NATIONAL FOUNDATION FOR AUSTRALIAN WOMEN

Submission to Productivity Commission Inquiry into Caring For Older Australians

WOMEN AND AGEING

Contents

1. INTRODUCTION

1.1. Overview of submission

The Productivity Commission has been asked by the Government to conduct parallel inquiries into means of providing and financing care for people with disabilities and for ageing Australians.

As there are some points of similarity in background discussions for both inquiries, NFAW will incorporate some common elements in each submission.

The key common points are discussions on:

- housing needs,
- the differences between eligibility and entitlement and the implications for new funding models, and
- consumer controlled funding per se.

In relation to caring for older Australians, this paper will primarily address three of the questions posed by the Commission:

- Who should pay, and what should they pay for;
- What role for regulation;
- Roles of different levels of government.

1.2. The need for policy analysis on the basis of gender

It is impossible, and moreover inappropriate, to consider the re-design of the systems for caring for older Australians without a framework of analysis by gender.

Women live longer than men. There are more older women than older men.

Moreover, in their working lives women earn lower incomes than men as consequences of both the gender wage gap and their intermittent work-force attachment because of caring responsibilities.

Women in retirement are poorer than men. Recent figures show that women's superannuation balances are less than half of those of men.[1] As a result, many women are solely or largely reliant on the Age Pension in retirement.

The aim of the Age Pension is to provide a safety net against poverty in retirement.[2] Yet the Age Pension does not provide an adequate level of living when compared to even modest expectations (see ASFA/Westpac retirement living studies surveys).[3]

At the end of 2008, women made up 57.4% of age pensioners and 71.8% of those on the single age pension rate.[4]

Women provide the great bulk of the informal care given to older Australians.[5]

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[1] Clare, Ross, 2008. Retirement Savings Update. Sydney, Association of Superannuation Funds of Australia. http://www.superannuation.asn.au/Reports/default.aspx, visited 2 July 2010.

[2] Commonwealth of Australia, Department of the Treasury, 2008. Australia's future tax system, retirement income, consultation paper, p. 5. http://taxreview.treasury.gov.au/content/ConsultationPaper.aspx?doc=html/publications/Papers/Retirement_Income_Consultation_Paper/index.htm, visited 3 July 2010.

[3] Association of Superannuation Funds of Australia Ltd, Media Release 28 June 2010—ASFA. http://www.superannuation.asn.au/mr100628/default.aspx

[4] Commonwealth of Australia, Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), 2009. Women's Budget Statement. http://www.facsia.gov.au/about/publicationsarticles/corp/BudgetPAES/budget09_10/women/Documents/p3.htm, visited 11 July 2010. The 71.8% figure for single age pensioners who are women was used also in FaHCSIA's Women's Budget Statement for 2010-11. See http://www.fahcsia.gov.au/about/publicationsarticles/corp/BudgetPAES/budget10_11/Documents/women/part_2.htm, visited 11 July 2010.

[5] Commonwealth of Australia, Australian Institute of Health and Welfare (AIHW), 2007. Older Australians at a Glance (4th ed.). Canberra, AIHW. http://www.aihw.gov.au/publications/index.cfm/title/10402, visited 4 July 2010.

"Overall, 19% of older people were carers and 5% were primary carers—among older people this proportion peaked in the 75–79 year age group among whom 6% were primary carers.[6] By age 85 few people were the primary carers of others (under 1%).

"Although 54% of all carers were women, less than half of older carers were women (46% or 208,300 carers). Women predominated among primary carers—over two-thirds (71%) of all primary carers were women and women outnumbered men in all but the oldest age group (aged 85 years and over)."[7]

Many women carers have poor health.

"Although the majority of older primary carers reported relatively good health, a significant proportion (59% or 66,400) had disability and around 15,100 (13%) had a severe or profound core activity limitation".[8]

Women's housing status is frequently insecure especially if after divorce they become renters or they have not been able to become home owners for other reason.

"ABS projections (Series II) suggest that, by 2026, about 907,000 people aged 75 years and over will be living alone, most of them older women (685,600)"[9]

Women predominate as users of government funded services for the aged.

"The Survey of Disability, Ageing and Carers (SDAC) conducted by the ABS in 2003...found that 43% (1,004,400 persons) of the 2.3 million people aged 65 years and over living in households expressed a need for some form of assistance to help them stay at home...The most common area of need was property maintenance

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[6] AIHW, 2005. Australia's welfare, 2005. Canberra, AIHW. http://www.aihw.gov.au/publications/index.cfm/title/10186, visited 6 July 2010.

[7] AIHW, 2007, op. cit., p. 33.

[8] Ibid., p. 34.

[9] Ibid., p. 11.

(29%) followed by transport (22%), housework (20%) and healthcare (20%)...Approximately 26% needed some assistance with personal activities, such as self-care, mobility, communication, cognition or emotion, and health care.

"A higher proportion of women than men aged 65 years and over required assistance for all activities except communication, a result which is consistent with their older age profile; overall 50% of women needed assistance with at least one activity compared with 35% of men".[10]

Women predominate as recipients of extended care at home packages. They pre-dominate as users of residential care.

"At 30 June 2006, there were 151,737 permanent residents and 3,135 respite residents in residential aged care…Around 72% of permanent residents were women. By far the majority of permanent residents were aged 75 years and over (87%); 53% were aged 85 years and over, and 7% were 95 years and over."[11]

These data suggest to us that any policies ultimately proposed by the Commission ought to have been carefully assessed in terms of gender equity.

There is no United Nations Convention on the rights of older people to parallel the Convention on the Rights of Persons with Disabilities which Australia has ratified. We consider the fact that this Convention points to the need for equitable outcomes for women and for men should influence the Commission's considerations.

