SUBMISSION IN RESPONSE TO THE PRODUCTIVITY COMMISSION'S DRAFT REPORT ON CARING FOR OLDER AUSTRALIANS

Prepared by

National Policy Office

on behalf of all COTAs

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EXECUTIVE SUMMARY

In our initial Submission to the Productivity Commission last July COTA called for substantive reform of the support and care system for older Australians. We proposed a set of principles and a framework that gave older people more choice and control over how their support and care needs would be met whilst still being affordable for the population as a whole.

In the Draft Report the Productivity Commission addresses all the fundamental issues we raised and its recommendations set out the blueprint for a very different system of support and care for older Australians. There is a high degree of convergence between COTA's proposals and the Draft Report's recommendations and so we support the majority of the recommendations whilst recognising that there is much detail to be worked through in the implementation process.

COTA is pleased to see that the Draft Report puts the older person at the centre of the system by introducing the notion of entitlement and attaching the funding to the individual rather than the service provider. Both of these measures ensure more consumer choice and control over the services they use. That choice should also extend to where people receive their support and care i.e. people can choose to have it at home or move into residential care.

COTA proposed the "Gateway" in our initial Submission and we are pleased that the Commission has recommended it. The Gateway helps to solve the problem of people not knowing what services are available and how to access them. If we are to have greater choice and control then we need to ensure that people have access to the appropriate information in a timely way.

On the funding side of the reforms COTA accepts the principle that people should pay for care according to their means and that accommodation should be separated from care. We support the recommendations around a national system of user contributions for care and the linking of this to a national set of prices for that care. We also support the extension of accommodation payments, including bonds, across all residential care as we think that is more equitable than the current approach of excluding high level care.

We were pleased to see the recommendations around the establishment of the Australian Aged Care Regulation Commission, particularly the inclusion of the Complaints Investigation Scheme within this independent body. This is something COTA and others have been arguing for a long time.

COTA does not fully support a small number of recommendations. The two most important areas of disagreement relate to the proposals for supported residents i.e. the use of a two-bed room as the standard for funding of supported residents and the proposals around trading supported resident places. We are concerned that the proposals as they stand will lead to supported residents not having choice of provider and only being able to access a much lower standard of accommodation than other residents. COTA notes that the Productivity Commission has recently indicated that it will rethink the standard for funding

and we recommend that a single room with ensuite at basic building standards should be adopted.

In our initial Submission we suggested that there should be a social insurance scheme for aged care. As explained in the submission we have decided not to pursue this.

One of the key issues in an entitlement model will be the assessment used to determine people's needs. We endorse the use of a two tiered system of assessment with nationally agreed and consistent assessment tools. We also agree with the idea that there needs to be an initial rapid response to people's immediate needs followed up by a more detailed assessment to develop a longer term support and care plan. We do have some concerns that the models outlined in Attachment B could lead to over-assessment which in turn could lead to over-servicing in the areas of care coordination and case management.

In terms of implementation COTA broadly supports the approach taken in the Draft Report but believes there will need to be more detail in the final report as laid out in our initial Submission. We believe the first three critical steps are the establishment of the Gateway; greater investment in and freeing up the supply of community care; and the independent determination of appropriate prices. We also think the Implementation Taskforce should be established independently of the Department of Health and Ageing and include service providers and consumers.

COTA identified a number of areas in the report which needed substantially more work. The first of these is respite and we are now proposing that carers should have the option to cash out their entitlement to respite and use the money to purchase services from a greater variety of people. We know many carers identify respite as a key service but then don't use it and we think the ability to cash it out and source their own service would increase the take up.

Whilst accepting that the proposed reforms would benefit people with dementia and their carers we would like to see the Commission support a comprehensive strategy to address dementia, which is such a core part of the demand for aged care. This would include quality care services, more research into the causes and possible prevention of dementia, measures to ensure more timely diagnosis and measures to ensure hospitals are safer for people with dementia.

COTA was disappointed with the paucity of the recommendations for special needs groups despite there being a chapter in the Draft Report outlining their particular needs. In particular we would like to see more about the needs of people with lifelong disabilities as they age. We believe the entitlement approach will assist with their being able to access services that better meet their needs but are suggesting that there be some trials of cashing out for specific groups to see if this will assist them further. We are also keen to ensure that people with special needs do not pay higher care contributions simply because their needs cost more to deliver.

We believe the Final Report should more explicitly acknowledge in its recommendations the specific issues around providing support and care to people in rural and remote areas. This needs to be reflected in the price that is developed for services and in workforce considerations. Again we are recommending a trial of cashing out in rural and remote areas to try to give more choice to consumers in those areas.

In terms of age friendly housing and communities COTA supports all the recommendations but believe the report should have gone further in two areas. We think there should be a default mandatory approach to the adoption of accessibility and adaptability standards for new building if the voluntary arrangement agreed by the National Dialogue on Universal Housing Design does not succeed.

We also think that the Commonwealth needs to have an active role in the planning framework around retirement specific living options. This would help to ensure that planning and other processes facilitate innovation around clustered and congregate housing models that will in turn assist with the delivery of community care.

In conclusion COTA believes that the recommendations should be seen as an integrated set of proposals and that they must not be dismantled or adopted in a piecemeal way.

COTA thinks it is important that the final report is structured in a way that puts the proposed care and support system first and then deals with how it would be funded, from government and from individuals. This reordering of the report and the recommendations would make it clearer that the package would reform the care provided as well as changing the way people pay for it; something which has tended to get lost in the discussion of the Draft Report.

Finally COTA has made many comments and suggestions on the Draft Report in this second submission. The richness and diversity of those is we hope helpful. However as valid and important as most or all of these are, nothing should divert attention from or diminish the strong commitment we have to the overall architecture of the age care and support system outlined in the Draft Report and recommended by the Commission. Its implementation is of the highest importance and all the rest can be sorted in that implementation.

1. INTRODUCTION

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

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. This submission incorporates the views of our members collected through various consultation mechanisms, including public forums, meetings of State Policy Councils and input from our extensive community and membership networks.

