in our old age.

The levy would be means tested in much the same way Medicare is. Where the means test declares that a person can't afford to pay the levy Government would pay it to ensure that there is a safety net. People would be able to choose who they were insured with and Government would determine where those it paid for were insured.

It may be that people would also have the option of buying additional insurance to cover additional service fees and/or to purchase additional services and support. In determining whether such an option would be made available the risk of creating a two tier system – one for the rich and one for the poor – would need to be carefully considered.

Accommodation and Living Expenses

Aged care currently provides accommodation/housing as well as a range of services and support.

The provision of accommodation/housing and support services needs to be “unbundled”. People should meet their own accommodation/housing and associated living costs as they do throughout their lives. For people who remain living in their own home Government concessions and rental assistance are provided to those who need financial assistance to meet these costs. For people who require residential care and are unable to meet the cost of their accommodation social insurance would pay.

The payment of accommodation expenses creates the capital funding to enable the ongoing provision of quality residential care. Because the cost of providing accommodation and care differs throughout Australia the amount paid by individuals (and the social insurance) will be different in different parts of Australia.

Where a person is required to pay a fee for their accommodation/housing they will have a choice of how to pay – such as paying rent, deferred contribution from their estate, a refundable lump sum (loan), depreciating premiums or other negotiated financial arrangements.

All accommodation/housing provided will meet the requirements of the Building Code of Australia and will be built to universal design principles.

Support & Care Services

Aged care provides a range of support and care services including meals, gardening, cleaning, bill paying, respite, therapy, personal care and nursing regardless of whether the person is living in their own home or a residential care home.

Funding for these services would be made available through the social insurance scheme following an eligibility and means test by an independent (from Government and the insurance companies) body. The social insurance payment is provided as a voucher, for a package of support and care designed to meet the individuals need, which can be used to purchase either care at home or in a residential home.

The package price for service delivery will be different in different parts of Australia recognising that it costs more to deliver services in some places, such as rural and remote Australia, or to different client populations, such as for people who come from different cultural and linguistic backgrounds.

The voucher is not time limited and can be claimed when the person is ready.

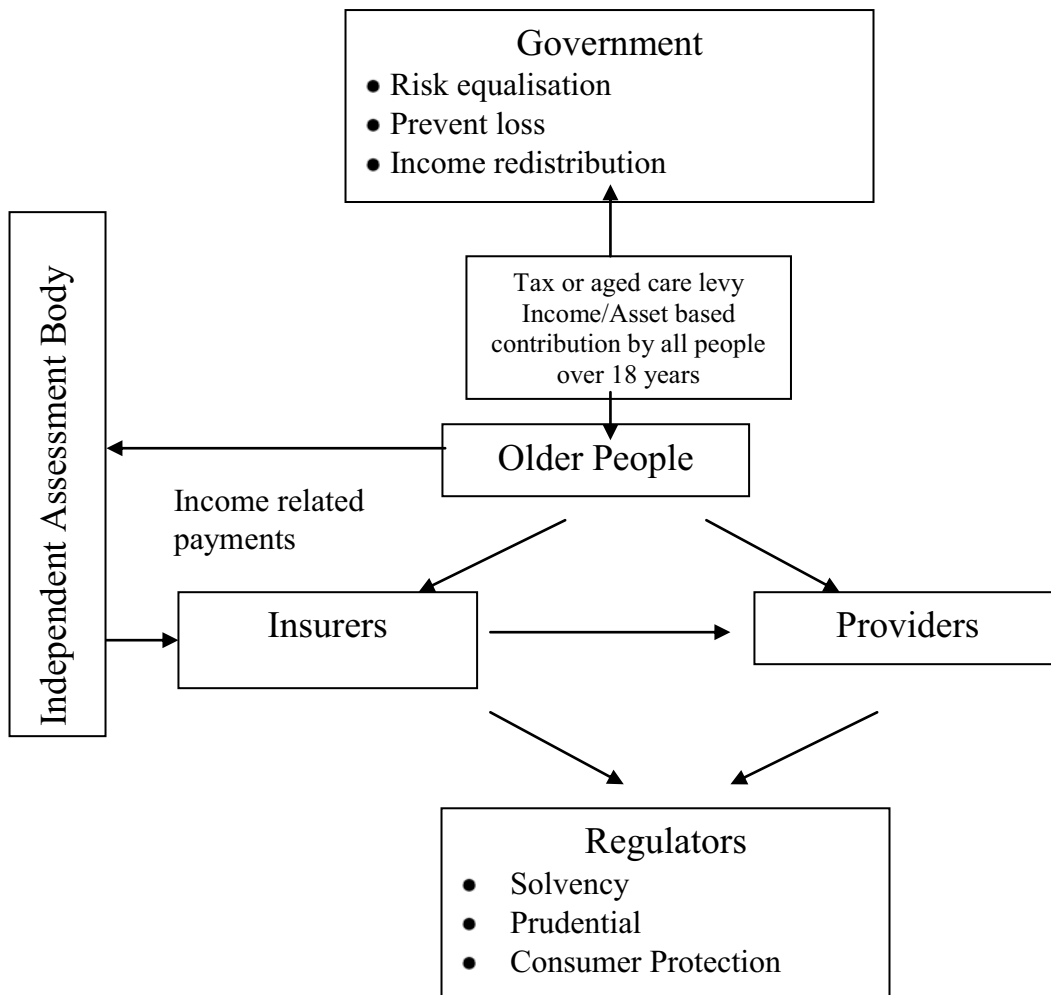
Respite Care

Respite care is a critical service for those people who are cared for at home by friends and/or family. It can be provided in the persons own home or in another venue – residential or centre. It may be just for a few hours or it may be overnight or for a period of days or weeks.

Good respite care provides both a break for the carer and an enjoyable and/or restorative component – including meals and therapy.

Social insurance would cover the cost of the support and care provided. Where the respite is provided in a centre or residential setting there is a capital component that must be met. This cost would be funded through a fee based on a means test.

Social Insurance Elements



The above diagram shows the elements, roles, and relationships within a social insurance scheme.

There is a considerable amount of consumer protection built into the scheme. Service providers would be licensed, including quality, financial and prudential requirements, by a separate regulatory body.

Eligibility assessment would be separated from Government, the regulatory body or insurance companies. This will ensure that decisions are made based on need rather than fiscal considerations.