Moreover, the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), also ratified by Australia, creates obligations in regard to equity in terms of outcomes for government policies and programs.

[10] Ibid., p. 103.

[11] Ibid., p. 134.

We are indebted to the Australian Institute of Health and Welfare for its admirable consistency in providing data analyses by gender—for the very good reason that health, education, income and other experiences and outcomes frequently differ by gender.

Regrettably, very little official data on housing status is disaggregated by gender.

The Productivity Commission has been asked by the Government to conduct parallel inquiries into means of providing and financing care for people with disabilities and for ageing Australians.

However, we note with some regret that there is no evident analysis in either Issues Paper areas of difference between outcomes for women from those for men. We trust that the Commission will undertake to remedy this in its Interim Reports.

1.2.1. Specific populations

At a broader level, gender is of course understood as more than purely a male/female distinction, and the rapidly growing base of research evidence which addresses the circumstances and need of sexual and gender diverse carers and consumers in aged care also warrants the Commission's attention.[12]

Women With Disabilities Australia (WWDA) was consulted extensively in the preparation of this submission.

We have also sought consultations with representatives of Aboriginal and Torres Strait Island women. However, we have not had time to obtain adequate responses before the due date for submission. We hope to be able to provide some information for the Commission at a later date.

12 Harrison, J and Irlam, CB, 2010. The removal of same-sex discrimination: Implications for lesbian, gay, bisexual, transgender & intersex (LGBTI) aged care. Discussion Paper, Australian Coalition for Equality and Diversity Futures, Adelaide. http://www.coalitionforequality.org.au/LGBTI-AgedCareDiscussionPaper.pdf, visited 15 July 2010.

We understand that comments which specifically address the needs of older migrant and refugee women will be provided to the Commission from the Australian Immigrant and Refugee Women's Alliance.

This submission has been endorsed by Dr J.A. Harrison, Fellow of the Aust. Assoc. Gerontology, School of Health Sciences, University of South Australia.

1.3. Emerging pressures for individual control of funding for services

In both instances there has been pressure generated from sectors of the community to consider more options to current policies, with strong advocacy for financing measures which place greater control over decisions and actual allocation of (Government financed) resources in the hands of the individuals who have need of such services. The underlying assumption is that the individual will have perfect knowledge of the market and the capacity to make informed choice.

This is not a valid assumption for very many older people.

This pressure for choice is also associated with arguments that if users of service are given choice, ("direct control") then the market will respond and offer appropriate service options. This faith in the market may not be well placed, given recent historical experience in age care.

1.4. Confusion between eligibility and entitlement

Historically, in the Australian social welfare system considered at a macro level, the Commonwealth has provided support in two ways. Support for individuals has been through the provision of income support payments under the social security system. The Commonwealth has also provided funds to service providers, allied with some degree of provision to individuals of tax benefits and voucher-style payments, to enable purchase of services from providers.

Thus, for individuals with a disability (acquired or congenital) the Commonwealth has since shortly after Federation paid a specific pension to enable the individual to

subsist. Since the 1950s the Commonwealth has also provided an expanding range of payments to service providers, as well more recently income payments to individuals who are formally occupied as primary carers of frail aged persons or of people with a disability.

A similar pattern exists of providing direct income supports to aged persons through the Age Pension allied with systems of providing grants to organisations to offer services, such as nursing homes or home nursing and home help.

Because income support payments operate on a universal basis for those determined as eligible, under clearly defined income and assets tests, the costs to the revenue are extremely high, and increases in rates of such benefits and pensions are managed very carefully in the Budget context. The current Government has sought to improve the level of the Age Pension, and as well introduced policies to improve superannuation for lower income people. Even so, the Review of Australia's Future Taxation System has suggested that most retired women will continue to be primarily dependant on the Age Pension.

Costs to Government are contained by constraints on the individual rate as well as by variations to eligibility rules.

There is no parallel guaranteed universal entitlement to a service. Eligibility for all Government subsidised services is based on pre-determined criteria, differing by service. This applies to all funding mechanisms currently being used. One exception to this practice has been in relation to the services guaranteed (under certain conditions) to Veterans.

Governments can control access either by increasing or decreasing funding overall, or by tightening eligibility, sometimes by a combination of both. Meeting the eligibility criteria for a service type does not ensure access.

The Australian Institute of Health and Welfare (AIHW) recently noted in a report on disability services that Government funding had increased for respite care, that

more people were accessing respite care, and that the period of respite care available per user was getting smaller. This is an example of rationing scarce resources by limiting the extent of provision to individuals.[13]

By way of another example, the concept of provision of residential beds by region based on the regional over-seventies population does not convey an entitlement to residential care for everyone aged 70 plus.

It may be useful to briefly discuss the difference between the concepts of eligibility and entitlement, which do seem to have been confused by some participants in the debates to date.

Some consumer advocates seem to want the concept of eligibility to be co-extant with the concept of entitlement. Indeed, some advocates have sought guarantees of entitlement.

There is clear confusion among some groups in their understanding that to fall within the disability based target population for the Home and Community Care Program does not of itself guarantee either eligibility for services or to a specific level or quantum of services.