COTA strongly welcomed the Draft Report on its release, and firmly believes that the reforms it recommends lay the groundwork for an enhanced aged care system that will give older people more certainty, choice and control over support and care services. Many of the recommendations align closely with positions that COTA has been advocating for a number of years and that formed the basis of our initial Submission to this Inquiry, as well as closely reflecting the National Aged Care Alliance (NACA) Vision.

In this submission we comment on the areas that we support, in most cases with qualifications and /or supplementary points. We then look at the few areas where we disagree with recommendations. We then briefly discuss matters on which the Commission specifically asked for comments. Finally we focus on the gaps that we have identified in the Draft Report recommendations and suggest some ways that the Final Report can be strengthened in regard to these.

2. SUGGESTIONS & COMMENT ON SUPPORTED ASPECTS OF THE REPORT

COTA supports the overall approach outlined in the Draft Report whilst recognising that much of the detail will be worked through in the implementation process. Our position on each of the 42 recommendations is at Attachment 1. Not every point in Attachment 1 is elaborated in the text of this submission.

In the following points we indicate our strong areas of support but in most cases provide additional comment and suggestion here, rather than repeating the item in section 5.

2.1 Older person centred

We believe that the recommended approach puts the older person much more at the centre of the system and will deliver more choice and control to them. The key elements of the proposed system that we support are outlined below. These need to be supported by

changes in assessment and the services menu over time to adapt to and support a "consumer as citizen"- centred culture.

2.2 Entitlement based

The move to an entitlement rather than rationed system which moves the funding from service providers to individuals is the most fundamental of the reforms and is strongly supported. Critical to its success will be the assessment process and the funding instrument used that will convert people's needs into a package of funding, both of which will need to be worked through carefully in the implementation stage.

2.3 Freeing up support and care provision

The associated abolition of the regional allocation of packages and places and freeing up of service types we believe will result in much more support and care in the home, something older people have been saying that they want. They will now be able to put together a self-selected set of services from a range of providers and have greater choice over where these services are delivered.

The freeing up of service provision will represent a challenge for many providers. There will be some fear that it will favour large, well resourced providers with a diversity of service types. However COTA believes that just as now some smaller providers 'defy the odds' by filling unique market segments, so many of them will be able to do seven more so in a more open and flexible environment – in some cases working in collaborative partnership.

2.4 Gateway proposal

The national 'Gateway' proposal is an important step in addressing the most commonly heard complaints about aged care i.e. that it is complex, people do not know how to find out what is available, and when they do it is difficult to get to and inconsistent and inequitable from place to place .

We support the Gateway being a source of nationally consistent and up to date information; undertaking assessments of both care needs and users' financial contribution to their care and giving advice on types and availability of services. We also think it is critical that the Gateway has the capacity to immediately connect people to available services.

For the Gateway to be effective it needs to include all services and be the initial entry for everyone. We note that a number of stakeholders are making the case as to why some service and providers should not be part of the Gateway. We do not support this approach but acknowledge that by making it all inclusive there is pressure on the Gateway to be responsive and ensure people are quickly referred to the best possible service.

An alternate approach might be to allow some services to take initial direct referrals but to then immediately feed the information back to the Gateway to ensure the individual's care record is commenced and there is an accurate record of their care contributions.

In our initial Submission we had envisaged a network of Gateways within one framework rather than a single unitary entity as suggested in the Draft Report. Whilst we can see merit

in having a single unitary entity, we think there are two issues that need more consideration.

The first is that the Gateway Agency needs to have access to local information and be locally accessible. Therefore the proposed regional approach needs to reach down to the appropriate local level in order to deliver this. This could be through a variety of delivery models appropriate to specific and differing circumstances. While the Gateway will be accessible by phone it also needs to provide for face to face access, so it must have a physical presence that people to which people can come.

The second is more an implementation issue. We think it might be preferable to initially network existing information and assessment services together, using a national information ”spine” and consistent assessment tools, to ensure continuity of service and to ensure local expertise and knowledge is not lost in transition.

2.5 Independent pricing

We strongly endorse the move to fund on the basis of prices recommended by an independent agency and that these prices would be mandated for services attracting the government subsidy. This is important as we do not want to move to a system like the Medicare benefits Schedule where the price only sets what subsidy government pays and providers are free to set their own prices resulting in significant gap payments for many consumers.

It is vital that moving to independently recommended pricing be one of the first and highest priority steps in implementation of the Final Report. Even if higher prices are phased in over a couple of years they need to be set as soon as possible. Without prices that truly reflect the cost of care the Commission’s integrated blueprint will not have the confidence of consumers, providers or unions.

The implementation of a fair and sustainable pricing regime is fundamental to the viability of the Commission’s proposed system.

2.6 Consistent and equitable user contributions

COTA also strongly supports the move to a national system of user contributions. It is important that the contributions are calculated using a nationally consistent and equitable means-test and we support using Centrelink /DVA for this purpose. We also strongly support the “stop loss” cap on the lifetime contribution to care.

COTA has not yet come to a final view about the precise structure of the proposed user contributions because of the difficulty of forming a view about their affordability without specific examples. We accept that this is itself very difficult when the Draft Report is proposing radical changes to pricing, services and accommodation.

COTA understands how the Commission has come to the framework for user contributions and agrees that it seeks to be equitable, progressive and sustainable. We welcome the proposal for a government endorsed equity release scheme which we believe should be on

a shared equity basis or a HECS-like loan recoverable from the estate, rather than a compounding interest loan.

In any scheme there should as now be protection for the partner, primary carer, cohabiting sibling or dependent child that ensures that person is not required to move from the home in order for the contribution to be paid out of the home equity. In such cases, the repayment should be required only once the dependent dies, moves to other accommodation, or is no longer a dependent.

2.7 Accommodation separate from care

COTA thinks it is essential that accommodation be separated out from care and supports the recommendations that make accommodation and living costs primarily the responsibility of users, with adequate safety net arrangements for people with insufficient means and with regulated funding arrangements for residential care. We think the arrangements around accommodation charges including periodic payments, greater transparency around amounts of bonds coupled with the equity release scheme and Pensioner Bonds will improve the capacity of people to fund this without being forced to dispose of their primary residence where this might be inappropriate.

