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STANDING COMMITTEE ON PETITIONS

Reference: Petitions presented before 27 June 2008

MONDAY, 1 SEPTEMBER 2008

CANBERRA

Extract

BY AUTHORITY OF THE HOUSE OF REPRESENTATIVES

[10.46 am]

DEPARTMENT OF HEALTH AND AGEING

LEARMONTH, Mr David, Deputy Secretary, Department of Health and Ageing

DELLAR, Mr Stephen, Acting First Assistant Secretary, Pharmaceutical Benefits Division, Department of Health and Ageing

HANCOCK, Ms Veronica, Assistant Secretary, Medical Indemnity and Dental Branch, Acute Care Division, Department of Health and Ageing

ROSEVEAR, Ms Allison, Assistant Secretary, Residential Program Management Branch, Ageing and Aged Care Division, Department of Health and Ageing

STUART, Mr Andrew, First Assistant Secretary, Ageing and Aged Care Division, Department of Health and Ageing

CHAIR—Although the committee does not require you to speak under oath, you should understand that this meeting is a formal proceeding of the parliament. Giving false or misleading evidence is a serious matter and may be regarded as a contempt of parliament. Before we move to discussions, I need to advise members that some responses received to date from the minister are due to be tabled this evening. Is it the wish of the committee to authorise those responses for publication? There being no objection, it is so ordered.

The committee may wish to examine these petitions in three blocks: the PBS listing of Alimta, the Commonwealth dental scheme and the dental health program, and aged care. My first question relates to access to Alimta. Could you advise the committee on the extent of community consultation you undertook in this area and the department's view on the level of community involvement and on raising awareness and its role in effecting change?

Mr Dellar—The way in which a drug is listed under the Pharmaceutical Benefits Scheme relates to consideration by the Pharmaceutical Benefits Advisory Committee. The act actually requires that before any drug can be listed on the PBS there must be a positive recommendation from the committee. The committee itself had, at the time, no arrangements for community consultation in place and therefore the process was that the company would submit an application which would be considered in due course and eventually acted upon.

Mr HAWKE—Do you know how many applications were made for Alimta? Was it the first application?

Mr Dellar—The important point to make is that Alimta was already listed for non-small-cell lung cancer, so this was an application for extension. I cannot tell you offhand but can find out for you whether or not this was the first application for mesothelioma.

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Ms GEORGE—In relation to the listing, it was my understanding that in some state jurisdictions Alimta was available to people suffering from mesothelioma under decisions of the dust diseases board. They had been receiving benefits from Alimta in some states but not at the federal level, so there had been some precedents set.

Mr Dellar—That would be my understanding as well. In a couple of states—in fact, in three or four states—access was being provided to Alimta through a state based scheme. The decision of the PBAC or the recommendation of the PBAC adds it onto the PBS, which means it is now available to anybody where a doctor prescribes it as being necessary.

Ms GEORGE—In the case of the listing, I am aware, as a member of parliament, of approaches that were made to my office and many others for support for a petition that was circulated. Do you have any idea how many people were involved in support of that petition? In cases like that, do the petitioners in that situation get a response from the minister or from the department?

Mr Dellar—There were petitions, but there were also significant correspondence from quite a few different people. People who wrote to the minister at the time would have received a response. In terms of the petition, the only information I have about the numbers is what was provided to me in relation to this committee.

CHAIR—Are there any other questions on that particular petition before we go onto another one? No. Then I would actually like to go to aged care in the Hunter and Central Coast. I know that the petitioners have got a number of concerns. They stated their request that the government take immediate action to address a chronic shortage of residential aged-care beds and Community Aged Care Packages in the Hunter and the Central Coast. I think you have the ministerial response in front of you. Do you want to add anything to that ministerial response? I would also like to know how a decision is made on what area is high care.

Mr Stuart—I have nothing to add formally to the minister's response. Can you repeat your question or clarify it?

CHAIR—Could you explain to the committee how a decision is made for a particular area—that they are high care. How do you come to that decision?

Mr Stuart—Do you mean for where additional places are required?

CHAIR—Yes.

Mr Stuart—Okay. We have a planning framework in place, which goes back quite a few years now, under which we count the number of people aged over 70 around Australia and then in each region. We compare that number in each area against a benchmark. We are currently aiming for 88 residential care places for every 1,000 people aged 70 or over. That helps us to direct the newly available places every year to the places with the greatest need.

Mr ADAMS—Do statistics show that some areas of Australia have more high-care than low-care needs? Have any of those statistics ever been put together?

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Mr Stuart—Yes, absolutely.

Mr ADAMS—How does the Hunter compare and how do we balance those two differences?