By way of another example: in the case of services for aged persons, after the introduction by the Commonwealth in the mid nineteen sixties of benefits to which all elderly residents in nursing homes were eligible, an exponential growth occurred in the numbers of nursing homes. Not only did the private for-profit sector grow and expand, so did the not-for-profit sector. States systematically began to transfer to the not-for-profit and the private sector many of those beds for long-term patients which they had provided previously. Not-for-profits found it possible to access Nursing Home benefits for their former “sick bays” for

[13] AIHW, 2009. Disability support services 2007–08: National data on services provided under the Commonwealth State/Territory Disability Agreement, p 8. Canberra, AIHW. http://www.aihw.gov.au/publications/dis/dis-56-10751/dis-56-10751.pdf, visited 25 July 2010.

residents in Independent Living Units, and so access Commonwealth grants for both capital and recurrent costs.

Demonstrably, the expansion of user-entitlement funding led to a market driven expansion of services by both not-for-profits and for-profits and a rapid growth in Commonwealth outlays.

The existence of an alternate grants-funded system of supporting home help and home nursing services, within annual budgetary limits, was not sufficient to place any constraints on the rate of growth of the nursing home industry. Several large commercial providers became extra-ordinarily profitable, and developed a degree of market domination.

Not all aged persons achieved services optimal for their needs.

In the early years of the Whitlam Government and again during the Hawke Government various reviews of policies took place.

Limits were placed by the Hawke Government on the numbers of beds per region which would be granted access to the voucher-style nursing home benefits funding; a system of assessment of the individual's need for full nursing care was put in place; the provision of grant-funded home care systems was expanded; and attention was given to development of individual care packages.

This change of direction underpinned the slowing of the rate of growth of nursing homes over the next decades, and allowed more attention to meeting actual needs of individuals so as to enable them to continue to live in the community. This was of particular benefit to those individuals in stable housing settings—many were home owners.

It has also enable better fiscal control over Government outlays, by comparison with the previous market driven approach.

However, while numbers of beds were controlled, costs per bed have continued to escalate, increasing pressure for reform. The introduction of expensive individual care packages has also led to this form of care eating up a disproportionate share of funding available for care in the community.

Infelicities still remain, and the industry complains of centralised quality controls just as the industry previously complained of having to meet both State and Commonwealth controls. Yet there is a constant stream of media stories of poor care standards in nursing homes, of patient abuse, of inadequate staffing and need for family members to be present at meal times to ensure patients receive nutrition.

Certainly, the introduction of the Medicare Levy has not led, nor indeed was ever intended to lead, to full coverage of all hospital and health care costs for individuals, even though Medicare is seen as a universal entitlement program and essentially works as such.

In fact, the rate of growth of costs, not least of hospitals, has been such that the shares of costs met by consumers in out of pocket expenses (or co-payments) have grown very considerably since the introduction of the levy. Not all health costs are comprehended by the levy—for example, some kinds of surgical procedures.

Medicare is seen to be, and is, a universal entitlement program solely for access to (a) bulk billing General Practitioners, and (b) treatment in a public hospital. It is complemented by funding of allied health services and pharmaceuticals through either Commonwealth or State programs. But even when all taken together, and including the private health insurance rebate, public funding does not cover all health costs. Elective surgery in private hospitals is the most costly exception, together with dental care.

We cannot expect a Medicare-like levy for funding disability services to solve all the problems in the field of disability services. We have made submissions along this line to the Commission's inquiry into disability.

1.5. Diverging responsibilities for aged care and disability services

Recently through the Council of Australian Governments, agreement has been reached for the Commonwealth to take over full responsibility for care services for aged people (apart from Victoria and Western Australia).

Pressure for giving care-voucher entitlements to individuals which has emerged in recent years has been given added stimulus with perceived opportunities for cashing out funding for some services (vide the Catholic Health Care submission to this Inquiry).

Cashing out is only feasible where the individual's eligibility and entitlement both are guaranteed and are ongoing.

1.6. A clearer focus on gender

Data on disability services provided through the Commonwealth State Territory Disability Service Agreements held by the Australian Institute of Health and Welfare suggest that more males than females receive services, across most age groups.[14]

This contrasts with AIHW reported usage patterns for services for the aged, where women predominate as users.

Women are also carers—both as workers in the age care industry, and as providers of informal care.

A recent study for the national women's alliance, economic Security4Women, makes this point about both formal and informal care: "The provision of care is a highly gendered activity, which reproduces inequality between men and women. More women than men provide both paid and unpaid care.

[14] AIHW, Functioning and disability. http://www.aihw.gov.au/disability/index.cfm, visited 6 July 2010.

"An overwhelming 93% of residential workers and 91% of community based workers in the residential and community aged care workforce in 2007 were women." [15]

2. ISSUES ARISING IN REFORM OF FUNDING AND DELIVERY OF SERVICES FOR OLDER AUSTRALIANS

2.1. Moves to further individualised funding for services

There is, as mentioned above, pressure for moving away from providing grants to support services for people with a disability, and in aged care, to providing in effect, care-vouchers as entitlements to individuals.

Among the issues to be debated, NFAW identifies the following:

Would direct-control models for aged or disability related services with resources placed in the hands of the individual be set at a level to cover all costs, or would there be a continued need for co-payments?

Would it be appropriate to designate the types of services which could be purchased?

Would use of a direct control model also permit the individual to continue to access other subsidised services, or should there be some kind of embargo placed on this?

These issues must be debated also:

Would voucher-style payments resolve the underlying problems identified?

[15] Adams, Valerie (forthcoming). Scoping the Australian Care Economy: A Gender Equity Perspective. Canberra, Security4Women.

How will Governments seek to constrain unacceptable levels of outlays through a consumer controlled voucher-entitlement system? For example, will Government hold down the value levels over time, so that the value of vouchers does not keep pace with increases in service costs to consumers?

Will a sometimes troubled service system grow or shrink with voucher style funding? In particular, how will the organisational infrastructure that is essential to supporting care delivery including sustaining a skilled workforce, be maintained?