COTA recognises that the proposals will lead to greater diversity of accommodation choices being provided in the aged care market, including variable standards of residential care accommodation based on differing capacities to pay. COTA believes this is an inevitable development and indeed exists at present in a constrained form through the growing "extra service" segment. COTA's proviso is that all aged care accommodation should be required to meet certain minimum standards and be provided only by approved providers, and that "supported residents" should have equitable access to good standard accommodation.

2.8 User Contribution Payment Methods ('bonds', daily fees and equity release)

As indicated in the preceding points, COTA welcomed the Commission's integrated set of proposals around user contributions to both care and accommodation, including choice of bond or daily fee, the equity release scheme, the relating of accommodation charges to costs of provision, and the Pensioner Bond.

We have noted some concern in the public arena about consumers having to pay for both care and accommodation, and about the payment of accommodation bonds as if this was a significantly new phenomenon, rather than the most common form of contribution at present, including for many in high care as low care bonds are rolled over as people age in place.

COTA notes that the Draft Report recommendations as a whole will mean many more people will be cared for at home with much better packages of service and therefore not have to consider an accommodation bond as they may never move into residential care.

COTA also notes that people have paid bonds to access residential care (hostels) since the early 1980s and 'extra- service' high residential care for the last 13 years. The current open ended bond arrangements and the exclusion of new entry residents to high care from the

option of paying a bond is severely distorting the aged care entry system, discriminating against direct entry to non extra service high care and encouraging 'cherry-picking'. In addition, because bonds are used to fund buildings and because they aren't allowed in standard high care, not enough high care is being built.

COTA also notes that a 'bond' is just a loan – the estate gets it back. We recognise that many older people would like to leave something in their estate for their children. The bond does just that and popular mythology to the contrary needs to be tackled head on.

It is also time that we directly confront the "estate beneficiaries" issue and ask who wants to put their hand up publicly and say that they want to put part of their inheritance at a higher priority than the partial cost of care of their parent? Or that when parents do have means to contribute to their care (and only up to a maximum limit) they should not need to because their children would like to inherit the funds, when this will lead to taxpayers on lower incomes subsidising the inheritances of those much better off.

The proposal that if you sell your house the money left over after the loan can go into an indexed government deposit and be exempt from the pension income and assets tests should be very welcome. It will significantly assist many people to pay for care and accommodation. However there is a public perception issue in the description of this facility as a "Pensioner Bond". Our consultations indicate confusion between this and accommodation bonds.

Concern has been expressed about the situation of couples / partners / siblings / long term cohabitants sharing the same house, where only one needs to access residential care, and also the situation of older people with adult children with significant disabilities who live with them.

As noted at 2.6 COTA understands that as now there would continue to be protection and flexibility in recovering the deferred contribution so that a partner, primary carer, cohabiting sibling or dependent child is not required to move from the home in order for the contribution to be paid out of the home equity. In such cases, the repayment would be required only once the dependent dies, goes to other accommodation, or is no longer a dependent.

The Commission might like to specifically address this in its Final Report.

2.8.1 Provider Concerns re bonds

Provider peaks have raised with COTA a number of concerns among sections of the industry about the allegedly potentially major and negative impact of changes to accommodation bond arrangements. In particular:

a. That the requirement to offer a periodic payment will likely lead to a major shift by consumers to selling their house, placing the full proceeds into a Pensioner Bond and then paying the periodic payment from that Bond. It is suggested that this will

result in funding difficulties for providers as current bonds are paid out and new residents opt for periodic payment.

As COTA understands the Commission's proposal on the 'Pensioner Bond' (we suggest it be renamed) the Bond would not attract interest but would be indexed by the CPI or another index. This means it would retain its real value but not generate real income, and would be reduced by the draw-down of the periodic payment. This compares to the accommodation bond which would not retain its real value so would decline in value by the rate of inflation, but would otherwise not be diminished (retentions having been abolished). In these circumstances it is not obvious to COTA that there would necessarily be a mass switch of payment method.

In any case COTA cannot at present see that it makes a substantial difference to the provider whether in essence it receives an accommodation bond that substitutes for a commercial loan, or receives a periodic payment that covers the borrowing cost of such a loan. There may be transitional issues which should receive attention and support as such. COTA will continue to discuss this issue with providers, and take independent financial advice, and may include this in a supplementary submission.

b. The restriction of the value of accommodation bonds to around the cost of providing the accommodation may cause some issues for certain providers that have been charging accommodation bonds well in excess of the cost of capital.

In COTA's view this is a transitional issue that can be addressed by transitional assistance. There is no long term justification for charging consumers (via interest forgone) well in excess of the value of the accommodation they are paying for; indeed that might well fall foul of new financial regulations, or if not, should do so in future.

c. It is suggested there is an issue in regard to those pensioners who have a home that has a value higher than the cut-off for being a supported resident but less than the cost of capital. The question is who pays the difference between the bond value and the value of the capital? At present that is met by charging consumers who have a higher level of assets an accommodation bond higher than build cost, but not open-ended.

In those circumstances perhaps the Commission should contemplate a part supported resident subsidy that would cover the gap.

However COTA does note that its original submission did not argue for a strict and regulated relationship between cost of capital and bond value. We argued that user contributions should be transparent, comparable and prudentially protected. In a competitive context it may not be necessary to regulate in this way; or the regulatory constraint could allow a substantive measure of flexibility.

These are matters COTA may wish to revisit in a supplementary submission.

2.9 Australian Aged Care Regulation Commission

The recommendations around changing the regulation arrangements with the establishment of a new single Australian Aged Care Regulation Commission (AARC) are strongly supported. We are particularly keen to ensure that there is an independent complaints service and more advocacy services to support people making choices. We would like to see the recommendation around the advocacy services strengthened to push for a truly national approach and significant increases in funding (see 5.7).

3. ASPECTS OF THE REPORT COTA DOES NOT SUPPORT

There are only a few areas in which COTA is opposed to specific recommendations in the Draft Report. A larger number of matters require further attention and these are dealt with in section 5.