Once the system is established it is anticipated that there will be a service and insurance market enabling the older person to choose the provider of service and who they are insured with. The market assumption will need to be further tested to ensure this is achievable. The system will need transition arrangements in place as well as the ability to be adjusted to match the prevailing, or lack of, market conditions.

Benefits of an Aged Care Social Insurance Scheme

The social insurance scheme benefits the entire community. Aged care is now a largely unfunded liability whose costs are met by families and the community through Government expenditure financed through general taxation revenue. The introduction of a social insurance scheme creates a transparent process for paying for aged care services into the future.

For **older people** there will be a transparent process, with effective consumer protections, for accessing the services needed. They will have choice of the type of services they receive, who provides the services and where they are delivered.

For the **Australian community** there is a transparent process and equitable way of funding the aged care services everyone is equally likely to need in their future.

For **government** there is increased funding available, from sources other than general revenue, to provide care for the growing aged population. A licensing and regulatory system would be responsible for guaranteeing quality service provision.

For the **aged care industry** there is a sustainable income source that meets the cost of providing care to each older person. In addition there is a streamlined and effective regulatory system.

Transition Arrangements

Moving from the current approach, to delivering and funding aged care, to a social insurance scheme is a major social and economic reform, similar to the introduction of Medicare. To be successful a transition plan must be put in place to assist all stakeholders make the move.

The current tax funded approach to aged care should continue while the system is reformed to be more flexible and open to consumer choice. This requires a number of changes to the current funding and regulatory arrangements along much the same lines as proposed in the NHHRC proposed reform.

The transition phase will need to include:

- Increasing the number and variety of community packages available, which is in line with existing Government policy;
- Addressing the current capital issue which is beginning to impact on the number of residential care beds being built
- Providing increased consumer choice, in line with the directions of the NHHRC reform agenda;
- The Commonwealth Government taking responsibility for all aged care services, in line with the directions of the NHHRC reform agenda;
- Improving the independence and operation of the assessment system;
- Providing a structural adjustment package to aged care service organisations to allow them to redevelop to operate in the new system or exit.
- Open up 'pricing' and 'supply' over a period of time, in line with the directions of the NHHRC reform agenda. As a minimum there is a need to increase price and legislate a 10 year price program.

One transition option could be for Government to take on the various roles of a social insurance scheme - insurer, policy setter and regulator - by creating separate statutory agencies.

As the model takes shape it will be possible to determine how long the transition process would take. It is envisaged that transition will occur over a minimum of 10-15 years.

Next Steps

This paper outlines the broad concept of a social insurance scheme to fund the provision and financing of aged care into the future. It is important for consumers and service providers to work in partnership to develop a model that ensures quality sustainable aged care services are available. There is considerable work still to be done to develop a definitive model that can be presented more broadly, including to Government. This work will be done following the internal consultation on this concept paper.



Older Persons Affordable Housing Alliance

A Fair Share for Older People -*The Need for a National Older Persons Housing Strategy*

Discussion Paper
March 2009

Introduction

At the time of writing this discussion paper Australia is in uncharted waters caused by the Global Financial Crisis (GFC). Unemployment is on the rise, retirement incomes have been adversely impacted by stock market losses and Government's have taken unprecedented action to stimulate the economy and shield Australia from the worst of the GFC. The Government's National Building Initiative includes 20,000 new social housing dwellings.

The Alliance fully supports and applauds the greatest expansion to social housing since World War 2. This short term initiative will provide some increased accommodation for older people. However the Alliance believes this short term initiative should be underpinned by medium and long term planning to ensure that safe, affordable and accessible housing options exist for the increasing number of older people requiring them.

The Alliance is keen to receive feedback on the paper and the strategies it outlines. Comments can be sent to ldredge@agedcare.org.au.

Action Needed

In early 2008, concerned with the growing housing crisis facing older people, Aged and Community Services Australia (ACSA) and the Council on the Ageing (COTA) formed the **Older Persons Affordable Housing Alliance**. This alliance of peak consumer and provider groups is calling for a collaborative approach at the Federal, State and local levels to create a **National Older Persons Housing Strategy**. The strategy would focus on two key areas:

- 1. Ensuring existing housing stock is maintained and enhanced to support people to age in place**
- 2. Increasing the supply of affordable and appropriate housing for older people**

All levels of government in Australia need to acknowledge the particular needs of older people in housing stress and the scale of the problem that is emerging. The Alliance is calling on the Rudd Government to develop a whole of government approach to affordable housing for older people and outline a national policy framework that facilitates state based policy outcomes. Such an approach would guarantee a fair share of resources to older people whether via short term economic stimulus packages or regular budgetary measures.

In February 2008, the UK Prime Minister Gordon Brown launched the *National Strategy for Housing in an Ageing Society*. The strategy combined with the UK *Green Paper for Homes* articulates a vision to meet the

challenges of an ageing society including plans for significant extra funding for new homes, a cross-government approach to housing and ageing and a commitment to accessible and adaptable housing for all. The Alliance believes it is now time for the Rudd Government to show similar leadership and outline its vision for the growing problem of housing older Australians.

The Context: Housing and Older People in Australia

While much of the current focus on housing affordability is on first home buyers, a significant number of older people are facing a housing crisis of their own. The scarcity of affordable housing is becoming a serious contributor to poverty and disadvantage among older Australians. Prime Minister Rudd acknowledged the housing affordability problems among older people when he quoted the NATSEM estimate that in March 2008 112,000 households headed by a person aged over 70 were in housing stress, compared with 56,000 in 2004, a 100% increase in four years.

The underlying causes of the housing problems particular to older people are set to worsen. The size of all the age cohorts of older people is expected to increase dramatically over the next two decades. The Australian Housing and Urban Research Institute (AHURI) has projected that the number of people aged 65 and over in low income rental households will increase by 115% from 195,000 in 2001 to 419,000 in 2026. A significant number of aged care providers are reporting that the new Aged Care Funding Instrument (ACFI) is making low care facilities less viable. This will lead to a reduced supply of low care and in turn to increased demand for housing for older people in the community.

Housing affordability directly affects healthy ageing. Access to local services is a key determinant of health outcomes for older people. Single older people are especially at risk of housing stress, causing poor physical and mental health. Low-income older people are at greatest risk of losing their independence when housing is beyond their means.