What are the risks of perverse outcomes, such as capture of consumer funding by sub-standard providers?

In general terms, if some relationship between use of funded services and access to direct control funding is to be developed, then it may be desirable to further explore the issues of entitlement and eligibility.

It is noteworthy that in the United Kingdom, where direct control has been a policy since the mid nineteen nineties, it covers only personal care services. It does not cover any health services whether of a domiciliary or residential nature.

For example, if some form of entitlement is introduced, Government could:

- Establish a basic set of personal care support services at a given cost per annum to which an entitlement is provided for individuals based on specified eligibility criteria;

- Guarantee funding sufficient to ensure eligible individuals have capacity to purchase/afford the basic service set;

- Enable competent eligible individuals to cash out a fixed proportion of the value of the basic set;

- Remove access to the set of basic funded services so as to avoid double dipping;

• Facilitate provision of private insurance to assist in management of co-payments and top-up services if required. We consider this would be of limited value to the many aged people (a high proportion of them women) who live in near or real poverty in retirement and on relatively low incomes during their working lives.

Government(s) would establish and maintain control over the rate of growth of outlays through budgetary measures, and ensure cost and quality controls over the basic service set.

Medicare and related programs do however demonstrate how both supply side and demand side controls have been applied to manage outlays, and to allow those who want more to satisfy their demands by accessing privately provided services—noting that virtually all practitioners deliver both privately and publicly funded services.

Service and practitioner registration requirements can prevent undue consumer exploitation—but these protections could be at risk with consumer directed payment systems which allowed the purchase of services from any provider at any quality. This is noted in the following section.

It would be necessary to explore the inter-relationship of Carer Pension payments and financing through direct control of personal care attendants. If an eligible individual receives Government funds to employ a carer, should there also exist concurrent eligibility for a second carer to be paid a Commonwealth pension?

2.2 United Kingdom Experience with Direct Payment

It would be useful at this point to consider some of the experiences of the past decade in the United Kingdom with their direct payments policy.

The UK policy originated in the intent to give users of social services (provided by local government authorities in the UK) greater control over their lives. The first candidates were people with learning difficulties—and the policy provided the

carers, usually parents of younger people with learning disabilities, with a budget which could be allocated to meeting costs of services directly. It should be noted as stated above that these budgets are for personal care and social services: they do not cover in-home health services, which remain the responsibility of the National Health Service.

Informal advice suggests that the policy was more effective in situations where there were competent adult carers in the family, and somewhat less effective where the person with a disability was not so supported.[16]

More recently the policy has been extended to older people ("adult care") and local government authorities now have a centrally mandated target to reach of the numbers of their clients who are in receipt of direct care payments. Two formats exist—either the individual has control of the budget and makes all decisions, or the social service department case manager assists decision making and holds the budget.

It is understood that one major challenge now for the policy is developing means of ensuring good quality in the individuals being recruited as personal care attendants by recipients of direct care grants.

Exploration is taking place as to whether in-service training might be appropriate, whether background checks are necessary, and so forth.[17]

Some might find it surprising that with some very vulnerable clients attention to quality and standards is taking place only some fourteen years after the introduction of the policy.

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[16] Personal communication to author, July 2010.

[17] Personal communication to author, July 2010

Some of the findings from an evaluation report by the Personal Social Services Research Unit (PSSRU) relevant to the Productivity Commission's Inquiry into Caring For Older Australians include the following:

"Direct payments were found to be provided most commonly to people with physical disability or sensory impairment, compared to other groups, and least commonly to people with a mental health problem, but there was considerable variation across local authorities, underlining how some local authorities have risen to the challenge of implementing user-centred care through direct payments while others lag behind…

"There were wide variations in the proportion of local community care budgets spent on direct payments, both between areas and across user groups. These were largely reflected in the strength in developments for different users [sic] groups, for instance, 15.5% of the budgets of English authorities for people with a physical disability was spent on direct payments, compared to 1.1% for people with a learning disability, 0.8% for older people and 0.4% for people with a mental health problem.

"Expenditure growth between 2003/04 and 2004/05 was notable for all user groups and for most parts of England, but nonetheless modest given the policy emphasis on encouraging the use of direct payments by people with social care needs.

"There were notable differences in the relative expenditure on direct payments across user groups; on average, expenditure on direct payments to people with a learning disability was lower than expenditure for mainstream services for this group, whereas the opposite is the case for people with a physical disability; there was no discernible overall pattern for elderly people and people with a mental health problem. These may relate to the effects of standardised direct payment rates across user groups.

"Direct payments provided to older people, people with a learning disability and people with a physical disability tended to be of high intensity (or average size). For instance, three quarters of recipients with a physical disability in England received funding equivalent to over 10 hours of support per week (and nearly one-third received 31 hours per week).

"Approximately three-quarters of local authorities in England and Scotland had made one-off direct payments in the preceding year, but there were wide regional variations in the numbers of such payments; these were most often made to assist the purchase of respite care or equipment, or to meet the set-up costs of longer-term direct payments.

"More authorities had made one-off payments to people with a physical disability than to any other group, but such payments were most commonly made to user groups for which direct payments provision was otherwise very low, such as carers and people with a mental health problem.

"Local authorities were found to pay similar rates to all user groups, with the exception of people with a learning disability who received higher core hourly rates; there was nonetheless considerable variation in rates across the UK, with lower rates paid by local authorities in Northern Ireland and Wales, compared to England and Scotland; there were also variations across England.