3.1 Supported resident provisions

COTA does not fully support the Commission's suggested approach for the safety net for people who cannot meet their own accommodation costs as set out in Recommendations 6.5 and 6.7.

We do support the continuation of the supported resident provisions and the setting of the obligation on a regional basis as an interim measure. In the longer term we would like to see the supported resident payment attached to the individual and believe that if the level of government subsidy is adequate then providers will take supported residents.

COTA is strongly opposed to Rec 6.7 which proposes that the subsidy for a supported resident should be set at the standard of a two-bed room with a shared en-suite.

COTA notes that the certification standard is an average of 1.5 bed rooms. However the community expectation is a minimum of a single bed room with a strong preference for a single ensuite bathroom, although some consumers have indicated that a shared bathroom is acceptable. However there are clinical / care situations in which a single ensuite is highly desirable.

We understand the industry is now overwhelmingly building single bed rooms with their own bathroom to meet this expectation. COTA sees no reason why supported residents should be funded for a substantially lower standard of accommodation than other residents.

Given that going forward most facilities will have all single-bed rooms, except where two-bed rooms are clinically indicated, funding supported residents at the recommended level will create a major disincentive to accepting them. If the regulatory system requires their acceptance then someone else is going to have to be cross-subsidising them.

COTA is fully aware that the separation of care funding from accommodation will free up accommodation options and, as recommended by the Draft Report, lead to a multiplicity of levels and standards of accommodation above the basic levels. However the basic level should be a one-bed room with ensuite at the basic building standards as to size, amenity, etc.

We have heard it argued that some clinicians believe that single rooms are not always the best option for some residents. However, this is nothing to do with their financial circumstances but is to do with their clinical and social needs and would therefore apply to both supported and not supported residents. This argument has nothing to do with average funding levels. Obviously there needs to be a mechanism that ensures that any resident can be placed in a two-bed room if that is deemed to be in their best clinical interests but such arrangements should provide for the same personal space and amenity as single-bed rooms.

In regard to other aspects of the supported resident provisions, COTA has reservations about Rec. 6.5 which recommends allowing trading of supported resident obligations between providers in the same region and the idea of a competitive tendering process after five years. Our concerns with both the trading and then tendering process is that they could significantly reduce the amount of choice consumers have, which is already limited by the obligation being on a regional rather than individual provider basis.

We are concerned that both will lead to a segmented residential aged care system – with supported residents marginalised in lower standard accommodation often not in their local community.

We recognise arguments from some providers that in certain circumstances this recommendation may improve choice. However COTA can only support this recommendation if there is a strong regulatory framework that ensures there is no diminution of choice for residents.

We assume that, in keeping with the basic framework of the Draft Report, the supported resident payment is an entitlement to consumers who are not able to pay their cost of accommodation and therefore is allocated to the consumer, not to providers.

In that case consumers may choose some providers rather others and that could result in some providers being "over" and others "under" for the supported resident obligations of that region. The setting of a regionally calculated obligation should also not act to diminish consumer choice

3.2 Disclosure

In the regulation section Rec. 12.7 calls for information on meeting the prudential standards to only be provided on request. COTA does not support this recommendation. As a general principle COTA does not favour an approach that means people have to know what questions to ask before they get the information they may need.

We accept the argument that providing a full set of information to existing and potential residents is onerous and may not be particularly useful. We suggest an alternate approach may be to provide a simple statement saying the provider complies with the prudential arrangements each year and letting people know how they can access further information.

3.3 Workforce matters

In its "scope" section of Ch11 (P.346) the Commission excludes workers such as cooks, drivers and tradespeople from its scope on the basis that they do not require aged care specific skills so the need for them should be dealt with in other workforce sectors.

COTA agrees with the views of other stakeholders that in many of these jobs an aged care specific set of skills is necessary alongside the generic skills of that trade or profession. Any workforce strategy for aged care must include a number of these trades and professions or key requirements for an aged support and care system will be missing.

4. AREAS IDENTIFIED BY THE COMMISSION FOR COMMENT

We will comment on three particular areas on which the Draft Report seeks additional information, i.e. the development of a social insurance scheme for aged care, transition/implementation arrangements and the models of care and operation of the Gateway as outlined in Attachment B of the Draft Report.

4.1 Social Insurance

In our Initial Submission we raised the issue of a social insurance scheme to fund aged care services. At that time there was a public debate on the merits of an insurance scheme for long term care for people with disabilities, an idea that the recently released Draft Report from the Productivity Commission Inquiry into Disability Care and Support did not support.

We are happy to accept the arguments in both this and the Disability Draft Reports about continuing to fund services through consolidated revenue using the broad tax base as the source of funding rather than using dedicated levies or taxes for that purpose.

However one aspect of the social insurance model that was particularly attractive to consumers was its reinforcement of the entitlement approach to care provision. We invite the Commission's consideration of how entitlement (subject to assessment and user contributions) can be reinforced in the model its Draft Report proposes.

4.2 Models of Care

In Attachment B to the Draft Report AACS outlines an assessment approach and a number of options for allocating funding. We support the approach taken, but believe much of this will need to be worked through in the implementation process once the general framework of the new system is agreed. For that reason at this stage our comments are more around the principles rather than the detail.

We would like to stress the importance of having nationally agreed and consistent assessment processes, including agreed tools. This would give consumers greater confidence that the aged care system is fair and equitable and that regardless of where they live, their needs will be assessed and resourced to the same level, taking into account any additional funding for special needs they might have.

As per our original Submission, we support the two tiered approach to assessment as we think it is important that the initial assessment is not over-comprehensive in relation to the need for support and care of the older person. There needs to be more work done around who undertakes the comprehensive assessment in terms of whether there perhaps needs to be a more specialist assessment service for this.

It is vitally important that people have timely access to the services they need, particularly the first low level services, as there is evidence that timely initial intervention has a positive impact on people's ability to maintain independence and support themselves for longer in the community.

This raises the issue of specifying essential performance criteria for the Gateway's assessments process. COTA believes this is critical to public and consumer confidence in a new aged care system

One concern we have with the processes outlined is there could be a tendency to over-service, particularly in terms of service coordination and case management. Whilst acknowledging people may need help in putting together a suitable package of services, there need to be mechanisms that promote self management and independence.