Each of the key elements in the strategic approach called for by the Alliance are detailed below.

1. Ensuring existing housing stock is maintained and enhanced to support ageing in place

The characteristics and requirements of older peoples' housing are as diverse as the 2.3 million people who are over 65 years of age in Australia. The overwhelming majority of older people choose to live independently in general purpose housing that they own or rent in the community. Purpose built housing for older people in Australia currently includes retirement villages, independent living units, supported accommodation, some public housing units and residential aged care.

While new initiatives such as NRAS and the Nation Building Package are welcome, we cannot afford to allow the billions of dollars currently invested in older persons' housing assets to continue to be ignored. Without a proactive social policy approach, this stock will diminish in its accessibility and availability. Growing numbers of older people throughout Australia will be at risk of becoming further marginalized and dependant on expensive state supported care. There is an urgent need to ensure Australia's existing older persons housing is maintained and where necessary upgraded to better meet older peoples' needs. The alliance believes three key areas require immediate attention:

- Independent Living Units**
- Existing public housing for older people**
- Home maintenance and modification programs**

1.1 Independent Living Units

Independent Living Units (ILU's) are self-contained dwellings managed by not-for-profit organisations, which provide housing to older persons with low incomes and low value assets, who do not own their own

home. Over 34,700 ILUs were developed between 1954 and 1986 with Commonwealth Government assistance.

Funding for the ILU program was transferred from the Commonwealth to the States in 1986, placing them in competition for funding with State Housing Authorities and community housing organisations. The result is that ILU's have been largely ignored by funding bodies ever since. Despite precarious funding, ILUs remain an important social housing option for older people with relatively low assets and incomes.

Despite the fact that ILU's currently provide 27% of all social housing for older Australians, there is no systematic approach to funding the capital work now required. Much of the ILU housing stock is now between 40 and 50 years old and in urgent need of upgrading, reconfiguration and in some cases, replacement. Most of the units are small (one bedroom) and below community standards. Organisations, both large and small, are increasingly deciding that they can no longer afford to operate ILUs. At a time when the number of older people with unmet housing needs is increasing, this forgotten but very significant social housing sector urgently needs an injection of capital that will enable them to continue to provide secure housing older people with low incomes and limited assets.

In 2004, researchers at AHURI recommended that detailed data collection be undertaken to better identify the scale and scope of the problems confronting ILU's and to articulate their importance to the overall aged care sector's role in housing older people. This recommendation has not been adopted.

Recommendation: The Alliance supports the operation of a strong ILU sector and urges the Commonwealth, State and Territory Governments to collaborate on a package of initiatives to:

Provide capital from social housing funding streams for urgent ILU upgrades – including ensuring that the National Rental Affordability Scheme and the Nation Building Social Housing Initiative support the redevelopment of ILU's

Fund sector capacity building measures including ILU research and assistance to providers to develop strategic plans and alliances that will lead to improved management, governance and housing stock with better links to community care providers

1.2 Existing public housing for older people

Currently 102,000 people or 29% of all public housing tenants are over 65 year of age and 48% of this group are over 75 years of age. The situations of older people in public housing vary dramatically. They may reside close to services or be located in fringe urban areas without public transport. They may live in a cramped bedsit or by themselves in a 3 bedroom house after the children have left home. Many older public housing tenants now face multiple disadvantages, low incomes, the absence of family support and limited access to support services.

It is clear that much of the public housing stock built in earlier decades is now unsuitable for older people. It has become run down or does not have the simple design features that would support older people to age in place, such as accessible bathrooms and open plan living areas. AHURI has noted that public housing throughout Australia is now being confronted by a range of major challenges, including:

the demand from older people for public housing is not being met and has not yet peaked
there will be more tenants in the older age-groups and many will need support with daily living
the size of housing units is too small and below community standards, much of it requires upgrading to new standards or demolition

The development of a new form of National Affordable Housing Agreement (NAHA) provides an ideal opportunity to develop a strategic policy approach to public housing for older people that allows older people to continue to live independently in the community in housing and neighbourhoods of their choice .

The recent “Nation Building Investment” package of the Rudd Government included funds to undertake urgent upgrades to dwellings and a fair share of these resources should be devoted to the older people’s stock.

Recommendation: A national coordinated approach to existing public housing for older people should now be developed which facilitates State Housing Authorities to develop social housing policies for older people that cover:

maintenance and operational support

desired social housing mix, stock location and stock design

community support services for older public housing tenants who face multiple disadvantages

In 2006 the NSW Government provided an excellent example of leadership in this area when it developed its policy: *Social Housing for Older People*.

1.3 Home maintenance, modification and energy efficiency programs

Home maintenance, modification and energy efficiency programs play a vital role in supporting older people to remain living in their own homes, often the most cost effective and person centred response to a housing problem. These programs can reduce risk and costs and in many cases greatly improve quality of life.

Most government sponsored home modification programs are funded by the Home and Community Care (HACC) program. Some State Housing Authorities also provide services such as loans for home modifications. The value of home maintenance and modification services can be found in client and societal outcomes. AHURI has found that consumer satisfaction is high with these services and that minor modifications provide improved safety and reduced risk while major modifications were perceived as life changing. Home maintenance and modification services can:

enhance safety within the home environment, particularly with respect to falls

support a slower rate of decline in older people and reduce care costs

enhance lifestyle and identity; increasing capacity for social participation, enhancement of physical and mental health

While expenditure on home maintenance and modification services is relatively small compared to expenditure on health and aged care for older people, it reduces Government’s spending in other areas by:

decreasing the levels of hospitalisation and length of stay

enhancing capacity to manage individuals with chronic conditions in the community

reducing or delaying entry into residential care

AHURI’s analysis of these services in Australia identified a complex patchwork of home maintenance and modification programs that has developed incrementally over the past two decades and is inadequate to meet the needs of an expanding older population. The Alliance is calling for a new vision that would see these services as an important element of a national approach to ensuring that housing for older Australians is suited to their changing needs and circumstances.

The United Kingdom has identified the value of home modification services with an added emphasis on sustainability programs such as green home audits and “weatherising” programs. The UK *Warm Front Scheme* provides heating and insulation measures that help keep vulnerable people healthy, warm and less reliant on government services.