"Average weekly rates for people with a learning disability, people with a physical disability and disabled children were all considerably *lower* than the average unit costs of residential care for these groups, whereas the average weekly live-in rates for older people and people with mental health problems were significantly *higher* than average unit costs for equivalent residential care." [18]

[18] PSSRU, 2007. Direct Payments**:** A National Survey of Direct Payments Policy and Practice, p. 1. http://www.pssru.ac.uk/pdf/dprla.pdf, visited 11 July 2010. Our underlining in the last paragraph; the italics are the authors' emphasis.

The variations between authorities identified in the PSSRU report could be replicated in Australia were responsibility for managing direct payments to be delegated to individual State/Territory agencies, regional authorities, or community agencies.

2.3. A note on housing issues

Without secure tenure of accessible and affordable housing, there will be no chance of success for new policies and new strategic approaches to meeting the needs of Australia's aging population, and needs of people with a disability.

Before World War 2 most poor people were forced to do the best they could as renters. Aged people and people with a disability unable to survive as renters, especially those with profoundly disabling conditions might become a burden on their families, or perhaps find a place in State institutions.

The Post War Reconstruction Program saw major investments in public housing by Commonwealth and State Governments, in the face of acute housing shortages due to scarcity of housing investments during the Great Depression, and the post-war shortage of building materials.

The Menzies Coalition Government introduced policies to stimulate affordable home ownership for people of modest incomes. Similarly, the Menzies Government introduced the first Aged Persons Homes Act providing capital grants specifically to encourage the churches and charities to invest in rental housing for the aged. Subsequent introduction of legislation to support disability charities saw the introduction of capital grants for both hostels and sheltered workshops for people with a disability.

Over time, these capital programs for housing were modified or abandoned, and in the case of the aged, the emphasis of Commonwealth policy moved to providing self-funded housing through the not-for-profit sector closely linked to the growth of nursing homes.

Allocations through the Commonwealth State Housing Agreements were gradually phased down, limiting new building, and from the nineteen eighties the Commonwealth encouraged the States to give priority in public housing to people with a disability and others with specific disadvantage.

Government investment in general public housing tapered off.

However, house prices have boomed over the past two decades, and the size of many family houses has grown beyond the imaginings of the beneficiaries of the Menzies Post-War policies encouraging home ownership.

Australia is now experiencing an acute shortage of affordable housing. Within this, there is also a shortage of accessible affordable housing—that is, housing built to a standard which makes it suitable for individuals who for reasons of age-related frailty or of disability require specific design features. Ministers are exploring options for universal access design and construction standards for all new buildings.

The recent Ministerial Discussion Paper on Regulation and Growth of the Not-for-Profit Housing Sector [19] states:

"Australia urgently needs to expand the stock of affordable rental housing. The housing supply gap is having a direct impact on housing affordability for both renters and home purchasers. Most of this impact is on low and moderate income earners who were not home purchasers before the housing boom commenced in the late 1990s.

[19] Commonwealth of Australia, Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), 2009, Discussion Paper on Regulation and Growth of the Not-For-Profit Housing Sector. http://www.fahcsia.gov.au/sa/housing/pubs/homelessness/not-for-profithousingsector/Pages/default.aspx, visited 7 July 2010.

"The affordability of the private rental housing market has declined in the last 12 years, particularly for those households on low or fixed incomes.[20] Between September 2006 and September 2009, real rents increased by 12 per cent.[21] Key workers and households on moderate incomes are having difficulty saving with rising rents and increasing house prices…In 2006, the estimated shortfall in the supply of affordable rental housing was around 251,000 dwellings."[22]

Given the withdrawal of Commonwealth funding for independent living units (and the focus on limiting access to nursing homes, whilst supporting various programs to assist aging in the community) the past recent decades have seen a major growth in the private sector in accommodation— mainly in self-funded accommodation for aged people in retirement villages.

Advertisements from developers sponsoring these developments typically feature images of healthy and active adults who may have just reached the age of sixty. Some but by no means all of these villages also offer some form of support services for residents who have needs for support at a lower level than the support provided by admission to a nursing home. Some may facilitate resident access to community cased home care services.

Relatively small elements of this market provide for low-income individuals or couples who may not have been home owners and are thus unable to sell and finance their way into owner funded accommodation.

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[20] Ibid. citing Australian Government, National Housing Supply Council, 2009, State of Supply Report, p91.

[21] Ibid. citing Australian Bureau of Statistics (ABS), 2009, Consumer Price Index, Australia, Table 7. CPI: Group, Sub-group and expenditure Class, Weighted Average of Eight Capital cities, ABS cat. no. 6401.0.

[22] Ibid, Chapter 1. The Shortage of Affordable Housing. http://www.fahcsia.gov.au/sa/housing/pubs/homelessness/not-for-profithousingsector/Pages/affordable_housing.aspx, visited 7 July 2010

This new industry is admirably documented in a recent report from the Australian Housing and Urban Research Institute (AHURI), Service Integrated Housing for Australians in Later Life[23]

The differing patterns of access to housing with integrated support services outlined in this document lead directly to discussion of who should pay, and for what?

As well, the Report raises the issue of the role of the Commonwealth in actively guiding this sector:

"Retirement villages and other forms of service integrated housing have developed in Australia over the past thirty years mainly through initiatives of the community and private sectors. The key question that now arises in a policy context characterised by renewed government interest concerns the ways in which a stronger leadership role could best be pursued.

"The strategies to this end identified in this report include

- facilitating the role of the community and private sectors in providing service-integrated housing;

- addressing the need to expand the provision of service integrated housing to low-income, low-asset older people;

- addressing the geographic distribution of services;

- developing principles and guidelines for the operation of service integrated housing;

- and expanding the research evidence base."[24]

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[23] Australian Housing and Urban Research Institute (AHURI), 2010. Service Integrated Housing for Australians in Later Life. http://www.ahuri.edu.au/publications/download/20287_fr, visited 6 July 2010.