In the classification options we tend to support Option 4 which is the layered funding model. This model seems to provide the best approach to ensuring clients' needs are met in a flexible way and its incremental approach should allow for funding to increase with need. It also provides a good mechanism for addressing special needs by the use of supplements that further refine and target the funding to where it is needed.

As noted in the Applied Aged Care Solutions report that forms Appendix B of the Draft Report, this model will require further work and discussion before being adopted. From both consumer and provider perspectives we would want to discuss whether the model ends up with too restrictive bands of funding for practical purposes, that might require too frequent reassessments, and whether it could be adapted to create some flexibility in thuis regard.

4.3 Implementation

The third area is the implementation of the reforms. In its initial Submission COTA put in a quite detailed implementation plan which we are resubmitting at Attachment 2 as we believe our proposals there are still sound and should be taken into account.

We would like to reiterate and even more strongly emphasise the importance of first dealing with community care, freeing it up and providing additional resources to allow it to support more people with higher care needs in the community. This would respond to a high priority need for consumers in which there are currently major blocks.

As demand for community care is met there would then be a clearer picture of what needs cannot be met in the community/home and allow time for more innovative models to be developed to meet those other needs in addition to the traditional residential care response.

We are aware of concerns that a significant increase in provision of community care could lead to higher levels of residential care vacancies and that therefore the increased provision of community care should be gradual. Our view is that consumers have been waiting a long time for more adequate and appropriate community care services and need to see real benefit from aged care reform as soon as possible.

COTA therefore believes community care should move to a full entitlement basis as soon as the Gateway is operational and prices are set, and in the meantime there should be a significant increase in places, allocated to take into account demand, and either rapid implementation of Model 4 in Appendix B or as an interim step a 'bridging' package between CACPs and EACHs.

Work needs to progress early on the Gateway, building on the Government's current reforms around the "front-end' of age care. Earlier we suggested that an initial step would be to more effectively network existing information and assessment services so we can start to get some benefits for consumers without having to create the new Gateway Agency which requires legislation.

As noted elsewhere in this submission we also think moving to independently recommended pricing that covers the full cost of care provision is also an urgent first order priority.

The Draft Report envisages the bulk of the recommendations as being implemented in a two to five year period. We think this is optimistic. Discussions with providers indicate a timeframe of six to seven years and the full roll-out in residential may take longer. We acknowledge and highlight the importance for the sector of setting a time table of progressive changes and then largely following that so that providers can plan for change.

Obviously a key aspect of the implementation phase is the identification of risks associated with recommended changes and development of risk mitigation measures. The Department obviously needs to do both (not just risk identification) for government, and we are aware and involved in the development of same by provider peaks.

This will need to be an iterative process over the phases of transition, as new risks and mitigation requirement will emerge as implementation progresses, and indeed as unforeseen consequences of previous mitigation.

It would be helpful in the Final Report for the Commission to set out an initial risk identification and mitigation measures table to kick-start this process. It is important that all stakeholders see clearly that risks are an unavoidable and necessary part of change, but that with commitment to that change risk can be successfully managed, undesirable consequences averted, and measures put in place to enable what might be difficult but unavoidable consequences of major structural change.

We think it is essential to the success of such major reforms that first, all stakeholders are centrally involved in managing the design and implementation of the new system and transition to it; and secondly that the change process is not managed from a 'business as usual" framework.

To this end we would like to see the proposed Aged Care Implementation Taskforce be established outside of the Department of Health and Ageing while acknowledging that the Department would need to be a key player within it.

We strongly suggest the Taskforce should include representatives of provider, consumer and professional stakeholders as members, in addition to it having world's best consultative processes. We recognise that there are decisions that would have to be made by the government agencies on the Task Force without the presence of external agencies but believe the Task Force could develop protocols for such operation while generally acting in a unified way to ensure the input and buy-in of all stakeholders.

We further suggest the Task Force Secretariat should include personnel coopted from the aged care sector.

5. AREAS NEEDING MORE ATTENTION

In a number of areas we do not so much disagree with the Draft Report but believe it should have gone further.

One particular issue here is that often the Draft Report contains within its text proposals and directions for action that are not then captured as formal recommendations. We think this is an issue going forward and ask the Commission to give further thought to this matter so that all of its comprehensive proposals are given the requisite status as the government moves to implementation.

5.1 Respite

COTA supports the recommendation that makes care an entitlement and allows older people to take that to a provider of choice. We note the comments on why a move to cashing out that entitlement is not deemed appropriate and for the majority of care services we support that position.

However, we think there needs to be a different approach for respite care, both planned and emergency. As acknowledged in the Draft Report, access to good quality respite care is an important contributor to helping carers continue in their caring role. In our consultations for our initial Submission, and also on the Draft Report, it is clear that whilst carers continually identify the need for respite services they often do not use what is available, especially residential respite care. This means the current models are not working so we need a mechanism that will allow people to access the type of respite that they believe meets their needs.

For this reason COTA is advocating a move to giving carers the choice to cash out their entitlement for respite and allow them to use those funds to purchase respite services that

suit them. This could be from approved providers but could also include purchasing from a broader range of services including extended family and friends but excluding carers living in the same house as the care recipient. A registration model similar to that used in the child care system could be adopted where people providing respite that is paid out of the cashed entitlement would be registered and probably have a police check prior to them being able to be paid for providing respite care. This cashing out would be for both planned and emergency respite.

Carers who did not want to take the cash out option would still be able to access respite from approved providers.

We believe the cashed out model would be particularly attractive to people from diverse backgrounds including the lesbian, gay, bisexual, transgender and intersex population and people from culturally and linguistically diverse backgrounds as they often complain about not be able to get culturally appropriate respite care. It would also have merit for the Aboriginal and Torres Strait Islander population especially those living in remote communities where there may not be a formal respite provider offering services.