In Australia, power and water costs are predicted to rise substantially in the coming years. An enhanced focus on environmental sustainability will have a positive impact on housing running costs and affordability levels. The development of energy efficient homes for older people in Australia in particular will provide positive outcomes for all, the ongoing running costs of homes will be reduced and older people with fixed incomes will be able to remain in their homes at an affordable cost. The Government's recent "Energy Efficient Homes Package" focusing on insulation and solar hot water is a positive development. The funding that will become available through Australia's Carbon Trading Scheme offers a further opportunity to expand the scale and scope of housing energy efficiency programs to support older people to reduce living costs and age in place. However some regulatory measures aimed at improving the energy efficiency of existing housing may disadvantage older people. Redress will be required if the impact of these measures is not to add to housing stress for older people.

Recommendation: The Alliance calls for the Commonwealth, State and Territory Governments to fund a national approach to home maintenance, modification and energy efficiency services that includes:

- a vision and framework for the extension of services to a wider population of older people**
- increased and consistent levels of service across the country**
- redress for the impact of energy efficiency upgrades where they further disadvantage older people**
- an emphasis on housing energy efficiency funded through the Carbon Trading Scheme**
- the development of a research agenda to underpin the program**

2. Increasing the supply of affordable and appropriate housing for older people

The Alliance has identified three key elements of a strategic approach to enhance the supply of affordable housing that is appropriate to older peoples' needs:

- An increase in the supply of older persons' rental housing through the NRAS scheme**
- Increases in older persons public/social housing stock**
- The adoption of universal design principles in built environments and urban design**

2.1 Supporting an increase in the supply of older persons' rental housing through the NRAS scheme

The National Rental Affordability Scheme (NRAS) is a supply side response to the housing affordability problem. NRAS subsidy programs have the potential to assist older people but the current scheme would benefit from enhancements to ensure it complements the current seniors housing models in Australia and promotes innovative approaches. Areas that require further consideration include:

- NRAS models that support older people to pay charges in a lump sum or to pay an ongoing contribution in order to maximise pension levels and benefits
- An incentive scheme to assist in redeveloping low care facilities into assisted living units
- Models developed to demonstrate how mixed developments (such as a combination sale, rental and retirement village models) can operate either within or outside a retirement village setting

Recommendations: NRAS is currently in its establishment phase and the Alliance has noted a number of issues that need to be addressed within NRAS including:

There are still concerns about whether NRAS is considered as a legitimate charitable activity within taxation legislation. While the Government has acted to protect the charitable status of those participating in the Establishment Phase the position is unclear for the Expansion Phase. Aged Care providers will not participate in NRAS if there is any question of a threat to their charitable tax status.

A major impediment to aged care organisational involvement in NRAS is the approach taken by a number of State Housing Authorities to exclude or limit the level of state based NRAS support for aged care providers. These barriers need to be urgently removed.

State level NRAS funding priorities are potentially shifting the focus of NRAS to high needs tenants, the current target market for public housing in most states. NRAS is not de facto public housing and should maintain its original focus on affordability for people at the margins of the rental market.

There is a need to be more flexible on project size below the current NRAS minimum of 20 dwellings. Many smaller and particularly rural providers are advocating that a small number of units is often the most appropriate service response for an area.

NRAS is an appropriate vehicle for ILUs to be rehabilitated and they should be afforded the same priority as new projects, regardless of the size of the development.

Further funding should be made available to facilitate the aged care industry to successfully participate in NRAS.

2.2 Increases in older persons public/social housing stock

It is currently extremely difficult for older people to access public housing as new entrants anywhere in Australia and the situation is projected to worsen. The shift in public housing to priority being given to single people with complex needs and younger families has created a generational shift in the makeup of new public housing residents. AHURI has projected the demand for public housing for older people is expected to increase by 76% between 2001 and 2016, with the highest increase in demand from those aged over 85 years. While demand is growing, ABS figures show in March 2008 public housing approvals fell to their lowest level in 30 years.

The previously mentioned NSW Government initiative: *Social Housing for Older People* provides an overarching policy framework for older persons public housing and includes significant new commitments to funding older persons public and community housing. This is the type of approach that needs to be facilitated by the Commonwealth Government and emulated by all State Housing Authorities around Australia.

The Government's recent "Nation Building Investment" of 20,000 new social housing dwellings is an historic investment in housing infrastructure. This large program provides the opportunity to design and develop older people's housing options in creative and innovative ways that reflect consumer input and choice. It opens the door for such initiatives as mixed social and commercial housing developments; intentional communities based on interests rather than income and assisted living models. For these to occur older people, and their service providers, must receive a fair share of these new dwellings.

Recommendation: A policy framework for funding public housing for older people is now urgently needed by Federal and State/Territory Governments within any NAHA and economic stimulus package.

2.3 The adoption of universal design principles in built environments and urban design

Governments at all levels need to do more to support the aspirations of older people to remain at home as they grow older. Supporting older people to age in place will require rapid progress on developing accessible building standards and improved urban design processes including improvements in the environmental sustainability of housing.

In recent years, there has been growing awareness of the critical role played in supporting older people to remain in their communities through the implementation of accessible or adaptable housing using universal design principles. Universal design incorporates products and building features that - to the greatest extent possible - can be used by everyone.

The features of universal design are:

- Equitable Use; the design must be useful and marketable to people with diverse abilities.
- Flexible in Use; it must accommodate a wide range of individual preferences and abilities.
- Simple and intuitive use; it must be easy to understand, regardless of the user's experience, knowledge, language skills or current concentration level.
- Perceptible Information; it must communicate the necessary information effectively to the user, regardless of ambient conditions or the user's sensory abilities.
- Tolerance for error; the design must minimise hazards and the adverse consequences of accidental or unintentional actions.
- Low Physical Effort; the design must be used efficiently and comfortably with a minimum of fatigue.
- Size and Space for approach and use; appropriate size and space must be provided for approach, reach, manipulation and use, regardless of user's body size, posture or mobility.

Currently there is no legal requirement for residential housing to be accessible in Australia. Without such regulation, it is very difficult to encourage builders and developers to provide barrier free environments or to create a consumer demand for such environments. In the United Kingdom *Lifetime Homes Standards* are progressively being phased in with full implementation for all new homes by 2013. These standards promote accessible and adaptable housing and it is estimated that compliance results in modest additional costs of 547 pounds per new home.

