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The Secretary
Senate Finance and Public Administration Committee
PO Box 6100
Parliament House
Canberra ACT 2600

Dear Secretary,

Inquiry into the funding, planning, allocation, capital and equity of residential and community aged care in Australia

COTA Over 50s is the peak consumer organization in aged care and has been so in various forms for over 40 years. It currently provides a national policy and representation platform for its eight state and territory member COTAs.

Between them COTAs in all states and territories represent many hundreds of thousands of older Australians, through over a thousand member organisations. A number of COTAs have regular and direct involvement with the aged care sector. For example COTA Seniors Voice in SA, Australia's second largest seniors organisation, has the Aged Rights Advocacy Service that provides direct services to aged care recipients and their families, and maintains an active Service Providers Forum in collaboration with aged care industry peaks.

With regard to each particular term of reference of the Inquiry:

a. whether current funding levels are sufficient to meet the expected quality service provision outcomes;

COTA Over 50s does not have the capacity to undertake our own detailed financial and economic analysis of the aged care sector. However we are in active and regular consultation with the aged care industry peaks and leading providers and we are founder sponsor members of the National Aged Care Alliance (NACA).

We have also read and considered a number of the aged care industry submissions to the government's current CAP Review. These include the joint submission from the two industry peaks under the auspice of the Aged Care Industry Council, the Access Economics analysis prepared for Baptist Care, Catholic Health and Uniting Care Ageing NSW & ACT), and the Grant Thornton Aged Care Survey.

It is clear to COTA Over 50s that the residential aged care industry is experiencing significant financial stress particularly in high care, and that the trends are worsening. We note that the CAP was intended as a temporary instrument while the longer term funding of the sector was reviewed and restructured.

We have also noted that the CAP has not been applied to the community care program even though the cost pressures on that program are similar to those in residential care.

We have put to government our view that the CAP Review should be broadened to examine and recommend on:

- the levels of funding required to ensure high quality aged care provision for all who are assessed as needing it, on an equitable and sustainable basis;
- the separation of care, living and accommodation costs;
- who should pay for what proportion of each of these three sets of costs, providing that no citizen should be excluded from care and support due to financial incapacity ; and
- a new model for service user contributions to these costs incorporating a number of payment method options.

One particular area requiring additional funding is the community aged care packages program. The current gap between CACPs and the various EACH packages is too great. The model should be either multiple levels of packages between the current CACP and the EACH Dementia levels, or preferably the development of a Community Aged Care Funding Instrument (CACFI) based conceptually on the new residential ACFI. Under such a model, a person would be assessed for care needs and allocated a level of funding which can be applied to various community care services.

As a member of NACA we fully support its Federal Budget submission position that "The Australian Government introduce a defined and properly costed benchmark of care for residential and community care that reflects the real costs - staffing and operating – of providing a quality aged care service in different regions in Australia to meet assessed care need."

b. how appropriate the current indexation formula is in recognising the actual cost of pricing aged care services to meet the expected level and quality of such services;

We support the NACA position that "The Australian Government to change the current care subsidy system from Commonwealth Own Purposes Outlays (COPO) to an indexation factor weighted 75% for wage growth and 25% for non-wage growth using the Labour Price Index (LPI) Health and Community Services for the wage element and the Consumer Price Index (CPI) for the non-wage element."

c. measures that can be taken to address regional variations in the cost of service delivery and the construction of aged care facilities;

The NACA position set out at the end of our comments on (a.) above needs to be applied on a differential basis across Australia to reflect varying real costs. We do not have a fixed view on

the geographic level of differentiation but believe that supplements or other means of addressing cost variations should apply wherever the cost differential is more than a determined percentage of the median value.

d. whether there is an inequity in user payments between different groups of aged care consumers and, if so, how the inequity can be addressed;

There are a number of inequities in user payments for aged care including (a) the subsidization of residential high care by low care residents who pay accommodation bonds, which is becoming increasingly unsustainable, and (b) the differential in some contexts between fees for Community Aged Care Packages and comparable sets of services delivered through the HACC program.

However the greater inequity between consumers is that of differential access to care and appropriate care. This is a function of a number of factors, including funding arrangements, the allocation ratios, the current distribution of beds and places, the structure of the aged care industry, the insufficient number of community care packages and inadequate HACC program funding, and the variable nature of the aged care assessment process.