COTA thinks the cashing out model could improve the supply of appropriate respite in two ways. First of all it would broaden the pool of possible providers which would be particularly important in rural and remote areas. Secondly it may encourage existing respite services to change the services they offer to better meet the demands of consumers in order to encourage them to bring their entitlement or their cash to that service. We think increased competition in the respite area will be beneficial to carers and the people they care for.

5.2 Dementia

Dementia is central to much of the need for aged care and its prevalence means that it is core business for aged care. It is the most disabling of all conditions amongst older people and the reason many people and their carers need to access services. It is particularly important in residential care where the majority of residents have some level of cognitive impairment.

COTA accepts that all of the reforms would benefit people with dementia and their carers as much as they will other groups of older people but firmly suggests there should be some more specific recommendations dealing with the needs of this significant group of older people. In our consultations on the Draft Report the absence of specific dementia strategies has been identified as one of the serious omissions and one that needs to be addressed in the final report.

COTA accepts that our own original Submission did not give full weight to the need for a comprehensive approach to dementia as a fundamental aspect of aged care demand and services. Dementia is not another special needs group but central to the nature of the aged care system.

We echo Alzheimer's Australia's call in their submission on the Draft Report for a comprehensive strategy to address dementia that includes quality dementia care services

and research into the cause and prevention of dementia, more timely diagnosis and making hospitals safer for people with dementia. This could build on the National Dementia Support Program.

We also believe that the funding model adopted should include specific supplements for caring for people with dementia. This is why we have indicated that we support the layered funding model proposed in Attachment B as it gives the most opportunity to provide additional funding as required as people's dementia progresses and their care needs increase.

Again we agree with Alzheimer's Australia that the existing barriers between the mental health and aged care systems need to be removed to ensure people with severe behavioural symptoms receive the care they need. Our preference would be to have a mixed model that involved more psycho-geriatric services being provided either as in-reach services by the mainstream mental health services or an outreach model similar to that recommended for palliative and end of life care. With both approaches there would need to be additional funding and training to ensure aged care staff were able to provide the appropriate support and care.

The option to cash out funding for respite as outlined above should be of particular benefit to carers of people with dementia. Often the carers of people with dementia do not use respite because it does not meet the needs of the person they are caring for. Cashing out would give them more opportunity to find a respite service that meets both sets of needs.

COTA urges the Commission to include a recommendation on the need for more research and action around the prevention of dementia. The Draft Report does not have enough emphasis on well being and prevention and this is one area where there definitely needs to be more activity and funding.

5.3 Workforce Issues

We have noted the responses of aged care sector trade unions to the Draft Report. Without responding to certain public comments, the essence of the shared joint concern of the unions appears to us to be that while the Draft Report recommends competitive wages should be included in the independent price setting regime recommended by the Commission, it did not recommend any immediate action to address current low wages.

The Commission has noted that previous efforts to address the wages gap for nurses have not been successful, and refers to evidence that funding restrictions prevent some providers from paying competitive wages and being able to attract and retain general services staff.

COTA concurs with the unions that addressing the under-remuneration of the aged care workforce cannot wait until the proposed Australian Aged Care Regulation Commission is established and undertakes its first round of pricing recommendations. However, we also agree with the Commission's observation that the current situation will not be overcome "unless there is a concerted effort by stakeholders" (p 364).

COTA is concerned that while the Draft Report is quite strong on the need for competitive wages for nurses where the 'gap' is clearly measurable against the public sector, it does not provide the same focus on the very low wages of most other care and general workers in the sector. Both issues need to be addressed if the quality of support and care services, for which sufficient numbers of well remunerated staff are vital, is to be improved and then maintained as need and demand expands.

A working group has been established through NACA to try to develop an approach that can be put to the Commission for its support, and to government, in the short term. COTA may wish to comment further on workforce matters once that working group has deliberated.

We believe any outcome must ensure that additional taxpayer and consumer funds that flow to providers must result in the appropriate level of real and sustained increase in wages within the aged care industry.

5.4 Diversity/Special needs groups

In our initial Submission we identified a number of special needs groups: older people with a lifelong physical and intellectual disability; older people with a psychiatric disability; gay, lesbian, bisexual, transgender and intersex (LGBTI) people, culturally and linguistically diverse people, Aboriginal and Torres Strait Islander people and Veterans.

COTA was disappointed with the recommendations around diversity and we are concerned that some of the excellent points raised in the body of the report with regard to this issue have not been translated into recommendations. Whilst accepting that the Commission did not want to have too many recommendations, we want to make sure that the needs of some of the special needs groups are addressed in the reform process.

We believe that the move to entitlement and giving people more control and choice will assist people with special needs to access services that are more appropriate and better meet their needs. We welcome the recommendations around diversity that recognise the need to include these special needs in both the assessment and pricing models.

For Aboriginal and Torres Strait Islander people we would like to see more recognition that many of them access mainstream services and those services need additional funds to ensure they can meet their needs. This may be one area where there needs to be a mixture of entitlements for the individual and block funding to the service provider to make sure there is an adequate supply of service providers who can meet their needs. The same is true for other special needs groups as the market may not respond appropriately without some additional incentives.

We want to ensure that consumers who need specialist assistance such as interpreters do not pay higher care contributions as a result of the cost of their service being greater. This would particularly be a problem if the additional services are simply built into the service price. There needs to be a way of quarantining them so they do not attract the care contribution; again the block funding for this type of service may be one way to deal with this.

The Draft Report has quite a substantial sub-section on the needs of lesbian, gay, bisexual, transgender and intersex (LGBTI) people but there are no explicit recommendations to address their specific needs. As a minimum we would like to see a recommendation for increased funding for initiatives for training to improve and raise awareness about the special needs of LGBTI people. We would also like to see the needs of this group more explicitly dealt with in the quality regime for the new system.

The needs of CALD people also need to be addressed in more detail. Whilst the two recommendations on diversity address some of the issues, there needs to be more explicit recognition throughout the report of this population's preference for community care over residential care and their reluctance sometimes to access the formal care system. The proposed Gateway Agency will need to address this latter issue and determine how to work with CALD organisations and communities to ensure people are accessing the services they need an a timely way.