In 1995 Standards Australia developed a Standard on Adaptable Housing – Australian Standard (AS) 4299. Although not currently enforced, the principles of adaptable housing outlined in AS 4299 include:

- adaptable housing incorporates design features often lacking in current housing that are designed to benefit all owners/occupiers
- it is possible at relatively little extra initial cost, and later modification to adaptable housing should be able to be effected at minimum inconvenience and minimum cost
- it provides houses with features, dimensions and materials designed for safety and ease of use
- it assists in maintaining community and family networks by allowing people with disabilities and older people to stay in their own homes, close to established support networks and familiar surroundings
- it is suitable for people with any level of ability - the adaptable house, due to its adaptable features, should suit any future occupant with any type of disability

Many countries throughout the world are currently using the WHO Aged Friendly Cities framework to address issues for older people such as housing, transport, community services, urban design and infrastructure. Some local governments in Australia are adopting the framework but require further funding for the range of developments required. The UK government is funding the development of *Lifetime Neighbourhoods*. Such a neighbourhood is designed to be welcoming, accessible and inviting. Community infrastructure such as transport services, civic space and amenities are designed to make it possible for older people to have a full life and participate in the life of their local community.

It is time for Australia to adopt similar enhancements to community infrastructure through urban design that acknowledges the wide range of needs of the growing number of older community members. Environmental sustainability and energy efficiency should be a key focus of such developments.

Recommendation: The Alliance calls on the Commonwealth, State and Territory Governments to:

- amend the Building Code of Australia to adopt the principles of adaptable housing in line with AS 4299 by 1 January 2010;**
- phase in Universal Design and sustainable living planning criteria**
- further facilitate the development of concepts such as Aged Friendly Cities and Lifetime Neighbourhoods.**

Mr Ian Yates
Chief Executive
COTA Australia
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Dear Ian,

Following our discussion yesterday, I recommend COTA Australia encourages the industry to develop a **systematic approach** to workforce data collection and analysis and to ensure **evidence based** workforce planning is the driver of workforce development strategies in your sector.

The Standards Australia 'Guidelines on Workforce Planning' (2008) offer a comprehensive and proven framework for undertaking workforce planning. There are also a number of other useful resources (Workforce Planning tools and templates) available nationally on which I can provide more advice if requested.

Some of the questions which I suggest you need to answer are:

1. **What are the Aged Care sector mission critical job groups?** i.e. if the sector cannot attract or retain people to these job groups it will be vulnerable in its capacity to meet legislative and regulatory requirements.
2. **Is there any significant difference in mission critical job groups by location** – state or territory wide, rural, remote, service provider level? If so why?
3. **Which of the mission critical job groups are also nominated as national skills shortage occupations? What other job groups from the sector should be on this list?**
4. **Which of the mission critical job groups are regarded as 'hard to fill'** i.e. there are enough people with the required skills sets in Australia but for a range reasons (location, remuneration, image of the sector) they do not choose to work in the Aged Care sector?
5. **Which of the mission critical job groups are regarded as:**
 - a. Globally advantaged (can deliver skills and services in global market)
 - b. Insulated (location dependent)
 - c. Vulnerable occupations (at risk of being performed off shore)
6. **What are the *current and projected* workforce supply gaps (quantified) for the sector, in particular for mission critical job groups?**

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7. What is the risk assessment and mitigation strategy for addressing these supply gaps? How does this differ by sector, service provider and location?
8. What is the cost of retaining employees in job groups with projected supply gaps in comparison to recruiting to fill these same supply gaps?
9. What is the working life stage - cohort of the Aged Care sector workforce in relation to the service provider they currently work for and also in the community services and health care industry generally?
 - a. Early career employees x job group x employer and x industry
 - b. Mid career employees x job group x employer and x industry
 - c. End career employees x job group x employer and x industry
10. What is the mobility (history and projections) of the Aged Care Sector workforce?
11. What sectors, industries and locations do they transition to and from?
12. What role can the Aged Care sector play in formalising/accrediting this mobility to attract and retain the required workforce?
13. What is the workforce profile by *employee characteristics*, and how does this differ from other industries and sectors?
e.g. Age, Gender, Cultural, Language and other diversity.
14. What is the workforce profile by *working arrangement* e.g. full time, part time, contract and volunteer workforce?
15. What is the workforce profile by *working arrangements by job groups, service providers and locations*?
16. What is the workforce profile by *working life intentions in the paid and unpaid workforce*?
17. What is the workforce profile by level of interest in upgrading skills? Does this vary by job group, working arrangements, location or place of employment?
18. What do the employees and volunteers in this sector consider are challenges for them to remain in the industry and sector?
19. How significant is the volunteer workforce as a source of paid workforce supply? i.e. level of interest, skills set, location, availability.
20. How can the workforce profile data strengthen a sector wide approach to workforce development strategies around:

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- a. **Attraction**
 - b. **Retention**
 - c. **Job design and re-design**
 - d. **Supply source: including underutilized labour market**
 - e. **Succession planning**
- 21. How can the industry and sector leaders collaborate to strengthen governance and leadership in workforce planning and workforce development?**
- 22. What other industries and sectors (nationally and internationally) are competitors to the Aged Care Sector, targeting the same workforce?**
- 23. What are the capabilities of existing workforce information systems being used by the sector to produce workforce planning data and reports?**
- 24. What does the Aged Care sector need to do to build and retain its workforce planning capabilities at all levels nationally?**
- 25. What is the cost to the Aged Care sector of not integrating workforce planning into normal business practice and policy development?**

Ian, I hope this helps with your submission and please call if you would like me to expand on any of the above.

Yours sincerely,

Julie Sloan
Director Workforce Planning Australia
7th July, 2010

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Submission to the
Department of Health and Ageing

on the

Review of the Accreditation Process
for Residential Aged Care Homes

24 July 2009

COTA National

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1. Introduction

COTA National ⁽¹⁾ is the national peak policy organisation of the state and territory Councils on the Ageing (COTAs). COTAs have been operating for over 50 years. Though their more than 1500 member organisations of seniors, and their own direct membership of seniors, COTAs represent the interests of over 500,000 older Australians.

COTAs have always had a strong interest and involvement in aged care, and have been and are represented on a range of departmental and ministerial advisory bodies dealing with aged care matters. As peak consumer bodies COTAs have a particular interest in resident and consumer rights and engagement.