These are all matters on which we can expand if requested to appear before the Inquiry,

e. whether the current planning ratio between community, high- and low-care places is appropriate; and

The original imposition of planning ratios for residential care was understandable as some in the provider sector were essentially recruiting into aged care at taxpayer expense residents who had no objective need to be there. However the current ratios have no evidence-based relationship to measured need in the community.

We question the need for the continuation of overall residential planning allocations, as compared with market forces determining future development. Any such move would, however, have to be gradual in nature as an abrupt change would likely have a significant negative impact on many within the industry.

This issue requires further discussion and consideration than we wish to do here. It should be noted that despite the years of planning allocations, beds continue to be maldistributed. Some areas remain "over-bedded" while in some "under-bedded" areas either allocated places are not taken up or new places are not allocated because it is known no providers will take them up.

If regional allocation ratios are retained for residential care the distinction between high and low care should be abolished. It has become very blurred since ageing in place and under ACFI the distinction is in any case related almost exclusively to the need for a dividing line under the Act between high and low care so as to determine eligibility for bonds.

We do not support allocation ratios for the provision of community care places (currently CACP, EACH and EACH D). As argued earlier we believe the current levels of packages should be replaced by either a continuum of stepped levels, or preferably by a Community ACFI which allocates a sum of money to a person.

Community packages should then attach to the individual and not to specific providers or geographic regions. There is no sensible rationale for community care to be allocated to providers or regions.

We strongly believe that the criteria for allocation of Community Packages should be approval by an Aged Care Assessment Team (ACAT). There should not be a rationed number of places, but rather an entitlement triggered by an ACAT assessment.

This position is supported by the Productivity Commission's September 2008 Research Paper which suggests the current dual gate-keeping system should be replaced by dispensing with the planning and allocation system and relying on entitlement for aged care being established by ACATs (over which the Commonwealth should take full control and funding). (Like the Commission we strongly support the continuation of aged care providers having to be approved; and the continuation of accreditation - though this needs to be reviewed and updated.)

Unblocking the supply of community care would over a fairly short period of time give a much better indication of the real level of need for residential care. Demand for residential care is currently inflated by the lack of community care due to its rationing, its nature and its distribution.

We would just briefly add that moving in this direction will require the greater resourcing and better management of ACATs on a national basis. People referred for aged care assessment should be seen within five working days. (However people referred for assessment for the first time from acute hospital beds after an acute episode should not be assessed for long term care until after a recovery and transition period.)

f. the impact of current and future residential places allocation and funding on the number and provision of community care places.

We have effectively answered this question in our preceding answers. Essentially what Australia needs at this time is a new vision for aged care. Neither side of politics has offered this to date. That vision starts within the health system with a much greater focus and resourcing on health promotion and illness prevention targeted specifically at older Australians.

At present health promotion and illness prevention is seen as a "whole of life" matter which translates as being about children. There is a lack of recognition that while childhood initiatives are unarguably important, so too are initiatives directed both to current "Baby Boomers" in terms of lifestyle change and to older people who can take greater control of their health, including chronic diseases, if their lives have meaning independent of their health.

Programs which achieve this are being practised but largely outside the formal health system. They are not supported by most health departments, indeed they have ceased to be funded at both Federal and some State levels.

After that we need in aged care a HACC Program that focuses on enabling and supporting people to address small but critical issues in their everyday lives that need support in order for them to maintain their wellbeing and contributions to family and community. This must include clear protocols that ensure that HACC is focused at the "front end' of both individual and community support and not converted into high level packages of care.

As argued earlier the community care packages program needs to be made more robust and established on an entitlement basis, not rationed by an artificial ratio. Prompt and effective assessment services should certify entitlement and ensure that there is rapid response to proven need.

Funding for care services and assistance with daily living needs to be separated from accommodation funding and the current distinction between high and low care in residential settings abolished. The separation of accommodation from care will better allow consumers to receive care in the setting of their choice and will focus greater attention on the need for more appropriate housing policies for older Australians.

User contributions to care and accommodation costs should be transparent, comparable and equitable. Payment methods should provide choice for consumers between periodic payments, up-front discounted payments, and loans or a mix of these.

Finally we emphasize the need for greater application and pilot testing of the principles of consumer directed care and the greater involvement of consumers and carers in the design, implementation and review of aged care service models and their accreditation and continuous improvement.

COTA Over 50s would be happy to develop further on this submission in an appearance before the Inquiry. For further information please contact the undersigned or the CE of COTA Seniors Voice, Ian Yates AM - one of our national representatives on aged care.

Yours sincerely,

Dr Geoffrey Bird
Executive Director