Mr Stuart—High care is what used to be called nursing home level care. Low care is what used to be called hostel care, but they all take place pretty much in the same kinds of buildings and aged-care homes now. The planning framework looks at both high care and low care across regions, and then we allocate new places to where the need is greatest. The differences in need arise from a number of things. People aged over 70 are congregating in particular places, and there are some areas of fairly rapid growth. I think the Central Coast is certainly one of those. One of the issues in the Central Coast is that the population of older people there has been growing faster than our capacity to allocate places and then have those built. There is actually quite a lot of aged care in the pipeline—that we have already allocated—and is in the process of being constructed on the Central Coast. Allison, you've got that number somewhere there, don't you?

Ms Rosevear—I do. As of 30 June 2007, there were 433 allocated residential places that needed to be built, and we allocated another 270 in December, just before Christmas 2007.

Mr CRAIG THOMSON—I have some obvious interest in the Central Coast. There is a problem, though, isn't there, between the allocation of beds and when they actually come on line? Some beds, for example, are allocated but never actually eventuate.

Mr Stuart—That is quite rare. The number that would never eventuate is very small. That happens because providers sometimes take far too long to get places on line, then we let those lapse and re-allocate them, to someone else. Generally, over the last few years, we have been allocating places ahead of time. We take into account the development timetable so that the lags in development are actually taken into account at the time that we allocate them, to try to meet the ratios in each area.

Mr CRAIG THOMSON—What are the levels of occupation in the Central Coast and the Hunter at the moment?

Mr Stuart—Do you mean what proportion of all the places that are operational have people in them?

Mr CRAIG THOMSON—How full are they?

Ms Rosevear—In residential aged care in the Hunter, the occupancy rate is 96.7 per cent, so they are pretty full. This is as at December 2007. In the Central Coast, the occupancy was 91 per cent, which is a bit low, but they have had a number of new facilities opening, so they can drop a bit around that time.

Mr CRAIG THOMSON—With the change between high care and low care, with the move to less low care and more high care as people stay in the homes longer, there are some real funding implications of that, aren't there, because it is only the low-care homes that can charge a bond and raise capital from the residents themselves. That is the current state of affairs, isn't it?

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Mr Stuart—Yes. In low care a bond can be charged; in high care an accommodation payment can be charged. In the package in March, which in fact was the previous government's package which the current government then carried through the parliament and has implemented, there were increases in resident accommodation charges over a four-year period. Those increases are also matched by increases in government accommodation payments for those who cannot afford to pay them. So at the moment we are on a pathway to a significant increase in resident payments in high care.

Mr CRAIG THOMSON—I understand that, but it is a real problem for the industry as you see the changing nature of the mix that is there and the way it has historically been funded. Certainly in low care there is more money that is accessible to the provider of an aged-care facility directly through the resident than there is in high care, even with the increase in funding that has occurred.

Mr Stuart—That is in significant part a result of the property boom rather than of government policy change.

Mr CRAIG THOMSON—I am not asking for the reason; I am just saying that that is a problem for the industry.

Mr Stuart—The increases in accommodation charges are the policy vehicle to address the shortfall of capital funding in high care.

Mr CRAIG THOMSON—I have one more question on this. You can have someone who changes, deteriorates and moves from low care to high care, and you have a whole separate regime for how the aged-care provider raises funding. That is a reasonably clumsy way of having a smooth integration between the two sectors, isn't it?

Mr Stuart—I am sorry; I do not completely understand.

Mr BROADBENT—Chair, I would boldly suggest on this that Mr Thomson may like to look at his own party's history with regard to this issue and the gathering storm that may accrue once we go into these rather cumbersome issues on this point. I do not think they are really questions to be laid out on this table at the moment.

Mr CRAIG THOMSON—That is fine. There is one other question that was in the petition that was not responded to, and that was about the red tape. Do you have some comments to make about the amount of red tape that the petitioners allege is there? The minister's answer did not address that particular question.

Mr Stuart—Yes, I do. The quality framework for aged care has been consistent now over a number of years, with some embellishments by Minister Elliott as she identified some issues and gaps on coming into office and seeing how it is operating. But the essential framework has been in place for over a decade. The issues in aged care are that we have relatively powerless older people going into aged care who are often not terribly well informed or able to easily discriminate about what is care quality. There is an imbalance of power and information, and older people need significant protection. So there are regulations about what level of funding older people can be required to pay, and there are also protections in place for accreditation and

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spot checks and for quality of buildings. They have all been fairly consistent features of regulation in this area over a period now.

Mr ADAMS—We pointed out in the minister's answer that the regulations are there and that they are entitled to receive a copy of what the nursing home has to deliver. It is about empowering the people that have petitioned the parliament. That is where I am coming from. Maybe in the future we could get more of that into giving it back to the petitioners.