COTA National plays a leading role (sponsor organisation) in the National Aged Care Alliance (NACA) and is co-leading a NACA initiative to develop a new vision for aged care based on the centrality of community care and support and client-directed care.

COTAs have bi-lateral links with aged care provider peaks and major provider organisations at both state/territory and national levels. COTA is in particular in a collaborative relationship with ACSA.

COTA National has not consulted either within NACA or with provider peaks in the development of this submission, in part due to the short time available to us to complete the submission.

COTA National has consulted with state and territory COTAs Policy Councils and received input from a number of them; and has also consulted with aged care consumer and advocacy bodies.

We are concerned that there does not appear to have been any departmental strategy to obtain input on the issues and questions of the Review's Discussion Paper directly from residents and families. This needs to be addressed in the next phase of the process and we deal with this in section 6 of this submission.

The views advanced in this submission have taken into account input from COTA Policy Councils and are fully consistent with and informed by COTA National policy principles and current policy. However the submission has not been through the formal COTA policy approval processes and some of its views are therefore provisional.

This submission has been prepared specifically from a consumer viewpoint. By "consumer" we mean a resident plus that resident's (chosen) family members, close friends and / or advocates.

We do mention in the submission matters relating to provider experience and perspectives. However our submission is without apology substantially written from the biased viewpoint of consumer interest and particular consumer experiences.

Some of our observations and recommendations may seem "unfair" to the majority of providers, or even to the Department. Some of the negative experiences and outcomes we

(1) *COTA National is the new trading name of COTA Over 50s Ltd. It is intended to formally change the name of COTA Over 50s Ltd in the near future. This may be to COTA National or to another appropriate related name.*

cite may apply to only a small minority of residents. However we make no apology for our goal being that such experiences and outcomes should not ever occur.

Our ultimate goal is that the aged care system should improve the quality of life of residents, rather than merely maintain life. That goal will require significant reform of the aged care framework and service models.

2. General comments on the current accreditation system

The Review Discussion Paper asks whether the current accreditation and monitoring regime for residential aged care homes is effective in identifying deficiencies in care, safety and quality, and if not, why not?

COTA strongly supports the need for an approved accreditation regime in aged care. However whether our current regime is optimal is open to debate – including in some key ways not canvassed in the Discussion Paper. We discuss this later.

We recognise that the vast majority of facilities would be accredited under any form of accreditation regime, as evidenced, for example, by the fact that around 90% have received three year accreditation.

However we do have significant concerns about some aspects of the current system. We have publicly expressed concern that some facilities have received three year accreditation and then within months been found to have major breaches of standards, with no change having occurred in key personnel or ownership which might explain this quandary. While the Accreditation Agency rejected our public criticism it could offer no credible explanation for the occurrence. No-one can. The system is not fail-safe. However there has been no independent forensic examination of why these events occur.

We can also cite instances of facilities which have been required to effect improvements in key areas of resident well-being (e.g. nutrition) and to accept external input to improve, then regaining full accreditation, but advocacy groups shortly thereafter being informed by residents that practice is a long distance from the paperwork (specifically in the nutrition case the new menus and the meals being delivered bearing little relation to each other).

In the next section of this submission we deal extensively with the issue of consumer engagement with the accreditation process so we shall only say here that this is the most sub-optimal aspect of the current system. Frankly it is unacceptable. The proposals in the Discussion Paper likewise go nowhere close to dealing with the issue. Public servants, providers and assessors are all in general out of touch with this aspect of the system.

In a way our concerns relate to the Discussion Paper's advice that the question of introducing Quality Indicators will be addressed separately, as will a review of the Standards. COTAs believe that these are inter-related matters. Indications are that so do consumers. We are increasingly concerned not principally with facilities' capacity to demonstrate a paper-based adherence to standards but with the capacity of facilities to improve rather than reduce residents' quality of life, something to which the system's overall structure, resourcing and incentives are as crucial as behaviours in individual facilities.

We return to a matter not addressed in the Department's Discussion Paper. We are aware of long stated suggestions that accreditation should occur through recognition of a number

of independent competitive accreditation bodies (as occurs in the hospital sector) rather than being undertaken by a body such as the Aged Care Standards and Accreditation Agency – government owned and public sector in culture.

There is a strong professional argument that the processes of accreditation and indeed industry education should be separate from monitoring, complaints investigation and compliance processes, which might be characterised as “policing”. If accreditation was independent and competitive as in the rest of the health sector, then a new agency, independent of but funded largely by federal government, could undertake monitoring, complaints handling and other quality compliance activities. COTA has long argued that these functions should be separate from the Department.

COTA is not, at present, saying we should definitely move in this direction. However it is a discussion worth having openly because it directly addresses the complexities and contradictions of trying to combine quality improvement with policing.

3. Engaging residents and their significant persons

The Discussion Paper asks whether the current accreditation process allows for appropriate levels of consumer input. If not, why not and how might this be improved?

The highest priority message that COTAs want to advance in response to this Review is in two parts. It is first that the current accreditation process falls down badly in terms of consumer engagement and input. In fact it is unacceptable and has significant deleterious effects on the adequacy of the accreditation process.

In its second part, our message is that meaningful consumer engagement in the accreditation process can really only occur if that engagement becomes part of the infrastructure of the aged care system itself. We cannot have consumer engagement in assessment if we do not have consumer engagement in the very processes of residential aged care and in the shape, resourcing and operation of the whole aged care system.

Let us look at the first part of our message. The current accreditation process fails to deliver appropriate levels of consumer involvement in the following ways:

- We know that often residents, families and other significant persons are unaware that a re-accreditation process is underway and a site visit about to occur. Some efforts may be made to inform them but these are either inadequate or the information does not get through.
- An even greater issue is that people do not understand what this process means, how they can be involved in it, how they could do so confidentially, exactly what is being looked at, and so forth. Much greater effort is required in many cases to inform consumers about the process and how they can be engaged in it.
- Despite that fact that it is expressly stated that this should not happen we are aware that in some instances the providers decide which residents and families will meet assessors and discourage other who wish to do so, or tell them that the arrangements have all been finalised.
- Interactions between assessors and residents are reported to often be confusing and unsatisfactory. There is often a lack of structure to meetings with residents and

families, with participants unclear what matters they could raise and no guidance from assessors.