We believe that there should be some piloting of cashing out the entitlement for certain special needs groups. We think both the CALD and LGBTI populations, especially in rural areas, may benefit from such an approach. If people could cash out their entitlement they could use the funds to purchase services from people and providers that they feel comfortable with and who understand their particular needs.

The other group that the report does not focus on at all is people with a lifelong physical or intellectual disability. We know that the Productivity Commission is also undertaking an inquiry into disability care and support, with the Draft Report from that Inquiry released at the end of February. We note that one of the recommendations in that Draft Report deals with what happens to people with disabilities as they age and recommends that they be given the choice to move to the aged care system or stay in the disability system. We do not think it should be an either/or but rather they should continue on disability support and have their emerging ageing needs met by the aged care system, in the same way that other people do.

Within this group we think there needs to be more consideration given to the possible impacts of the proposed aged care reforms on older people who have a resident adult child with a disability. There is much emphasis in the report on freeing up the wealth stored in the family home to pay for care, but this becomes more complicated when there are other dependents living in the house. There need to be explicit safeguards around the continued security of tenure of partners and other dependents built into the equity release scheme and the valuation of the home as an asset.

5.5 Rural and Remote

On our initial Submission COTA called for a number of measures to improve aged care and support for people in rural and remote locations. These included more flexible models such as enhancing the multi-purpose service model as well as explicit recognition of the additional cost of providing care in such locations.

The Draft Report discussed all of these issues but does not make any specific recommendations. Recommendation 9.3 talks about remote services and the need for

funding models to be sustainable but it is not clear if this refers to all remote services or just those providing services to Aboriginal and Torres Strait Islander people.

We believe the price set for services and the funding allocated both need to take into account the additional cost of providing services in rural and remote areas. Some of this is increased labour costs, particularly for nurses and allied health professionals who have to come in on a fly in fly out basis or from agencies who charge considerably more for staff than if they can be sourced locally.

Another issue is costing the travel time for providing a service particularly when it is not in the rural centre. This has been a particular issue with both HACC and CACPs when sometimes the travel time far exceeds the time for delivering the service and it is not adequately funded, if at all. This has to be built into the price of the service and, as with special needs groups, COTA believes this needs to be quarantined in some way from the calculation of the care contribution. Again this is where more consideration needs to be given to block funding service providers so that it does not become part of an individual's entitlement and not attract the care contribution.

We also believe that the market does not always work as well in rural and remote areas and that encouraging competition may be quite inefficient. We think there is scope for looking at other ways to give consumers more choice and control.

One possibility may be to allow them to cash out and access the support and care they need from local businesses/services/people rather than an approved provider based in the rural centre, which may be some distance away. As with respite services this would involve potential services being registered and meeting some standards but not the full range of aged care accreditation and quality standards.

We think this approach may be beneficial for CALD groups living in rural areas where the number of potential clients would not justify a full service but there may be local people who could provide support and care. As with cashing out for special needs groups, we think this approach should initially be a pilot with a rigorous evaluation to assess whether it is working or not.

5.6 Age-friendly housing and communities

While COTA does not disagree with any of the actual recommendations in Ch 10 we believe the Commission should have gone further in two areas.

First, the Commission came down against mandatory accessibility and adaptability standards for new building, but it supported the Liveable Housing Design Guidelines developed through the National Dialogue on Universal Housing Design – of which COTA Australia is an active member. While COTA supports the voluntary standards and timeline of this initiative it has made clear, as have other participants, that should that timeline not be largely followed COTA will forcefully lobby governments for a mandatory standard. We urge the Commission to support this approach.

The Commission also implies that retirement villages are always built to accessible and adaptable standards. Regrettably this is not always the case; COTA and others have called

for age-targeted housing, and indeed all public housing, to be built to the new Liveable Housing Design standards. The Commission should endorse this call.

Secondly, the Commission makes suggestions about state legislation on retirement villages being made consistent and approaches to affordable housing being coordinated through COAG. However, the Commission misses the broader picture present throughout this chapter. Essentially the Commonwealth is now responsible for all aspects of aged services. It has a major stake in matters such as the development of innovative and diverse approaches to congregate and cluster housing, which would in turn facilitate the efficient provision of community based aged support and care. However the States have jurisdiction over planning legislation, the powers of Local Government, housing standards, etc. without any incentive to improve outcomes for appropriate and affordable age-focused housing.

We urge the Commission to recommend that the Commonwealth through COAG seek a national approach to this issue and make its funding support to the states contingent on such cooperation.

5.7 Consumer Support and Advocacy

There has been a lot of focus and will be in the implementation context on transition and change management issues for aged care providers. This is fair enough as the changes will over time be quite major.

However COTA draws attention to the fact that the new aged care system proposed will also have major implications for consumers and that transitional issues are as important for them if the benefits of new arrangements are to be taken advantage of and realised.

A well equipped and properly funded Gateway will be an essential and critical resource for consumers and their families in this regard. However it will not be sufficient by itself. We will not enumerate all the issues and possibilities here, but for example:

- Consumers will have financial decisions to make on which both general financial advice and in some cases specific advice will be essential so that they fully understand their options and the implications of these. Such decisions will have financial implications for them and often for the taxpayer. Bodies like NICRI could be funded to provide a general advice service and financial advisors could be trained and accredited to provide individual advice (accreditation perhaps also linked with retirement village advice, which is often done poorly now).

- Few consumers will have experience at co-designing and negotiating a personalised package of support and care. This will become easier as the culture of the industry itself changes, but that will not happen for some years. In the transition there may be a need for a role we might describe as “advocate broker” - people trained in the advocacy discipline so they empower and support consumers rather than taking over the consumer’s role, but also skilled in knowing what kinds of services and supports will meet assessed needs and where these might be found while the provider sector is itself adapting.

- As we observed in the original submission a more open, flexible and community / home focused system built around the consumer is likely to require more advocacy services, which are already overstretched and constrained in scope in the current system. The Commission supported greater use of advocacy services in two sections of its report, but did not make a specific recommendation, which we urge it to do in the Final Report.

COTA urges the Commission to draw attention to these kinds of issues and to specifically recommend development of a strategy to identify and address them in the implementation and transition phase, including extra resources for advocacy.