Mr Stuart—Sorry. It did not jump out at me that we did not completely answer the question, and I will take that on board for next time. Thank you.

Mr CHESTER—With regard to the population modelling for your forecasting future needs, are you comfortable with the modelling you have available to you now that you can forecast where you are going to be allocating beds in the future? Is it working well, in your view?

Mr Stuart—It is working pretty well. We have been doing this for some time and the department is not too bad at it. We use ABS data from the census and we have just recently got access to the new 2006 census data. That now has new regional breakdowns and we are just starting to pay attention to that. It is important that we get updated census data from time to time. We also have helpers with that. We have aged-care advisory committees, which are appointed in each state and territory, which are expert in aged care and which help advise the department on what kind of new aged-care services are required and where.

Mr CHESTER—Are clear trends coming out of the research that you are doing? Is it the coastal trend and that type of thing that you expected to see?

Mr Stuart—Yes, we have pretty good information on where there are sometimes comfortable levels of supply and where the deficits are against that formula; that is right. The government has announced a review of this process and that review is getting underway.

CHAIR—Is it getting underway, has it started or is it about to start?

Mr Stuart—It is about to start. There are two reviews in this area. One looks at the ratios, how they have been derived and how well they deal with population growth in particular areas, with some thought about increases in dementia and how we can plan for that. The other one is more about the nuts and bolts of how the department goes through the allocation process itself, based on that data.

Ms GEORGE—Just in terms of forward projections, there are two issues that I had previously raised with the minister: one is the relative paucity of community packages, particularly in my region, the Illawarra; and the other is the substantial difference between approved places and those that are operational. In some cases, in questions on notice, providers have been given approval and two or three years down the track have still not built the places. Could you comment about the community packages? Is the ratio still five—

Mr Stuart—The ratios were increased.

CHAIR—Is it 1 to 113, or 1 to 108—and five of those are community—

Mr Stuart—Allison, why don’t you spell it out. The ratios went up not a year ago, I think.

Ms Rosevear—The target ratio to be reached by June 2011 is 113 places per person and, of those, 25 are places in the community, 21 are aged-care packages, and four I think are EACH-D.

Mr Stuart—So we reached the previous target ratio of 108 last year and the government then announced an increase to 113 with the expansion being in community care, up to 25 places per 1,000 older people. So we are consistently allocating a lot of community care.

Ms GEORGE—So the shortfall in my region hopefully will be addressed by the 25 goal?

Mr Stuart—Hopefully, but I think it would be fair to say that in this area demand is rising as more older people find out about the availability of community care and it is a constant race really between demand and provision.

Ms GEORGE—And the time delays to bring the approved into operational—

Mr Stuart—Community care places come on stream very quickly.

Ms GEORGE—No, the others.

Mr Stuart—Residential care places can take some time. As I said in answer to another question, we now plan in the delay so that we meet the ratios by actually allocating ahead of time.

Ms GEORGE—What is the time limit? If you give an aged-care provider approval to build and three years down the track there is no sign of the sod being turned, at what point do you withdraw the approval and let someone else have a go?

Mr Stuart—We do that very much on a case by case basis, and it depends on whether we think the provider has made a really earnest attempt to get them built or whether we think someone else having a go would be of benefit. So it depends on what the kinds of impediments are. Often there are planning considerations. Everybody wants aged care for mum in their suburb but nobody, apparently, wants aged care in their own backyard or next door. So there is a conundrum here about the planning issues, and that can be a source of major delay. If it is simply that the provider is having trouble getting their act together and getting plans drawn and finding money, we are much more likely to let those allocations lapse and then those places go back into the next round.

Ms GEORGE—So there is no time limit, like two or three years?

Mr Stuart—Our objective is for two years. Again, as part of the government’s review, the government wants to look at getting places online more quickly, and it is also allocating the zero real interest loans with an objective of getting places out into the regional areas and getting those online more quickly than they otherwise would have been.

CHAIR—Getting good, qualified staff is an issue as well.

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Mr Stuart—Yes. I think that staffing is one of the challenges that all aged-care providers face at the moment, in common with others in the health sector.

Mr BROADBENT—Finding community care providers is also an issue. You have mentioned the review. Does it take in the changes to the demographic make-up of the aged-care community over 70 years of age—the well-being and relative wealth and health of those who are over 70? You said you were very good at it before.

Mr Stuart—I think we are pretty good at it. The department has been honing its capacity in this area for some time.

Mr ADAMS—What does the Auditor-General say about that?

Mr Stuart—We have had several reports by the Auditor-General over the last few years, including one last year. Overall I think they have been a reasonable endorsement of the department's processes, but there are constant challenges. As you say, the population is changing. Older people are living longer and staying healthier longer. The average age of entry is now 82 or 83. More people want to stay at home for longer if they can, and the key issues that lead to people entering residential aged care now would be dementia and incontinence, which carers find very difficult to deal with. I do want to say that the issue of means is not one that we take into account. I think there is a bit of mythology about how well off older people are now and will be into the future as well.