[24] Ibid., p. 11.

The Report notes that the numbers of aged people resident in private and not-for-profit aged persons villages and the like is now comparable to the numbers in nursing homes, high care residential settings, and in consequence this sector is certainly worthy of close policy consideration.

Under recent Federal Government housing initiatives, new developments are occurring in the affordable and accessible housing sector.[25]

There is scope for ensuring a national standard in building codes to ensure that the generality of newly built housing is more accessible and appropriate for an aging population, and for people with a disability (although not necessarily suitable for individuals with very high needs). This is sometimes called "no barriers" building standards or universal design.

Through the National Partnership Agreement on Social Housing, it is intended that the states and territories will increase the supply of social housing, providing approximately 1600 to 2100 additional dwellings by 2009-10, and provide opportunities to grow the not-for-profit housing sector.

These will include housing for people with a disability and aged people.

There seems to be a strong antipathy in the disability sector to any approach to the provision of housing clusters for people with a disability. This contrasts with retirement housing—many proposals clearly envisage a cluster housing integration of ageing residents with the wider general community.

AHURI noted in its 2008 report on "The housing careers of people with a disability and carers of people with a disability":

[25] The National Affordable Housing Agreement (NAHA) aims to ensure that all Australians have access to affordable, safe and sustainable housing that contributes to social and economic participation. It is an agreement by the Council of Australian Governments, commenced on 1 January 2009, which initiated a whole-of-government approach in tackling the problem of housing affordability. It will provide $6.2 billion worth of housing assistance to low and middle income Australians in the first five years.

"From a disability perspective and from an ageing perspective, health and wellbeing are now a significant influence on the housing transitions of many Australian households. Importantly, whereas the home was a place for the provision of care for children in the second half of the 20th century, in the 21st century it will take on a considerable role in the provision of care for adults.

"There does not appear to be a consensus on appropriate policy interventions, but this work has led to the call for new, more fine-grained, approaches to the provision of housing assistance and the potential re-ordering of priorities in the light of what we know about 21st century housing transitions. Home ownership remains a priority of all tiers of government and both Labor and Coalition parties.

"Shifts in the relationship between individuals and governments have had an appreciable impact on housing transitions and the need for government assistance. This change is seen most clearly in the areas of housing for older Australians and persons with a disability where established, largely institutionally-based, policy interventions have been abandoned in favour of greater integration with the broader community.

"This shift has generated new demands for housing assistance and support with independent living, and it is likely that this will be an area of considerable program development over the next two decades." [26]

Moreover, the great bulk of the older existing public housing built under the former Commonwealth State Housing Agreements is now unsuited to the frail aged or people with a disability. Retro fitting is not feasible in many instances—re-building may be the most appropriate course.

[26] Australian Housing and Urban Research Institute (AHURI), 2008. The housing careers of people with a disability and carers of people with a disability, p. 51. http://www.ahuri.edu.au/publications/download/40427_rp, visited 6 July 2010.

This public housing is not accessible for wheelchairs and may lack elevators as well as suitable kitchens and bathrooms.

It is unrealistic to expect that the private rental sector will be able to respond promptly and effectively to meeting the needs of lower income people with special housing needs without changes to building codes, and perhaps also to tax incentives. Even then we do not expect the sector to meet the needs of profoundly disabled individuals.

The Ministerial Discussion Paper on Regulation and Growth of the Not-for-Profit Housing Sector cited above contains an extensive listing of current players in the not-for-profit housing sector, and outlines options for increasing the engagement of this group. It says:

"Australian Housing Ministers agreed in May 2009 that jurisdictions and the Commonwealth develop, over time, a large scale not-for-profit sector comprising up to 35 per cent of social housing by 2014.[27] A not-for-profit sector that leverages private finance against its assets as well as attracting Government subsidies may play an important role in achieving growth in stock to address forecast need. Governments should only responsibly assist not-for-profits to expand their asset base if those providers are well governed, financially sound and able to operate at scale.

"The not-for-profit sector could play a part in building a social housing market that includes strong operators who can deliver growth in affordable rental housing supply. This could occur through the emergence of new models of financing and management through the consolidation and expansion of housing portfolios.

[27] FaHCSIA, op. cit., citing A Progress report to the Council of Australian Governments from Commonwealth, State and Territory Housing Ministers—Implementing the National Housing Reforms, November 2009, published by the Victorian Government Department of Human Services on behalf of the Housing Ministers Conference and available at the COAG Web site, p.26.

"Currently there are 930 community [housing] organisations in Australia."[28]

However, it is unfortunately not possible to obtain any gender disaggregated data on the extent to which women are obtaining tenancies in their own right. There is a limited number of these not-for-profit housing groups making single women, including those with a disability or other special needs, their target population. There are apparently no central data on numbers of women thus accommodated.

Informal discussions suggest that reliance on the community housing sector to develop new accommodation (rather than manage publicly financed accommodation) may not provide a solution.

In particular, community housing providers/developers providing housing for people with disabilities need close contractual agreements with support service providers, to enable them to manage risk.

New players are needed in this sector with the capacity to make long-term investments in affordable rental housing for low-income people. We consider that more encouragement needs to be given by Government to new players such as superannuation funds, for example.

The need for more affordable accessible housing is urgent.

It appears clear that future policies for the provision of affordable and accessible housing for people with a disability and for people who are ageing should be developed within the framework of the Commonwealth-States Affordable Housing Agreement and the Council of Australian Governments.