5.8 Elder Abuse

We were disappointed that the report does not say much about elder abuse and has no specific recommendations about it. Currently the States and Territories take responsibility for elder abuse initiatives and services; there is general agreement that this is an under researched and under resourced issue. COTA believes that the report should make a recommendation for harmonisation of legislation and that the Commonwealth should work with the States and Territories through COAG and the Ministerial Council on Ageing to improve data collection, research and initiatives to encourage the identification of elder abuse and to combat it.

5.9 *MyAgeCare* website

Under the proposed reforms consumers would have more choice and control of their services. For people to be able to make informed decisions there needs to be more information available about the services on offer. We propose that there should be a *MyAgeCare* website similar to the *MySchool* and *MyHospital* sites. This would provide information on accommodation charges, services available, outcomes in any accreditation process and other information that would assist older people and their carers to make more informed decisions on which services would best meet their needs.

6. CONCLUSION

COTA believes that the reforms laid out in the Draft Report provide a strong framework for the aged care system in Australia for the next 20 years. Overall we agree with the direction and although we have identified a few areas of difference we believe these are not substantial and do not fundamentally affect the reforms.

We have also identified some areas that we think need strengthening particularly around respite and care for people with dementia. We think the Final Report should set the stage for more innovation in the respite area by introducing cashing out, which we think could encourage more carers to access respite when they need it.

Whilst accepting most of the proposed reforms would benefit people with dementia, we think there need to be some additional initiatives directed specifically at improving the care for people with dementia. In particular COTA urges the Commission to include a recommendation on the need for more research and action around the prevention of dementia.

We believe that the recommendations must be seen as an integrated set of proposals and that it would be reprehensible if the basic structure of the proposed reform was dismantled or ignored and recommendations cherry-picked or adopted in a piecemeal way.

There should be a staged and well sequenced implementation with a clear timetable established so that providers, consumers and professionals can plan for the future with a fair degree of certainty.

COTA thinks it is important that the Final Report is structured in a way that puts the proposed care and support system first and then deals with how it would be funded, from government and from individuals. This reordering of the report and the recommendations would make it clearer to all stakeholders and the public that the package is designed to reform the care provided as well as changing the way people pay for it; something which has tended to get lost in some discussion of the Draft Report.

Finally COTA has made many comments and suggestions on the Draft Report in this second submission. The richness and diversity of those is we hope helpful. However as valid and important as most or all of these are, nothing should divert attention from or diminish the strong commitment we have to the overall architecture of the age care and support system outlined in the Draft Report and recommended by the Commission. Its implementation is of the highest importance and all the rest can be sorted in that implementation.

If adopted and implemented, the recommendations of this Draft Report, further developed as we have suggested, will result in Australia having the world's best aged support and care system. That is an aspiration that COTA believes the Australian public shares and that older Australians and their families deserve.

ATTACHMENT 1

SUMMARY OF COTA POSITION ON RECOMMENDATIONS

(numbers from main report not summary list)

RECOMMENDATION	COTA POSITION
Framework	
4.1	Support • Add to the principles "high quality" in 2nd dot point; the commitment to entitlement; and a well qualified and remunerated workforce.
Paying for Aged Care	
6.1	Support
6.2	Support • clarification re protection of cohabiter of primary residence
6.3	Strongly support with preference for a much shorter timeframe for community care.
6.4	Support but need more work on whether periodic payment level should be fixed on entry or potentially variable, and impact on specific segments
6.5	Partial Support • Support continuation of supported resident obligation, but must be as entitlement • Doubts about trading and not support tendering
6.6	Support • it needs a different name as there is evidence of public confusion with accommodation bonds. • Should use same indexation arrangements as Age Pension-not just CPI.
6.7	Support and Oppose • Support principle of funding and regional variation • Strongly oppose use of 2-bed room as standard for supported resident funding
6.8	Support but needs more work on what would comprise the "basic living expenses".
6.9	Support but need to consider whether pension non-home owner asset test appropriate level
6.10	Support but would like to see rationale for $60,000 limit
6.11	Support in principle but unsure whether the Regulation Commission 'best fit' for this task.
Broadening Funding Base	
7.1	Support with proviso that there is adequate consumer protection. Strongly prefer shared equity and HECS style equity

	release rather than compound interest loans.
Care and Support	
8.1	Support but need to recognise specific measures to ensure CALD and Indigenous access and willingness to use such services, and fully appropriate for dementia consumers and families.
8.2	Support – essential that regional requirements be fully taken into account
8.3	Support and this should be extended to psycho-geriatric care.
8.4	Support in principle. Obviously there needs more detailed discussion on how this would work in practice v/v other options.
8.5	Support and would like to see some specific measures to increase the provision of allied health services/use of nurse practitioners and access to GPs.
Catering for Diversity	
9.1	Support
9.2	Support
9.3	Support
Housing and Retirement Villages	
10.1	Support`
10.2	Support provided remove 65 years determining factor for eligibility.
10.3	Support
10.4	Support not aligning retirement living options with aged care but think the Commonwealth needs to have a more significant role in this domain (see submission).
10.5	Support but extend scope.
Workforce Issues	
11.1	Support but it shouldn't be in the workforce section. Needs to be more on innovative respite.
11.2	Support
11.3	Support • Extend recommended training to include mental health and well being of older people
11.4	Support-needs to be a holistic model
11.5	Support
Regulation	
12.1	Support • reservation about pricing function (see Rec 6.11) • mechanism for Carers complaints needs to be included
12.2	Support
12.3	Support
12.4	Support
12.5	Support

12.6	Support
12.7	Not support. This should be provided automatically. Can be in summary form with reference to full material.
12.8	Support
12.9	Support national harmonisation and removal of duplication
Aged Care Policy Research and Evaluation	
13.1	Support
Reform implementation	
14.1	Support the approach provided proposed Taskforce includes non-government stakeholders (refer to submission).

ATTACHMENT 2

EXCERPT FROM COTA'S ORIGINAL SUBMISSION TO THE INQUIRY - TRANSITION MEASURES AND ARRANGMENTS

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:

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.

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).

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.

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 though 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.