Mr BROADBENT—In an area like Caloundra or that part of Queensland, where you talked about the movements of people, the over-70-year-olds would be wealthier and healthier in Caloundra than they would be in my electorate of Wonthaggi, where the over-70s would not be as wealthy or healthy. I have no complaints, Mr Stuart. I hope I did not cause that coughing, David, by saying I have no complaints. I believe our area of Gippsland is very well served by the policies of the department and it has given good operators very good consideration. Often there are providers who already have facilities built and who want to gain opportunities. I think we are way off the track here but I am very supportive of the department's approach to try and get some facilities into regional and country areas through their no-interest loans, or whatever they are called.

Mr HAWKE—In relation to the time taken by people constructing these facilities, are you saying that the key reason given that affects the variance in different areas is the local government area's ability to process planning applications and things like that?

Mr Stuart—Planning considerations are often a key source of delay. There are two parts to that story. One part is local complaints or objections that planning authorities have to take account of. Another part is that aged-care providers from time to time want to build in areas which are perhaps not necessarily the most suitable and then have to go through a process with the council. The relationship between aged-care providers and councils is where most of the time is often lost.

Mr HAWKE—Do you examine these things? Are there LGAs that are more receptive to these developments than others?

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Mr Stuart—We have not done any particular analysis of that.

Mr ADAMS—Regarding nursing homes, what size would you be looking for when someone lodges an application or wants to add to—

Mr Stuart—We do not have a figure in mind in the department.

Mr CRAIG THOMSON—The Hogan report talked about 60 being an optimal size economically, I think—

Mr Stuart—The Hogan report also said that there were examples of homes ranging from very small to very large that could be viable. One of the key conclusions of Hogan was that size does matter but it is far from the only thing that matters.

CHAIR—Could we go to another petition that we have had tabled, and that is about the Commonwealth dental scheme and the Dental Health Program. We have a copy of the ministerial response in front of us. Does the department want to add anything to that ministerial response?

Ms GEORGE—A bill to introduce Labor's election commitments about dental health is still being debated, as I understand it, in the Senate. Is that right; is that the case? What is happening to the former scheme? When is the deadline for the former scheme, linked to chronic illness? What is the state of play for that?

Ms Hancock—It is not a bill as such. There was a motion of disallowance in the Senate on 19 June that prevented the minister's determination to close down the chronic disease dental items from taking effect. The effect of that motion is that the chronic disease dental scheme remains open. The government has indicated its intention to close that scheme at the first opportunity during these present sittings.

Ms GEORGE—For people who are still registering and going to a dentist under the chronic disease dental scheme, will their costs of up to $4,000, or whatever it is, be covered? What do local members of parliament tell their constituents?

Ms Hancock—Claims under the chronic disease items continue to be paid, as the scheme remains open. However, the government has indicated its intention to close the scheme as soon as possible.

Mr HAWKE—There is no date for that yet, is there?

Ms Hancock—That is subject to the action taken in the Senate.

Mr HAWKE—The disallowance motion takes effect as soon as the Senate passes it?

Ms Hancock—The disallowance motion is currently in effect. What the Senate would need to do is, in effect, rescind that motion. That would then allow the minister to make the determination which would close the scheme. It is subject to the Senate's action.

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Ms GEORGE—Is it hypothetically possible to have the chronic illness scheme coexisting with the new commitments that Labor has made, if that were the will of the Senate? Is that a feasible option?

Ms Hancock—The minister cannot close the scheme without a determination to do so. The determination is a disallowable instrument. That means that the Senate needs to agree.

Ms GEORGE—Is the minister saying that the new scheme will not be given effect until such time as the previous scheme is terminated?

Ms Hancock—The minister has made various statements concerning what the government's options may be.

Mr CHESTER—You may not have the information in front of you, but has there been a noticeable increase in activity in the existing scheme? Does there appear to be a rush because people believe the scheme is set to discontinue?

Ms Hancock—There is data for the month of July due to be released later today. The data which is presently publicly available goes to the end of June, and that shows an increase over the previous month.

Mr CHESTER—That is available later this afternoon, is it?

Ms Hancock—Yes, I believe so.

CHAIR—Would you like to add something, David?

Mr Learmonth—The committee asked before whether it was the first time that Alimta had been considered for mesothelioma in November last year. It was in fact the fourth; it had been considered on three prior occasions but not recommended on those.

CHAIR—I would like to thank the witnesses for their attendance today and their participation.

Proceedings suspended from 11.16 am to 11.26 am

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