The Commission has posed these questions in this area:

The Commission seeks comment on the regulatory and financial issues facing retirement villages. How do retirement specific living options interact within the broader aged care system and what

[28] FaHCSIA, op. cit., citing AIHW, Community Housing 2008-09, Executive Summary, AIHW, 2010.

changes are expected in both the number and structure of villages over coming years? Should the regulation of retirement specific living options be aligned more closely with the rest of the aged care system?

Are there any factors that act as a barrier to older Australians entering retirement specific living options (such as opportunities to age in place and departure fees)? And, more generally, is the way the retirement village sector operates compatible with an ageing population, including in regards to quality, clients' expectations and as a platform in which to receive aged care services?

Are there particular models of retirement specific accommodation that are suited to the provision of social housing to meet the needs of low income or disadvantaged older Australians?

We are disposed to the view that there is scope within the COAG process for the sharing of information about the regulatory framework for retirement villages. The development of consistent principles and guidelines could similarly proceed at the State and Territory level, harmonised as needed through COAG.

The issues of geographic planning raised in the AHURI report on integrated care seem to lie most sensibly with States and Territory planning bodies. However, the Commonwealth has jurisdiction in terms of providing tax and financial incentives to developers of such villages and should move to establish a national policy framework.

These villages are, in the main, able to access home care services funded by the Commonwealth on behalf of residents. It would be sensible for the Commonwealth to clarify future policy on access and fees. Some residents are better placed to make a co-payment than others. Some residents will be better served by access to a case management or brokerage arrangement to access appropriate care packages from external providers.

There exists, in our view, considerable urgency in policies to ensure provision of integrated service housing for low income and disadvantaged older Australians, without home equity of their own, many of whom will be women.

3. OPTIONS FOR NEW FUNDING MODELS

The Commission has posed the following questions:

How well does the aged care system interface with the wider health and social services sectors? To what extent should the aged care system be treated as a separate arm of government policy to other social policies?

Is the current system equipped, or can it adapt, to meet future challenges?

Should there be greater emphasis on consumer-directed care in the delivery of services, and would this enable older Australians to exercise their preference to live independently in their own homes for longer with appropriate care and support?

In regard to services for the aged, it seems fairly clear that the Commonwealth will have core responsibility for care and health services, although States and Territories will still have responsibility for policies to ensure accessible and affordable housing and transport policies for aged people—albeit with some specific purpose grants and Commonwealth taxation and financial arrangements involved.

The final shape of changes to health services—hospital regions, Medicare locals—seems to be still emerging, although to date it seems that States and Territories will continue for the foreseeable future to play an important role vis a vis hospital services.

The relationship between health care for older Australians and aged care services specifically will likely continue to require close management by the new structures which emerge, even as the Commonwealth assumes a greater financial role.

Adequate health management of older Australians in community settings will do a great deal to reduce unnecessary acute hospital admissions. Better planned and provided geriatric rehabilitation, and supportive services in the home, associated with access as necessary to high care longer term settings, such as nursing homes,

will do much to both reduce bed-block in acute hospitals and improve outcomes and patient satisfaction.

Getting the inter-relationships between system elements is clearly an urgent task for the Commonwealth, in cooperation with States and Territories, and clarity of roles and responsibilities of regional hospital networks and their links with Medicare locals must be ensured at an early date.

Current Commonwealth Government outlays are substantial, although it is widely accepted that the ageing of the population will place pressures for additional expenditures.

Pay-as-you-go transfers from the annual Commonwealth Budget process appear likely to continue to be the main source of funds for meeting the costs of services for the aged, although there is (limited) pressure for moving away from providing funds to services, including for nursing homes, and placing cash entitlements in the hands of the eligible individual to enable consumer choice.

There has also been discussion around the relation between costs of nursing home care and whether the accommodation element ought to be met by claims on the individual's existing housing equity.

Where the aged person is still partnered, with a partner living in the owner-occupied family home or unit, such a claim is hard to put into place.

This of course is not relevant to those individuals who are not home owners, and who have no such equity—an increasing proportion of the aging population falls into this group.

We have consulted widely on issues facing women who are carers in the context of reform of barriers to women's work-force attachment, and the Review of Australia's Future Tax System.

We note that carers for ageing parents have a strong case for guaranteed access to re-training to enable them to re-enter the workforce should their responsibilities cease due to death or entry to residential care.

We also consider it appropriate in the context of retirement policies for younger carers reliant on the Carer Pension for the Commonwealth to make provision for a superannuation contribution payment on their behalf, to improve their financial position in retirement.

It is useful to note that ageing is normative, and will happen to most of us, but disability is exceptional.

It would also appear that the need for special funding to meet the costs of disability is deemed to disappear once the individual reaches retirement age. We see this as inappropriate.

Moreover, we note that the Australian Institute of Health and Welfare points out that there are significant numbers of people with a disability now aging, who will need disability-specific services throughout their lifetime.

Some transfer to the Commonwealth aged care policy and program system of special service needs for certain categories of severe disability in persons over 60 would be appropriate.

We recognise that disability arising from the ageing process is a separate consideration, but we can foresee some interesting arguments as to whether a condition deterioration say for a person with paraplegia is a consequence of something entirely separate from and other than ageing.

There is a need for careful consideration of the issues at the interface of disability and aged care systems to ensure the most appropriate care is provided to people with disabilities as they age.

Disability associated with an increased likelihood of dementia is a case in point as all expertise for managing dementia care lies in the aged care system including management of early-onset dementia.

So policy and arrangements must take account of the nature and extent of care needs, rather than being based on simple age limits.

The roles of and supports for carers, whether they be carers for a person with a disability, or an aged person, also need cross-policy arrangements consideration.