- The above is exacerbated by the fact that assessors are seen as part of the system with considerable power over the facility and therefore over the lives of residents. Residents and families may want to talk about things that are not “up to scratch” or could be significantly improved, but not at the risk of losing their home.
- A different angle on the same dynamic is that as we know many residents do not complain to provider managements because of the substantial power imbalance between consumer and provider which carries the fear of retribution or withdrawal of service. Residents do not always have confidence that matters they might raise will be treated confidentially, so they do not raise them. However a couple of weeks later they might raise those issues with an advocate, when they would not with an assessor.
- Assessment visits and meetings with residents and families are rarely held in evenings or on weekends, thus further disenfranchising many family members.

Consumers should have a range of channels and times through which they can communicate with assessors in advance of a site visit, during a visit, and after the visit. One specific need is for an “exit interview” between consumers and assessors.

We receive reports that many assessors have limited experience and skills at engagement of residents and families in the accreditation process, especially given the imbalance of power referred to above. Assessors need to have specific training in this regard, and the accreditation process needs expert advice and assistance from consumer organisations and advocates in the consumer engagement.

In addition the assessors should either include a consumer representative or should have access to an expert advisor with demonstrable experience in consumer engagement.

This brings us to the second part of our message - that meaningful consumer engagement in the accreditation process can really only occur if that engagement becomes part of the infrastructure of the aged care system itself.

Time constraints do not allow us to develop this message in depth in this submission, but we will be doing so over coming months in articulating a new vision for aged care reform.

However making consumer engagement integral to the aged care system has many dimensions. These range from the goals and assumptions on which aged care is based, to the balance and proportions of community and residential care, to the service models in both forms of care, to the way in which individual services and facilities operate.

At the simplest level all residential facilities and provider organisations should be required to develop consumer engagement policies and strategies which should have the same priority as care policies and planning. Such policies and strategies should be developed with expert advice from consumer organisations with proven expertise in consumer engagement.

4. Announced or unannounced? and related issues

The Discussion Paper spends some time on the question of announced or unannounced accreditation site visits and related questions of whether facilities should have to reapply for accreditation and if so how this should occur.

COTAs are sympathetic to the point that the accreditation process should not require substantially more paperwork than is required for normal business, clinical and care management needs. We have some sympathy with the view that quality accreditation processes in the health and aged care sectors have placed too much emphasis on excessive paper trails rather than on actual outcomes being achieved.

Therefore a simplification of paperwork is supported.

However the question of whether or not facilities should have to reapply or not, or be reassessed without reapplying, somewhat mystifies us, unless it is assumed that not having to reapply would mean not having to do a self-assessment as part of the re-accreditation process.

We would not support this, as self-assessment is a vital component of an accreditation process with continuous quality improvement as its goal. If paperwork requirements are streamlined then self-assessment is not an onerous requirement unless a facility has let its quality processes drop.

While COTA understands the different concerns behind the “should visits be announced or unannounced?” debate, we suggest that:

- Accreditation processes do require notice and preparation. They constitute a periodic major review of quality control systems and procedures for a facility and accreditation processes of which we are aware involve the facility knowing well ahead when the formal visit will occur. Accreditation processes are not about catching facilities out, they are about promoting and enabling quality improvement.
- Monitoring and “policing” processes of their very nature need to be unannounced. COTAs are very keen on a rigorous program of unannounced visits for monitoring purposes within the current aged care services construct.

This distinction raises again the question of whether these two different functions should be undertaken by the same body and seen as the same process. At present the policing function is dominant in the relationship between the Commonwealth and the residential aged care sector. This appears to be detrimental to the core accreditation process.

While COTA believes this question should be further addressed in some depth among all stakeholders, COTA also believes that whatever the system there must be both random and targeted unannounced visits.

It is difficult to comment on the precise proportion of facilities that should be subject to random visits but 5% is not unreasonable. The suggestion that another 5% could be selected based on their risk profile is more problematic. COTAs suggest that the percentage should be determined by the risk profile. All facilities that meet certain risk profile parameters should be subject to unannounced visits.

However COTAs also recognises that unannounced visits can create major issues for providers that have nothing to do with compliance with standards. For example, providers having to cancel staff training and indeed resident activities, recall managers from important commitments, and similar, due to unannounced visits.

We suggest that in the case of randomly generated visits the facility is contacted at senior level on the day and should have the opportunity to request a brief deferral of the visit by up to a limited number of days (e.g. 3 days) on reasonable grounds (of which a list of likely reasons could be agreed).

5. Other Discussion Paper questions

We list here all questions in the Discussion Paper and advise which we believe we have answered elsewhere in the submission, and provide brief answers to others.

Questions for consideration p10

Should approved providers have to apply for re-accreditation or should the accreditation body conduct a rolling program of accreditation audits, which ensures that each home is reassessed prior to their current period of accreditation running out (without the need for the approved provider to put in an application)? What are the advantages/disadvantages of the two approaches?

Should the provision of detailed self-assessment data continue to be a requirement of any application process? If so, why?

Would the removal of the requirement to provide self-assessment data on application create a more stressful accreditation site audit? If so, how might this be avoided?

COTA has addressed the substance of these questions in sections 2, 3 and 4 of this submission.

Questions for consideration p10

What problems, if any, have approved providers /services experienced in respect of accreditation audits and electronic records?

What are the current barriers to assessment teams utilising electronic records and how might these be overcome?

We have no comment on these questions

Questions for consideration p 11

Should approved providers continue to be able to nominate a quality assessor as a member of the assessment team that will be conducting the site audit on their aged care home?

We do not believe that providers should be able to nominate an assessor. They should be able to object to an assessor on certain grounds.

Questions for consideration p13

Should the accreditation body have the flexibility to contract 'expert members', who are not quality assessors, to participate on an assessment team? If not, why not?

If yes, what sort of 'expert members' might be used and what safeguards, if any, would need to be put in place to maintain the integrity of the assessment process?

Should it be a legislative requirement for assessment teams conducting visits to high care facilities, or to low care facilities with a significant number of high care residents, to include a quality assessor who is a registered nurse?

Yes they should have this capacity. Our major concern is that it should be used to provide expertise in relation to consumer engagement, in which the accreditation process is currently deficient.