Of particular concern is what happens to people with disabilities who have been looked after by parents, consequently accessing few if any services, when the parents age and can no longer cope. Many of these individuals will need residential care in aged care hostels—which could be more suited for them if they are in their fifties, than in accommodation for much younger people.

Conversely a person with a long-term disability such as paraplegia may well develop other conditions and symptoms of ageing much earlier. In both cases a designated chronological age for eligibility to services becomes irrelevant.

In Section 2.2 of this submission we have drawn attention to the experience of the United Kingdom in the development of personally directed or consumer-directed, but publicly funded, care.

We can see only a limited role for the general applicability of direct payment or consumer controlled budgets in the field of aged care. Our position on this is underpinned by the work of Professor David Challis (see Attachment A), and the PRSSU Report cited above.[29]

[29] Challis, D., 2009. Developing More Flexible and Consumer Centred Services: Implications for different stakeholders, lessons from recent UK research. Perth, Aged & Community Services Australia (ACSA) 2009 National Conference. [See Attachment A.]

We note that the Carer Allowance here already constitutes a fair share of consumer controlled Commonwealth Budget outlays—almost as much as Budget provisions for the Home and Community Care Program as a whole.

The pressure for direct control of cash resources is strongest from people in the disability sector but it does exist in the field of aged care. There is an argument that people with high support needs (or their carers) see that support dollars are drastically diluted between the funding source, i.e. government, and the point of service delivery by a poorly remunerated support worker, via a series of brokers and care organisations all of which impose administrative charges.

The drive for direct payment of funds comes in part from a desire to by-pass this claimed wastage in the service system. It should be noted that direct payment schemes for people with a disability are already in operation in some jurisdictions.

In our view there is no doubt whatsoever that any move to direct control of cash resources will be accompanied by the growth of market driven providers (including not-for-profits), and potentially of issues arising from limits to consumer sovereignty—whether the individual has perfect knowledge of the market, and as well, ability to make informed decisions.

Individuals who lack competence, intellectual or psychological, will most likely need to engage fund-holders or brokers to manage direct payments on their behalf, and to purchase appropriate service packages. This has to potential to absorb money otherwise intended for service purchase. That is to say, there could be limits to net 'savings' from using this model.

We note that the Alzheimer Association is a strong proponent of direct control models, with the management of the funds (entitlement) to be in the hands of presumably a trustworthy family carer. At the same time, we note reports of incidents of financial abuse of older Australians with dementia, who have given power of attorney over their assets to children.

We therefore are inclined to doubt the wisdom of placing direct control over cash entitlements in the hands of family members, preferring to see the use of other forms of budget holding such as by case management agencies, or Public Trustees.

We see value in consideration of other options for policy changes—for example, a community living allowance instead of the current Carer Allowances, paid to individuals needing support instead of to carers where the individual is competent to manage.

We see this as necessarily continuing to be matched by pay-as-you go Budget sourced funding of certain service types, and most likely still requiring individuals to meet many out-of-pocket costs. As mentioned above, it should be possible for the Commonwealth, now having direct control over home and community care services, to develop a system of fees based on a means test.

We consider that a fully Commonwealth controlled system of aged care assessment could be developed which includes a capacity for case management with managers holding budgets for care. Such as system needs linkages to new systems of planning primary and acute health care.

We have noted our reservations about a general move to direct funding models, although we see these as being of definite benefit for certain limited groups of individuals, and applicable to certain specified purposes.

MARIE COLEMAN
CHAIR
NFAW SOCIAL POLICY COMMITTEE

4. SUMMARY AND CONCLUSIONS

1. There is a need for better integration of policy and programs responding to the needs of ageing people with disabilities.

2. There is an urgent need to expand the supply of affordable housing constructed to universal design principles, which will assist ageing people to continue to live in the community with access to in-home support services. The Commonwealth should work closely with other jurisdictions to manage supply, and should take a role in providing financial and taxation initiatives to stimulate supply.

3. There should be more integrated planning between the Commonwealth agencies responsible for planning and financing aged care services and those responsible for policy and planning of affordable accessible housing. This has capacity to reduce the demand for residential care for frail older people.

4. The Commonwealth could, once having direct control over aged care in most jurisdictions, develop a set of standardised budgets for identified home care supports, and provide funding for eligible individuals on that basis, with the use of a standardised means test to provide for co-payments by those individuals with capacity to meet such costs. These service packages would in the main be managed by case managers in close collaboration with recipients.

5. There should be some capacity in appropriate conditions for direct control methods to be allowed, subject to assessment of the suitability of the individual or the carer to manage such budgets efficiently.

6. The Commonwealth should re-develop the current Age Care Assessment Teams, placing some budgetary control with case managers in these teams, and providing appropriate linkages to new planning and management structures proposed for primary health care and acute health care.

7. Where cluster housing or village arrangements exist, it will be appropriate for management to enter into arrangements with care providing agencies to provide care packages to residents, on the basis suggested in (3) above.

8. Improvements to the position of full and part-time family carers are important, including providing access to re-training and to superannuation contributions by Government.

9. Close attention to the professional development and quality standards of the aged care workforce is important, not least in the case of workers employed as attendants either by case-management agencies or by individuals under direct control models.

10. Given the extent of the feminisation of the caring sector (paid and unpaid) and the extent to which women outnumber men as users of aged care services, it is important that the specific issues impacting on women are identified and managed by planners and managers.

Attachment A is a separate Portable Document Format slideshow used by Professor David Challis at the ACSA 2009 National Conference. Please see Attachment A, NFAW Submission on Caring for Older Australians, Challis.pdf