Questions for consideration p16

Should accreditation site audits be unannounced?

If not, why not? How can the public perception that announced site audits provide the assessment team with an inaccurate picture of a home's general performance be addressed?

If yes, what strategies need to be put in place to minimise disruption to staff and residents?

What strategies might the accreditation body use to encourage input to the accreditation site audit from residents and their representatives?

Should a home be able to nominate some 'black-out' days, during which the accreditation body will try to avoid scheduling a site audit? If not, why not?

COTA has addressed the substance of these questions in sections 2, 3 and 4 of this submission.

Questions for consideration p19

Does the current accreditation process allow for appropriate levels of consumer input? If not, why not? How might this be improved?

Should there be a minimum target set for consultations with residents and/or their representatives during visits to a home by the accreditation body? If so, what would be an appropriate number or percentage?

Should assessment teams seek to attend homes out of normal business hours? Would this increase opportunities for consultation with relatives/representatives?

Are there other strategies that may increase engagement with residents and/or their representatives?

COTA has addressed the substance of these questions in sections 2, 3 and 4 of this submission.

Questions for consideration p20

Should approved providers be required to organise a meeting with residents and their representatives to discuss incidences of non-compliance?

If so, should this be a general requirement for any non-compliance, or should it only apply where there is major non-compliance, for example, non-compliance with four or more expected outcomes, or non-compliance against specified outcomes?

Providers should have to inform consumers in relation to any matter of non-compliance. This should occur as part of their consumer engagement strategy. Consumer representatives should in fact be automatically informed of matters of non-compliance as part of an engagement strategy.

Questions for consideration p21

Does the lack of confidentiality for staff act as a barrier to them providing frank information to the accreditation body?

Should the confidentiality protections provided in the Aged Care Principles for residents or their representatives be extended to all persons who provide information to the accreditation body?

Confidentiality protections provided in the Aged Care Principles for residents or their representatives should be extended to all persons who provide information to the accreditation body.

Questions for consideration p22

Is the current accreditation and monitoring regime for residential aged care homes effective in identifying deficiencies in care, safety and quality? If not, why not?

If the accreditation and monitoring regime was to be enhanced, what approaches should be adopted?

Should homes be required to collect and report against a minimum data set?

COTA has addressed the substance of these questions in sections 2, 3 and 4 of this submission.

Questions for consideration p23

Should decisions only be appealable to the Administrative Appeals Tribunal if they have already been subject to reconsideration by the accreditation body?

The answer to this question depends on the future role of the Accreditation Agency. In principle, however, all internal appellate processes should be exhausted before appeal to another authority.

Should the accreditation body be able to undertake 'own motion' reconsideration of decisions in certain circumstances?

Yes.

Questions for consideration p23

Is the current way in which audit reports and decisions are published adequate? If not, why not?

Should audit reports and decisions of the accreditation body that are subject to reconsideration or review be made publicly available prior to the finalisation of the review process? If not, why not?

Should approved providers be required to provide residents and carers with access to reports and decisions of the accreditation body?

We recognise the complexities of public and media exposure and highlighting of these matters. However, consumers should be informed of all reports and decisions, and if the provider is appealing them.

Question for consideration p24

Are the current distinctions between different types of visits conducted by the accreditation body appropriate? If so, why? If not, why not?

COTA has addressed the substance of these questions in sections 2, 3 and 4 of this submission.

Questions for consideration p26

Is it problematic for the accreditation body to provide education to industry?

If not, why not? What are the benefits of the current approach?

If yes, what are some alternate models for providing education to industry?

Does there need to be another source of advice for industry, besides the accreditation body, about issues in respect of accreditation and improving performance? If so, what would be an appropriate source for such advice?

It is not problematic for an accreditation body to provide education. However, that should be as part of a broader education program in which the accreditation body is one but not the only partner. Other partners need to include the industry itself and key representatives of consumers.

It becomes problematic when the accreditation body is also policeman.

Questions for consideration p26

Should there be a maximum period of accreditation specified in the legislation?

Should homes that have sustained compliance with the Accreditation Standards over a number of years be rewarded with a longer period of accreditation?

Are there other means of rewarding good performance?

COTA does not think that a maximum period should be legislated. Three years is a reasonable period but there is no gain in legislating it.

Yes, there should be an option of an extension in the circumstances outlined. This has in the past been covered by providers. Subject to later experience the extension should be only one year. It should not exclude that provider from random audits.

6. Process for Improving the Accreditation Process

COTA notes that this Review has been generated internally to the Department and that there are no external processes to involve consumers in the process. As far as we are aware there are similarly no such processes in relation to providers, or the public. Indeed the public is unaware of this and related internal “reviews” of bits and pieces of the current aged care system.

COTA has for some years been of the view that the aged care system in Australia is in need of major reform. We have participated in several efforts of government that might have led to that, but which failed to see the light of day. This was not due not lack of clear answers – these were agreed by departmental, consumer, provider and expert representatives - but due to a failure of government leadership and commitment.

If we are looking just at improving the accreditation process then COTA suggests the next steps in the Review should be:

- The Department prepares a report on the submissions and other input obtained.
- That report should not aim at either a “consensus” or a lowest common denominator outcome, but should reflect the full variety of views and evidence presented.
- That report should be provided to all stakeholders.
- A roundtable should be convened comprising the Department, provider representatives, consumer representatives and other key players and experts.
- The roundtable should be externally and expertly facilitated.
- The roundtable should be tasked with coming up with a model of the optimal accreditation, monitoring and compliance processes in residential aged care and recommending it to the government

However, the degree to which we can improve the accreditation process is limited by the current nature of the aged care system itself. Therefore the process proposed above is in the end secondary to a major review of the overall system.

7. Conclusion

COTA hopes that the government will finally agree to initiate a major review of the Australian aged care system, of which the accreditation process is but one, albeit important, part. As we have indicated earlier the accreditation process is itself a sub-set of the basic values, assumptions, goals and infrastructure of that system.

It is past time that the Australian aged care system be the subject of fundamental review. The core elements and indeed basic outcomes of that review are understood and largely agreed by leading providers, consumer representatives and the public service already. The task before us is to design a system that is sustainable to 2050 and of which Australia can actually be proud.

It is time to act to delineate a new vision of aged care and to put into place the steps to achieve it.

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